Mental health in general practice: GP perspectives and exploration of a clinical psychology pilot initiative

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Title of degree programme	**Professional Doctorate in Clinical Psychology**
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Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.   Signed: Stephanie Raybould Date: 11.09.19

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Preface

Presentation

Chapter 1 is written broadly in line with the author guidelines for the Journal of Mental Health (see Chapter 1, Appendix 4 for details), however, deviates in some respects to aid readability (e.g. figure is included within the main text). Minor aspects such as this will be amended prior to submission, and the word count will also be amended in accordance with journal guidelines.

Chapter 2 is written broadly in line with the author guidelines for the British Journal of General Practice (see Chapter 2, Appendix 17 for details). It is noteworthy that section headings within the main body have been slightly amended. Due to the analytic method used, presentation of study results inevitably contain interpretation and discussion. To signal this, the traditional results section is titled 'results and discussion' and the traditional discussion section is titled 'further discussion'. The recommended 'how it fits in' section is not included in an effort to limit repetition. These deviations will be amended prior to submission and the word count will also be reduced in line with the journal requirements.

Language

The term 'patient' is used throughout this thesis to refer to individuals who have used general practice services. Use of this term diverges from the Division of Clinical Psychology guidelines (DCP; Division of Clinical Psychology Beyond Functional Psychiatric Diagnosis Committee, 2015) which advise against using this language because of its association with the biomedical perspective and connotations of power imbalance. The DCP therefore recommend using terms such as 'client' or 'service user'. However, the research contained in both the literature review and empirical paper are set in GP practices, where the biomedical model is customary and use of the term 'patient' is commonplace. It was felt that using a different terminology to other researchers/ study participants would be confusing for the reader and therefore a well-considered decision was made to use the term 'patient'.

Thesis abstract

General practice is the typical entry-point for the National Health Service (Mind, 2016), however, current reports indicate that it is facing growing pressures (British Medical Association, 2015), including increased workload and recruitment problems (Baird, Charles, Honeyman, Maguire & Das, 2013).

This thesis focusses on mental health in general practice. While mental health consultations are a large proportion of the general practice workload, GPs have minimal training in this area. Available literature investigates GPs' views on working with patients presenting with particular mental health difficulties, however, there is no broad overview of how GPs feel more generally about this aspect of their work and thus whether this contributes to the current pressures. In an effort to address this, a review of the available qualitative literature regarding GPs' perspectives on working with patients presenting with mental health difficulties was conducted (see Chapter 1). A narrative analysis highlighted common themes which included feelings of uncertainty, perceived professional incompetence and frustration. GPs appear to experience working with patients presenting with mental health difficulties as challenging.

Chapter 2 explores a pilot initiative which entailed a Clinical Psychologist working across two GP practices with the aim of providing care to patients presenting with mental health difficulties. As this approach is novel within the current context, an exploratory grounded theory method was utilised. Through analysing the perspectives of staff, patients and the Clinical Psychologist, a model of the processes involved in introducing the clinical psychology service was constructed. Of particular interest, given the reported pressures in general practice, were categories highlighting feelings of empowerment and shared strain, for both staff and patients. While this research presents promising findings from the pilot initiative, the need for further research is highlighted.

Chapter 3 presents a participant-accessible executive summary of chapter 2.

References

Baird, B., Charles, A., Honeyman, M., Maguire, D. & Das, P. (2013). *Understanding pressures in general practice.* London: The King's Fund.

British Medical Association (2015). *Responsible, safe and sustainable: towards a new future for general practice.* London: BMA.

Division of Clinical Psychology Beyond Functional Psychiatric Diagnosis Committee (2015). *Guidelines on language in relation to functional psychiatric diagnosis.* Leicester: BPS.

Mind (2016). *Mental health in primary care: a briefing for clinical commissioning groups.* London: Mind.

Chapter 1

How do General Practitioners experience working with patients presenting with mental health difficulties?

This chapter is written broadly in line with the author guidelines of the Journal of Mental Health (see Appendix 4 for details).

Word count = 7953

Abstract

Background: GPs provide a high proportion of consultations for patients presenting with mental health difficulties; however, they have little formal training in this area.

Aims: To explore the existing literature concerning GPs' experience of working with patients presenting with mental health difficulties, particularly focussing on GPs' emotional responses.

Method: PsycINFO, Medline, EMBASE, CINAHL, Scopus and EThOS were searched. Key inclusion criteria included: conducted in a UK setting; no earlier than 2004. After screening by title, abstract and full paper, common themes across studies were generated through narrative analysis. Quality was appraised using the Critical Appraisal Skills Programme for qualitative research checklist.

Results: Fifteen articles were included in the analysis. Common themes included feelings of uncertainty and anxiety, perceived professional incompetence and disempowerment, scepticism and dread, hopelessness, frustration, and burden and responsibility. Methodological limitations in both the reviewed literature and current review are highlighted for context.

Conclusions: GPs appear to experience working with patients presenting with mental health difficulties as testing. In light of the current proportion of GP workload that relates to mental health, this is concerning. Support may be provided through improved communication and collaboration with specialist services, as well as enhanced training.

Declaration of interest: None.

Keywords: General practice, health service personnel, mental health, treatment, views.

Introduction

General practice

Within the National Health Service (NHS), care is delivered at various levels, by either specialist or generalist professionals. General Practitioners (GPs) are an example of generalist professionals and are positioned at the level of primary care (NHS Providers, undated), which is typically the entry point for contact with the UK healthcare system (Mind, 2016). For the majority of people, general practice is the most commonly used form of primary care (The King's Fund 2011) and it is described as being the foundation on which the NHS is built (Baird, Charles, Honeyman, Maguire & Das, 2013). A general practice typically employs various clinicians, including Practice Nurses, and Health Visitors (Royal College of General Practitioners; RCGP, 2011), however, consultation with the GP remains central to this level of care (The King's Fund, 2011).

GPs are doctors trained in all aspects of general medicine and their role is to assess, diagnose, treat and manage health concerns (RCGP, 2011). GPs also function as gatekeepers to specialist services (RCGP, 2011) and, therefore, serve a key function to the NHS.

According to the latest figures, there are currently 7613 general practices in England, 958 in Scotland, 454 in Wales and 349 in Northern Ireland (British Medical Association; BMA, 2017a). General practices are typically located within the local community and aim to provide care across the lifespan (BMA, 2017b). The latest data indicates that the average individual in England has six general practice consultations each year; 62% of which are with GPs (Hippisley-Cox & Vinogradova, 2009).

Current pressures

The BMA states that general practice is currently in the midst of a growing crisis (BMA, 2015). Consultation rates increased by 15% between 2010-2011 and 2014-2015 (Baird et al., 2013), and are projected to increase further in the coming decades (BMA, 2017a). Such projections take account of the ageing population and growing numbers of people living with long-term health

conditions (BMA, 2017a). This growing workload is coupled with a workforce that has failed to expand at a comparable rate due to difficulty recruiting and retaining GPs (Baird et al., 2013). Such issues directly impact upon patients; resulting in longer waiting times and shorter consultations (BMA, 2015). Nine out of 10 GPs report that their current workload has negatively impacted on the quality of care they are able to provide (BMA, 2015).

Mental health in general practice

The majority of mental health-related difficulties are managed in primary care, whereby individuals have minimal contact with specialist mental health services (Care Quality Commission; CQC, 2015). On average, one in four patients of every full-time UK GP requires treatment for a mental health difficulty (CQC, 2015), and approximately one in three GP consultations includes a mental health component (Mind, 2016a). The CQC report that in 2013-2014 approximately 3 million adults were on GP registers for depression and 500,000 for serious mental health problems (CQC, 2015). Furthermore, the trend of accessing GP consultations for mental health has steadily increased. Within the 2014 Adult Psychiatric Morbidity Survey, the number of respondents that reported discussing their mental health with a GP rose from 38.2% in the year 2000 to 46.4% (McManus, Bebbington, Jenkins & Brugha, 2014).

While mental health is viewed as the core business of general practice by some (e.g. Mind, 2016b), only one out of 21 GP training modules are dedicated to this (RCGP, 2015). Furthermore, in spite of advancement in the recognition and understanding of mental health in recent years, GP training has not been updated for 30 years (England, Nash & Hawthorne, 2017). In addition to this, a GP Speciality Trainee's option to complete a clinical placement in a mental health service is limited to those provided in hospitals or secondary care, as opposed to community-based settings. Moreover, between 2013 and 2015, less than half of GP Speciality Trainees in England and Wales elected to undertake a clinical placement in mental health (Mind, 2016b). Therefore, the majority of GP Speciality Trainees that join the workforce have limited

academic training in mental health and no recent practical experience of working with emotional distress.

Policy context

In 2004 a new General Medical Services (GMS) contract was introduced that fundamentally changed the funding of general practice (Gowin, Pawlikowska, Horst-Sikorska & Michalak, 2011). The contract launched the UK-wide Quality Outcomes Framework (QOF) which represented the first attempt by any healthcare system to systemically reward practices financially for the quality of their care (GMS, undated). Quality indicators were implemented with respect to ten clinical conditions; one of which was mental health.

Since its original implementation, the QOF has been updated annually and the latest version for England (2017/2018) includes quality indicators for 14 clinical conditions; two of which relate to mental health. The first of these is depression and the second is the broad category of mental health, with specific reference to schizophrenia, bipolar affective disorder and other psychoses (NHS England, undated). Variations of the QOF remain in place in Wales (NHS Wales, 2017) and Northern Ireland (Department of Health, Northern Ireland, undated), however, the QOF was replaced by a global sum method of funding in Scotland in 2016 (BMA, 2018).

Inclusion of mental health-related conditions within the framework by which general practices secure funding supports the argument positioning mental health as core business of general practice. While GPs provided consultations regarding mental health prior to the introduction of the QOF (e.g. McManus et al., 2016), financial incentivising of the identification and review of various mental health conditions seems likely to have increased the focus placed on such work. This appears at odds with the aforementioned lack of mental health training provided to GPs. Furthermore, GPs have raised concerns that specialist mental health services have raised their eligibility criteria; resulting in patients being managed in primary care without specialist support (Baird et al., 2013).

The BMA have made a number of recommendations for alleviating the current difficulties in general practice (BMA, 2015). These include enhancing support for GPs through greater collaboration with community and secondary care, as well as augmenting the team of healthcare professionals within and around general practices (BMA, 2015). The Five Year Forward View for Mental Health also highlights the need for integration of mental and physical healthcare and the integration of psychological therapies into primary care as a priority (Mental Health Taskforce to NHS England, 2016). Such proposals align with the ongoing governmental aim to achieve parity of esteem between mental and physical healthcare (Department of Health, 2011).

Within the past decade there have been various national strategies for addressing the gap in primary care mental health provision, such as Improving Access to Psychological Therapies (IAPT) in England. However, services of this nature are overwhelmed with demand and therefore general practices continue to play a fundamental role in caring for individuals with mental health difficulties (Mind, 2016b).

Rationale of the review

Given the current proportion of mental health-related consultations provided by GPs, coupled with their lack of training in this area, and the current pressures in staffing, it appears pertinent to investigate GPs' views on working with individuals presenting with mental health difficulties. While the available literature examines GPs' views on working with patients presenting with distinct mental health difficulties, a broad overview of how GPs feel more generally about this aspect of their work is lacking.

The following review aims to synthesise the available research concerning the perspectives of GPs with regard to providing consultations relating to mental health, with a particular focus on the emotional responses associated with such consultations. The review is intended to provide a broad perspective and allow for the identification of any issues, particularly those that may contribute to the current challenges in general practice, and ultimately inform recommendations for clinical practice.

Research question

How do GPs experience working with patients presenting with mental health difficulties?

Method

Search strategy

The literature review was conducted systematically and surveyed a wide range of literature within the fields of psychology, medicine, nursing and allied health. Using the EBSCOhost and Healthcare Databases Advanced Search portals, the following databases were searched: PsycINFO, CINAHL, Medline, EMBASE and Scopus. The British Library EThOS; an online repository for unpublished doctoral theses, was also searched.

All searches were conducted on 27.05.18. Search strategies were marginally adjusted for each database in order to maximise the available features, such as limiters and thesauruses.

Five of the six database searches contained search terms relating to at least four of the following concepts: GPs, mental health difficulties, the provision of support and personal views. The search conducted on the EThOS database was limited to the three concepts of GPs, mental health difficulties and the provision of support as no results were returned at this stage.

Search terms used by concept:

- *GPs*: gp* OR "general practitioner*" OR "general practice*" OR "family doctor*" OR "primary care physician*".

- *Mental health difficulties*: "mental illness" OR "mental health" OR "mental disorder" OR psychiatric OR psychological OR psychosocial.

- *The provision of support*: treat OR treatment* OR treating OR consultation OR support OR intervention*.

- *Personal views*: perspective* OR view* OR opinion* OR viewpoint* OR attitude* OR belie* OR thought* OR feel OR feeling* OR perception* or perceive.

Search terms were combined using the Boolean operator 'AND'. For each concept, thesaurus terms were also used, where available.

For databases that did not offer the ability to limit search results by country, the following search term relating to the concept of the United Kingdom was also used: NHS OR "national health service" OR UK OR "United Kingdom" OR "Great Britain" OR Wales OR Scotland OR England OR "Northern Ireland".

Further details of individual database search strategies are provided in Appendix 1.

The search returned 1878 results, which were imported into the reference management software, RefWorks. After duplicates were removed, the papers were screened by title, followed by abstract, and finally, through reading the full paper.

Screening criteria

The following inclusion criteria were applied:

- Published in the English language. The author is unable to read other languages and translation resources were unavailable.

- Study conducted in the UK. The NHS is unique to the UK and therefore GP views in non-UK countries may be non-comparable.

- Published no earlier than 2004: the year that the QOF was introduced. Due to the impact on organisational priorities and functioning, GP views prior to the introduction of the QOF may differ from those post-QOF.

- Includes the perspective of GPs.

- Focus of the study is working with patients presenting with mental health difficulties.

The following exclusion criteria were applied:

- Views of GPs and other participants cannot be separated for analysis.

- Clear indication that data collection took place prior to 2004 (despite being published in 2004 or later).

- Study focusses on a change to practice as normal, for example, a randomised controlled trial or other intervention.

- Focus of the study is a physical health, neurological or cognitive condition.

- Focus of the study is medically unexplained symptoms, chronic fatigue syndrome or myalgic encephalomyelitis. Such presentations do not necessarily equate to mental health difficulties and may be experienced differently by GPs.   presentations

- Focus of the study is substance abuse or smoking. While such presentations can occur alongside mental health difficulties, the current review attempts to focus solely on mental health.

- Focus of the study is co-occurring physical and mental health conditions.

- The paper is a review or editorial.

Search results

Application of the above criteria resulted in 14 articles. Four further articles were not accessible to the author and therefore, after screening by title and abstract, could not be screened by full paper. An additional article was included due to being referenced as a companion to one of the included papers and containing the majority of the methodological description. Therefore, the total number of papers reviewed was 15.

The search process, including the number of studies screened at each stage, is depicted in Figure 1.
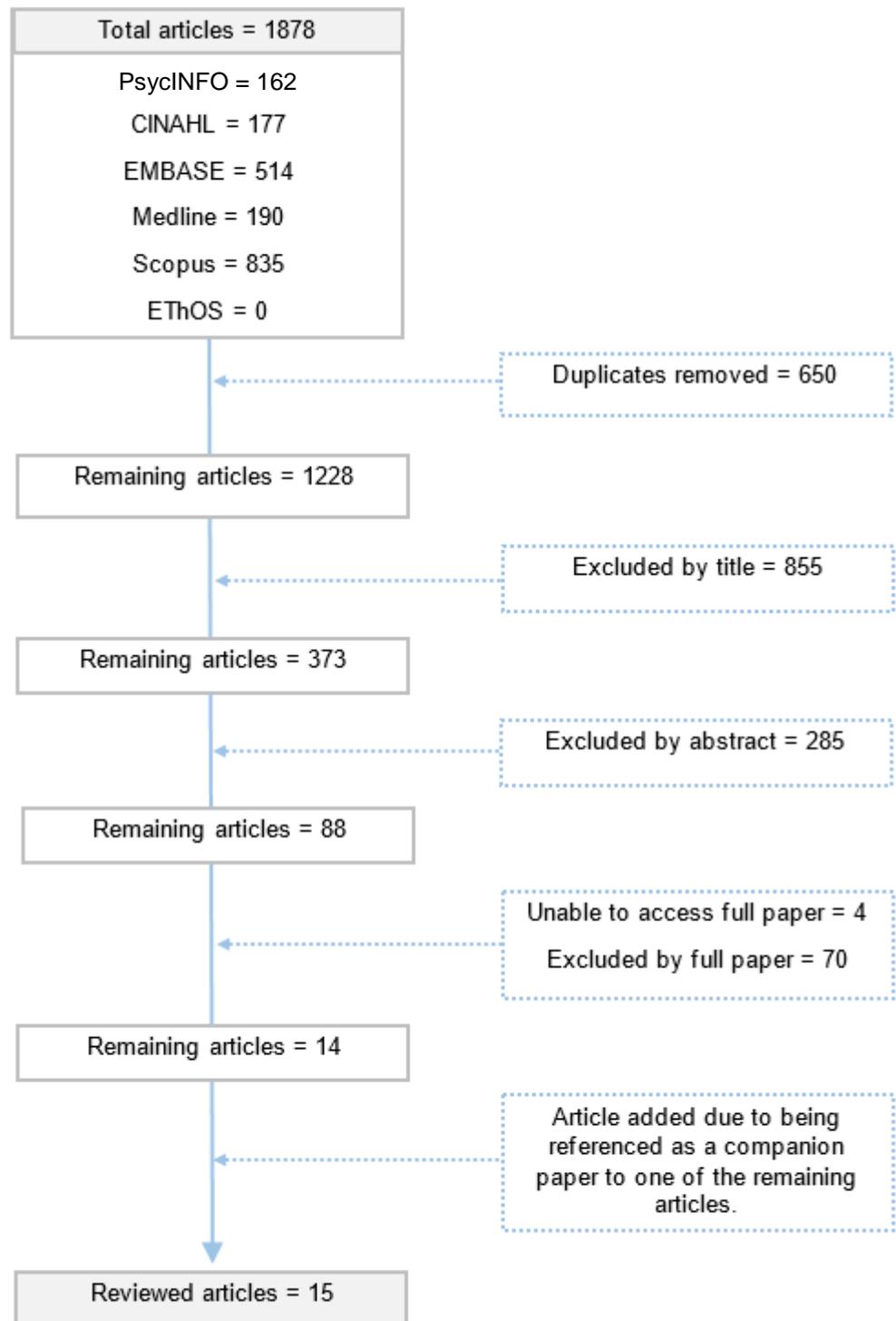
Figure 1. Article screening process

Analysis

A narrative review of the identified articles was undertaken, informed by the guidelines of Green, Johnson and Adams (2006). This approach was selected to allow for a structured approach to addressing the somewhat broad research question. Following thorough readings of each article, notes were made regarding various aspects, such as the design, findings and limitations. Notes regarding the findings of each article were integrated across articles and organised into common themes.

A critical appraisal tool was also used to assess the quality of the reviewed articles. As all of the articles were qualitative, the Critical Appraisal Skills Programme qualitative research checklist (CASP, 2018) was utilised. The checklist appraises whether the research meets 10 indicators of quality and thus allows for a contextual interpretation of the findings.

Results

An overview of the aims of each reviewed article is provided below, followed by discussion of participants and settings, methods of data collection and analysis and, finally, the main findings across the studies. Further detail on each study is available in Appendix 2.

Overview of studies

- Hunt and Churchill (2013) aimed to explore GPs' understanding and experiences of managing presentations of anorexia.

- Leavey, Mallon, Rondon-Sulbaran, Galway and Rosato (2017) investigated failure to prevent suicide in primary care by surveying the views of relatives and GPs.

- McPherson and Armstrong (2009) explored GPs' experience and management of patients diagnosed with depression, for whom anti-depressant medication appeared ineffective.

- Michail and Tait (2016) explored GPs' experiences of assessing and managing young people expressing suicidal ideation.

- O'Brien, Harvey, Young, Reardon and Creswell (2017) investigated the experiences of GPs regarding the identification, management and access to specialist services for children with anxiety disorders.

- Riley et al., (2018) surveyed the views of GPs with regard to current wellbeing, sources of stress and stress management. This article was included due to referencing psychosocial components of GP workload, for example, patients presenting with low mood.

- One study examined GPs' perspectives and experiences of consulting with young people presenting with emotional distress. Findings from different levels of the analysis were presented across three companion papers (Roberts, Crosland & Fulton, 2013; Roberts, Crosland & Fulton, 2014a; Roberts, Crosland & Fulton, 2014b).

- Saini, Chantler and Kapur (2016) explored GPs' views regarding patient communication and treatment prior to suicide and relationships with specialist services.

- Shaw (2004) investigated GPs' perceptions of individuals who are subject to frequent short-term admissions to psychiatric hospital.

- Sigel and Leiper (2004) surveyed GPs' views on psychological problems, psychological therapies and referral decisions.

- Strachan, Yellowlees and Quigley (2015) investigated GPs' perspectives on their assessment and treatment of common mental health difficulties in older adults and contact with specialist services.

- Tavabie and Tavabie (2009) investigated the effects of using a mental health questionnaire on GPs' views concerning the management of individuals with depression.

- Whitehead and Dowrick (2004) examined discrepancies between GPs' actual and preferred management decisions during consultations for mild to moderate mental health difficulties.

Participants and settings

The number of participants recruited to each study ranged from nine (Strachan et al., 2015; Whitehead & Dowrick, 2004) to 47 (Riley et al., 2018). The average number of participants was 20.

Articles for two of the 13 separate studies did not provide information regarding the gender ratio (McPherson & Armstrong, 2005; Whitehead & Dowrick, 2004). The 11 remaining studies included both male and female participants. Gender was matched relatively evenly in five of these studies; with between 56% and 42% male participants (Hunt & Churchill, 2013; Leavey et al., 2017; O'Brien et al., 2017; Riley et al., 2018; Tavabie & Tavabie, 2009). Three studies had at least 65% male participants (Saini et al., 2016; Sigel & Leiper, 2004; Shaw, 2004), and two studies had at least 65% female participants (Riley et al., 2018; Strachan et al., 2015). Gender information is missing for four out of 28 participants in Michail and Tait (2016), however, the number of male participants was between 32% and 46%.

Nine studies were confirmed as being conducted with GPs currently working in England. Some studies were conducted across various areas of England (O'Brien et al., 2017; Riley et al., 2018) and others were restricted to The Midlands (Hunt & Churchill, 2013; Michail & Tait, 2016; Shaw, 2004), Northern England (Roberts et al., 2013; Whitehead & Dowrick, 2004) and London (McPherson & Armstrong, 2009; Tavabie & Tavabie, 2009). One study did not state the location in which it was conducted (Sigel & Leiper, 2004). Saini et al. (2016) state that participants were linked to patients previously under the care of mental health services in North West England, but do not state the location in which the recruited GPs were currently working. One study recruited GPs in the Scottish Borders (Strachan et al., 2015), and another recruited GPs in Northern Ireland (Leavey et al., 2017).

With the exception of Riley et al. (2018), all participants were currently practising GPs. Three studies provided details regarding the current role of GP participants. O'Brien et al. (2017) included partners, principal and salaried GPs and Roberts et al. (2013; 2014a; 2014b) included partners and salaried GPs. Riley et al. (2018) recruited partners, salaried, locum and registrar GPs, as well as GPs that were currently on sick leave or retired. Nine studies provided details of participants' years in practice and these varied considerably, for example, less than two years to 47 years (Michail & Tait, 2016), and eight to 37 years (Saini et al., 2016). One study commented on the ethnicity of participants and included equal numbers of white British and non-white British GPs (McPherson & Armstrong, 2009).

A number of studies explicitly stated that participants practiced in a mix of urban, and rural communities (Leavey et al., 2017; O'Brien et al., 2017; Roberts et al., 2013, 2014a, 2014b; Shaw, 2004). Studies included GPs who worked across a range of deprived and affluent communities (Roberts et al., 2013; 2014a; 2014b), socioeconomic statuses (Leavey et al., 2017), and areas of higher and lower mental health need (McPherson & Armstrong, 2009). A number of studies included GPs that worked across a range of practice sizes (Michail & Tait, 2016; Riley et al., 2018; O'Brien et al., 2017; Shaw, 2004; Sigel & Leiper, 2004).

Data collection and analysis

All studies used a qualitative design and gathered data through interviews. Whitehead and Dowrick (2004) also collected quantitative data using questionnaires, however, these were not relevant to the current review and will not be discussed further. With the exception of two studies, all interviews are described as semi-structured. Shaw (2004) omits details of the nature of the interviews, while Hunt and Churchill (2013) used interviews that were unstructured, aside from opening with pre-prepared case scenarios.

The majority of studies collected data at one time point through the use of individual interviews (Riley et al., 2018; Saini et al., 2016; McPherson & Armstrong, 2009; Roberts et al., 2013, 2014a, 2014b; Sigel & Leiper, 2004; O'Brien et al., 2017; Whitehead & Dowrick, 2004; Shaw, 2004; Leavey et al.,

2017) or group interviews (Michail & Tait, 2016, Strachan et al., 2015, Hunt & Churchill, 2013). The exception to this was the study by Tavabie and Tavabie (2009) which used individual interviews followed by focus groups on two occasions, six months apart. Responses were compared to ascertain the qualitative impact of the introduction of a mental health questionnaire.

Most interviews were conducted face-to-face, however, within two studies interviews were conducted on the telephone; either exclusively (O'Brien et al., 2017), or alternately with face-to-face interviews (Riley et al., 2018).

A variety of analysis methods were used. These included thematic analysis (Riley et al., 2018; Saini et al., 2016; McPherson & Armstrong, 2009; O'Brien et al., 2017; Strachan et al., 2015; Whitehead & Dowrick., 2004; Leavey et al., 2017), grounded theory (Sigel & Leiper, 2004; Tavabie & Tavabie, 2009) and grounded theory plus situational analysis (Roberts et al., 2013, 2014a, 2014b). Other studies utilised cognitive mapping (Shaw, 2004), corpus linguistic conventions plus discourse analysis (Hunt & Churchill, 2013), and framework analysis (Michail & Tait, 2016).

The studies explored GPs' views and experiences of mental health consultations relating to a variety of presentations and demographics. These included children presenting with anxiety disorders (O'Brien et al., 2017) adolescents presenting with psychological difficulties (Roberts et al., 2013, 2014a, 2014b) and young people requiring suicide risk assessment and management (Michail & Tait, 2016). Other studies focussed on patients presenting with mild to moderate mental health difficulties (Whitehead & Dowrick, 2004), psychological problems (Sigel & Leiper, 2004), anorexia nervosa (Hunt & Churchill, 2013), depression (Tavabie & Tavabie, 2009) and depression for which anti-depressants appear ineffective (McPherson & Armstrong, 2009). Shaw (2004) focussed on individuals who had been subject to multiple short-term admissions to psychiatric hospital and were described by GPs as loosely fitting diagnoses of anxiety, depression, personality disorder, bipolar disorder or psychosis. Two studies focussed on GPs who had seen individuals who died through suicide (Saini et al., 2016; Leavey et al., 2017), and one study concentrated on older adults presenting with common

mental health difficulties (Strachan et al., 2015). Conversely, Riley et al. (2018) did not discuss a distinct mental health diagnosis and instead discussed the general sources of stress and distress for GPs which referenced psychosocial aspects of GP workload, for example, patients presenting with low mood.

Main findings

Across the reviewed studies, common findings were identified and collated into six central themes entitled: uncertainty and anxiety, perceived professional incompetence and disempowerment, scepticism and dread, hopelessness, frustration, and burden and responsibility. Each theme is presented and discussed below. Frustration was a particularly strong theme and is presented along with a number of sub-themes.

Uncertainty and anxiety

Within a number of studies, GPs reported a general sense of uncertainty and anxiety associated with mental health consultations. This occurred particularly in relation to consultations with children and adolescents, during which GPs reported uncertainty regarding identifying anxiety disorders in children (O'Brien et al., 2017) and emotional distress in young people (Roberts et al., 2013; 2014a; 2014b). GPs viewed adolescents as particularly unpredictable (Michail & Tait, 2016). The perceived volatility of adolescents led to feelings of uncertainty as to the course of the consultation, as well as activating memories of previous experiences of young people dying through suicide (Roberts et al., 2013; 2014a; 2014b). GPs also discussed suicide in adults as unpredictable (Saini et al., 2016).

GPs described the uncertainty in the identification of suicide risk and children's anxiety difficulties as being compounded by patients often presenting with physical rather than mental health problems (Leavey et al., 2017; O'Brien et al., 2017). Within this context, GPs in Sigel and Leiper's (2004) study expressed wariness in raising the subject of mental health with patients. Participants in Hunt and Churchill's (2013) study also described caution regarding the potentially detrimental impact of their verbal communications to

the patient. GPs also described concern about making incorrect decisions (O'Brien et al., 2017; Riley et al., 2018).

A further source of uncertainty was the reported a lack of clarity regarding the level to which GPs may reasonably be expected to manage patients presenting with mental health difficulties (Roberts et al., 2013, 2014a, 2014b).

Perceived professional incompetence and disempowerment

With the exception of one study (Strachan et al., 2015), GPs generally lacked confidence when working with patients presenting with mental health difficulties. GPs reported a lack of training in mental health and/or suicide prevention (Leavey et al., 2017; O'Brien et al., 2017; Roberts et al., 2013; 2014a, 2014b), and a perceived lack of communication skills. For example, GPs described feeling uneasy talking to parents about an anxiety diagnosis for their child (O'Brien et al., 2017) and experienced communication difficulties within triadic consultations, especially for a young person who is attending an appointment against their will (Roberts et al., 2013; 2014a; 2014b). A number of GPs described communication with young people as difficult, particularly when discussing suicidal ideation (Michail & Tait, 2016). GPs described difficulty establishing rapport, choosing the appropriate words and tone, and making sense of the young person's description of their experiences (Roberts et al., 2013; 2014a; 2014b). Deficits in communication skills were also raised in relation to consulting with patients with a diagnosis of anorexia, which occasionally resulted in using biological measurements to legitimise clinical recommendations (Hunt & Churchill, 2013).

However, some GPs reported confidence, for example, working with general mental health difficulties (Michail & Tait, 2016) and children presenting with anxiety-related difficulties (O'Brien et al., 2017). Within a study focussed on working with older adults presenting with common mental health difficulties, no participants expressed apprehension and a sub-group expressed confidence. Within this study GPs viewed themselves as uniquely able to benefit patients due to the long-term nature of their relationship (Strachan et al., 2015).

Scepticism and dread

Within a number of studies, GPs reported negative views of patients with whom they consulted. Some described patients as manipulative (Hunt & Churchill, 2013; McPherson & Armstrong, 2009; Shaw, 2004) and having unpleasant characteristics (McPherson & Armstrong, 2009), such as being demanding and disruptive (Shaw, 2004). GPs described patients presenting with diagnosable depression, for whom anti-depressants appear ineffective, as manipulating the system, for example to obtain benefits (McPherson & Armstrong, 2009), and some viewed self-harming behaviour as an attempt to seek attention (Shaw, 2004; Saini et al., 2016). GPs communicated views indicating a loss of empathy towards patients and this was attributed to discourses that patients did not take personal responsibility for their wellbeing (McPherson & Armstrong, 2009).

Some GPs reported attempts to avoid patients presenting with mental health difficulties. These included using strategies to reduce contact (McPherson & Armstrong, 2009) and to dissuade patients from consulting, for example by deliberately increasing waiting times and being unfamiliar during interactions (Shaw, 2004). GPs also described closing down consultations prematurely (Roberts et al., 2013; 2014a; 2014b), and rushing consultations in the hope that a mental health issue is not voiced (Tavabie & Tavabie, 2009). Other GPs communicated desires to have patients removed from their lists (Shaw, 2004).

Hopelessness

Some GPs reported feeling hopeless with regard to their ability to help patients presenting with mental health difficulties (McPherson & Armstrong, 2009; Sigel & Leiper, 2004; Michail & Tait, 2016). A sense of 'heart sink' was communicated with regard to working with both patients for whom medication appeared ineffective (McPherson & Armstrong, 2009), and adolescents at risk of suicide (Michail & Tait, 2016). Some GPs questioned whether patients that were seen as untreatable should continue to receive healthcare input (Sigel & Leiper, 2004).

Frustration

Secondary care:

A major source of GPs' frustration was the perceived inadequate input from secondary care mental health services, with GPs describing this leaving them feeling helpless and stuck (O'Brien et al., 2017). GPs described feeling professionally isolated and disconnected from secondary care services (O'Brien et al., 2017; Leavey et al., 2017; Saini et al., 2016). Some reported a desire to learn from secondary services and for them to appreciate the pressures of general practice (Leavey et al., 2017).

GPs felt that limited contact with secondary care compromised their ability to work with mental health difficulties (Roberts et al., 2013; 2014a; 2014b). The perceived slowness and rejection rate of referrals to specialist services was highlighted as being particularly frustrating (O'Brien et al., 2017; Roberts et al., 2013, 2014a, 2014b), alongside long waiting times for intervention (Sigel & Leiper, 2004).

GPs also described secondary care services as undermining and devaluing their judgement of mental health difficulties (Leavey et al., 2017; Michail & Tait, 2016; Whitehead & Dowrick, 2004). For example, some GPs described the rejection of referrals as *"a slap in the face"* (O'Brien at al., 2017).

GPs expressed frustration and upset when they perceived that secondary care services let them or their patients down (Tavabie & Tavabie, 2009; Leavey et al., 2017). They described feeling excluded from decisions made by secondary care and being placed in the difficult position of explaining the lack of resources and long waiting lists to patients (Saini et al., 2016). Some GPs stated that lack of access to other interventions and feelings of powerlessness resulted in offering medication (Saini et al., 2016).

General confusion associated with the lack of understanding of available treatments (O'Brien et al., 2017), and lack of clarity regarding the structure of mental health services and referral criteria (Saini et al., 2016; O'Brien et al., 2017; Roberts et al., 2013, 2014a, 2014b) were also described as frustrating. Furthermore, GPs expressed frustration at the perceived high thresholds of

referral criteria (O'Brien et al., 2017) and felt that this functioned to ration services (Saini et al., 2016) and offload onto general practice (Leavey et al., 2017).

However, some GPs described good relationships with secondary care services (Leavey et al., 2017; Saini et al., 2016; Strachan et al., 2015) and, where better relationships with CAMHS, for example, were reported, GPs voiced less anxiety (Roberts et al., 2013, 2014a, 2014b).

Patient-related factors:

GPs also expressed frustration associated with factors relating to patients themselves. This occurred in relation to lack of adherence to treatment and attendance at follow-up appointments (Saini et al., 2016; Shaw, 2004; Leavey et al., 2017), as well as lack of engagement with attempts to provide care (Hunt & Churchill, 2013). Frustration also occurred in response to the perceived ineffectiveness of their attempts to support the person (Tavabie & Tavabie, 2009; McPherson & Armstrong, 2009).

Incompatibility with general practice:

GPs described feeling frustrated by the mismatch between facilitating mental health consultations and the operating structures within general practice. Across numerous studies, GPs described lacking the time to provide mental health consultations (Sigel & Leiper, 2004; Leavey et al., 2017; Michail & Tait, 2016; O'Brien et al., 2017; Strachan et al., 2015; Whitehead & Dowrick, 2004). Some GPs related this to patients often requiring additional time to disclose their true difficulties (Leavey et al., 2017). Forming an accurate picture of suicide risk within a ten minute consultation was described as impossible (Michail & Tait, 2016). Difficulty ending consultations (McPherson & Armstrong, 2009) and going beyond the allotted ten minute slot, despite the knock-on impact on the remainder of their appointments (Leavey et al., 2017) were also reported. Some described enjoying providing a level of counselling to their patients, however, were frustrated that, due to lack of time, this role is usurped by another professional (Leavey et al., 2017).

GPs also reported experiencing challenges with the requirement to provide regular reviews (O'Brien et al., 2017), prompt access to appointments and continuity of care (Roberts et al., 2013; 2014a; 2014b) for patients presenting with mental health difficulties. Some GPs highlighted the lack of access to supervision in general practice, in comparison to other professionals that work with emotional distress (Roberts et al., 2013; 2014a; 2014b). Some GPs stated that such systems-related issues cause them to reach for medication earlier than they would like (Whitehead & Dowrick, 2004).

GPs experienced the expectation to use standardised mental health screening tools as a barrier to therapeutic engagement (Leavey et al., 2017), and felt that they were useless (Strachan et al., 2015) and closed down communication (Sigel & Leiper, 2004). Some GPs felt that they possessed the skills to obtain the information in a more sensitive manner (Leavey et al., 2017), and saw such tools as undermining their abilities (Leavey et al., 2017; Michail & Tait, 2016). However, some GPs were more positive about screening tools (Strachan et al., 2015; Tavabie & Tavabie, 2009).

The role that some GPs felt responsible for taking in their work relating to mental health also appeared to differ from the typical medical role. Some GPs viewed their role as a sounding board and described supporting patients by intervening with benefits applications and social housing. Some GPs saw this as a denigrated role and revealed the provision of such input reluctantly (McPherson & Armstrong, 2009).

Burden and responsibility

Consultations for emotional issues were described as requiring emotional investment on behalf of the professional (Riley et al., 2016; Tavabie & Tavabie, 2009), and this investment was seen as a particular source of stress and distress for GPs (Riley et al., 2016). GPs described experiencing working with mild to moderate mental health difficulties as emotionally difficult, tiring and stressful (Whitehead & Dowrick, 2004).

GPs also reported feeling burdened by the responsibility that they felt for patients (Tavabie & Tavabie, 2009), particularly when it is perceived that

patients have been *"passed from pillar to post"* (O'Brien et al., 2017). A sense of feeling mentally and practically burdened by some patients was also described (McPherson & Armstrong, 2009).

Quality analysis

In order for the findings to be considered in context, the quality of both the reviewed literature and current review are discussed below.

Reviewed literature

During critical appraisal of the reviewed literature, it was judged that all studies stated clear aims for which the application of qualitative methods appeared appropriate and entailed methodologically sound features. However, numerous shortcomings were also highlighted.

The papers included a general lack of detail regarding recruitment. Some papers lacked information on methods of participant identification (Roberts et al., 2013; 2014a; 2014b; Strachan et al., 2015), while others failed to clarify the participation uptake rate (Leavey et al., 2017; O'Brien et al., 2017; Riley et al., 2018; Strachan et al., 2015) or omitted reasons why approached individuals declined to partake (Hunt & Churchill, 2013; Leavey et al., 2017; Michail and Tait, 2016; O'Brien et al., 2017; Shaw, 2004; Sigel & Leiper, 2004; Strachan et al., 2015; Tavabie & Tavabie, 2009; Whitehead & Dowrick, 2004). Other papers lacked detail regarding their overall recruitment strategy (McPherson & Armstrong, 2009; Shaw, 2004; Tavabie & Tavabie, 2009; Whitehead & Dowrick, 2004).

The studies also tended to lack detail concerning data collection methods. This was particularly the case with regard to development of the interview topic guide (Leavey et al., 2017; McPherson & Armstrong, 2009; Shaw, 2004; Sigel & Leiper, 2004; Strachan et al., 2015; Tavabie & Tavabie, 2009; Whitehead & Dowrick, 2004). While the majority of studies used an iterative approach, Saini et al., (2016) analysed data following completion of all interviews, which would have prevented emerging concepts from being tested out. Some authors made no reference to data saturation (Leavey et al., 2017; Saini et al., 2016; Sigel & Leiper, 2004; Strachan et al., 2015; Whitehead & Dowrick, 2004). Hunt

and Churchill (2013) acknowledged that they were unable to claim saturation as data collection was curbed by recruitment. Additionally, two of the grounded theory studies made no reference to using memos which are key elements of this approach (Sigel and Leiper, 2004; Tavabie & Tavabie, 2009). Two studies utilised telephone interviews (O'Brien et al., 2017; Riley et al., 2018). O'Brien et al. (2017) acknowledged the impact that this may have had on the detection of non-verbal communication, however, justified the decision by highlighting practical issues.

Significantly, numerous studies failed to discuss the impact of the interviewer on data collection (Hunt & Churchill, 2013; Leavey et al., 2017; McPherson & Armstrong, 2009; Michail & Tait, 2016; O'Brien et al., 2017; Saini et al., 2016; Shaw, 2004; Whitehead & Dowrick, 2004). Hunt and Churchill (2013), however, stated that they reduced the influence of the interviewer by using focus groups, which began with a vignette and were unstructured thereafter.

Only one study clearly stated the theoretical position of the researchers (McPherson & Armstrong, 2009), and the majority of papers omitted or inadequately discussed researchers' professional roles or background (Hunt & Churchill, 2013; Leavey et al., 2017; McPherson & Armstrong, 2009; Michail & Tait, 2009; O'Brien et al., 2017; Roberts et al., 2013, 2014a, 2014b; Saini et al., 2016; Shaw, 2004; Sigel & Leiper, 2004; Whitehead & Dowrick, 2004). However, both Tavabie and Tavabie (2009) and Sigel and Leiper (2004) acknowledged the potential impact of the lead researchers' positions as a GP and a Psychologist, respectively.

Three studies discussed the nature of the pre-existing relationship between the researchers and participants. While Michail & Tait (2016) stated that there was no prior relationship, existing professional relationships were noted in two studies, which may have influenced the views expressed by GPs. Efforts were made to mitigate this through providing the opportunity to submit anonymous follow-up comments (Strachan et al., 2015) and following-up individual interviews with focus-groups (Tavabie & Tavabie, 2009).

Ethical concerns were also raised. In part, these related to a lack of detail, for example, relating to how the research was explained to prospective

participants (Hunt & Churchill, 2013; Leavey et al., 2017; McPherson & Armstrong, 2009; Michail & Tait, 2016; O'Brien et al., 2017; Shaw, 2004; Sigel & Leiper, 2004) and consent procedures (Leavey et al., 2017; McPherson & Armstrong, 2009; O'Brien et al., 2017; Shaw, 2004; Sigel & Leiper, 2004; Tavabie & Tavabie, 2009; Whitehead & Dowrick, 2004). It is particularly of note that within the Tavabie and Tavabie (2009) study it is stated that participation was voluntary and contributions were anonymous. However, this is likely to have been compromised by the lead researcher being a GP in one of the participating practices. A further ethical concern entailed O'Brien et al. (2017) continuing to interview two participants once saturation was achieved. Moreover, no studies mentioned how they handled the effects of the study on participants. Despite these shortcomings, it should be noted that, with a single exception (Whitehead & Dowrick, 2004), all papers included details of formal ethical approval.

Numerous studies also omitted discussion of the impact of the interviewer on the analysis (Leavey et al., 2017; McPherson & Armstrong, 2009; Michail & Tait, 2016; O'Brien et al., 2017; Roberts et al., 2013, 2014a, 2014b; Saini et al., 2016; Shaw, 2004; Sigel & Leiper, 2004; Strachan et al., 2015; Whitehead & Dowrick, 2004). One study omitted the presentation of extracts to support the analysis (Sigel & Leiper, 2004), while many others lacked detail regarding how the extracts were selected from the original sample (Hunt & Churchill, 2013; Leavey et al., 2017; McPherson & Armstrong, 2009; Michail & Tait, 2016; Riley et al., 2018; Roberts et al., 2013, 2014a, 2014b; Strachan et al., 2015; Tavabie & Tavabie, 2009; Whitehead & Dowrick, 2004). Some papers also omitted the inclusion of contrasting data (Hunt & Churchill, 2013; McPherson & Armstrong, 2009; Shaw, 2004).

Some studies provided inadequate detail regarding the analysis procedures (McPherson & Armstrong, 2009; Michail & Tait, 2016; Whitehead & Dowrick, 2004). Furthermore, the majority of studies failed to examine the validity of their results, for example by using respondent validation or triangulation (Hunt & Churchill, 2013; Leavey et al., 2017; McPherson & Armstrong, 2009; Michail & Tait, 2016; O'Brien et al., 2017; Roberts et al., 2013, 2014a, 2014b; Saini et al., 2016; Shaw, 2004; Sigel & Leiper, 2004; Whitehead & Dowrick, 2004).

Riley et al. (2018) also failed to obtain respondent validation but did acknowledge this as a limitation which they moderated by including academic GPs and individuals with lived experience of mental health difficulties within the research team. Tavabie and Tavabie (2009) obtained respondent validation regarding interview transcription only, however, triangulated their findings by following up individual interviews with focus groups.

The majority of studies also omitted discussion regarding the generalisability of their findings (Hunt & Churchill, 2013; Leavey et al., 2017; McPherson & Armstrong, 2009; O'Brien et al., 2017; Whitehead & Dowrick, 2004). Roberts et al. (2013; 2014a; 2014b) state that generalisability was not the aim of their research, however, acknowledge that this remains untested, while Sigel and Leiper (2004) highlight that their study contains the views of a small group of GPs within a single locality. Similarly Strachan et al. (2015) emphasise that the setting of their study, which was rural with a high average population age and a trend of longstanding GP relationships, may impact on the generalisability of the findings. Tavabie and Tavabie (2009) also acknowledged the lack of ability to generalise their findings, and Shaw (2004) stated that the recruited participants could not be considered representative of the wider population of GPs.

A visual depiction of the appraisal of each study using the CASP is available in Appendix 3.

Current review

The limitations of the current review also require consideration. While in some respects it is a strength, it is noteworthy that the reported studies investigated GPs' views of working with a range of mental health presentations and demographics. This makes drawing direct comparisons between findings across the studies inappropriate. The wide breadth of the review may also have contributed to a lack of depth in the analysis. Nevertheless, the variety of mental health presentations encompassed within the review may more accurately reflect the clinical experience of GPs.

It is also notable that the overwhelming majority of studies reviewed were conducted in England, with single studies being conducted in both Scotland and Northern Ireland and none in Wales. While the NHS structures are broadly comparable across these UK countries, there are also differences and thus the findings may not generalise well to countries outside of England.

Some studies were published in 2004 but did not make reference to the date of data collection. Therefore data may have been collected before 2004, when the QOF system was not in place and thus the operating systems within general practice may have differed significantly from those in place at the present time. However, the NHS is an ever-evolving organisation and thus a wholly exact comparison would be unfeasible.

Due to focussing solely on mental health presentations, the current review is not able to make conclusions regarding the relative impact of working with mental health difficulties compared with other presentations.

It is further notable that, given the qualitative design of all of the reviewed literature, the current review was based on the analysis conducted by the original researchers and therefore was somewhat removed from the original raw data. This has the potential to increase misinterpretation and dilution of the expressed views. It is also possible that the current researcher, who is a Trainee Clinical Psychologist, exerted an impact on the analysis. The current researcher has a particular interest in mental health which may have contributed to an overly critical evaluation of the study findings. However, while the current researcher currently works within secondary mental health services this is balanced with previous employment within an administrative role in a general practice setting and thus a level of understanding and empathy associated with the pressures involved in working in this type of setting. Where evident within the reviewed literature, efforts were made to balance negative experiences of working with patients presenting with mental health difficulties with positive experiences/ views.

Finally, it is important to highlight that publication bias may also have played a role in the literature available for review. While an attempt was made to include

unpublished doctoral theses, none of the included studies were identified via this route.

Discussion

Summary of findings

The current review has highlighted common themes across the literature relating to GPs' experiences of working with patients presenting with mental health difficulties. The nature of the themes is indicative of largely negative emotional experiences, including anxiety, hopelessness and frustration. This is particularly concerning given that the proportion of GPs' workload relating to mental health is ever-increasing (McManus et al., 2014). While the consensus amongst studies adds some weight to the findings, it is important to remember the variable quality of the reviewed literature, as well as the shortcomings of the current review.

The current findings suggest that GPs are aware of their lack of formal training with regard to working with mental health, and this appears to be a considerable contributor to feelings of anxiety and uncertainty. Given that the core roles served by GPs are to assess, diagnose, treat and manage health concerns (RCGP, 2011), it is unsurprising that GPs indicate feeling professionally disempowered when working with patients presenting with mental health difficulties. The current findings suggest that GPs do not feel adequately equipped to undertake either these roles, or the role of gatekeeping to specialist services. Thus, GPs may perceive being thwarted in each of their core functions when working with patients presenting with mental health difficulties.

GPs reported occasionally taking on a different, non-medical, role which was seen as denigrated. This view may be strengthened by the increase in workload in general practice (Baird et al., 2013), whereby GPs may feel that their time is more appropriately spent working in a conventional medical fashion, in which they feel more competent. Furthermore, the reduction in consultation times in response to workload pressures (BMA, 2015) appears to be particularly problematic in the realm of mental health, and has likely

contributed to increased views that mental health consultations are incompatible with current structures within general practice.

Clinical implications

The current review suggests a number of implications for clinical practice. GPs consistently reported a lack of training, which fits with existing evidence (RCGP, 2015; Mind 2016b). A particular deficit in perceived communication skills was highlighted. As well as training in clinical skills in the context of mental health consultations, further training with regard to the range of mental health-related presentations may also be beneficial. This may support GPs to understand and empathise with patients; reducing feelings of dread, negativity and frustration.

Another pervasive finding was GPs' frustration with secondary care mental health services, which were seen as disconnected, rejecting, confusing and disappointing. The findings suggest that improved communication and collaboration between primary and secondary care services is vital, not only for the wellbeing of patients but also that of GPs. This has the potential to take various forms, such as regular face-to-face liaison meetings or basing specialist professionals within general practice. It appears important to clarify the expectations and remit of the tiers of care, as well as discussing current pressures at different levels. Group supervision sessions, for example, facilitated by a Clinical Psychologist may also support GPs with the emotional burden and responsibility that was reported.

The current review has also suggested potential avenues of future research in the field of mental health in general practice. It may be beneficial to explore GPs' relative experiences of consulting with the range of physical and mental health presentations. It may also be pertinent to conduct a review of the impact of varied attempts at collaboration between primary and secondary services with regard to the provision of mental health care, with a particular focus on the emotional impact on GPs. Finally, given that a considerable proportion of GPs' experiences of working with mental health related to views of secondary mental health services, exploring the views of secondary mental health professionals is also pertinent.

Finally, it is important to consider the findings from the perspective of a patient. Presenting at the GP surgery is typically the only option for an individual to access publicly funded professional support for a mental health difficulty. Findings of the current review have implications for patient experience and reaffirm the importance of developing other sources of support in the community.

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Appendices

Contents

Appendix 1: Search terms by database

	Database: PsycINFO via HDAS on 27.05.18	
Search no.	*Search terms*	*Additional notes*
1.	(gp* OR "general practitioner*" OR "general practice*")	
2.	"GENERAL PRACTITONERS"/ OR "FAMILY PHYSICIANS"	Thesaurus terms
3.	("family doctor*" OR "primary care physician*")	
4.	1 OR 2 OR 3	
5.	exp "MENTAL DISORDERS"/ OR "PSYCHIATRIC SYMPTOMS"/	Exploded thesaurus terms
6.	("mental illness*" OR "mental health" OR "mental disorder*" OR psychiatric OR psychological OR psychosocial)	
7.	5 OR 6	
8.	(treat OR treatment* OR treating OR consultation* OR support OR intervention*).	
9.	7 AND 8	
10.	(perspective* OR view* OR opinion* OR viewpoint* OR attitude* OR belie* OR thought* OR feel OR feeling* OR perception* OR perceive).	
11.	"HEALTH PERSONNEL ATTITUDES"	Thesaurus term
12.	10 OR 11	
13.	4 AND 9 AND 12	
14.	13 [DT 2004-2018] [Languages English] [Location England or Great Britain OR Northern Ireland OR Scotland OR United Kingdom OR Wales] [Record type Conference Proceedings OR Dissertation OR Dissertations Abstract OR Journal OR Journal Article OR Non-peer-reviewed Journal OR Peer-reviewed Journal OR Peer-reviewed Status-unknown]	Limiters

Database: CINAHL via HDAS on 27.05.18		
Search no.	Search terms	Additional notes
1.	(gp* OR "general practitioner*" OR "general practice*")	
2.	"PHYSICIANS, FAMILY"	Thesaurus term
3.	("family doctor*" OR "primary care physician*")	
4.	1 OR 2 OR 3	
5.	exp "MENTAL DISORDERS"	Exploded thesaurus term
6.	("mental illness*" OR "mental health" OR "mental disorder*" OR psychiatric OR psychological OR psychosocial)	
7.	5 OR 6	
8.	(treat OR treatment* OR treating OR consultation* OR support OR intervention*).	
9.	7 AND 8	
10.	(perspective* OR view* OR opinion* OR viewpoint* OR attitude* OR belie* OR thought* OR feel OR feeling* OR perception* OR perceive).	
11.	"ATTITUDE OF HEALTH PERSONNEL"	Thesaurus term
12.	10 OR 11	
13.	4 AND 9 AND 12	
14.	(NHS OR "national health service" OR UK OR "united kingdom" OR "great Britain" OR Wales OR Scotland OR England or "Northern Ireland")	
15.	13 AND 14	
16.	15 [DT 2004-2018] [Languages eng]	Limiters (DT = date published)

Database: EMBASE via HDAS on 27.05.18		
Search no.	*Search terms*	*Additional notes*
1.	(gp* OR "general practitioner*" OR "general practice*")	
2.	"GENERAL PRACTITIONER"/ OR "GENERAL PRACTITIONERS"	Thesaurus terms
3.	("family doctor*" OR "primary care physician*")	
4.	1 OR 2 OR 3	
5.	exp "MENTAL DISEASE" OR "MENTAL DISORDER" OR "MENTAL DISORDERS"	Exploded thesaurus terms
6.	("mental illness*" OR "mental health" OR "mental disorder*" OR psychiatric OR psychological OR psychosocial)	
7.	5 OR 6	
8.	(treat OR treatment* OR treating OR consultation* OR support OR intervention*).	
9.	7 AND 8	
10.	(perspective* OR view* OR opinion* OR viewpoint* OR attitude* OR belie* OR thought* OR feel OR feeling* OR perception* OR perceive).	
11.	"HEALTH PERSONNEL ATTITUDE"	Thesaurus term
12.	10 OR 11	
13.	4 AND 9 AND 12	
14.	(NHS OR "national health service" OR UK OR "united kingdom" OR "great Britain" OR Wales OR Scotland OR England or "Northern Ireland")	
13.	13 AND 14	
14.	15 [DT 2004-2018] [English language] [Languages English]	Limiters (DT = date published)

Database: Medline via HDAS on 27.05.18		
Search no.	*Search terms*	*Additional notes*
1.	(gp* OR "general practitioner*" OR "general practice*")	
2.	"GENERAL PRACTITIONERS"/ OR "GENERAL PRACTICE"/	Thesaurus terms
3.	("family doctor*" OR "primary care physician*")	
4.	1 OR 2 OR 3	
5.	("mental illness*" OR "mental health" OR "mental disorder*" OR psychiatric OR psychological OR psychosocial)	
6.	(treat OR treatment* OR treating OR consultation* OR support OR intervention*).	
7.	5 AND 6	
8.	(perspective* OR view* OR opinion* OR viewpoint* OR attitude* OR belie* OR thought* OR feel OR feeling* OR perception* OR perceive).	
9.	"ATTITUDE OF HEALTH PERSONNEL"	Thesaurus term
10.	8 OR 9	
11.	4 AND 7 AND 10	
12.	(NHS OR "national health service" OR UK OR "united kingdom" OR "great Britain" OR Wales OR Scotland OR England or "Northern Ireland"	
13.	11 AND 12	
14.	13 [DT 2004-2018] [Languages English]	Limiters (DT = date published)

Database: Scopus via EBSCOhost on 27.05.18		
Search no.	*Search terms*	*Additional notes*
All in one	(TITLE-ABS-KEY ("mental illness*" OR "mental health" OR "mental disorder*" OR psychiatric OR psychological OR psychosocial) AND TITLE-ABS-KEY (gp* OR "general practitioner*" OR "general practice*" OR "family doctor*" OR "primary care physician*") AND TITLE-ABS-KEY (treat OR treatment* OR treating OR consultation OR support OR intervention*) AND TITLE-ABS-KEY (perspective* OR view* OR opinion* OR viewpoint* OR attitude* OR belie* OR thought* OR feel OR feeling* OR perception* OR percieve)) AND (LIMIT-TO (PUBYEAR , 2018) OR LIMIT-TO (PUBYEAR , 2017) OR LIMIT-TO (PUBYEAR , 2016) OR LIMIT-TO (PUBYEAR , 2015) OR LIMIT-TO (PUBYEAR , 2014) OR LIMIT-TO (PUBYEAR , 2013) OR LIMIT-TO (PUBYEAR , 2012) OR LIMIT-TO (PUBYEAR , 2011) OR LIMIT-TO (PUBYEAR , 2010) OR LIMIT-TO (PUBYEAR , 2009) OR LIMIT-TO (PUBYEAR , 2008) OR LIMIT-TO (PUBYEAR , 2007) OR LIMIT-TO (PUBYEAR , 2006) OR LIMIT-TO (PUBYEAR , 2005) OR LIMIT-TO (PUBYEAR , 2004)) AND (LIMIT-TO (SUBJAREA , "MEDI") OR LIMIT-TO (SUBJAREA , "PSYC") OR LIMIT-TO (SUBJAREA , "HEAL")) AND (LIMIT-TO (DOCTYPE , "ar") OR LIMIT-TO (DOCTYPE , "re") OR LIMIT-TO (DOCTYPE , "cp") OR LIMIT-TO (DOCTYPE , "sh") OR LIMIT-TO (DOCTYPE , "ip")) AND (LIMIT-TO (AFFILCOUNTRY , "United Kingdom")) AND (LIMIT-TO (LANGUAGE , "English"))	Limiters: Subject area • "MEDI" = medicine • "PSYC"= psychology • "HEAL" = health Doc type: • "ar" = articles • "re" = reviews • "cp"= conference papers • "sh" = short surveys • "ip"= article in press

Database: EThOS via EBSCOhost on 27.05.18		
Search no.	*Search terms*	*Additional notes*
All in one	(gp* OR "general practitioner*" OR "general practice*") AND ("mental illness*" OR "mental health" OR "mental disorder*" OR psychiatric OR psychological OR psychosocial) AND (treat OR treatment* OR treating OR consultation* OR support OR intervention*).	

Appendix 2: Data extraction form

No.	Author(s) & Date	Title	Sample	Methods	Key findings	Relevant?
1	Hunt, D. & Churchill, R. (2013).	Diagnosing and managing anorexia nervosa in UK primary care: A focus group study	12 GPs from 3 practices in East Midlands (4 from each). 6 females, 6 males. Ages between 30 and 49.	3 x focus groups (of co-working GPs). Began with case scenarios of patients presenting with an eating disorder but after this were unstructured. Analysed using corpus linguistic conventions and discourse analytic approaches.	Keyword analysis. 8 themes of words that appeared frequently. Then go on to analyse context of four themes: • Diagnosis, • Defining 'eating disorder', and 'anorexia' • Treatment and referral • Patient management (not presented separately).	Partially.
2	Leavey, G., Mallon, S., Rondon-Sulbaran, J., Galway,	The failure of suicide prevention in primary care: Family and	72 relatives or close friends bereaved by suicide.	Individual in-depth interviews	5 key barriers to suicide prevention: • Recognition and management • Liaison and communication with mental health services	GP section only.

	K., Rosato, M. & Hughes, L. (2017).	GP perspectives - a qualitative study	19 GPs who experienced at least 1 x patient suicide. Northern Ireland. 11 females, 8 males. Diverse primary care settings (SES, urban/ semi-urban/ rural). All long-serving (15+yrs), all experienced 3+ suicides.	Used a topic guide. Assume thematic analysis (state this is how they analysed relatives' data but don't say GPs).	• Dealing with bereaved families • Professional and personal impact of patient suicide Discussed under 13 headings: • No contact • Stigma • Assessing risk • GP scepticism • Risk assessment process • The ten-minute rule • Suicide as unpredictable • Paradoxical presentation • Continuity of care and poor engagement • Alcohol and drug use • Psychiatric services • Inadequate response • Communication and liaison with psychiatry	
3	McPherson, S. & Armstrong, D. (2009).	Negotiating 'depression' in primary care: A	20 GPs - Purposively sampled so had mix of: ethnicity, mental health	Individual semi-structured interviews.	Nine major themes (with sub-themes) – included in Appendix. Paper explores analytic content	Some themes relevant or

		qualitative study.	needs of area, mental health links at practice, practice size and length of time in practice. Doesn't state gender. 10 White British, 10 non-White British. All within greater London (inner city UK).	Some details of types of questions asked. Analysed using thematic analysis.	(deeper level) – connections across themes. • Explanatory frameworks • Loss of empathy • Unhelp-able patients • Social prescribing • Labelling	partially relevant.
4	Michail, M. & Tait, L. (2016).	Exploring general practitioners' views and experiences on suicide risk assessment and management of young people in primary care:	28 GPs working in Nottingham City. Males = 9 Females = 15 (4 participants didn't state gender). Age 27-55	4 x practice-based focus groups, 1 x in-depth interview. Used a topic guide (piloted this). Analysed using framework analysis.	3 key themes identified: • Challenges in the assessment and management of suicide risk in young people (sub-themes: lack of specialist knowledge and clinical skills, patient related barriers, organisational barriers) • Attitudes and beliefs of GPs • Ways of addressing challenges in the assessment and management of youth	Most themes are relevant or partially relevant.

		A qualitative study in the UK	Years' experience = 1.6-40. Varied practice sizes.		suicide risk in primary care (sub themes: provision of specialist education, educational content and implementation, provision of suicide risk assessment tool).	
5	O'Brien, D., Harvey, K., Young, B., Reardon, T. & Creswell, C. (2017).	GPs' experiences of children with anxiety disorders in primary care: a qualitative study.	20 working GPs (partners, principal or salaried – no locums) Across England. 9 males 11 females	Individual telephone interviews, using a topic guide. Thematic analysis used.	Identified 3 themes: • Decision making • Responsibility • Emotional response Also an overarching theme of GPs feeling ill-equipped.	Partially.
6	Riley, R., Spiers, J., Buszewicz, M., Taylor, A.K., Thornton, G. & Chew-Graham, C.A. (2018).	What are the sources of stress and distress for general practitioners working in England? A qualitative study.	47 GPs working in England - Bristol, Manchester and London. Partners, salaried, locum, registrars, retired, on sick leave, more than one role.	Interviews (led by topic guide) conducted face-to-face or over telephone. Thematic analysis.	Key sources of stress • Emotion work • Practice culture • Work role and demands	Section on emotion work is relevant (difficulties dealing with the psycho-social issues

			Female = 33 Males = 14			brought by patients).
7	Roberts, J., Crosland, A. & Fulton, J. (2013).	"I think this is maybe our Achilles heel …" exploring GPs' responses to young people presenting with emotional distress in general practice.	19 GPs recruited from 18 practices in North East England. All GPs had 4+ years of experience. Females = 10 Males = 9 Urban, rural and semi-rural. Varied ages, professional experience and roles (salaried or partner).	Individual interviews using a topic guide (based on literature). Grounded theory and situational analysis used.	(Initial coding stage) • Anxiety about professional practice (within consultation, at an external level, across disciplinary boundaries). • Anxiety related to interacting with young people • Anxiety associated with the complexity of presentations of adolescent emotional distress	Yes.
8	Roberts, J., Crosland, A. & Fulton, J. (2014a).	Patterns of engagement between GPs and adolescents presenting with	See 7.	See 7.	(Axial coding stage) Three main themes: • GP performance in the clinical encounter (subthemes: the triadic consult, communicating with	Partially.

		psychological difficulties: A qualitative study.			adolescents, responding to cultural clashes). • GPs' views of adolescents and perception of their health needs (subthemes: adolescents as 'different' or seen to be on a life journey, understanding the developmental period of adolescence, importance of trust in the doctor-patient relationship, a 'duty of care'). • GPs' preferred epistemological framework.	
9	Roberts, J., Crosland, A. & Fulton, J. (2014b).	GPs' responses to adolescents presenting with psychological difficulties: a conceptual model of fixers, future planners, and collaborators.	See 7.	See 7.	(Theoretical stage) Explores interrelationship between the axial codes. Theory proposes 3 GP role archetypes: • Fixer • Future planner • Collaborator • (also floater, mix of above)	Partially.

10	Saini, P., Chantler. K. & Kapur, N. (2016).	General practitioners' perspectives on primary care consultations for suicidal patients.	39 GPs - named GPs for patients who had died by suicide. Patients had also been in contact with mental health services in the North of England. Females = 11 Males = 28	Semi-structured face-to-face interviews. Thematic analysis.	Key themes: • GPs' interpretations of suicide attempts or self-harm. • Professional isolation. • GP responsibilities vs patient autonomy (subthemes: medication, lack of appropriate hospital beds, missing appointments, clear intent to die).	1 theme is very relevant, 1 theme is partially relevant, 1 theme not relevant.
11	Shaw, I. (2004)	Doctors, "Dirty Work" Patients and "Revolving Doors".	12 GPs working in UK Midlands (range of practices, caseload sizes, and mix of urban and rural) Only 2/12 were female. Date of registration from 1971-1993.	Analysis of GPs' patient records and 12 x individual interviews. No indication of topic guide or questions asked. Cognitive Mapping technique used to analyse.	No clear statement of findings Headings used are: • Medical irritation • "problem patients" – management strategies • Responsibility, blame and authority • Toward an understanding of the revolving door phenomenon	Yes.

| 12 | Sigel, P. & Leiper, R. (2004). | GP views of their management and referral of psychological problems: a qualitative study. | 10 GPs in one geographical locality.

Males = 7

Females = 3 | Semi-structured interviews.

Grounded theory. | 5 components of conceptual model

- Exploring psychological problems
- Containing patients' health problems
- View of psychological problems and psychological therapies
- Referral decisions
- Professional interactions with psychologists | Partially. |
| 13 | Strachan, J., Yellowlees, G. & Quigley, A. (2015). | General practitioners' assessment of, and treatment decisions regarding, common mental disorder in older adults: thematic analysis of | 9 GPs in the NHS Borders area (rural Scotland).

3 male, 6 female.

Did not record demographic information. | 3 x semi-structured small group interviews (practice-based).

Thematic analysis. | Identified 7 themes:

- Cohort effects
- GP role
- Assessment
- Decision-making
- Intervention
- Role of secondary care
- More than a health issue (subthemes: social problems, social solutions) | Only 1 theme (GP role) relevant. |

			interview data.			
14	Tavabie, J.A. & Tavabie, O.D. (2009).	Improving care in depression: qualitative study investigating the effects of using a mental health questionnaire.	16 GPs from 4 practices (affluent and deprived) in South London (varied gender, full or part-time, years in practice). Female =7 Males=9 Nothing on role.	Individual semi-structured and focus groups before and after MHQ was introduced into practice. Analysed using grounded theory.	3 main themes: • Control and responsibility • The doctor's relationship with the patient • Support for the doctor	Only the 'before' sections relevant. Not all easy to pick apart.
15	Whitehead, L. & Dowrick, C. (2004).	Assessing service provision and demand in the management of mild to moderate mental health difficulties in primary care.	16 GPs completed questionnaires related to management of mental health problems. 9 of these were followed up for interview. Don't know location but reportedly	Individual interviews. Analysed using thematic analysis.	3 issues undermined ability to manage people with mild-moderate mental health difficulties effectively: • Time/ ability • Inability to access services • Patients who decline to follow suggested management options	Qualitative section only.

| | | | representative of the Health Authority in terms of gender, practice size, location and deprivation.

No detail on demographics. | | | |
|---|---|---|---|---|---|---|

Appendix 3: CASP summary

Article	CASP Criteria									
	Clear aim	Appropriate for qualitative study	Appropriate design	Appropriate recruitment	Data collection	Relationship between research and participant considered	Ethics	Data analysis	Clear statement of findings	Value of research
1. Hunt & Churchill (2013)	Green	Green	Green	Amber	Red	Amber	Amber	Amber	Amber	Amber
2. Leavey et al. (2017)	Green	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber
3. McPherson & Armstrong (2009)	Green	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber
4. Michail & Tait (2016)	Green	Green	Green	Amber	Green	Amber	Amber	Amber	Amber	Amber
5. O'Brien et al. (2017)	Green	Green	Green	Amber	Green	Green	Amber	Amber	Amber	Amber
6. Riley et al. (2018)	Green	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber
7. Roberts et al. (2013; 2014a; 2014b)	Green	Green	Green	Amber	Green	Green	Amber	Amber	Amber	Amber
8. Saini et al. (2016)	Green	Green	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber
9. Shaw (2004)	Green	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber
10. Sigel & Leiper (2004)	Green	Green	Green	Amber	Amber	Green	Amber	Amber	Amber	Amber
11. Strachan et al. (2015)	Green	Green	Green	Amber	Amber	Green	Amber	Amber	Amber	Amber
12. Tavabie & Tavabie (2009)	Green	Green	Green	Amber	Amber	Green	Amber	Amber	Green	Amber
13. Whitehead & Dowrick	Green	Green	Green	Amber	Amber	Amber	Amber	Amber	Amber	Amber

Appendix 4 – Condensed author guidelines for the Journal of Mental Health

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<u>About the Journal</u>

Journal of Mental Health is an international, peer-reviewed journal publishing high-quality, original research. *Journal of Mental Health* accepts the following types of article: Original Article, Review Article, Research and Evaluation, Book Review, Web Review.

<u>Preparing Your Paper</u>

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

Word Limits

Please include a word count for your paper. The total word count for Review Articles should be no more than 6000 words. We do not include the abstract, tables and references in this word count. Manuscripts are limited to a maximum of 4 tables and 2 figures.

Style Guidelines

Any spelling style is acceptable so long as it is consistent within the manuscript.

Please use double quotation marks, except where "a quotation is 'within' a quotation". Please note that long quotations should be indented without quotation marks.

References

Please use this reference guide when preparing your paper (link to paper entitled Taylor & Francis Standard Reference Style: APA)

Checklist: What to Include

I.   Should contain a structured abstract of 200 words. Use the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest.

II.   Between 3 and 8 **keywords**. Read making your article more discoverable, including information on choosing a title and search engine optimization.

III. **Funding details.** Please supply all details required by your funding and grant-awarding bodies.

IV.   **Disclosure statement.** This is to acknowledge any financial interest or benefit that has arisen from the direct applications of your research. Further guidance on what is a conflict of interest and how to disclose it.

V.   **Data availability statement.** If there is a data set associated with the paper, please provide information about where the data supporting the results or analyses presented in the paper can be found.

VI.   **Supplemental online material.** Supplemental material can be a video, dataset, fileset, sound file or anything which supports (and is pertinent to) your paper. We publish supplemental material online via Figshare. Find out more about supplemental material and how to submit it with your article.

VII. **Figures.** Figures should be high quality (1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour, at the correct size). Figures should be supplied in one of our preferred file formats: EPS, PS, JPEG, GIF, or Microsoft Word (DOC or DOCX). For information relating to other file types, please consult our Submission of electronic artwork document.

VIII.   **Tables.** Tables should present new information rather than duplicating what is in the text. Readers should be able to interpret the table without reference to the text. Please supply editable files.

Using Third-Party Material in your Paper

You must obtain the necessary permission to reuse third-party material in your article. The use of short extracts of text and some other types of material is usually permitted, on a limited basis, for the purposes of criticism and review without securing formal permission.

Chapter 2

Clinical psychology in general practice: perspectives on a pilot initiative

This paper has been written broadly in line with the recommendations of the British Journal of General Practice (see Appendix 17 for details).

Word Count: 7979

Abstract

Background: General practice is under pressure and GPs find supporting patients with mental health difficulties particularly problematic. A pilot initiative designed to support GP practices was set up in The Midlands, whereby a Clinical Psychologist joined two GP practices.

Aim: To develop a model to coherently explain the social and psychological processes involved in integrating a clinical psychology service into general practice.

Design and Setting: A constructivist grounded theory approach was employed. Semi-structured interviews were conducted across both GP practices.

Method: Through purposive sampling, 10 practice staff in clinical and non-clinical roles, nine patients who had used the service and the Clinical Psychologist were recruited. Data collection and analysis were carried out simultaneously and an iterative approach was taken. Interview transcripts were subject to initial and then focussed coding, followed by category and theory development.

Results: Seven categories were constructed. The desire to provide or obtain help was positioned as an over-arching category which influenced experience of the clinical psychology service. A contextual category of impotence was also developed. The five remaining categories were: making an investment, fostered confidence, empowerment, shared strain, and structural and personal moderating factors.

Conclusion: A clinical psychology service was functional within the GP practices studied. Following initial investment by practice staff and patients, the service was sustained through being experienced as beneficial. This care model may contribute to addressing the current pressures in general practice; however, given that this is a qualitative study of one initiative, further research is required.

Keywords: General practice, mental health, clinical psychology, primary health care.

Introduction

Current context

General practice is the typical entry point for accessing the National Health Service (NHS).[1] Around 307 million patient consultations take place at GP surgeries each year in England[2] and general practice has been described as the base upon which the NHS is built.[3] Core roles served by General Practitioners (GPs) include consultation, treatment and referral to specialist services,[4] and therefore the functioning of general practice is vital to the NHS across-the-board.

The British Medical Association (BMA) describes general practice as being in a state of crisis.[5] General practice is faced with an unsustainable workload, and a workforce that has failed to expand sufficiently, due to problems with the recruitment and retention of GPs.[3] GPs acknowledge the negative impact of their current workload on the quality of care; with patients facing longer waiting times and shorter consultations.[5]

Mind have described mental health as being a core aspect of general practice[6] and it is estimated that one in four patients presenting to a GP in the UK will require treatment for a mental health problem.[7] Mental health consultations are a particular source of stress for GPs due to a perceived lack of professional competence,[8,9] incompatibility with the operating structures in general practice,[10,11] and the emotive nature of such consultations.[12,13] Furthermore, GPs perceive that specialist mental health services have raised their eligibility criteria, resulting in the need for many patients to be managed in primary care without specialist support.[3]

Ways forward

To ease the current pressures in general practice, the BMA made a number of recommendations. These include enhanced collaboration between GPs and clinicians working in community and secondary care, as well as further

professional development for those working within general practices.[5] The Five Year Forward View for Mental Health also highlights the importance of integrating psychological therapies into primary care.[14] The General Practice Forward View (GPFV) set out NHS England's overall strategy and developing the workforce was a key feature.[15] As well as increasing the number of GPs, the importance of capitalising on the skill sets of other professionals including Practice Nurses, Pharmacists and Mental Health Therapists was highlighted, alongside plans to support the introduction of 5000 extra non-GP staff into general practice by 2020-2021.

In 2016-2017 the GPFV led to the implementation of the Clinical Pharmacists in GP Practices scheme, which aimed to build the general practice workforce by employing over 2000 Pharmacists in general practice by 2020.[15] While this scheme remains in its infancy, evaluation of the implementation phase found that 490 Pharmacists had been recruited to work across over 650 general practices by February 2017.[16] At this time, stakeholders perceived that the Clinical Pharmacists had provided valuable and distinctive functions and positively contributed to patient care, for example, through increasing patient safety and practice capacity. Findings from a similar, more established, scheme are also positive.[17] Eight GP practices across West London employed a team of practice-based Pharmacists for approximately three years prior to evaluation.[17] Within this arrangement, Pharmacists served various functions such as providing face-to-face appointments for patients with long-term health conditions, reviewing medication and managing repeat prescriptions. GPs reported a decrease in their workload which enabled them to more appropriately utilise their skills through patient-facing activities such as diagnosis and prescription. GPs described the accessibility of the practice-based Pharmacists as promoting their ability to seek informal advice. Patients appreciated the access to appointments and the Pharmacist's knowledge.[17] This is one example of the effective integration into general practice of clinicians who are not usually employed in such roles.

The GPFV also proposed the expansion of the Improving Access to Psychological Therapies (IAPT) programme through introducing 3000 practice-based Mental Health Therapists into primary care by 2020.[15] IAPT

was introduced across England in 2008 to provide evidence-based interventions principally using cognitive-behaviour therapy (CBT) for adults presenting with anxiety and/ or depression. The programme continues to be extended, for example, to treat individuals under the age of eighteen.[18] IAPT is open to self-referral as well as GP or secondary care referral and provides a service to approximately 900,000 individuals each year.[18]

While the effectiveness of IAPT continues to be the subject of debate,[19, 20] it is clear that the programme has provided contact with specialist mental health services for a large number of individuals.[18] Nevertheless, there remains a gap between the relative accessibility of primary care mental health services such as IAPT and that of general practices, which serve the majority of the population. For example, in April 2019, more individuals were registered at general practices in England than were projected to be living in the country.[21] Moreover, IAPT does not routinely offer interventions for some mental health presentations, such as psychosis and personality difficulties.[18] The waiting time targets of between 6 and 18 weeks for an initial IAPT appointment,[18] delays before second appointments,[22] and perceived stringent criteria[22] illustrate that general practice remains central to the provision of mental health care.

Some GPs have also raised concerns about employing the additional Mental Health Therapists pledged by the GPFV through IAPT, rather than directly through general practices and have questioned whether they will be truly integrated.[23] One of the key components of the effectiveness of the Clinical Pharmacist scheme reviewed above[17] was the co-location of the Pharmacist, which permitted accessibility for informal and rapid advice-giving.

A role for clinical psychology?

Clinical Psychologists (CPs) are arguably one of the most rigorously trained professions within health and social care.[24] Throughout training CPs are exposed to a broad range of theoretical models and gain experience of working with a wide variety of service users, in a variety of modalities, from childhood to older-adulthood. CPs are well placed to contribute to the

psychologically-informed practices of other clinicians, through staff development, supervision, and consultation.[24]

Historically, many CPs worked into integrated care teams in GP practices providing interventions to individuals and families, as well as supporting the wider team.[25] However, following governmental reforms such as The NHS Plan in 2000,[26] which introduced Graduate Mental Health Workers into primary care, and the introduction of IAPT in 2008,[27] CPs have had less presence within general practice.

Given the current pressures in general practice, recommendations to integrate specialist clinicians, and encouraging findings from the integration of other clinicians into general practice,[16,17] this study presents findings from a pilot initiative in which a CP was incorporated into general practice.

Within this pilot initiative a CP worked across two general practices. The role included offering consultations with rapid assessment and advice-giving, referral to other services, and formulation and support for individuals or families identified as posing a high demand on GP resources; for whom an underlying psychosocial component may be apparent. The role also incorporated the provision of psychological advice and consultation with other disciplines within the practices.

This study is exploratory in nature because this integration of a CP into a general practice was a pilot scheme. The aim of the study is to develop a model of the social and psychological processes involved in integrating a clinical psychology service into general practice, which is grounded in the experiences of both staff and patients who have been involved in the service.

Method

Design

A constructivist grounded theory method[28] was used. Grounded theory was selected due to the exploratory nature of the research and aim to provide a model of social and psychological processes.[29] The constructivist stance acknowledges the intersubjective nature of the research process and the

researcher's position as neither value-free nor neutral.[28] This mode of grounded theory suited the researcher's contextualist epistemology, which posits that knowledge is constructed and context-dependent,[30] as opposed to objectively emerging from the gathered data, which is more in line with traditional grounded theory approaches. Therefore the study findings are understood to be situated in both the personal contexts of participants and the researcher, as well as the context in which the interviews took place.

Setting

The research sites were two GP practices in The Midlands and were selected due to being the only practices within the region participating in the pilot. As an indication of practice size, the number of registered patients in each practice, as of 01.04.19, was 15,000 and 8000 (rounded to the nearest thousand).[31] The pilot initiative commenced in March 2016 and entailed a CP working in each of the two practices for two days per week.

Patient consultations in the clinical psychology service (CPS) were typically 30 minutes in duration. This was based on the clinical judgement of early proponents of the pilot initiative who perceived that this would be sufficient to fulfil the CP role yet also relatable to GPs. One practice permitted self-referral from the outset. The other, larger, practice implemented a clinician-only referral system before moving to self-referral after approximately one year, when it became evident that the CPS was not overwhelmed by demand.

Participants

Inclusion criteria

<u>Staff:</u>

- Employed at the practice for at least 3 months prior to the commencement of the CPS. This allowed staff to compare the situation before and during the initiative.

Patients:

- Attended the CPS during June 2018 (month 15 of the initiative). This month was selected to facilitate recollection due to proximity to the originally planned interview start date which was October-November 2018. Sampling from one month of consultations was designed to reflect an accurate cross-section of individuals that used the service.
- Registered with the GP practice for at least three months prior to the introduction of the CPS. This allowed patients to compare the situation before and during the initiative.
- Age six or above. This was due to the required ability to verbally express views and the inappropriateness of requesting written assent from very young children.

Exclusion criteria

Patients:

- Adults assessed by practice staff as lacking the capacity to consent to take part in the research, despite the availability of accessible documentation.
- Age 6-15 with no recorded evidence of a parent or guardian's knowledge of the CPS appointment.

Sampling and recruitment

Staff

Staff members were purposively sampled through nominations by a senior staff member at each practice. These were a Managing Partner and a GP Partner, and their involvement was due to their respective roles in the operation of the CPS (for example, attendance at planning and review meetings). Their identification of staff members was intended to promote the involvement of staff with rich experience of the CPS, within a variety of clinical and non-clinical roles. The CP was also invited to participate.

Staff members were invited to participate in the study by the senior staff member, who provided them with a study information sheet (see Appendix 7). Prospective staff participants were asked whether they would like to be

contacted by the researcher to further discuss the research and/ or arrange an interview. A total of 10 expressions of interest were forwarded to the researcher.

Patients

All eligible patients were approached. A letter of invitation from the appropriate general practice was sent to their home address (see Appendix 8) and a study information sheet and return envelope were enclosed. For individuals under the age of 16, the documentation was addressed to their parent/guardian and additional age-appropriate versions of the study information sheet were enclosed. A more accessible version of the letter of invitation and study information sheet was also available for identified adults.

Patients (or a parent/guardian) indicated whether they would like to discuss taking part in the research through completing a reply slip or directly contacting the researcher. The positive response rate was relatively low and is detailed in Table 1. Negative responses were withheld from the researcher and therefore the total response rate is unavailable.

Table 1. Positive response rate to patient letters of invitation

Practice	Total patients contacted	Yes responses
A	63	7 (11%)
B	49	6 (12%)

Prospective patient participants were contacted in a random order until a maximum of five were recruited from each practice. At this stage, some prospective participants stated that they no longer wanted to take part, or were unable to attend the practice in order to do so.

The recruited sample

An initial sample of 21 participants, comprising of five staff and five patient participants from each practice, and the Clinical Psychologist was sought. Returning to the settings in order to collect further data in accordance with

theoretical sampling was initially envisioned but was not possible due to time constraints. The employed sampling strategy may therefore be considered consistent with an abbreviated form of constructivist grounded theory.[32] Nevertheless, the initial sampling strategy was informed by a degree of a-priori theoretical sensitivity as the recruited sample was purposely heterogeneous and thus represented rich information sources with a variety of perspectives. Due to the heterogeneity of grounded theory studies and focus on data quality as opposed to quantity,[28] there is no universally agreed minimum sample size. As a guide, Creswell[33] intimates that 20 interviews may be enough to achieve theoretical saturation.

Staff

Five staff members were recruited from each practice. Description of participant roles and duration of employment at the practice is available in Table 2. Given the novel nature of the pilot initiative, demographic information is limited in order to protect the anonymity of staff.

Table 2. Demographic details of staff participants

Role	Number of years employed at practice
Administrative/ Managerial	11-15
Administrative/ Managerial	6-10
Administrative/ Managerial	0-5
Administrative/ Managerial	16-20
Practice Nurse	0-5
Practice Nurse	26+
GP	11-15
GP	11-15
GP	6-10
GP	0-5

The Clinical Psychologist was also recruited.

<u>Patients</u>

Nine patient participants were recruited: five from one practice and four from the other. Patient participant demographic details are provided in Table 3. Further demographic details such as number of CPS appointments are not provided in order to protect anonymity.

Table 3. Demographic details of patient participants

Age	Gender	Years registered at practice
50-59	F	11-15
60-69	M	26+
70-79	F	26+
50-59	M	16-20
60-69	M	26+
60-69	M	26+
60-69	F	26+
80+	M	20-25
80+	F	20-25

Research ethics

Ethical approval was provided through Independent Peer Review at Staffordshire University and by Nottingham 1 Research Ethics Committee. See Appendices 1-3 for the corresponding documentation. Research and Development approval was obtained directly from the participating general practices (see Appendices 4-6).

Written informed consent was obtained by the researcher immediately prior to each interview (example available in Appendix 9). A process for obtaining

consent on behalf of patient participants aged below the age of 16 was devised, however this was not utilised as no participants within this age range were recruited. Participants were assured of their right to terminate the interview at any time. Within the study information sheet participants were also informed of their right to withdraw their information up to four weeks after the interview. Due to the iterative approach employed, it was intended that participant data would have been removed but changes to subsequent questions based on that data would have remained. No participants requested for their data to be removed from the study. A pre-identified clinician at the GP practice (e.g. the on-call doctor) was available to support patient participants, if necessary.

Data collection

Interviews were conducted between February 2019 and April 2019. All interviews were carried out by the same researcher, at the appropriate practice site. Interviews lasted between 16 and 58 minutes, and the average duration was 28 minutes (all times are rounded to the nearest minute).

All interviews were semi-structured and made use of an interview guide (see Appendices 10-12). This was informed by guidelines for interviewing in constructivist grounded theory[28] and developed through consultation with the research supervisor. Data collection and analysis followed an iterative method whereby analysis took place following each interview or small number of interviews and questions were adjusted to reflect gaps in the existing data (see Appendix 13 for an example of an adjusted interview guide). Interviews were audio-recorded and transcribed by the researcher. Participant identifying details were removed during transcription in order to maintain anonymity.

Data analysis

Analysis followed the approach described by Charmaz.[28] Analysis began with applying initial codes to small fragments of the data (e.g. lines or phrases) with the aim of defining the contents. Initial codes typically took the form of action terms named gerunds which emphasise the processes and actions reported by participants.[29] Examples from the current study include: *questioning*

satisfaction (staff member 1, L46) and *anticipating limited capacity* (patient 4, L58).

Initial codes which occurred frequently or appeared analytically significant were identified and became focussed-codes. Focussed codes were subsequently organised into groups that were felt to most accurately and wholly represent the data. This was conducted by hand, utilising arrangements of sticky notes which allowed for visual representation and repeated reorganisation of the groups. These groups were named and served as categories. Appendix 14 and 15 illustrate the process of analysis.

Constant comparison was conducted throughout the analytic process, first by comparing data within an interview and then across interviews. This promoted the identification of analytic distinctions and conditional relationships. In order to develop analytic understanding of the data, memos were maintained throughout the research process (see Appendix 16 for an example). Memo-writing encouraged the recording of insights from the data, including properties of categories. Both constant comparison and memo-writing supported the process of theoretical coding during which relationships between categories were explored and a theoretical explanation of the data was constructed.

Reflexivity and rigour

In line with the constructivist methodology, the researcher maintained a stance of critical curiosity regarding the impact of their own characteristics and experiences on the findings. The researcher's interest in the current pressures in general practice originated in a background of working in general practice in an administrative role and having personal relationships with individuals working in such settings. The researcher was employed as a Trainee Clinical Psychologist and thus had an alliance with the clinical psychology profession which may have subconsciously led to the assumption that the CPS would be valuable. This awareness informed aspects of study design (e.g. the use of open questions) and emphasised the importance of rigour throughout the analysis. Further examination of the researcher's influence was achieved through the maintenance of a research journal, research supervision and attendance at a qualitative research methods peer support group.

Results and discussion

Overview

Seven categories of grouped focussed codes were constructed in order to coherently explicate the data and these are listed in Table 4. Relationships between categories are diagrammatically represented in Figure 1. Each category is discussed in turn and relationships between categories are highlighted throughout.

Table 4. Categories and contributing focussed codes

Level of analysis	Contributing grouped focussed codes
Over-arching category	
Help	• Desire to provide help • Desire to obtain help
Category	
(Contextual) Impotence	• Mental health being everyday business (staff) • Perceived ability to help (staff) • Perceived efficacy of discussing mental health in general practice (patients)
Making an investment	• Striving to use the service appropriately (staff) • Giving it a go (patients)
Fostered confidence	• Abilities of the CP (staff) • Working alongside (staff) • Reciprocal confidence (staff and patients) • Feeling at ease (patients) • Working collaboratively (patients) • Control (patients)
Empowerment	• Feeling effective in role (staff) • Exploring alternatives (patients)
Shared strain	• Sharing the burden (staff)

|		
		• Opening up (patients)
Moderating factors	*Structural*	• Proportionate CP time
		• Ease and simplicity
		• Waiting times
		• Location
		• Duration
		• Taking to someone new
	Personal	• Management style (staff)
		• Preferences (patients)
		• Timing (patients)
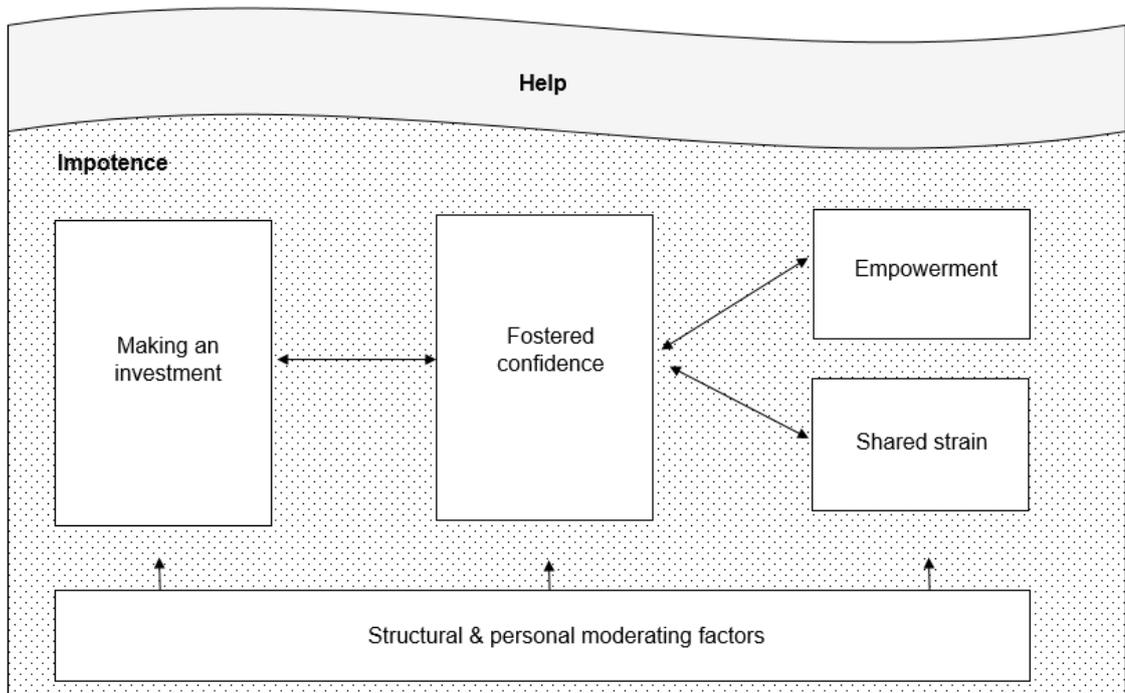
Figure 1. Theoretical model of the operation of the CPS

Help

Help was positioned as an over-arching theme. This captured the desire of all participants to provide (staff participants) or obtain (patient participants) help. This theme became a core category due to its integral influence on all other aspects of the CPS.

For staff participants, this theme captured the core value of genuinely wanting *"to help our patients as a practice"* (staff member 5, L106-109). One staff participant highlighted this as being "*part of why you work here*" (staff member 5, L205-207), and another stated that they would "*never send a patient away without … trying to find some help … for them"* (staff member 1, L44-45). Staff participants did not discriminate patients presenting with mental health difficulties from other patient groups and described *"treating everybody as kindly as you can and trying to help them*" (staff member 6, L26-27). This core value of wanting to provide help informed all other aspects of staff participants' experience of the CPS.

For patient participants, this theme concerned wanting to obtain help for the difficulties they were experiencing. While patient participants described a variety of reasons for their distress, they were unified in their identification of a need for help: variously describing *"deteriorating to a point where I was unable to cope"* (patient 1, L29), and reaching *"the point where I felt that now I couldn't deal with it and I needed … some help"* (patient 9, L26-27). The desire for help informed all other aspects of patient participants' experience of the CPS.

Impotence

Impotence is a contextual category and reflects the backdrop against which the CPS was introduced. Participants described inability to take effective action towards providing (staff participants) or obtaining (patient participants) help for mental health difficulties.

Staff participants viewed mental health as *"part and parcel of general practice"* (staff member 3, L22), yet many reported a lack of perceived ability to help patients presenting with mental health difficulties. The confidence of clinician participants was particularly nuanced. Some described actively assessing for mental health problems and feeling "*confident enough*" to ask questions (staff member 7, L30-31), while others reported being put off asking questions (staff member 1, L55) and being "*overly reliant on medication"* (staff member 10, L46) due to not feeling "*well-equipped for the counselling … side of things"* (staff member 10, L45-46).

Staff also described a *"lack of time"* for mental health in consultations (staff member 9, L168) and difficulties with specialist mental health services, for example, frequent changes (staff member 1, L31-32) and inadequate capacity (staff member 3, L176), resulting in patients "*often having to wait months to actually … see somebody"* (staff member 10, L8-9).

Correspondingly, patient participants perceived that limited mental health help was available at the practice. Numerous patient participants perceived that GPs "*don't have the time to talk"* about mental health (patient 9, L25) and therefore did not want to "*waste a Doctor's time"* (patient 2, L21-22). Patient participants also described the time constraint of a GP consultation as inhibiting opening up (patient 8, L28-29) and increasing anxiousness (patient 6, L131). Patient participants felt that general practice "*didn't seem to really include mental [health]"* (patient 9, L10-11).

These factors contributed towards participants feeling ineffective and powerless and conflicted with their core values and desires.

Making an investment

In response to the introduction of the CPS, all participants were required to invest in the opportunity, based on no guarantee that the service would be effective or maintained after the pilot period. Entertaining the CPS required all participants to invest time, effort and hope.

For staff this occurred in the context of hosting *"a lot of services throughout the years"* (staff member 5, L97) and prior experience of a pilot scheme introducing another specialist health professional not working well (staff member 9, L125-140). Staff participants saw the CPS as another change*,* for example, stating *"lots of different services have changed, including this with mental health"* (staff member 4, L8-9). Despite this, staff participants typically described a positive response, alongside a degree of anxiety indicative of their aspiration for the service to work well. Staff participants described initially feeling *"nervous"* (staff member 9, L124), taking "*a couple of weeks … to pick up our confidence"* to use the service (staff member 4, L128-129), and having various questions relating to *"how it would fit in"* (staff member 8, L54), and

"how well it would be used" (staff member 7, L51). Staff participants were generally keen to use the service to its full potential and expressed wanting to *"actively be able to use it correctly"* (staff member 4, L290).

A level of investment was also indicated by patient participants. While some initially questioned the benefit of the service (patient 6, L89), others invested hope *"that it would help"* (patient 4, L67), and therefore decided to *"give it a go"* (patient 7, L73) and *"see what … was on offer"* (patient 3, L30).

Fostered confidence

In order to sustain participants' initial investments, their confidence in both the efficacy of the CPS and their own ability to use the service required cultivation. Staff participants valued having someone who was *"more specialised"* (staff member 1, L292) and someone for whom psychology is their *"main thing"* (staff member 7, L152-153). While some staff participants questioned the necessity of the professional being a CP as opposed to another mental health professional (staff member 8, L100-102), another staff participant emphasised the importance that the professional *"is clinically experienced and has the expertise to assess people and take on board a level of risk"* (staff member 9, L87-88).

The development of staff confidence required active nurturing by the CP. Locating the CPS within the practice building promoted this: allowing the CP to *"get to know"* practice staff (staff member 9, L250), discuss queries (staff member 1, L247-248), liaise about referrals (staff member 6, L172-174) and discuss patient concerns (staff member 7, L116-118). One staff participant stated:

> *"I think it helped us all to understand the service because [it's] … based in the building … when you signpost someone down the road, we don't see someone come out of their appointment, we don't see that they've followed it up, we don't see how they're getting on…"* (staff member 4, L177-180).

Staff participants also described valuing the flexibility of the CP, for example, agreeing to provide home visits (staff member 9, L203-204), fitting patients in

"urgently" (staff member 5, L77), and providing online resources for patients who did not want a face-to-face appointment (staff member 1, L168-171).

Patient participants' confidence in the CPS was promoted through their experience of the service, which emanated from both structural aspects of the CPS as well as the perceived professional competency of the CP. Many patient participants reported having "*time to get it out of your system, what was on your mind*" (patient 8, L19-20) and not feeling rushed (patient 6, L136-137). Patient participants also described "*being made to feel at ease*" (patient 1, L53), experiencing the sessions as "*relaxed*" (patient 3, L142) and finding the Psychologist "*easy to talk to*" (patient 5, L148). One patient participant described feeling "*freer to speak*" because of the CP's understanding (patient 5, L149), and another appreciated talking to someone who "*had an idea where I was coming from*" (patient 9, L177-178).

Patient participants also appreciated the diminished power differential fostered by the CP. Patient participants described working collaboratively with the CP (patient 8, L207), for example, through being asked for their own views (patient 6, L184). Similarly, patient participants described feeling "*almost on a level playing field*" with the CP (patient 9, L305-306), and a sense of the CP trying to "*stand in your shoes*" (patient 8, L64-65). However, one patient participant stated "*I didn't enjoy them [appointments], but I kept thinking 'well if it's going to help then it's going to help' … I don't think it was the right time for me, really*" (patient 7, L89-90).

The confidence of patient participants was also fostered through self-control of the timing and frequency of service use. Patient participants reported appreciating that the decision to attend further psychology appointments was "*up to you*" (patient 8, L182-187). While some patient participants saw the CP on more than one occasion, the modal appointment frequency across the pilot was one session (CP, L34), and the CP felt able to "*contain a lot*" in one session (CP, L66-67). Numerous patient participants also valued controlling the timing of service use, for example stating "*if I was not coping … I could always come back which was reassuring*" (patient 1, L201-202). Patient participants described seeing the CP in bursts (patient 2, L109-110), and

needing mental health support *"every so often"* (patient 6, L210). The CP felt that patients' knowledge of the availability of the service resulted in them feeling less need to use the service "*because they know they can"* (CP, L48) and, therefore, that the system structure "*allows it to be a lot more containing*" (CP, L51). One patient participant valued having the service as *"a back-up"* when needed (patient 8, L202-203) and another stated "*I want my independence but I need to know that somebody is there for me as well"* (patient 9, L197-198).

Empowerment

Many participants described a sense of empowerment as a result of the CPS and this occurred in numerous ways. There was a sense of empowerment of the practice as a whole, for example, with some staff participants perceiving that the quality of patient care had improved (staff member 5, L177-178; staff member 7, L141; staff member 10, L206). One staff participant stated that this was evidenced in *"… the way they [patients] talk when they come back [from seeing the CP]. They say 'I saw [CP pronoun], thank you very much'"* (staff member 1, L285-286). Another staff participant stated "*… it's [the CPS] providing them [patients] with support for their emotional needs, mental health needs and … offering them a treatment from a specialist …*" (staff member 7, L149-150). When discussing the impact of the CPS on patient care, another staff participant stated "*I think it depends on the patient's perceptions as well, so some patients I think want an instant fix so they haven't been happy with the appointment with the Clinical Psychologist*" (staff member 3, L129-130), whereas, with reference to another patient and their family member "*both feel that [CP name]'s input has dramatically changed how … [the patient] deals with self-harming and just [their] general anxiety levels*" (staff member 3, L127-128).

Some staff participants also appeared to view the practice in which they worked positively for trialling the new approach to patient care. Staff participants described the CPS as "*pioneering*" (staff member 1, L324), stated *"it's something that we offer that other practices don't have"* (staff member 7, L158), and also *"… as a practice … we like to try and offer nice and new things*

for our patients" (staff member 5, L107-108). This may have impacted on staff members' views about working in the practice.

Some staff participants reported a practical impact of the CPS. Some clinician participants described the service as reducing their own follow-up appointments (staff member 7, L95-100; staff member 9, L215-219) and *"halving the amount of time"* spent with a given patient (staff member 10, L110-111). One clinician participant stated *"my job becomes more … about pharmacodynamics"* (staff member 9, L225-226). Other staff participants felt that the service *"relieves the pressure … on the practice"* (staff member 6, L159) and *"helps the workload"* (staff member 4, L304). Another staff participant stated *"it's not been a noticeable change [in workload] … we're pretty busy … I wouldn't say that I've seen any change in the number of patients who are anxious or who have got mental health issues that require attention today"* (staff member 8, L145-149). This staff participant highlighted the difficulty in predicting how services would have been used without the CPS and acknowledged that the impact on workload may be subtle (staff member 8, L143-145). Through impacting on practical aspects of some staff participants' jobs such as time, workload and the nature of consultations, this appeared to allow staff to feel effective and capable within their role, allowing clinicians to utilise their skills more appropriately. Furthermore, one staff participant described reading the CP's clinical notes as *"quite powerful … because you pick up on other strategies for … providing psychological aid to people in your appointments"* (staff member 9, L67-71) and another described being directed to previously unknown resources (staff member 1, L177-180) to use in their own practice.

The ability to offer a specialist service also empowered staff participants. Staff participants described offering the service as going *"that step further"* for patients (staff member 6, L146) and stated *"it's just nice to be able to offer ... something … a way of maybe helping that patient out"* (staff member 5, L201). Other staff participants stated *"if you can offer something tangible then you feel … it's more satisfying"* (staff member 9, L243-244), and another appreciated having *"something to offer when you can feel a bit impotent"* (staff member 8, L126-127).

Patient participants also felt empowered by the CPS in a variety of ways. These included learning *"to let go of embarrassment about showing emotions"* (patient 1, L198-199), and learning different strategies for dealing with issues (patient 6, L184-189). A number of patient participants reported feeling enabled to help themselves and consequently being in a position to proceed independently of the CPS (patient 1, L206-208).

Empowerment was maintained after using the CPS, with patient participants reporting an ongoing impact of appointments (patient 9, L356-363). One patient participant described the CP as "*the catalyst to changing my life around"* (patient 1, L302-303) due to beginning their journey into exploring other mental health support (patient 1, L164-168). Numerous patient participants reported receiving helpful resource recommendations from the CP, which allowed them to help themselves outside of sessions, and some were signposted to other services (patient 5, L236-238).

Shared strain

Participants also viewed the CPS as sharing the strain. Staff participants described the CPS as "*sharing the burden"* (staff member 9, L235-236) and sharing clinical *"responsibility"* (staff member 10, L194). Staff participants reported feeling "*less concerned"* about patients who would otherwise be waiting for another mental health service (staff member 9, L241), and described the CPS as taking *"some of the stress off"* (staff member 3, L165-166) as well as *"being able to sleep … a bit easier"* (staff member 10, L198). Other staff participants perceived no personal emotional impact of the service.

Some patient participants described "*talking openly for the first time"* within the CPS (patient 9, L170-171) and saw the *"initial benefit of seeing [the CP as] … talking, opening up"* (patient 1, L281). Other patient participants described being helped to *"understand myself"* (patient 8, L366), gaining hope (patient 1, L56) and having experiences and feelings normalised (patient 1, L63-66). Patient participants reported feeling listened to (patient 6, L136-137) but also appreciated talking to someone who "*didn't just listen"* (patient 9, L177) but also suggested alternative options (patient 1, L275-277; patient 8, L364-369).

Moderating factors

Various factors impacted on all stages of participants' engagement with the CPS. These included structural aspects and personal characteristics.

Structural

Numerous structural and process-related factors impacted on participant CPS use. The ratio of CP time to practice size was an important aspect. One practice had almost twice as many registered patients than the other and correspondingly had a larger staff team. As the CP was present in both practices for the same time, the larger practice experienced proportionately less of the CPS. This was reflected in comparisons between clinicians' reports of the difference made by the CPS across the practices. The CP reflected that in the larger practice, staff had less "*frequency of outcome or … experience of what it's like when [their] patient has gone and seen the Clinical Psychologist*" (CP, 357-359). Having a smaller team also allowed the CP to have more personal contact with team members and build a greater level of rapport (CP, L350-352).

The importance of the simplicity and ease of referral to the CPS was also highlighted, with staff describing the importance of "*not putting any restrictions on accessing the clinical psychology service*" (staff member 9, L42). In order to facilitate this open service, the CP described the importance of "*being trained at the breadth and depth of a clinical psychologist*" (CP, L83-84), due to needing to draw on a variety of psychological models (CP, L472-481). Patient participants also emphasised the importance of obtaining mental health support not being made difficult (patient 8, L296-300), and highlighted the key role of reception staff in this process (patient 1, L232-236).

Staff participants valued the "*short waiting times*" for appointments (staff member 10, L79-80), and a number of patient participants experienced the service as responsive (patient 6, L265-270) due to obtaining "*an appointment quite quickly*" (patient 3, L153-157). One patient participant described having "*little time to chicken out*" (patient 1, L51). Efficient practice IT and paperwork

systems contributed to the CP's availability through limiting the time they spent on administrative tasks (CP, L459-461).

The majority of patient participants appreciated the locality of the service, which meant not needing to travel (patient 7, L195-196), which would have dissuaded them (patient 8, L294-295). Locating the service within the practice was also important. Patient participants described feeling *"confident going to your doctors"* (patient 8, L293-294), and saw this as "*being on home ground*" (patient 7, L195).

Another moderator was the length of the CP appointments. Staff participants described how patients *"need time to talk"* (staff member 1, L235) and therefore valued having someone *"who's got time to spend"* with patients (staff member 8, L104).

Patient participants also commented on their feelings regarding talking to a new professional. Some reported that practice staffs' familiarity with their family (patient 7, L158-159) and knowing staff socially (patient 1, L222-224) were barriers to discussing personal matters at the practice. While some described not knowing the CP beforehand as a positive factor (patient 1, L221-222), others were reluctant to re-tell their story to a new person (patient 5, L92-93).

Personal

Staff management style also moderated service use. One clinician participant described a tendency to *"try to manage things myself"* in the first instance (staff member 8, L107) and therefore being "*not a high referrer to anybody*" (staff member 8, L107), including the CPS. Contrastingly, another clinician described suggesting the service at *"that initial consultation where they [a patient] come in with anxiety or depression …"* (staff member 10, L170).

Patient participants also described a number of personal characteristics that affected the suitability of the CPS. Some patient participants described preferences regarding the CP's age. While one stated *"I think I can talk to somebody younger [better] now than somebody older or in my own age group"* (patient 8, L211-212), another reported preference for talking with a CP of a

similar age to them due to perceiving that they would have "*more experience of life*" (patient 7, L136-144). One patient participant also reported preference for the CP being female (patient 8, L377).

Patient participants also varied in their feelings regarding talking about mental health. While one described being experienced at "*talking and sharing*" (patient 6, L16), others disliked talking about personal issues (patient 7, L97).

The timing of using the CPS was also a key moderator for patients. One patient participant described the importance of seeing the CP at "*the right time*" (patient 9, L267-268), and others reported that their ability to engage fully with the CPS was impacted by their life circumstances, for example, due to the deteriorating health of a family member (patient 7, L60-61).

Further discussion

Summary of findings

This study utilised a constructivist grounded theory method to develop a model of the social and psychological processes involved in integrating a clinical psychology service into general practice. A framework was developed which positioned the categories of *making an investment, fostered confidence, empowerment* and *shared strain* against a context of *impotence*. A core over-arching category termed *help* was also developed. Both staff and patient participants contributed to each of these categories and this underscores the key and reciprocal roles of both groups within the collective experience of the CPS. The CP was also positioned as an active contributor, for example, being required to actively *foster the confidence* of both groups. A number of factors which moderated engagement with and experience of the CPS were also identified.

The current findings indicate that a CPS was able to operate within the two distinct general practices that were studied. Some level of efficiency is indicated by the modal appointment frequency being one and participant reports of short waiting times. Some participants also experienced the CPS as having a positive personal effect. However, over-arching claims of efficiency or effectiveness are inappropriate following this formative qualitative research.

Limitations

This study has explored an approach to mental health care that is novel within the current context and provides a model of the social and psychological processes involved, from multiple perspectives.

Limitations of the study should also be borne in mind when considering the findings and implications. All patient participants were over the age of 50 and this may have been due to the relatively reduced time commitments of some individuals within this age-bracket, for example, due to retirement. The views of patient participants may therefore represent only particular generations and not the wider group of individuals who utilised the CPS. For example, the experience of talking to a mental health professional may have been comparatively less novel for younger adults due to recent increases in media attention and anti-stigma campaigns concerning mental health.

It may also be considered a limitation that staff participants were nominated by senior staff members in each practice. While this was intended to promote the recruitment of informed participants within a variety of roles, it is possible that there was bias in the nomination of prospective staff participants. Selection bias may also have been present at the participant level, whereby those who positively experienced the service may have been more likely to take part. Furthermore, as a result of the eligibility criteria, all patient participants had used the service. Exploring reasons why some individuals decided against using the service may also have been fruitful.

As a result of time constraints and the sampling strategy, it is unlikely that theoretical saturation was achieved within the current study. While a considerable number of interviews were conducted, it is acknowledged that the sample was comprised of heterogeneous sub-groups, and thus that saturation is likely to have required relatively more participants compared to a homogenous sample.

The researcher's position as a Trainee Clinical Psychologist may also be considered a limiting factor. It is possible that this caused participants to suppress their views of the CPS. It remains possible that the researcher's

alignment to the clinical psychology profession may also have unwittingly impacted on other aspects of the research process, such as analysis and reporting of findings.

Trustworthiness of findings

Numerous steps were employed to enhance quality and rigour. While the constructivist mode of grounded theory encouraged awareness rather than prohibition of the researcher's influence, steps were also taken to ground the findings in the reports of participants. This was achieved through applying initial coding to small fragments of data, as opposed to large sections, and therefore ensuring that participant accounts were represented wholly rather than selectively. Memos were also maintained throughout the research process and served to clarify the analytic process and maintain consistency in the categorisation of coded data. Efforts to promote the credibility of tentative categories were also made through the iterative process of adjusting interview questions in response to the ongoing analysis. The analytic process was also shared with peers during qualitative peer supervision and a supervisor who is experienced in the application of the grounded theory method. This allowed for the analytic process and findings to be questioned and commented on, which subsequently helped to ensure that the analytic process made logical sense to other people and that the interpretations had credibility.

Comparison with existing literature

As this study explored an approach to service provision that is novel within the current context, comparable research is limited. However, some of the identified factors resonate with similar work concerning the incorporation of other professionals into GP practices. GPs' reports of feeling more able to appropriately use their skills following the introduction of Clinical Pharmacists[17] echoes the category of *empowerment* constructed herein. The importance of the accessibility of the new professional to practice staff was also endorsed in the current study.

Nelson et al.[34] conducted a review of international research on skill-mix changes in general practice, encompassing various roles including Advanced

Nurse Practitioners and Physiotherapists. While such changes were generally found to support patient care and satisfaction, the impact on GP workloads was questioned. Notably, the current findings suggest that it may not solely be clinician workloads that are problematic but the nature of the work. This study suggests that the introduction of a specialist professional may empower clinicians both to signpost patients with whom they previously felt ineffective and to more appropriately utilise their skillset.

It is further notable that the contextual factor of staff participants' perceived *impotence* regarding supporting patients presenting with mental health difficulties concurs with an array of existing literature. The current study supported previous findings of staff members questioning their own professional competence,[8,9] and experiencing mental health as incompatible with general practice operating structures.[10,11] This alignment indicates that the practices studied herein may be somewhat representative of wider general practices and thus the findings may be transferable to a certain extent. However, further research is required to verify this.

Implications for research and practice

This study has explored one method of implementing policy recommendations which aim to address the current pressures in general practice[3,5] through incorporating specialist clinicians.[5,15] The findings posit that the integration of a CP into general practice was a functional model of care within the studied contexts. The research also provides a theoretical account of the processes involved in the operation of the service and suggests a number of factors that moderate engagement with and experience of the service. These may inform the design of future healthcare services.

However, the scope of the current qualitative research did not permit exploration of every aspect of incorporating a CP into general practice. Future research investigating quantitative factors such as financial implications for host practices is crucial. Research on the impact of the general practice CPS on the use of local specialist mental health services is also pertinent. Examination of whether the introduction of the CPS affected trends of patients

registering/ transferring to the host general practices, and the subsequent impact on the host practices and other local practices, is also of interest.

It may also be informative to investigate the views of clinicians within general practices which have a CPS regarding whether the service impacts on their skills and confidence concerning working with patients presenting with mental health difficulties, for example, through impacting on opportunities to learn through experience. Finally, careful consideration is required regarding the potential impact on numbers within the wider clinical psychology workforce should the model be implemented more widely.

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WE0OGItNGVjM2QwNjAzZGQ0IiwidCI6IjUwZjYwNzFmLWJiZmUtND
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Appendix 1: University ethical approval to conduct study

STAFFORDSHIRE UNIVERSITY

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	Stephanie Raybould
Title of Study	How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?
Award Pathway	DClinPsy
Status of approval:	Approved

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Action now needed:

You must now apply through the Integrated Research Applications System (IRAS) for approval to conduct your study. You must not commence the study without this second approval. Please note that for the purposes of the IRAS form, the university sponsor is ▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇.

Please forward a copy of the letter you receive from the IRAS process to ethics@staffs.ac.uk as soon as possible after you have received approval.

Once you have received approval you can commence your study. You should be sure to do so in consultation with your supervisor.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

When your study is complete, please send the IPR coordinator ▇▇▇▇▇▇▇▇▇ an end of study report. A template can be found on the ethics BlackBoard site.

Comments for your consideration:

▇▇▇▇▇▇▇▇▇

Signed: ▇▇▇▇▇▇▇
University IPR coordinator

Date: 16.10.18

Appendix 2: Health Research Authority (HRA) approval letter

Ymchwil Iechyd
a Gofal Cymru
Health and Care
Research Wales

NHS
Health Research
Authority

Email: hra.approval@nhs.net
Research-permissions@wales.nhs.uk

Staffordshire University
Clinical Psychology Department, Science Centre,
Staffordshire University
Leek Road
Stoke-on-Trent
ST4 2DE

11 February 2019

Dear

**HRA and Health and Care
Research Wales (HCRW)
Approval Letter**

Study title:	How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?
IRAS project ID:	255455
REC reference:	19/EM/0008
Sponsor	Staffordshire University

I am pleased to confirm that HRA and Health and Care Research Wales (HCRW) Approval has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications received. You should not expect to receive anything further relating to this application.

How should I continue to work with participating NHS organisations in England and Wales?
You should now provide a copy of this letter to all participating NHS organisations in England and Wales, as well as any documentation that has been updated as a result of the assessment.

Following the arranging of capacity and capability, participating NHS organisations should **formally confirm** their capacity and capability to undertake the study. How this will be confirmed is detailed in the "*summary of assessment*" section towards the end of this letter.

You should provide, if you have not already done so, detailed instructions to each organisation as to how you will notify them that research activities may commence at site following their confirmation of capacity and capability (e.g. provision by you of a 'green light' email, formal notification following a site initiation visit, activities may commence immediately following confirmation by participating organisation, etc.).

It is important that you involve both the research management function (e.g. R&D office) supporting each organisation and the local research team (where there is one) in setting up your study. Contact details of the research management function for each organisation can be accessed here.

How should I work with participating NHS/HSC organisations in Northern Ireland and Scotland?
HRA and HCRW Approval does not apply to NHS/HSC organisations within the devolved administrations of Northern Ireland and Scotland.

If you indicated in your IRAS form that you do have participating organisations in either of these devolved administrations, the final document set and the study wide governance report (including this letter) has been sent to the coordinating centre of each participating nation. You should work with the relevant national coordinating functions to ensure any nation specific checks are complete, and with each site so that they are able to give management permission for the study to begin.

Please see IRAS Help for information on working with NHS/HSC organisations in Northern Ireland and Scotland.

How should I work with participating non-NHS organisations?
HRA and HCRW Approval does not apply to non-NHS organisations. You should work with your non-NHS organisations to obtain local agreement in accordance with their procedures.

What are my notification responsibilities during the study?
The document "*After Ethical Review – guidance for sponsors and investigators*", issued with your REC favourable opinion, gives detailed guidance on reporting expectations for studies, including:
- Registration of research
- Notifying amendments
- Notifying the end of the study

The HRA website also provides guidance on these topics, and is updated in the light of changes in reporting expectations or procedures.

I am a participating NHS organisation in England or Wales. What should I do once I receive this letter?
You should work with the applicant and sponsor to complete any outstanding arrangements so you are able to confirm capacity and capability in line with the information provided in this letter.

The sponsor contact for this application is as follows:

Name:
Tel:
Email:
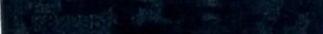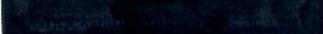
Who should I contact for further information?
Please do not hesitate to contact me for assistance with this application. My contact details are below.

Your IRAS project ID is **255455**. Please quote this on all correspondence.

Yours sincerely

████████████

Assessor

Telephone: ████████████
Email: hra.approval@nhs.net

Copy to: ██████████████████████ *Sponsor Contact, Staffordshire University*

Appendix 3: Research Ethics Committee (REC) approval letter

NHS

Health Research Authority

East Midlands - Nottingham 1 Research Ethics Committee
The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

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

11 February 2019

█████████
Clinical Psychology Department,
Science Centre, Staffordshire University
Leek Road,
Stoke-on-Trent
ST4 2DE

Dear █████████

Study title:	How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?
REC reference:	19/EM/0008
Protocol number:	N/A
IRAS project ID:	255455

Thank you for your letter of 01 February 2019, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to make a request to postpone publication, please contact hra.studyregistration@nhs.net outlining the reasons for your request.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

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

Management permission must be obtained from each host organisation prior to the start of the study at the site concerned.

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

Guidance on applying for HRA and HCRW Approval (England and Wales)/ NHS permission for research is available in the Integrated Research Application System, at www.hra.nhs.uk or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

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

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will

be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from the HRA. Guidance on where to register is provided on the HRA website.

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

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Staffordshire Universty IPR Feedback (final)]		16 October 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Staffordshire University IPR Feedback - Reviewer 1 of 2]		12 October 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [Staffordshire University IPR Feedback - Reviewer 2 of 2]		16 October 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [GCP Certificate]		05 October 2018
Confirmation of any other Regulatory Approvals (e.g. CAG) and all correspondence [R & D Contacts]		
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [Staffordshire University Indemnity Insurance Certificate]		16 July 2018
Interview schedules or topic guides for participants [Draft Interview Schedule - Patients]	1.00	24 September 2018
Interview schedules or topic guides for participants [Draft Interview Schedule - Staff]	1.00	24 September 2018
Interview schedules or topic guides for participants [Draft Interview Schedule - Clinical Psychologist]	1.00	24 September 2018
IRAS Application Form [IRAS_Form_11122018]		11 December 2018
IRAS Application Form [IRAS_Form_01022019]		01 February 2019
Letters of invitation to participant [Standard Letter of Invitation - Patient]	1.01	30 January 2019
Letters of invitation to participant [Accessible Letter of Invitation - Patient]	1.01	30 January 2019
Letters of invitation to participant [Email Invitation - Staff]	1.01	30 January 2019
Letters of invitation to participant [Email Invitation - Clinical Psychologist]	1.01	30 January 2019
Participant consent form [Standard Patient Consent Form]	1.01	29 January 2019
Participant consent form [Accessible Patient Consent Form]	1.01	29 January 2019
Participant consent form [Staff Consent Form]	1.01	29 January 2019
Participant consent form [Patient - Parent of Child or Young Person	1.01	29 January 2019

Age 6-15 Consent form]		
Participant information sheet (PIS) [Standard Patient Study Information Sheet]	1.01	29 January 2019
Participant information sheet (PIS) [Accessible Patient Study Information Sheet]	1.01	29 January 2019
Participant information sheet (PIS) [Staff Study Information Sheet]	1.01	29 January 2019
Participant information sheet (PIS) [Clinical Psychologist Study Information Sheet]	1.01	29 January 2019
Participant information sheet (PIS) [Patient - Child age 6-10 Study Information Sheet]	1.01	29 January 2019
Participant information sheet (PIS) [Patient - Young person age 11-15 Study Information Sheet]	1.01	29 January 2019
Participant information sheet (PIS) [Parent of child/ young person Study Information Sheet]	1.00	29 January 2019
Research protocol or project proposal [Research Proposal Approved by Staffordshire University Independent Review Panel]	1.00	24 September 2018
Summary CV for Chief Investigator (CI) [Summary CV for Chief Investigator]	1.00	19 October 2018
Summary CV for student [Summary CV for Student (Principal Investigator - Stephanie Raybould)]	1.00	22 October 2018
Summary CV for supervisor (student research) [Academic Supervisor CV (Dr Helen Combes)]	1.0	19 October 2018
Summary CV for supervisor (student research) [Academic Supervisor CV (Dr Helen Combes - Chief Investigator)]	1.0	19 October 2018

Statement of compliance

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

After ethical review

Reporting requirements

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

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

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

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

19/EM/0008	Please quote this number on all correspondence

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

Yours sincerely,

[redacted]

Chair

Email:NRESCommittee.EastMidlands-Nottingham1@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: [redacted] *See attached document 'Confirmation of any other regulatory approvals – R & D Contacts'*

Appendix 4: E-mail communication with West Midlands Clinical Research Network (CRN) advising re. R&D approval

From: ██████████████ @nihr.ac.uk>
Sent: 29 May 2018 08:14
To: RAYBOULD Stephanie L
Cc: ██████
Subject: Re: Query - Primary Care Research

Hi Steph

Thanks for your reply. The two GP Practices you have identified can provide the permission directly, and I can see you've pre-identified them, so it will be a matter of confirming their support for the study to occur at the Practices. If you were working with the CCG we would advise to approach the point of contact there. In your case and for other student research (Masters or Doctorate level) we advise for permission to be obtained at Practice level as they would have to determine that they have the capacity and capability to support your research, such as room hire for interviews.

I hope this helps.

Kind regards,

██████

██████
Senior Research Support Facilitator | CRN West Midlands | NIHR Clinical Research Network (CRN)

NHS
National Institute for Health Research

Appendix 5: Example of GP practice confirmation of capability and capacity to host the research

Management permission to conduct study

I _____ confirm that I have read the Health Research Authority (HRA) approval letter and supplementary documentation and that ████████████ has the capability and capacity to host the research as described.

Date: _____ 21.2.19 _____

Signed: _____ ████████ .

Appendix 6: Example letter of access to GP practice

Date: 14.02.19

Dear Stephanie Raybould

Letter of access for research

In accepting this letter, ▮▮▮▮▮▮▮▮▮▮▮confirms your right of access to conduct research through their organisation for the purpose and on the terms and conditions set out below. This right of access commences on 13.02.19 and ends on 26.04.19 unless terminated earlier in accordance with the clauses below.

As an existing NHS employee at ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ you do not require an additional honorary research contract with the participating organisations. The organisations are satisfied that the research activities that you will undertake in the organisations are commensurate with the activities you undertake for your employer. Your employer is fully responsible for ensuring such checks as are necessary have been carried out. Evidence of pre-engagement checks should be available on request to ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ Clinical Psychology Department at Staffordshire University.

You have a right of access to conduct such research as confirmed in writing in the 'management permission to undertake study' note from this organisation. Please note that you cannot start the research until the Principal Investigator for the research project has received this confirmation from us giving the organisation's permission to conduct the project.

You are considered to be a legal visitor to ▮▮▮▮▮▮▮▮▮▮▮premises. You are not entitled to any form of payment or access to other benefits provided by ▮▮▮▮▮ ▮▮▮▮▮▮▮▮to employees and this letter does not give rise to any other relationship between you and ▮▮▮▮▮▮▮▮▮▮ in particular that of an employee.

While undertaking research through ▮▮▮▮▮▮▮▮ you will remain accountable to your employer ▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮▮ but you are required to follow the reasonable instructions of your nominated points of contact in the organisation or those given on her/his behalf in relation to the terms of this right of access.

Where any third party claim is made, whether or not legal proceedings are issued, arising out of or in connection with your right of access, you are required to co-operate fully with any investigation by ▮▮▮▮▮▮▮▮▮▮in connection with any such claim and to give all such assistance as may reasonably be required regarding the conduct of any legal proceedings.

You must act in accordance with ▮▮▮▮▮▮▮▮▮policies and procedures, which are available to you upon request, and the Research Governance Framework.

You are required to co-operate with ▮▮▮▮▮▮▮▮▮in discharging its duties under the Health and Safety at Work etc Act 1974 and other health and safety legislation and to take reasonable care for the health and safety of yourself and others while on ▮▮▮▮▮▮premises. Although you are not a contract holder, you must observe the same standards of care and propriety in dealing with patients, staff, visitors, equipment and premises as is expected of a contract holder and you must act appropriately, responsibly and professionally at all times.

NHS to NHS letter of access for NH researchers who have a substantive NHS contract of employment with the organisation or clinical academics with an honorary clinical contract with an NHS organisation Research in the NHS: HR Good Practice Resource Pack. Adapted 13.02.19.
Page 1 of 2

If you have a physical or mental health condition or disability which may affect your research role and which might require special adjustments to your role, if you have not already done so, you must notify your employer and each participating site prior to commencing your research role at each site.

You are required to ensure that all information regarding patients or staff remains secure and *strictly confidential* at all times. You must ensure that you understand and comply with the requirements of the NHS Confidentiality Code of Practice and the Data Protection Act 1998. Furthermore you should be aware that under the Act, unauthorised disclosure of information is an offence and such disclosures may lead to prosecution.

The organisation(s) will not indemnify you against any liability incurred as a result of any breach of confidentiality or breach of the Data Protection Act 1998. Any breach of the Data Protection Act 1998 may result in legal action against you and/or your substantive employer.

You should ensure that, where you are issued with an identity or security card, a bleep number, email or library account, keys or protective clothing, these are returned upon termination of this arrangement. Please also ensure that while on the premises you wear your ID badge at all times, or are able to prove your identity if challenged. Please note that the organisation(s) accept no responsibility for damage to or loss of personal property.

This letter may be revoked and your right to attend the organisations terminated at any time either by giving seven days' written notice to you or immediately without any notice if you are in breach of any of the terms or conditions described in this letter or if you commit any act that we reasonably consider to amount to serious misconduct or to be disruptive and/or prejudicial to the interests and/or business of the organisation(s) or if you are convicted of any criminal offence. You must not undertake regulated activity if you are barred from such work. If you are barred from working with adults or children this letter of access is immediately terminated. Your employer will immediately withdraw you from undertaking this or any other regulated activity and you MUST stop undertaking any regulated activity immediately.

Your substantive employer is responsible for your conduct during this research project and may in the circumstances described above instigate disciplinary action against you.

If your circumstances change in relation to your health, criminal record, professional registration or suitability to work with adults or children, or any other aspect that may impact on your suitability to conduct research, or your role in research changes, you must inform the organisation that employs you through its normal procedures. You must also inform the nominated manager in each participating organisation..

Yours sincerely

████████ **GP Partner** ████████

cc: ████████ **Administrator to Trainee Clinical Psychologists at** ████

Appendix 7: Example participant study information sheet (staff version)

STAFFORDSHIRE UNIVERSITY

Study Information

How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?

Purpose of Study

This study will form part of a Doctoral thesis undertaken at Staffordshire University. This study will investigate how having a Clinical Psychologist within the team at a general practice affects the experience of staff and patients.

The local GP surgery is the first place that most people go to talk about their health problems, including mental health. However, at the moment some GPs have described feeling that they are under a lot of pressure. As around 1 in 4 GP consultations is about mental health, professional organisations have recommended having staff who specialise in mental health working in general practices. The current research aims to investigate the experience of this, for staff and patients.

What does the study involve?

Taking part in the study will involve attending an interview with a researcher, in the practice in which you work. Interview questions will be about your experience of your job role before and after a Clinical Psychologist has been in the team. The interview is designed to last around 30 minutes but you will be able to stop the interview at any time, without any effect on your employment. The interview will be audio-recorded so that the researcher can look at your responses in more detail later on.

What are the possible benefits of taking part?

This study may gather important information about a new kind of GP service. This will contribute to understanding how GP services may be developed differently in the future.

What are the possible negatives of taking part?

There are no known risks of taking part in the study. Your interview information will be confidential and anonymous and you will have the option to withdraw from the interview at any time.

1

What happens after the interview?

In the consent form prior to the interview, you will be asked whether the researcher may contact you again if other questions come up during this study that you may be able to help us answer. Your answer to this will not affect your ability to take part in the first interview. Depending on your response to this, you may be contacted again.

When the study is finished it will be written into a report. This will be submitted to Staffordshire University as well as appropriate committees within ▓▓▓▓▓▓▓▓ ▓▓▓▓▓▓▓▓▓▓▓▓▓ It will also be sent for publication in an academic journal.

What if I change my mind after taking part in the interview?

If, after taking part in the interview, you decide that you no longer want your responses to be used then you can request to have your responses removed from the study. This will be possible for up to 1 month after your interview has taken place. After this time the data would have been processed and anonymised. You can make a request to have your responses removed by sending a letter or e-mail to Stephanie Raybould using the details below.

Data Handling and Confidentiality

Staffordshire University, based in England, is the sponsor for this study. The University will be using information from you in order to undertake this study and will act as the data controller for this study. This means that the University is responsible for looking after your information and using it properly.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study more than 1 month after interview data has been collected, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible. You can find out more about how Staffordshire University will use your information at http://www.staffs.ac.uk/data-protection/.

Staffordshire University will collect information from you for this research study in accordance with the instructions. Once you have indicated that you would like to be contacted regarding taking part in the study (via your reply slip/ direct contact with the research team), your reply slip and contact details will be passed to the research team at Staffordshire University. The research team at Staffordshire University will then use your name and contact details to contact you about the research study. The only people in

2

Staffordshire University who will have access to information that identifies you will be people in the specific research team or people who audit the data collection process. When the interview data is being analysed it will be anonymous. This means that the researcher will not be able to identify you from the data or find out your name or contact details.

During the study your personally-identifiable information will be stored securely at Staffordshire University. Staffordshire University will keep identifiable information about you from this study for less than 3 months after the study has ended.

Audio recordings will be temporarily stored on a password-protected University computer and permanently deleted after the interview has been transcribed. Transcription is expected to take place no later than one week following the interview.

After the study has ended, anonymous data generated from the study will be kept at a secure research deposit in the university and will be destroyed after 10 years, as per the institution's research policy.

Individuals from Staffordshire University and regulatory organisations may look at the research records to check the accuracy of the research study.

What if there is a problem?

If you would like to make a complaint about the research, you can either use the contact details in the below table or contact researchservices@staffs.ac.uk.

Contact details

Principal Investigator	Research Supervisor
Stephanie Raybould	
Clinical Psychology Department Staffordshire University, Science Centre, Leek Road, Stoke-on-Trent, ST4 2DE e-mail: ▇▇▇@student.staffs.ac.uk	Clinical Psychology Department Staffordshire University, Science Centre, Leek Road, Stoke-on-Trent, ST4 2DE e-mail: ▇▇▇

Has anyone reviewed the project?

The study has been reviewed and accepted by the Staffordshire University Independent Peer Review Panel and the Nottingham 1 Research Ethics Committee.

Thank you for taking the time to read this Study Information Sheet.

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Appendix 8: Example patient letter of invitation (standard version)

Letter of invitation – Patient-Standard - V1.01   General Practice Logo/ header
IRAS ID: 255455
Date: 30/01/2019

** To be edited at the discretion of 'link' staff member or practice staff member identified by 'link' staff member **

Date

Recipient address   *General Practice address*

Dear *(prospective participant name)*,

Invitation to take part in a research study

As you know, a Clinical Psychologist has been working in [practice name] for a number of months. We are contacting you as you, or an individual under the age of 16 for whom you are a parent/ guardian, have used this Clinical Psychology service.

Stephanie Raybould, a Trainee Clinical Psychologist at Staffordshire University who works for ▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓▓ is currently carrying out some research about the clinical psychology service at [practice name]. Stephanie would like to talk with individuals who have used the service to find out how you, or the person in your care, found this. We are contacting you to let you know about the research and to give you the opportunity to take part, if you so wish.

Please find enclosed a Study Information Sheet for more information about the study and what taking part would involve.

If you are being contacted in relation to an individual under the age of 16 for whom you are a parent/ guardian, a second, more accessible Study Information Sheet is included which may help the child/ young person to decide if they would like to take part.

When you have read the Study Information Sheet, please complete the reply slip at the bottom of the letter.

Please tear off the reply slip and return this to the practice using the stamped-addressed envelope provided. If you would prefer to contact the research team directly then they can be called on ▓▓▓▓▓▓▓ If there is no answer then please leave your name and an

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answerphone message. If you wish for the research team to return your call then please also leave a contact number.

If you have stated that you would like be contacted by telephone to discuss the research then you can expect this to happen within 3 weeks of the research team receiving your response.

If you do not return the reply slip or contact the research team within 3 weeks of this letter then it will be assumed that you do not wish to take part.

[Signed off by member of practice staff]

Enc. Study Information Sheet, stamped-addressed envelope.

_ _

REPLY SLIP

I would like the researcher to contact me by telephone to talk more about the research and/ or arrange an interview.

I would not like the researcher to contact me by telephone to talk more about the research and/ or arrange an interview.

_____   _____   _____

Name of person completing slip   *Date*   *Signature*

_____

Name of person that used the Clinical Psychology service
(if not the same as above)

_____

Preferred contact number

2

Appendix 9: Example participant consent form (patient - standard version)

CONSENT FORM

How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?

Name of Researcher: Stephanie Raybould, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read the Study Information Sheet. I have had the opportunity to consider the information, ask questions and am satisfied with the answers.

2. I am aware that the interview will be audio-recorded and know why this is the case and what will happen with the recording.

3. I understand that my taking part is voluntary and that I am free to withdraw at any time without giving any reason and without my healthcare or other rights being affected in any way.

4. I understand that the anonymous data I provide will be shared with the research team in Staffordshire University and ▮▮▮▮▮▮▮▮▮ where it is relevant to the research.

5. I understand that personal details from the study will not be shared with anyone outside of the research team unless there is a serious risk of harm to me or others. I know that if the researcher believes there is a serious risk, they will share this with my GP or another member of staff at the general practice.

6. I understand that only part of the interview transcripts may be included in the study report and that any identifying details will be removed beforehand. Study findings, including part of the interview transcript, may also be shared in other formats, such as academic publications and professional conferences.

7. I agree to take part in this study.

8. Following the initial interview, I consent to being contacted by the researcher to discuss the option of providing further information for the study.

_____   _____   _____
Name of Participant   Date   Signature

_____   _____   _____
Name of Researcher   Date   Signature

Page 1 of 1

Appendix 10: Original interview guide – patient

How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?

Participant No. _____

1. **Did you visit your GP practice to talk about a mental health difficulty before March 2016? If so. Tell me about your experience of this.**
   Prompts:
   - *How did you feel about talking about this with the staff member? How did the conversation go?*
   - *What was the staff member's response/ what happened next?*
   - *In what way did this experience affect how you felt about visiting your GP practice to talk about mental health in the future?*

2. **Tell me about your experience of having a Clinical Psychologist join the Practice Team**
   Prompts:
   - *How did you find out about the Clinical Psychologist joining the team? What were your thoughts about this?*
   - *How did you feel before your appointment with the Clinical Psychologist? What were you expecting?*
   - *What was your experience of the appointment?*
   - *What happened next?*
   - *(If previous experience) How did this compare to your previous experience of discussing your mental health at your GP practice?*
   - *Tell me about your contact with other GP practice staff members in relation to your mental health since the Clinical Psychologist has worked at the practice*
   - *In what way did meeting with the Clinical Psychologist affect how you felt about discussing your mental health?*

3. **Is there anything else you would like to tell me about having a Clinical Psychologist join the Practice Team?**

Appendix 11: Interview guide – Clinical Psychologist

Clinical Psychologist Interview Schedule_V1.00
Date: 24/09/2018

How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?

Participant No. _____

1. **Tell me about your experience of joining the Practice Team.**
   Prompts:
   - *Initial feelings/ expectations/ apprehensions?*
   - *What was your experience of the early weeks/ months/ setting up of the pilot?*
   - *What was your experience of early consultations? Did this change as time progressed?*
   - *Did your role change as time progressed? Why?*
   - *Have you had any feedback (positive or negative) from patients or staff?*
   - *How did the role compare to your previous Clinical Psychology posts?*
   - *Overall, how have you found the role?*
   - *What do you feel would be important for another Clinical Psychologist to know if they were considering taking a similar post?*

2. **Is there anything else you would like to tell me about joining the Practice Team?**

Appendix 12: Original interview guide – staff

How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?

Participant No. _____

Role within organisation: _____

Amount of time working within the organisation: _____

1. **Tell me about how the mental health difficulties of patients directly affected you in your job role prior to the Clinical Psychologist joining the team.**
   Prompts:
   - *How much of your job role concerned patients presenting with mental health difficulties? Had you noticed a change in this?*
   - *How equipped did you feel to understand and interact with patients presenting with mental health difficulties?*
   - *In what way did the nature of this work impact on you (for example, emotionally/ job satisfaction)?*

2. **Tell me about your experience of having a Clinical Psychologist join the Practice Team**
   Prompts:
   - *Initial feelings/ expectations/ apprehensions?*
   - *Prior conceptions of Clinical Psychologists?*
   - *First meeting or interaction with Clinical Psychologist.*
   - *Working alongside the Clinical Psychologist – examples.*
   - *In what way has this impacted on the practical aspects of your job (e.g. workload, time)?*
   - *In what way has this impacted on the emotional aspects of your job (e.g. satisfaction, self-efficacy, support)?*
   - *In what way has this impacted on the quality of care you (or the Practice) are able to give patients?*
   - *What do you feel would be important for staff at another Practice to know if they were considering developing a clinical psychology service?*

3. **Is there anything else you would like to tell me about having a Clinical Psychologist join the Practice Team?**

Appendix 13: Example of an adjusted interview guide – staff (additions highlighted)

Staff Interview Schedule_V1.02
Date: 11/03/2019

How does incorporating a Clinical Psychologist within a General Practice team impact on staff and patients?

Participant No. _____

Role within organisation: _____

Amount of time working within the organisation: _____

1. **Tell me about how the mental health difficulties of patients directly affected you in your job role prior to the Clinical Psychologist joining the team.**
   Prompts:
   - *How much of your job role concerned patients presenting with mental health difficulties? Had you noticed a change in this?*
   - *How equipped/ confident did you feel to understand and interact with patients presenting with mental health difficulties?*
   - *In what way did the nature of this work impact on you (for example, emotionally/ job satisfaction)?*

2. **Tell me about your experience of having a Clinical Psychologist join the Practice Team**
   Prompts:
   - *Initial feelings/ expectations/ apprehensions?*
   - *Prior conceptions of Clinical Psychologists?*
   - *First meeting or interaction with Clinical Psychologist.*
   - *Working alongside the Clinical Psychologist – examples.*
   - *How regularly do you refer to the Clinical Psychology service?*
   - *Tell me about your decision process for referring to Clinical Psychology service?*
   - *In what way has this impacted on the practical aspects of your job (e.g. workload, time)?*
   - *In what way has this impacted on the emotional aspects of your job (e.g. satisfaction, self-efficacy, support)?*
   - *In what way has this impacted on the quality of care you (or the Practice) are able to give patients?*
   - *Where do you position the Clinical Psychologist in relation to the wider practice team?*
   - *What do you feel would be important for staff at another Practice to know if they were considering developing a clinical psychology service?*

3. **Is there anything else you would like to tell me about having a Clinical Psychologist join the Practice Team?**

Appendix 14: Illustrative example of transcript coding

Initial Codes	Transcript	Focussed Codes	Grouped Focussed Codes
Taking the cork out of the bottle/ Learning to let go of embarrassment/ Normalising emotions/ Gaining hope/ CP as being a rock to move on from/ Knowing the CP's door was always open/ Feeling reassured by ability to return to CP	P: Oh totally. It was like taking the cork out of a bottle. It umm I learnt to let go of err embarrassment about showing emotions and umm that it's normal, we've all got them. Umm and that was really, you know, I go back to the hope, umm that gave me umm a rock to err move on but I always knew that if I needed it, if I was not coping then [CP'] door was open and I could always come back which was reassuring.	Opening up. / Being more comfortable talking about... / Normalising experiences / Being in control	Opening up. / Exploring alternatives. / Opening up. / Control.
	S: Yeah. And it sounds like you did that, at various points throughout your journey with other services, you were able to fall back onto (CP forename).		
CP serving their purpose / Being in a position to proceed independently of CP / Having half an hour being immense / Being saved	P: Yes, yes. I only stopped going to see [CP pronoun] because I realised that umm, I realised that, this is terrible, that [CP pronoun] had served [CP pronoun's] purpose. In that err [CP pronoun] had pointed me in the right direction, however that direction might have changed as I went along the journey and err that umm I could better umm proceed with the others, the other people that I was in, well my psychologist [CMHT psychologist name] who I see for an hour and I can talk, and I do, whereas with (CP forename) I only had half an hour, and half an hour at the time was immense umm, so it's I guess it's umm, [CP pronoun's] actually been err, I'm not going to say my saviour but I will. It is thanks to Dr (CP surname) that I am here talking to you.	Feeling empowered to help self. / Having the time to talk.	Exploring alternatives. / feeling at ease.
	S: Mm, that's powerful.		
Realising the depth of darkness/ Feeling hopeless	P: Totally. I never umm, it's only when you've come through it that you realise the umm depth of the dark place that you were in and how umm hopeful you felt. Hopeless (laugh), there we go!	Experiencing distress.	

Categories: ☐ Shared Strain   ☐ Empowerment   ☐ Fostered Confidence

Appendix 15: Example of category development – Empowerment

Category	Grouped focussed codes	Focussed codes	Sample of initial codes
Empowerment	Feeling effective in role (staff)	• Practically affecting own role	• Helping with workload, benefitting GP's time, no noticeable change in on-the-day, having an impact on receptionists, big impact on GP time, revolutionising handling of MH, helping time for Practice Nurse, following-up patients less, reducing GP appointments, booking to see CP not GP, GP appointments being available for other patients, halving time spent with patient, not impacting on job, impacting on staff, GP role becoming only about medication, relieving pressure, other doctors reporting how much CP helped their patients, impact being subtle, not finding CP service useful personally.
		• Changing patient care	• Varying patient satisfaction, impacting on quality of care, practice making a strong impact, impacting positively on patients, never hearing any negative feedback, improving quality of care, varying impact of seeing CP. • [Patients] Learning new strategies, augmenting what already knew, helping patient to solve own problems, not just listening, good outcomes, helping patient decide what want next, building rapport,

				•	empowering patients, challenging to be honest, diffusing situation, un-muddling things.
		•	Contributing to the team	•	Psychological skills rubbing off, originally attending team meetings, having input to complex case discussions, learning events, using CP as a resource, recommending books (staff)/ online resources, taking opportunities to ask CP questions, de-escalating patients in waiting room.
		•	Having something to offer	•	Knowing you have pointed someone in the right direction, done your part, knowing a service is available, offered patients something, knowing somebody is there, knowing you have taken action, patients not expecting the CP offer, going a step further, something to offer when feeling impotent, showing the patient you're trying, feeling nice to be able to offer something, patients having someone to speak to, patients feeling something is being done, feeling more satisfying to offer something tangible, (not) feeling you have failed.
		•	Positive views on practice innovation	•	Providing a holistic service, pioneering, other practices envying, something other practices don't have.
	Exploring alternatives (patients)	•	Feeling different about talking	•	Learning to open up, changing feelings about opening up, having an impact on feelings about taking about mental health, learning to let go of embarrassment.

		• Feeling empowered to help self	• Onus being on you, acknowledging own role in recovery, having to make an effort.	
			• Being encouraged to be independent, acknowledging own strength, building confidence to manage situations differently, getting confidence from the CP, CP serving their purpose, being supported to self-manage, being able to proceed independently of CP, CP helping to help self, having the tools to manage, being empowered to help self x 2, helping self outside of sessions.	
		• Developing new strategies	• Learning not to dismiss family, refocusing on self, learning to look after self, learning different strategies, opening the mind, getting a different response from CP, looking at problems in new ways, getting surprising answers, receiving unexpected replies from the CP, experiencing the CP's approach as different.	
			• Initially doubting benefit of new strategies, taking a leap, getting a good response, implementing recommended strategies, partner's approach adapting to strategies used,	
			• Lifted up, helped, saved life, not recalling what was discussed, valuable, big impact, saviour, beneficial, getting a lot, feeling different, ongoing impact, success leading to further success.	
		• Widening resources	• Receiving resources from the psychologist, being told about things to research on the internet, getting book recommendations, receiving resources/ paperwork, CP giving recommendations that fitted with existing skills, being helped by book recommendation.	

			• CP gradually suggesting other support options, self-referring to IAPT, trusting CP's recommendations, CP thinking CMHT would be helpful, CP being a catalyst for other support, signposting to specialist services, feeling supported by community group.

TIME

Appendix 16: Example of a memo

Memo: 27.02.19

As yet, staff responses to the introduction of the service are rather similar. Most staff have described feeling positive/ hopeful but this is mixed with concerns and questions.

Wil it work?

How will it fit in?

Is this an expected response? I wonder whether staff have come to lack trust in new 'initiatives'. Many staff have held their job roles for a long time and have described seeing many changes in general practice. I have been surprised by how much these directly affect staff – not knowing what's available, where to direct patients. Some services end and staff aren't aware, some services start up and they aren't aware. This seems to add to the problems of perceived self-efficacy in supporting patients with mental health.

Moreover, staff responses in these initial interviews illustrate the large impact that the starting of a *new* service (especially if it is situated in the practice) has on them. Particularly administrative and managerial staff. There are practical issues to contend with such as organising rooms, booking clinics, developing advertisements etc. They have also described being front-line to patients (i.e. on reception) and thus having some responsibility/ expectation to promote the service/ answer calls from patients about the service etc. Their level of knowledge about the service is vital. Also for clinicians who are promoting the service within consultations. They may have a long-term relationship with the patient and therefore may be taking somewhat of a 'risk' by recommending a new 'untested' service with an unfamiliar member of staff. Why do staff bother? To some extent it is part of their job but staff genuinely seem to want to be able to use the service correctly and get the most out of it.

Tentative staff category:

Wanting to use the service correctly

Feels like more than a 'wanting' to use the service correctly, possibly a 'striving'?

Update: 11.04.19

Suggested staff category of 'navigating a new service' with contributing grouped focussed codes: developing confidence (in using the service) and striving to use service appropriately. These groups interact – staff develop confidence in the service through interacting with CP (helped by CP being in the practice building) and observing patient use of the service. This feeds into staff's appropriate use of the service – e.g. from informal discussions with CP. This category requires staff time and dedication.

Update: 18.04.19

Is there an equivalent of this tentative category for patients? Is the time and effort required from staff to make use of the service mirrored in the time and emotional risk taken by patients? E.g. raising their hopes, giving it a go. For many, using the CPS was a formative experience of talking about their distress – possibly exposing, unnerving. Some have described negative experiences of health services in the past, such as feeling dismissed. Many have described finding opening up hard but still they chose to do it by attending the CPS.

Possible titles: leap of faith, taking the leap, investing in changes, buy-in.

Final title: Making an investment.

This category captures the time, effort and hope invested in trying out the CPS (for both staff and patients).

Appendix 17: Condensed author guidelines for the British Journal of General Practice (BJGP)

Retrieved from: www.bjgp.org

Title

The title should be a clear description of the topic of the research and the methods and setting used for the study. It should not exceed 12 words. Dividing the title into two clauses may be helpful, for example 'Prevalence of problem gambling in young people: cross-sectional study in general practice'

Abstract

All research articles should have a structured abstract of no more than 250 words. This should be set out with the following headings: Background, Aim, Design and Setting, Method, Results, Conclusion, and Keywords. In particular please ensure that the most important results are fully reported and that the Conclusion is as specific as possible about the implications of your work for practice and research.

Keywords

You can include up to six keywords, which should be MeSH headings. Ensure that primary health care, family practice, or general practice are included where appropriate.

How this fits in

Summarise, in no more than four short sentences, what was previously known or believed on the topic and what your research adds, particularly focusing on the relevance to clinicians.

Main text

Articles should follow the traditional format of Introduction, Method, Results, and Discussion.

(From qualitative research section): Articles describing qualitative research should conform to the guidance set out in: O'Brien BC, Harris IB, Beckman TJ, et al. Standards for reporting qualitative research: a synthesis of recommendations. Acad Med 2014; **89(9):** 1245-1251.

Illustrative quotes should be included in the results section of the text where the themes are described. We recommend that the total word count including main text and quotes does not exceed 4000 words.

Introduction

(From standard 'research' section): This should be a succinct and up to date review of the key publications informing the intellectual background to the study. It does not need to be a systematic review, but should avoid obviously selective citation of the literature. The introduction should lead to the framing of the research question being asked, and this should be clearly stated.

From O'Brien et al.:

- Problem formulation: Description and significance of the problem/phenomenon studied; review of relevant theory and empirical work; problem statement.
- Purpose or research question: Purpose of the study and specific objectives or questions.

Method

(From standard 'research' section): This section should include a description of setting, patients, intervention, the time that the study took place, instruments used to measure outcomes, statistical tests applied, and software used for analysis, stating the version number. It should also include any arrangements for data oversight.

From O'Brien et al.:

- Qualitative approach and research paradigm
- Researcher characteristics and reflexivity
- Context

- Sampling strategy
- Ethical issues pertaining to human subjects
- Data collection methods
- Data collection instruments and technologies
- Units of study
- Data processing
- Data analysis
- Techniques to enhance trustworthiness

Results

This section should contain all the information required by reviewers and readers to assess the validity of the conclusions.

From O'Brien et al.:

- Synthesis and interpretation: Main findings (e.g., interpretations, inferences, and themes); might include development of a theory or model, or integration with prior research or theory
- Links to empirical data: Evidence (e.g., quotes, field notes, text excerpts, photographs) to substantiate analytic findings

Discussion

Structure the discussion using these subheadings:

- Summary
- Strengths and limitations
- Comparison with existing literature
- Implications for research and/or practice

Authors are expected to adopt this structure unless there are good reasons for not doing so. Additional subheadings can be used if they are likely to help readers understand the article.

From O'Brien et al.:

- <u>Integration with prior work, implications, transferability, and contribution(s) to the field</u>: Short summary of main findings; explanation of how findings and conclusions connect to, support, elaborate on, or challenge conclusions of earlier scholarship; discussion of scope of application/ generalizability; identification of unique contribution(s) to scholarship in a discipline or field
- <u>Limitations</u>: Trustworthiness and limitations of findings

Tables and figures

Up to a total of six tables, figures, or boxes are permitted in an article.

Additional information

At the end of the text and before the references we ask authors to report:

- Funding
- Ethical approval
- Competing interests
- Acknowledgements

References

These are presented in Vancouver style, with standard NLM title abbreviations for journals. References to personal communications in the text should include the date. Do not use automatic formatting features of your software such as footnotes and endnotes to indicate references.

Clinical Psychology in General Practice: Perspectives on a Pilot Initiative

Chapter 3: Executive Summary

Stephanie Raybould

May 2019

This executive summary is written with the participants in mind and therefore targeted towards the general public.

The contents page will be renumbered prior to dissemination.

Word Count: 2759

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Current context

The GP practice is the first place that most people go to talk about their health problems. As well as being important to patients, this means that GP practices are vital to the wider National Health Service (NHS). However, organisations including The British Medical Association (BMA) have raised concerns about GP practices being under pressure, due to difficulty recruiting GPs.[1] Some GPs feel that the current pressures have had a negative impact on patient care, with patients facing longer waiting times and shorter consultations.[1]

Mental health is a large part of the workload in general practice.[2] However, for reasons including not feeling skilled,[3] and the time-limit of GP appointments,[4] some GPs experience this aspect of their role as difficult.

Ways forward

In response to the current pressures in GP practices, a number of recommendations have been made. These include introducing into GP practices staff who specialise in key aspects of general practice care, such as pharmacy and mental health.[5] A scheme introducing Pharmacists into GP practices is already underway across England,[6] and staff and patient reports from a more established scheme of this nature have been positive.[7] For example, GPs reported a decrease in their workload, and patients described appreciating the Pharmacist's specialist knowledge.[7]

What about clinical psychology?

Historically, many Clinical Psychologists worked in GP practices.[8] However, various governmental changes, such as the Improved Access to Psychological Therapies (IAPT)[9] service resulted in Clinical Psychologists moving away from general practice to more specialist mental health settings. Despite this, as Clinical Psychologists are to use a variety of approaches to support people,

through childhood to older adulthood,[10] they may be particularly suited to supporting the broad range individuals presenting with mental health difficulties in general practice.

The current research

This study presents findings from a pilot initiative which involved a Clinical Psychologist working across two GP practices. The role included providing patient appointments with assessment and advice-giving, as well as more long-term support and/ or referral to other services, if needed. The role was also designed to support the wider practice team, for example, through advice-giving.

As the introduction of the clinical psychology service was a pilot initiative, the study is exploratory. The aim of the study is to provide an understanding of how a clinical psychology service works in general practice through talking with staff and patients about their experiences of the service, as opposed to collecting number-based measurements.

METHOD

Study design

A grounded theory method was used. This method is useful for exploring new topics and aims to develop a model of processes that is based (or 'grounded') in the experiences of participants.[11] A 'constructivist' approach was taken.[12] This means that each participant, as well as the researcher, was considered to have a unique lens through which they experience the world. Interview responses were therefore considered to depend on both the participant and researcher's context (e.g. their prior experiences/ age/ gender), rather than being an exact 'truth' to which all individuals would agree.

The researcher also carefully considered the ways in which their views may affect the research findings.

Setting

The research took place in two GP practices in The Midlands. During this pilot initiative, the Clinical Psychologist worked in each of the practices for two days per week. Appointments were typically 30 minutes long.

Participants

- *Staff*

  Staff members were invited to take part after being nominated by a senior staff member at their practice. Eleven staff members were recruited. They had a mix of clinical and non-clinical roles, such as GPs and receptionists.

- *Patients*

  Patients who used the clinical psychology service in June 2018 were invited to take part. Nine patients consented to take part and these included patients from each GP practice. Out of these patient participants, 4 were female and 5 were male. Patient participants were all over the age of 50 and registered at the GP Practice for over 10 years.

Data collection

Staff and patients took part in semi-structured interviews about their experience of the clinical psychology service. All participants were asked to provide written consent to take part in the study and were assured of their right to withdraw from the interview at any time. Interviews were carried out by the same researcher, at the relevant GP practice, and lasted an average of 28 minutes.

All interviews were audio-recorded and then typed up. Interview transcripts were analysed following each interview or small number of interviews. Questions to be asked in later interviews were then adjusted to make sure that they reflected the issues that seemed most significant to participants.

Data analysis

Analysis followed the grounded theory approach described by Charmaz.[12]

1. The interview transcripts were broken down into lines or phrases and given a name (called a 'code') which captured what was being described. These codes focussed on the actions that participants described. Examples of codes used in this research included: '*questioning satisfaction*' and '*anticipating limited capacity*'. Where possible, participants' exact words were used.

2. Codes that came up a lot and seemed particularly important were considered further.

3. These codes were then organised into the categories that were felt to most accurately and completely represent participants' responses.

4. Through comparing the responses of different participants, and keeping detailed notes, the researcher also considered the relationships between categories. A model which takes account of all the categories was then developed.

FINDINGS

Categories

The following 7 categories were developed:

1. Help
2. Impotence
3. Making an investment
4. Fostered confidence

5. Empowerment

6. Shared strain

7. Moderating factors (structural and personal)

These will be described in turn.

1. Help

Help was a key theme which summed up the desire of all participants to either provide (staff participants) or obtain (patient participants) help.

For staff participants, this theme captured the core value of genuinely wanting *"to help our patients as a practice"* (staff member 5). Staff participants did not discriminate patients presenting with mental health difficulties and described *"treating everybody as kindly as you can and trying to help them"* (staff member 6).

For patient participants, this theme concerned wanting to obtain help. For example, one patient participant described reaching *"the point where I felt that now I couldn't deal with it and I needed … some help"* (patient 9). Participants' desire to provide or obtain help guided all other aspects of their experience of the clinical psychology service.

2. Impotence

This category concerned the practice context in which the clinical psychology service was introduced. Participants described barriers to providing (staff participants) or obtaining (patient participants) the help they wanted.

Both staff and patient participants highlighted that there was a "*lack of time"* (staff member 9) to fully discuss mental health problems during appointments. Some patient participants felt that GPs "*don't have the time to talk"* about mental health (patient 9) and viewed a GP's role as medication only (patient 2). However, other patient participants described feeling helped by practice staff, including being signposted to other services, for example, a counsellor

(patient 2). Some patient participants felt that general practice "*didn't seem to really include mental [health]*" (patient 9) and tended to use it only for "*normal medical issues*" (patient 1).

3. Making an investment

This category captured the investment that staff and patient participants made in the service, in order to give it a chance of working. Making use of the service required the investment of time, effort and hope and participants did this, based on no guarantee that the service would be helpful or long-lasting.

Despite describing how *"lots of different services have changed, including this with mental health"* (staff member 4), most staff participants expressed wanting to *"actively be able to use [the service] correctly"* (staff member 4). Staff participants described initially feeling *"nervous"* (staff member 9), and having various questions about the service. Investment was also required from patient participants. While some questioned the benefit initially (patient 6), others invested hope "*that it would help*" (patient 4) and decided to "*see what … was on offer*" (patient 3).

4. Fostered confidence

In order to build on staff and patient participants' initial investment, it was important that their confidence in both the usefulness of the clinical psychology service and their ability to use it was developed.

Locating the service within the practice helped to build the confidence of staff participants as it allowed them to "*get to know*" the Clinical Psychologist (staff member 9) and discuss queries (staff member 1) and referrals (staff member 6). While some questioned whether the service required a Clinical Psychologist specifically (staff member 8), another felt it was important that the professional *"has the expertise"* (staff member 9).

Confidence of patient participants in the clinical psychology service developed through their experience of the sessions and related to organisational factors

as well as the skills of the Clinical Psychologist. Patient participants described not feeling rushed (patient 6), and finding the Clinical Psychologist *"easy to talk to"* (patient 5). Some linked this to the Psychologist's knowledge *(*patient 5). Many patient participants appreciated working collaboratively with the Clinical Psychologist (patient 8), however, one stated that they "*didn't enjoy"* the sessions (patient 7). The confidence of patient participants was also developed through allowing self-control over when and how often they used the service. For example, one patient participant stated *"if I was not coping … I could always come back which was reassuring"* (patient 1).

5. Empowerment

Many participants described gaining a sense of empowerment from the clinical psychology service.

Some clinician participants reported that the clinical psychology service had a practical impact on their jobs, including reducing follow-up appointments (staff member 7; staff member 9) and making medication the focus of their mental health consultations (staff member 9). This helped staff to feel effective and capable within their role. Some staff participants also reported *"psychological strategies rubbing off"* on them (staff member 9), and being directed to resources to use in their own work (staff member 1). Being able to offer a specialist service also empowered staff participants. Some felt that this was going *"that step further"* for patients (staff member 6) and appreciated having "*something to offer"* (staff member 8).

Patient participants also felt empowered by the clinical psychology service. This occurred through learning *"to let go of embarrassment about showing emotions"* (patient 1), looking at problems in new ways (patient 8), and developing different coping strategies (patient 6). Empowerment was maintained after using the service. Many patient participants reported receiving helpful resource recommendations from the Clinical Psychologist, which allowed them to help themselves outside of sessions, as well as signposting to other services (patient 5).

6. Shared strain

Participants also viewed the clinical psychology service as sharing their strain.

Some staff participants reported feeling "*less concerned*" about patients who would otherwise be waiting for another mental health service (staff member 9), and saw the clinical psychology service as taking *"some of the stress off"* (staff member 3). However, other staff participants stated that the introduction of the service did not result in any emotional impact for them.

Some patient participants described "*talking openly for the first time*" with the Clinical Psychologist (patient 9). Patient participants also described thinking deeply (patient 9), being helped to *"understand myself"* (patient 8), and gaining hope (patient 1). Patient participants reported feeling listened to (patient 6) but also appreciated talking to someone who "*didn't just listen*" (patient 9) but also suggested alternative options (patient 1).

7. Moderating factors

Various factors affected all stages of participants' experience of the clinical psychology service. These included structural factors and personal characteristics.

a) Structural

- **Ratio of Clinical Psychologist time to practice size** - due to differences in practice size, one practice experienced proportionately less of the service and this was reflected in how helpful staff found it.

- **Simplicity and ease** – both staff and patient participants highlighted the importance of "*not putting any restrictions on accessing the clinical psychology service*" (staff member 9) and not making it difficult to get mental health support (patient 8).

- **Short waiting times** – staff and patient participants valued having rapid access to appointments.

- **Location** - most patient participants appreciated the service being local (patient 7) and felt that placing it within the GP practice was also important. Patient participants described feeling *"confident going to your doctors"* (patient 8) and saw this as "*being on home ground*" (patient 7).

- **Talking to a new professional** – Patient participants differed in their views on getting help from a new person. Some appreciated not knowing the Clinical Psychologist beforehand (patient 1), but others were reluctant to re-tell their story (patient 5).

b) *Personal*

- **Staff management style** – Clinician participants differed in whether they preferred to help patients themselves in the first instance before referring to another service.

- **Preferences on the Clinical Psychologist's characteristics** – Patient participants reported differing preferences regarding the preferred age of the Clinical Psychologist. One preferred the Psychologist to be younger than them (patient 8) and another stated that they would like the psychologist to be of an older generation (patient 7). One participant also stated a preference for the Clinical Psychologist to be female (patient 8).

- **Feelings about discussing mental health** – Patient participants felt differently about discussing their mental health. While one patient participant described being experienced at *"talking and sharing"* (patient 6), another disliked sharing personal issues (patient 7).

- **Timing** - Some patient participants felt that their ability to engage fully with the clinical psychology service was affected by their life circumstances, such as the deteriorating health of a family member (patient 7).

The proposed model

The categories and relationships between them are represented in Figure 1.
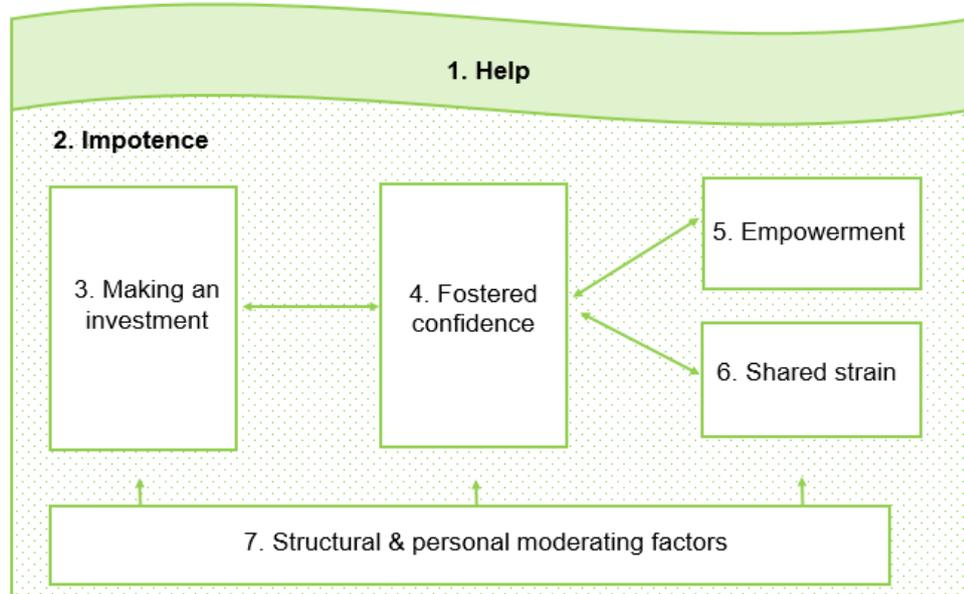
Figure 1. Model of how the clinical psychology service works

SUMMARY

Outline of findings

This study explored an approach to mental healthcare that is novel within current times. The findings suggest that a clinical psychology service can work within the current general practice framework.

The function of the service appeared different from that of other specialist mental health services such as IAPT. Due to features such as the convenient location and rapid appointment availability, patient participants using the clinical psychology service were typically at an early stage in their journey into obtaining psychological support for their mental health. For many patient participants, the service provided the initial opportunity to discuss their mental health with a professional and receive direct help and/ or signposting when appropriate. A number of patient participants described an ongoing impact from using the service.

As well as *sharing the strain* for some staff and patient participants, the service also promoted *empowerment,* which included, for example, feelings of satisfaction for some staff participants and reduced embarrassment relating to discussing mental health for a patient participant.

Limitations

Limitations of the study should also be kept in mind when considering the findings. The research involved a sub-set of staff and patients from each GP practice and, therefore, may not represent the experience of all staff and patients who used the service at the practices. The recruitment of additional participants may have allowed the model to more accurately represent the wider practice team and patient population.

As participants chose to take part, there may have been an over-representation of those with a positive experience of the service. However, in both the staff and patient participant groups, evaluations of the service were varied.

All patient participants were over the age of 50 and this may mean that the views of younger patient groups are not represented in the current findings.

WHAT NOW?

Implications for research / practice

The current study suggests that it is possible for a clinical psychology service to work in general practice, within the current context. The research provides a model that explains the processes involved in introducing this kind of service within the two studied practices. A number of factors that affect how helpful participants found the service have also been presented. These findings may be used to inform the design of future primary care services.

The current research did not, however, explore every important aspect of introducing the clinical psychology service. Investigation of other factors including financial implications for the practices are also important, as well as

the potential impact on numbers within the wider clinical psychology workforce should the model be used more widely.

Dissemination

This Executive Summary will be provided to participants, as well as the management team within each practice.

A longer version of the study report will be submitted to Staffordshire University as part of the researcher's doctoral thesis. This report will be published online on the British Library's online e-theses website 'EThOS' (www.ethos.bl.uk). The report will also be submitted for publication in an academic journal.

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