Management of Common Mental Health in Primary Care

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Acknowledgements

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Declaration

This work has not been submitted in substance for any other degree or award at this or any other university or place of learning, nor is being submitted concurrently in candidature for any degree or other award.

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This thesis is the result of my own independent work/investigation, except where otherwise stated.

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Contents

List of Tables

List of Figures

Summary

Mental health is recognised as a global burden of disease and amongst the leading contributors to disability, with common mental health affecting one in six adults. The impact of these conditions on individuals and the economy are significant. Primary care is the first point of contact and general practitioners, as public health gatekeepers are of key importance in the recognition and management of these. It is suggested that general practitioners find consultations challenging, though it is not clear what these difficulties are.

The aim of this thesis was to investigate what, if any, problems general practitioners experience with regards to the common mental health consultation. A scoping study and survey provided information on general practitioners' understanding of common mental health and its management. Another survey investigated the perceptions, beliefs and understanding of the general public in relation to common mental health and its management. A theory of planned behaviour study looked at factors that influenced general practitioners' prescribing and referral behaviours. And finally, a triangulation study examined the findings from the programme of research with other key professionals who are also part of the pathway of care - primary care counsellors and clinical psychologists.

Results of this thesis suggest that general practitioners do experience difficulties with the management of common mental health. Challenges were shown to be associated with the general practitioner's role as the patient's advocate, lack of knowledge and education, confidence, personal experience, patient expectation and management systems. Results also showed General practitioners' and lay persons' understanding of common mental health in everyday practice was different to that in public policy. General practitioner treatment management was shown to be in conflict with clinical guidelines.

Furthermore, prescribing and referral behaviours were shown to be influenced by their attitude, significant others and whether they possessed adequate skills or knowledge.

Chapter 1: Introduction

This chapter provides a short introduction to the thesis and the main issues, brief aims of the research, methodological approaches, participating populations, and also outlines the 'programme of research' as presented in the body of the thesis.

1.1 Management of common mental health problems in primary care – The issues

Mental health disorders are well recognised to be a major public health problem across the world. A World Health Organization (WHO) study of the global burden of disease reported mental health disorders make up five of the ten leading causes of disability worldwide (Murray & Lopez, 1997).

Large numbers of people visiting their general practitioner (GP) are suffering with conditions that are more commonly known as 'common health problems' or 'common mental health problems' (CMHPs), or rather those conditions that are psychological or psychosocial based disorders (e.g. anxiety, depression, somatisation, stress, functional or unexplained symptoms). It is suggested that one in six adults are affected by a CMHP, thereby costing UK employers £25 billion each year through lost work days (National Institute for Health and Clinical Excellence [NICE], 2012). Therefore, effective management of CMHPs is of high importance. Early consultations in primary care are crucial for engagement, recognition, assessment and decision making; if left undetected these conditions can become chronic, disabling and enduring.

It is suggested that GPs are best placed to recognise these conditions, and that the recognition and treatment of common mental health disorders is an everyday task for GPs. One in three GP consultations has a mental health element to it, and 90 per cent of mental health disorders are treated in primary care (NICE, 2012). However, it is also suggested that GPs find the management of these consultations difficult. Interventions have been created and introduced to deal with these difficulties, although there seems a lack of clear evidence as to what these difficulties are. In addition, there seems to be confusion around the definition of common mental health and what it refers to, while it is more popularly cited in health literature to refer to anxiety and depression.

1.2 Aims of the research

The aim of the present research programme was to: (a) establish what general practitioners understood the term 'common mental health' to refer to, and (b) to investigate general practitioner management of common mental health in primary care, to ascertain what, if any, difficulties general practitioners experience.

1.3 The approaches used and research populations

In order to fully explore the complexities of this area, this programme of research employed mixed-methods, using both quantitative and qualitative approaches. A variety of techniques were used to investigate the various areas of interest such as: survey design, established behaviour models and semi-structured focus group interviews. Various analytical techniques were used that were appropriate to the data collected. Furthermore, a triangulation study was used to set the overall

findings from the programme into context. The triangulation study involved key health professionals working within the primary care arena who had day-to-day experience with patients managed by general practitioners.

The participant populations taking part in this research consisted of working general practitioners across Wales, the general population, primary care counsellors and clinical psychologists.

1.4 The structure of the thesis

The body of the thesis presents the various stages of the research, and is organised as follows:

- Chapter Two provides a review of the literature around common mental health and its management by GPs in primary care settings.

- Chapter Three describes the initial study to scope GPs' understanding of common mental health and to ascertain if GPs were indeed experiencing any difficulties managing patient presenting with common mental health problems.

- Chapter Four concerns the GP Survey. Informed by the 'Scoping Study', the purpose of this study was to investigate in more detail those issues raised around CMHPs, the prevalence of these conditions in primary care, to further unpick the management of these issues/problems and to explore how equipped general practitioners are to deal with them.

- Chapter Five outlines the 'Theory of Planned Behaviour Study' of prescribing and referral behaviours. This study utilises the well-established model of the Theory of Planned Behaviour to look more specifically at general practitioners' treatment management of patients presenting with CMHPs.

- Chapter Six presents the 'Mental Health Literacy Survey'. This survey investigated what the general population understand common mental health to be and their perception of its management in primary care.

- Chapter Seven describes the 'Triangulation Study'. This study was concerned with validating and contextualising the findings from the programme of research.

- Chapter Eight provides a general discussion. Within this final chapter, general conclusions are drawn from this programme of research and how it compares to previous research. This chapter also discusses the thesis in light of recent policy changes implemented before completion. Finally, limitations of the research are addressed and further research directions are presented.

1.5 Ethical approval

Full ethical approval was achieved for each of the studies from the Research Ethics Committee for Wales. Furthermore, in accordance with NHS ethical and access requirements for research, further approval was sought and achieved from each of the seven Local Health Boards in Wales for each of the studi

Chapter 2: Review of the Literature

This Chapter seeks to present an organised, systematic and comprehensive literature review of the relevant research and factors associated with general practitioners (GPs') medical management and treatment of patients with common mental health problems in primary care,

2.1 Introduction

Numerous people present to their general practitioner (GP) with problems that can be described as having a psychosocial or psychological foundation. These conditions are more usually referred to as 'common health problems' or 'common mental health problems'.

Common mental health problems are those problems that are, in general, managed in primary care. The proportion of those presenting in general with mental health issues is high, reportedly one in three patients (Ormel et al., 1994; RGCP, 2008). The impact therefore upon general practices and healthcare systems in general is significant. Mental health problems are also recognised as presenting a serious risk to health, making up five of the ten leading causes of disability (Murray & Lopez, 1997). One hundred and sixty million working days each year are lost due to sickness absence of which 28 million (two in five days) are due to anxiety and depression. In addition, 40% of new claimants of incapacity benefit have a mental health problem (Oxford Economics 2007).

The role of GPs is to assess for appropriate therapy, make assessments of fitness for work, and manage communication and formulate back-to-work plans for

individuals who have been off work. The difficulty encountered by many GPs is that there appears to be a tension between acting as an advocate on behalf of the patient and providing the most appropriate advice on an individual's capacity to work. Furthermore, while GPs are key to helping people with conditions such as anxiety and depression and return to work, issues around delayed recognition of potentially remediable conditions can mean that these conditions under-treated and under-supported for prolonged periods, leading to increased suffering and chronicity (Van der Brink, Leenstra, Ormel, & van de Willage, 1991).

The management of common health problems in general practice is of high importance. Recognition and identification of a problem is difficult in primary care, especially mental health problems, not least because the consultation itself is time limited and the presentation of symptoms by patients can be complex and disordered. Patients often do not present with a psychological problem as their main condition, more frequently patients' descriptions and assessments of their problems are influenced by external events or circumstances, such as the exacerbation of an existing physical health condition, or problems at work or home (Cohen, 2008). Teasing out whether psychological or physical experiences are normal responses to life events, disease or injury, or abnormal responses to regular events can be difficult for the GP. However, possible effective intervention or treatment rests upon receipt of a diagnosis; the sooner an appropriate diagnosis is made with regard to mental health related problems the chance of improved outcomes is increased. In addition, access to psychological treatment and interventions remain problematic as demand for adult health services outweigh existent resources. A shortage of qualified therapists and increasing waiting times

and patient reluctance to enter into therapy mean that greater numbers of individuals remain in primary care and seek support from their GP (Fox, Acton, Wilding & Corcoran, 2004).

GPs struggle with their role in the management of common health problems as well as meeting their training needs in relation to common health problems within their working practice. A narrative review of psychological management approaches concluded that preliminary evidence for the clinical effectiveness of GP psychological management in routine consultations is scarce but encouraging (Cape, Barker, Buszewicz & Pistrang, 2000). Success of any psychological intervention is largely centred on the trust the patient places in the care provider, since patients already have a relationship with their GP it could be assumed the familiarity of the doctor's office is preferable to visiting an unfamiliar specialist (Huibers, Beurskens, Bleijenberg & Schayck, 2008). GPs require ongoing support to be able to build on their existing knowledge and skills in the management of individuals with CMHPs. The importance of education and training for GPs in the management of common mental health problems has been highlighted by a briefing paper from the Sainsbury Centre for Mental Health (SCMH, 2007). It is clear that GPs could benefit from appropriate psychosocial skills training and tools to help manage the common mental health consultation and discussion with patients.

2.2 Aims
This review aims to present a coherent review of all available literature looking at GPs' management of patients with common mental health in primary care.

2.3 Method

2.3.1 Design

A protocol for a systematic review was agreed and inclusion and exclusion criteria

specified.

2.3.2 Data sources and search strategy

The electronic databases Ovid Medline, Cinahl, Embase, PsychINFO,

PsycARTICLES Full Text and PubMed were searched, along with reference

mining from key research papers and the grey literature.

2.3.3 Criteria for considering studies

This is an area that is not well indexed and therefore we used a strategy designed

to achieve maximum recall/sensitivity rather than precision/specificity.

Inclusion criteria were for all the following to be met.

1. Primary care and all its associated terms

2. Common mental health and all its associated terms

3. Consultation and all its associated terms

4. Articles were peer-reviewed from 1996 (1982 PsychINFO)

5. Articles limited to humans and the English language

2.3.4 Search terms

(PRIMARY CARE or GENERAL PRACTICE or FAMILY PRACTICE or

FAMILY MEDICINE)

(COMMON MENTAL HEALTH or MENTAL HEALTH PROBLEMS or

MENTAL ILL HEALTH or MENTAL ILLNESS or ANXIETY or DEPRESSION

or STRESS or SICKNESS CERTIFICATION or PSYCHOLOGICAL WELL-

BEING or MENTAL DISTRESS or DISABILITY or PSYCHIATRIC DISORDER or COMMON MENTAL DISORDER or ADJUSTMENT DISORDER or COPING or PSYCHOLOGICAL DISORDER or MENTAL DISORDER)

(CONSULTATION OR REFERRAL) AND (APPOINTMENT or SCHEDULES)

2.3.5 Selection Process

Articles included were restricted to those dating from 1999, when the Department of Health published the National Service Framework. The bio-psychosocial model of care has been considered, but the exploration of these factors was not part of the programme of research which was focussed on the medical management and treatment of common mental health in primary care. All reference titles identified by the electronic search were judged for inclusion/exclusion alongside the criteria depicted in Table 2-1. Abstracts were retrieved where there was doubt about their relevance; these were once again set against the inclusion/exclusion criteria. Full texts were acquired where the reviewer believed that the reference warranted further deliberation.

Table 2-1: Inclusion and exclusion criteria

Sifting combinations	Chronic Health Conditions	Systematic Review	Mental Health	Primary Care	GP Consultation	Intervention/Management	Patients	Decision
1	X	X	X	√	X	X	X	NO
2	X	X	√	√	√	X	X	YES
3	X	X	√	√	X	X	X	NO
4	√	X	X	√	√	X	X	YES
5	X	X	√	√	√	√	X	YES
6	X	X	√	√	X	√	√	YES
7	X	√	√	√	√	√	X	YES
8	X	√	X	√	√	√	X	NO

2.3.6 Data extraction

Data extraction and review was conducted by KW.

2.4 Results

2.4.1 Retrieved articles

The search identified 2487 abstracts (Ovid Medline, Cinahl, Embase, PsychINFO,

PsycARTICLES Full Text and PubMed) in the first instance, after application of

the inclusion/exclusion criteria and sifting duplicates a total of 70 articles

remained. Further articles were identified through reference mining and the grey

literature, some of which due to their importance precede the 1999 cut-off date.

These were retrieved for further screening.

2.4.2 Scope of included articles

Of those articles recovered via the electronic database search, only n=19 articles

are from the UK, with the remaining papers from the USA (n=23), Australia (n=8),

New Zealand (n=6), the Netherlands (n=3), Hong Kong (n=2), Sweden (n=2),

Belgium (n=1), Budapest (n=1), Denmark (n=1), a European study (n=1), India

(n=1), Qatar (n=1) and Taiwan (n=1).

Articles covered various topics: prevalence, management, treatment, recognition

and assessment and general practitioner attitudes toward management and

treatment in primary care.

2.4.3 Prevalence of common mental health

Rates of those presenting in primary care with mental health problems is

recognised as being significantly high, with numbers presented in studies varying

from one in three patients (Ormel et al., 1994; Kroenke et al., 1997) to figures ranging from 26% to 60% (Roca et al., 2009; Ansseau et al., 2004; Spitzer et al., 1999; Norton et al., 2007; Jackson et al., 2001) using the same diagnostic instrument. A World Health Organization (WHO) study of the global burden of disease assessed mental health disorders as making up five of the ten leading causes of disability worldwide (Murray & Lopez, 1997). Furthermore, studies have shown that in many cases mental health disorders are not seen as a single presentation. It has been shown that a large proportion of those presenting with mental health issues do so with co-occurring conditions, or more specifically overlapping diagnostic categories such as conditions relating to mood, anxiety and somatisation (Kessler et al., 2005a; McManus et al., 2009; Roca et al., 2009; Ansseau et al., 2004; MaGPIe Research Group, 2003). As reflected in the WHO study of the Global Burden of Disease (Murray & Lopez, 1997), the picture of prevalence in relation to mental health and common mental health appears to be shown fairly consistently in studies from across the continents.

In the UK, the Office for National Statistics (ONS) Household Survey of adult psychiatry morbidity (ONS, 1993, 2000, 2007) found that the proportion of adults meeting the criteria for at least one disorder increased between 1993 and 2000 (15.5% and 17.5% respectively) but did not change between 2000 and 2007 (17.6% and 17.6% respectively) (McManus et al., 2009). Furthermore, figures presented showed that 16.2% of adults (classified 16 years and over) surveyed met diagnostic criteria for at least one disorder in the week prior to interview (McManus et al., 2009). The prevalence of individual common mental health

disorders varies considerably, with results from a national survey conducted in 2007 reporting that one-week prevalence rates were 4.4% for generalised anxiety disorder, 3% for post-traumatic stress disorder, 2.3% for depression, 1.4% for phobias, 1.1% for obsessive-compulsive disorders, and 1.1% for panic disorder (McManus, 2007). Of those who were said to have a common mental health disorder more than half were said to present with mixed anxiety and depression. Gender differences were apparent in findings, showing women were more likely than men to have a common mental health disorder (19.7% and 12.5% respectively), moreover rates were shown to be significantly higher for women across all categories of common mental health disorders with the exception of panic disorder and obsessive compulsive disorder (McManus et al., 2009). Prevalence varied too amongst social economic status, with people living in households with the lowest levels of income reportedly more likely to have a common mental health disorder compared to those living in the highest income households (McManus et al., 2009).

In the United States it is estimated that 26.2% Americans (aged 18 and above), or about one in four adults, suffer from a diagnosable mental disorder in a given year (Kessler et al., 2005a). Moreover, this research shows that many people present with more than one mental disorder, they suggest that 45% of those presenting with a mental disorder meet criteria for two or more disorders, with severity strongly related to the comorbidity (Kessler et al., 2005a). Anxiety disorders in the United States, including panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, generalized anxiety disorder, and phobias (social phobia,

agoraphobia, and specific phobia), are said to affect around 40 million American adults (18 years and older), or about 18.1% of people in this age group. Furthermore, anxiety is said to frequently co-occur with depressive disorders or substance abuse, with the likelihood of those presenting with an anxiety disorder also possessing another anxiety disorder (Kessler et al., 2005a; Kessler et al., 2005b).

In Europe the picture is similar. A study by Roca et al (2009) using the Primary Care Evaluation of Mental Disorders (PRIME-MD) questionnaire with adult primary care patients, showed that 53.6% of patients indicated the presence of one or more mental disorders (also see Spitzer et al., 1999; Ansseau et al., 2004). Anxiety disorders accounted for 11.7% of the sample, while the highest comorbidities were found in patients with depressive and anxiety disorders (19.1%), depressive disorders and somatoform disorders (18.6%) and anxiety and somatoform disorders (14.8%). The most prevalent co-morbid disorders (mood, anxiety and somatoform) were said to be observed in 11.5% of patients attending for primary care services (Roca et al., 2009).

In Belgium, a study by Ansseau et al (2004) highlighted the high prevalence of psychiatric disorders among patients consulting in primary care, indicating that psychiatric problems are the main reason for visits to the general practitioner. Findings indicated that anxiety disorders accounted for 19.1% and minor depressive disorders 4.2% of those in the sample presenting to primary care. More notably, and in line with studies previously discussed, the co-occurrence of

disorders was of significance with 21.2% of all screened patients presenting with at least two concurrent disorders and 8.4% showing a combination of the three diagnostic categories (mood, anxiety and somatoform disorders) (Ansseau et al., 2004).

In New Zealand, more than one third of people attending their GP were reported to have had a diagnosable mental disorder during the previous 12 months, the most common disorders being anxiety, depression and substance use disorders (8.5%, 6.8% and 5.9% respectively). Commensurate with previous studies, considerable overlap of DSM-IV disorders were found, identifying more people with anxiety disorders had comorbid depression than had anxiety alone. Further, it was suggested that mixed-presentations were as common as disorders presented alone (MaGPIe Research Group, 2003).

Comparable with other reported studies in Western countries, a study of Qatari patients demonstrated that prevalence of psychological disorders accounted for 11.5% of the sample (Bener, 2010). Findings are compared to Saudi Arabia where psychiatric morbidity in primary care is estimated at 30-46% with a 19.3% prevalence of somatisation and 20% of depression (Becker, 2002).

2.4.4 Management of common mental health problems

As discussed there is a high prevalence of mental health and common mental health disorders in primary care, such that primary care is suggested to have become our de facto mental health services system (Norquist & Regier, 1996). Of the general population of New Zealand it is reported that three-quarters of those with recent mental health disorder have attended a health service, in the main general practice, with only about one-third seeking help from an agency (Dowell, 2004). Therefore diagnosis and treatment of mental disorders is a key area for quality improvement in the primary care (Kroenke, 2000). GPs are said to experience difficulties in the management of common mental health problems and despite the acknowledgement of its high prevalence, significant issues persist in the recognition and treatment of people presenting with mental health and common mental health disorders. The literature presents a complex interrelation of factors that are present within the common mental health consultation (financial, structural, interpersonal, cultural, resource).

Many studies over the last decade have reported a lack of detection and treatment of mental health disorders by general practitioners. It is estimated that of those who do present in primary care, only 30% will be diagnosed and offered treatment because health professionals fail to recognise their problems and have a lack of awareness of care pathways for these conditions (NICE, 2009). Key influential factors suggested are the presentation of symptoms (see reviews by Regier et al., 1993; 1994; Katon & Gonzales, 1994; Coyne, Thompson, Klinkman & Nease, 2002), and practitioners own knowledge and understanding of disorders. One

example is the area of 'caseness', where differing views or understanding of 'caseness' by different groups (patients, GPs, researchers) prove challenging toward recognition, with patients considering 'caseness' in terms of problems, general practitioners in terms of management and researchers in terms of diagnostic classifications (Goldberg, 1992; Ustan & Sartorius, 1995). Other factors being the creation of and appropriateness of screening and diagnostic tools and manuals (for instance: Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition [DSM-V]; APA 2013), International Classification of Diseases [ICD-10] (WHO, 2010), Hospital Anxiety and Depression Scale [HADs] (Zigmond & Snaith, 1983), Patient Health Questionnaire [PHQ-9] (Spitzer, Kroenke & Williams, 1999; Kroenke, Spitzer & Williams, 2001; Löwe et al., 2004), General Health Questionaire-12 [GHQ], Goldberg & Hillier 1979), Beck Depression Inventory (Beck, Ward, Mendelson, Mock & Erbaugh, 1961), Beck Depression Inventory - Primary care edition [BDI-PC] (Beck, Guth, Steer & Ball, 1997), Primary Care Evaluation of Mental Disorders [PRIME-MD], Bakker et al., 2009), World Health Organization's Disability Assessment Schedule II [WHODAS-II], (WHO, 2001), Composite International Diagnostic Interview [CIDI] (WHO, 1990), SPHERE (Hickie et al, 2001), the Mental Status Examination (Synderman & Rovner, 2009)) to aid general practitioners in this task has also received much attention (see Williams, Pignone, Ramirez & Perez, 2002; Löwe et al., 2002; Spitzer, Kroenke, Williams & Löwe, 2006; Klinkman, 1998; Brugha et al., 2001).

The above areas have been comprehensively discussed elsewhere (Kessler et al., 1994; Lepine, Gastpar, Mendlewicz & Tylee, 1997; Coyne, Thompson, Klinkman

& Nease, 2002; Goldberg, 1992; Davidson & Melzer-Brody, 1999; Gilbody, House & Sheldon, 2001) and therefore will not be re-presented in this review in its entirety. The current review intends to focus upon that of common mental health problems and literature after 1996, when the Department for Health published recommended changes to mental health provision in primary care within the National Service Framework. However that said, while I do not wish to re-present the literature, I will be drawing upon examples in order to set current understanding in context with past appraisals.

2.4.4.1 Instruments

In terms of practitioner recognition and diagnosis, studies of common mental health problems have, in the main, focused upon utilisation of a host of instruments, such as disorder specific scales (Fink et al., 1999; Borowsky et al., 2000; McLeod, 2004; Bakker, 2009), self-administered screening questionnaires (Smith, 1998), and interviewer or clinical administered schedules to detect well defined psychological problems (Ustan & Sartorius, 1995; McLeod, 2004). While the focus upon general practitioner perception of case definition has been focused around interviews with general practitioners (Borowsky et al., 2000; Snyderman & Rovner, 2009) and specific diagnoses as recorded within case notes and rating scales (physical and psychological severity) completed during the consultation (Ustun & Sartorius, 1995; Bower & Sibbald, 2000; McLeod, 2004). It has been posited that there is an assumption that diagnostic instruments, such as the CIDI which incorporates diagnostic criteria into readily applicable assessment tools,

represent a 'gold standard', and that it provides a definitive diagnosis against which the GP's clinical opinion can be measured (McLeod, 2004). However it has also been found that, when compared to clinical assessments of depression the CIDI is said to have poor sensitivity (Brugha et al., 2001).

A study by the MaGPIe group (Mental Health and General Practice Investigation), sought to compare GP clinical opinion with the following instruments, the GHQ-12, CIDI, SPHERE-12 and the WHODAS and evaluate levels of agreement. While accepting differences of instrument focus and purpose, findings reported a variation in the comparison between screening and diagnostic instruments and clinical opinion of psychological disorder. Using the CIDI GPs identified 70.3% with a diagnosable disorder (over the last month), while they also identified psychological issues for 53.4% of patients who were not identified as having a CIDI diagnosis (McLeod, 2004). The newly updated NICE (2011b) clinical guidelines for the identification of common mental health problems recommend that in the initial stages, the use of two questions and to be 'alert' to possible depression, and in the assessment of possible anxiety, the use of the 2-item Generalized Anxiety Disorder scale (GAD-2) (*see* Table 2-2). If the patient scores positively for either of these screening questions it is recommended that a competent healthcare professional perform a mental health assessment using PHQ-9 or the Hospital and Anxiety Depression Scale (HADS) or the 7-item Generalized Anxiety Disorder Scale (GAD-7) (NICE, 2011). It is suggested that the use of simple identification tools provide primary care staff with the potential to close the treatment gap, estimated to account for more than 50% of anxiety and depression

disorders, by identifying a much larger proportion of people who might otherwise fall beneath the radar and fail to receive the appropriate level of help for their needs (Kohn et al., 2004).

However, studies have also discussed that while in general these types of assessment and diagnostic instruments have relatively high sensitivity (Spitzer et al., 2006) they possess limited specificity (Mulrow et al., 1995; Patel et al., 2008). Furthermore, that the classification and diagnosis of mental health disorders based on secondary care thinking does not fit well into primary care diagnostic and management frameworks (Dowell, 2004), and that diagnostic criteria in psychiatry need to be operationalized for use in primary care (Bakker et al., 2009). Other studies support the assertion of a misfit of screening instruments and predefined criteria, that there is no 'gold standard' questionnaire for the diagnosis of common mental health disorders in primary care (Patel et al., 2008), and until recently there was no classification for the mixed presentation of anxiety and depression commonly seen by GPs (Dowell, 2004; MaGPIe Research Group, 2004). As discussed earlier, greater diagnostic efficacy in the assessment of common mental health is suggested to be achieved by using the CIDI (Wittchen et al., 1991), however, the complexity and length of the instrument is said to render its use in busy primary care setting unfeasible (Patel et al., 2008). Other studies conclude routine screening to be a costly exercise with little benefit in improving psychosocial outcomes for individuals with psychiatric disorder managed in non-psychiatric settings (Gilbody, House & Sheldon, 2001).

In addition to screening and diagnostic instruments, intervention programmes or continual medical education programmes have been introduced to improve practitioner efficacy in this area, such as computer-based e-learning, behavioural change modules and clinical decision support systems. Computer-based clinical decision support systems combine patient information with treatment guidelines to produce patient-specific guidelines (Johnson et al., 1994). A study by Thomas et al (2004) evaluated the clinical effectiveness of case-finding followed by feedback of computer-generated patient-specific clinical guidelines to the general practitioner compared with case-finding and usual care. Non-significant findings were found between computer generated patient specific guidelines when compared to usual care (1.2 points between groups on the GHQ). While, case-finding followed by feedback to GPs of psychiatric assessment and computer-generated patient-specific guidelines were associated with a significantly lower mean GHQ score six weeks after randomisation. No demonstration of significance was found for treatment effect on recovery from episodes of common mental health disorders. This said, the authors make the suggestion that such tools may be associated with a faster treatment effect (Thomas et al., 2004).

A review of the literature on interventions to improve provider recognition and management of mental disorders in primary care, found the effectiveness of these to be varied. Simple lectures and screening as a single intervention were considered less likely to improve provide or change provider behaviour when compared to those interventions involving more extensive provider training efforts (Kroenke, 2000). The authors suggested that similarities of trends within their

review (while recognising overall case study numbers were small) were reflective of the findings from a systematic review conducted by Davis (1998) who suggested that as the number of interventions increased from one to two to three so did efficacy (60% to 64% <80% respectively). However, differences in disorders were acknowledged to make comparisons of studies problematic. Kroenke and colleagues also reported that in some studies using a simple letter to primary care physicians caring for somatising patients also reported improved clinical outcomes (Kroenke et al., 2000; Rost, Kashner & Smith, 1994; Smith, Rost & Kashner, 1995), and likewise small benefits were shown to be likely from the use of computerised patient-specific guidelines for management of common mental disorders (Thomas et al., 2004).

The need to recognise and update classifications to more accurately reflect symptoms and conditions that people are routinely presenting with in primary care is demonstrated by the current review and inclusion of anxious depression by the World Health Organization of their International Classification of Diseases. The aim being to reduce the burden associated with mental disorder in WHO member countries (Lam, 2013). Moving away from predefined criteria within diagnostic screening instruments, greater specificity and accuracy may be found in self-report, as it has been suggested that much of self-reported distress assessed in primary care samples are said to reflect psychosocial problems, physical symptoms including pain, and unhappiness, which are not appropriately construed as emotional disorders (Coyne & Kagee, 2000).

Table 2-2: Clinical guidelines: Identification and assessment of depression and anxiety

Identification: Depression	
Questions:	**Scoring Answers:**
1. During the last month, have you often been bothered by feeling down, depressed or hopeless? 2. During the last month, have you often been bothered by having little interest or pleasure in doing things?	1. Yes 2. No
Interpretation:	
If a person answers 'yes' to either of the above questions consider depression	
Identification: Anxiety (GAD-2)	
Questions	**Scoring Answers**
Over the past 2 weeks, how often have you been bothered by the following problems 1. Feeling nervous, anxious or on edge 2. Being unable to stop or control worrying	1. Not at all: 0 2. Several days: 1 3. More than half the days: 2 4. Nearly every day: 3
Interpretation:	
If the person scores three or more on the GAD-2 scale, consider anxiety disorder	

2.4.4.2 Recognition and assessment
2.4.4.2.1 Symptom Presentation
Explicit clinical cues are suggested to aid in the detection and recognition of

common mental health disorders. A study looking at the screening and diagnosis

of depression in women visiting GPs, found that GPs did selective screening for those who mentioned mental symptoms and were also more likely to offer a scheduled repeat follow-up visit (Stromberg et al., 2008). A study looking at the disability associated with common mental health disorders and the detection of mental health disorders in primary care showed, the presentation of and presence of disability, (such as occupational, and social functioning and activities of daily living), helped GPs' recognition of mental health problems (Collings, 2005).

2.4.4.2.2 Individual characteristics - the general practitioner

Further to symptom presentation, there is a suggestion that practitioners' own understanding of caseness toward disorders leads to difference in the mapping or assigning a diagnosis. This disparity can be seen in studies looking at cultural influences (Bhui, 2001), where practitioners are suggested to experience difficulty in diagnosis of mental disorders to physical complaints without prominent psychologised expressions of distress and where mental disorder is more likely to be diagnosed in patients who present with or attribute physical symptoms to psychological causes (Goldberg & Huxley, 1992; Kirmayer et al., 1993; Kessler et al., 1999). Cultural influences are suggested to be a pervasive factor in the acknowledgement of and detection of common mental health problems. The lack of detection of Punjabi patient cases with depressive ideas was suggested to be culturally influenced, in that the non-pathological presentation of depressive ideas may reflect that of the general practitioners' own cultural beliefs. These beliefs, along with those of their Asian patients, include a more karmic view of life in which hopelessness might be accepted more readily as a culturally concordant

belief without resort to illness labels (Bhui, 2001). This echoes previous primary care data around cultural belief influences upon detection and recognition (see Wilson & MacCarthy, 1994; Uebelacker et al., 2009). Moreover, Punjabi patients with a common mental disorder were more likely to be assessed by their Asian general practitioners as presenting with a mixture of 'physical illness and somatic' complaints, when compared to those patients presenting who were considered English only, where general practitioners were said to be more likely recognize a psychiatric disorder or mixtures of 'physical from psychiatric' disorder (Bhui, 2001).

In terms of general practitioner recognition of common mental health problems, the pervasive position of the patient in their presentation is demonstrated where GPs are said to respond to meaningful clinical clues resulting in increased detection and diagnosis of common mental health disorder, for instance when patients attribute their symptoms to a psychological cause rather than a physical one (Klinkman, 1998; Araya et al., 2001, Bushnell, 2005). While it is recognised that chest and abdominal discomfort and other somatic symptoms are common manifestations of some mental health disorders (Rost et al., 1994; Zang, 1995), if a patient visits their general practitioner while experiencing an acute somatic illness, it is less likely that the accompanying anxiety and/or mood disorder will be simultaneously diagnosed (Füredi & Rózsa, 2003). General practitioners' attitude toward treatment was also said to be a factor present in the detection of disorders, in that a physician's proclivity toward the provision of counselling influenced the likelihood of detection (Borowsky, 2000).

2.4.4.2.3 Individual characteristics – the patient

Individual differences around patients, disorders and their presentations appear to be both facilitators of, and barriers to, the clarification of patients presenting complaints and the appropriate recognition of disorders. It is suggested that many people feel reluctant to seek help for emotional and psychological problems (Bessant, 2011; Moscrop, Siskind & Stevens, 2012). Up to a third of patients with a diagnosable disorder can identify some reason why they find it difficult to disclose problems to their doctor (Dowell, 2004). The MaGPIe study found the most common reasons for not disclosing were because the patient felt they should be able to deal with the problem themselves or that a GP is not the right person to talk to about psychological problems (MaGPIe Research Group, 2004). Studies examining patient characteristics show sociodemographic characteristics such as race, gender and age are influential in the detection of mental health problems in primary care (Cooper et al., 2010; Shen-Ing et al., 2004; Uebelacker et al., 2009). An example of this is demonstrated by Bhui et al's (2001) study on cultural influences on the prevalence of common mental health disorder and general practitioners' assessments. They found that although Punjabis were more likely to suffer with 'depressive ideas' (worthlessness, hopelessness and suicidal ideas), general practitioners were less likely to detect common mental health disorders in Punjabi cases with depressive ideas. It is suggested that this lack of detection could be in part due to patients being reluctant to express depressive ideas (see Jacob et al., 1998) and cultural beliefs and attitudes of patients and practitioners, for instance that hopelessness might be accepted more readily as a culturally concordant belief without resort to illness labels (Bhui, 2001). A further example

is noted in relation to the construct of pain, where Asian cultures hold a plethora of beliefs centred on the experience of pain, the inevitability of its presence, and the virtues of both endurance and transcendence without resort to illness labels and medical help-seeking (Pugh, 1991).

Similarly a study by Borowsky (2000) found physicians were less likely to detect mental health problems in African Americans and patients younger than 35years old, while results from the 2007 Adult Psychiatric Morbidity survey in the UK found older people were less likely to receive evidence-based treatment for common mental disorders (Cooper et al., 2010). Moreover, in relation to age and race, and perhaps reflecting detection rates, treatment differences were apparent where 14.3% of elderly White individuals, compared with only 5% of African Americans in the Piedmont region of North Carolina were found to be receiving an antidepressant (Blazer, Hybels, Simonsick & Hanlon, 2000; Uebelacker et al., 2009). In addition, studies have also shown a relationship between patient gender and detection of disorders, such as the Medical Outcomes Study (MOS), where physicians were less likely to correctly diagnose depression among depressed men when compared to women (Potts, Burnam & Wells, 1991; Wells et al., 1988).

2.4.4.2.4 Time pressure

GPs manage uncertainty routinely in their daily practice and demands upon GPs' time is said to have intensified, with general practitioners said to experience more complex consultations. Consultations with patients presenting with common mental health symptoms are recognised to be time consuming, and as such accurate presentation, identification and treatment of symptoms are suggested to be

influenced by the pressure of consultation time. Patients are said to have an acute awareness and sense of consultation time which increases their anxiety to the consultation (Pollock & Grime, 2002), that there is not time to disclose fully or discuss adequately their concerns, and that the general practice consultation is not an appropriate setting for dealing effectively with depression (Pollock & Grime, 2003). It is suggested that there is a direct relationship between consultation length and quality of care (Pollock & Grime, 2003). Differences regarding GP management of, and attitude toward, lengthy consultations is described in the literature where for example, patients requiring lengthy consultations presented at more constricted times (such as emergency appointments) thus resulting in a busy waiting room and a sense of frustration for some GPs. Other GPs were said to view a busy waiting room as a reflection of themselves as a caring and conscientious practitioners, while it was also said that GPs viewed running over time as indicative of no longer being in command of their working situation, and giving rise to feelings of incompetence and 'approaching chaos' for inexperienced GPs (Pollock & Grime, 2003; Ringsberg & Kranz, 2006). Pollock and Grime (2003) report an inverse relationship between giving time and prescribing drugs, they suggest having more time to give to patients, either in active counselling or a more passive listening role could reduce the need for antidepressants. However antidepressants were considered by GPs to work more quickly than talking therapies and were said to have the advantage of being readily available without restriction. Furthermore, GPs interviewed reported a necessity of extending appointments with depressed patients, seen as an investment of time to establish their understanding of the problem. Time given to patients was said to be

influenced by situational factors, such as the individual doctor's tolerance of running late and perceived need. Once treatment was established GPs reported consultations took on a more routine nature and, in the main, ran within time boundaries. GPs' confidence and interest in dealing directly with patients' psychosocial problems and the amount of time they were willing to give to these also varied (Pollock & Grime, 2003).

General practitioners are often faced with patients suffering multi-morbidity which presents barriers and challenges to the detection and effective management of common mental health (Kessler et al., 2005a; McManus et al., 2009; Roca et al., 2009; Ansseau et al., 2004; MaGPIe Research Group, 2003). The co-existence of long-term conditions and mental health problems have an important impact on clinical decision making and making sense of the relationships between conditions is complex (Bower et al., 2011). Other studies show that general practitioner detection of mental health disorders are higher when symptoms presented are more severe and clearly classified (Borowsky, 2000). However, where it appears that there is the presence of other medical illness, studies differ in their reporting of whether the detection of common mental health or mental health or mental health disorders are higher due to the presence and awareness of a primary condition (Borowsky, 2000), or whether the presence of a medical condition inhibits recognition or detection.

2.4.4.3 Treatment

As discussed common mental health problems are recognised to be highly prevalent in primary care and it is estimated that they may affect 15% of the population at any one time (NICE, 2011b). Therefore early recognition and treatment is crucial for positive outcomes. If left undetected and untreated sub-threshold disorders such as minor depression represent a source of considerable impairment and risk to major depression (Broadhead, Blazer, George & Tse, 1990). The proportion of individuals seeking treatment within primary care is substantial (Ronalds et al., 2002), for example it is reported of New Zealand that while one-quarter of those receiving treatment for mental health disorders were said to get it from specialist mental health or addiction services, around three-quarters of were in receipt of treatment from GPs for mental disorders. Studies show that patients are not receiving appropriate mental health treatments for their disorders (Beel, Gringart & Edwards, 2008; Vines et al., 2004). Other studies show that even when emotional disorders are detected it is found that they are likely to be inadequately treated or not treated at all (Katon, Von Korff, Lin, Bush & Ormel, 1992, Schulberg et al., 1999; Regier et al., 1993).

Collaborative and integrative models of care feature within Engel's bio-psychosocial model of care, which assumes that the patient's complaints cannot be considered in isolation from their psychological causes and consequences (Engel, 1977, 1980). This model of care is patient-centred and recognises the multidimensional nature of health and illness, taking into account the interacting biological, environmental, social and psychological factors (see Australian

Institute of Health and Welfare [AIHW], 1999). Management treatment approaches that follow this model therefore require more than one service to accommodate each of these contributory factors. Liaison between a multitude of professionals other than general practitioners and psychiatrists, such as mental health nurses, clinical psychologists, counselling psychologists, social workers and occupational therapists.

Antidepressants are only one line of treatment, it is suggested that successful management should involve counselling that addresses issues such as the difficulty of coming to terms with having a depressive disorder, so as to improve general coping skills and address psychological and social risk factors (AIHW, 1999). The appropriate detection and recognition of the disorder is crucial and the point of presentation, but more commonly individuals' presenting disorders are comorbid, complex and symptoms may be attributed to various causes or normalised – the danger being that disorders may be missed as a consequence (AIHW, 1999).

Despite potential benefits to the management of mental health disorders using the multidimensional bio-psychosocial model of care model of care the most effective means of delivering a bio-psychosocial approach is not well understood (Frantsve & Kerns, 2007) practitioners are reticent to its employment such as lack of

awareness of networks and operational constraints and an unwillingness to refer on to other care providers for specific types of treatment (Aoun et al., 1997).

Therefore, general practitioner understanding, knowledge and awareness of appropriate treatments and management for disorders is key to positive outcomes (Emerson, 2003). Despite the awareness of significant numbers requiring treatment for mental health and common mental health disorders from general practitioners, barriers to appropriate management of these and access to treatment persist.

2.4.4.3.1 Treatment guidelines

In the UK, updated clinical guidelines continue to be released informing and directing general practitioners toward the appropriate treatment avenues and management of individuals with common mental health and mental health disorders. Treatments recommended to be beneficial for common mental health disorders, such as those said to be low-intensity interventions: self-help (Bibliography; Frude, 2004), computerised cognitive behavioural therapy, physical activity programmes, group-based peer support programmes and psychoeducational groups for those presenting with common mental health problems are various (see Table 2-2). Recently, updated guidelines stress the importance of access for patients, such as 'multiple means of access (including self-referral)' to services rather than the single-point of entry model that has been characteristic of many services (NICE, 2011a), along with promoting the

development of local care pathways (integration of primary care and acute services).

Confidence in treatment success and effectiveness is an issue for GPs. Following on from the issues around whether patients received treatment or not upon detection of a common mental health or mental health problem, the discussion is then about what treatment it is that the patient receives. As previously mentioned, Borowsky (2000) points out in his findings that it is the general practitioners proclivity or inclination toward counselling that influenced detection of common mental health disorder. General Practitioner attitude toward treatment as an influence may be shaped by practitioners' own awareness and confidence in the effectiveness of treatment, which may be affected due to the variability in reported patient benefit and subsequent patient nonattendance (Murphy et al., 2013; Grant et al., 2012). Durability of interventions to aid general practitioners in the process of care, that of recognition, assessment and management do not appear to be long lasting. Studies, including those more complex interventions utilising a multifaceted approach, appear to show decay following discontinuation, and a return to usual care within a 6-month period (Rutz, 1992; Katon et al., 1995; Lin et al., 1997).

As has been already discussed general practitioner recognition of more severe mental health problems is good, while assessment of and making sense of symptoms that are minor and interrelated are not. The lack of clarity with symptom presentation can make recognition of patient improvement difficult too. In terms

of measuring patient benefit from interventions, it is suggested that the sub-threshold nature of conditions, symptoms are less severe, may make demonstrating measuring benefit from treatment difficult (Callahan, 2001).

The literature speaks of a range of different treatments said to be available to GPs in the management of common mental health problems. Controlled studies of interventions targeted to those suffering minor depression (collaborative care, psychotropic medication, problem-solving, placebo), have reported null effects and moderate results, it is suggested that this could be due in some way to the temporal nature and improvement of conditions for patients aside from the intervention (Barrett et al., 1999; Katon et al., 1995; Neeleman, Oldehinkel & Ormel, 2003). In terms of comparing treatments for effectiveness, a meta-analysis study of self-help interventions for anxiety disorders, showed unguided self-help to be less effective than face-to-face treatments (standardized difference for all studies was d = –0.42; 95% CI = –0.62 ~ –0.22), while for studies in which regular support was given during the self-help treatment results reported were not significantly different to that of face-to-face therapies (d = –0.11; 95% CI = –0.42 ~ –0.20; mean effect size 0.68 (95% CI = 0.54 ~ 0.83 (Cuijpers & Schuurmans, 2007)).

General practitioners are said to be able to refer patients to other services for appropriate treatment, and it is said that patients would prefer to see someone other than their GP (Dowell, 2004). However, while general practitioners' are not always fully aware of services that are available to them, another barrier can be the

temporary nature of services that rely on limited funding options (Emmerson et al., 2003). Factors surrounding lack of knowledge can affect the confidence, sense of control and willingness of the GP to refer out their patients, additionally the reluctance to refer is also compounded by the lack of communication from psychiatrists or psychologists, resulting in dissatisfaction and uncertainty (Beel, Gringart & Edwards, 2008; Sigel & Leiper, 2004). A study evaluating a GP consultative psychiatric service found GPs felt that psychiatrists tended to 'take over' the management of their patients, that they did not communicate well with the GPs and when communication was received information was of limited use (Emmerson et al., 2003).

A stepped-care strategy wherein patients that fail to remit after 8 weeks of treatment by the primary care physician are provided additional visits with a mental health specialist have been found to significantly improve clinical and functional outcomes (Schulberg et al., 1999; Katon et al., 1996). Access to psychological interventions, said to be preferred by patients (MacDonald et al., 2007), remain limited in spite of continued commitment to widening access to 'talking therapies' (Department of Health, 2011a, 2011b) and as such it is not clear what proportion of patients could or would be referred if services were freely available. Perhaps, influenced by this lack of provision reported referral rates are not substantial, for example only 22%, of a sample population n=219, said to have received an explicit diagnosis were referred to a mental health professional, with most (73%) being treated with psychotropic medication (MaGPIe Research Group, 2006), these results are similar to other studies (Ashworth et al., 2002).

Community mental health nurses (CMHNs) care for people living in the community and provide counselling and support for patients with less severe mental illness (as well as severe and chronic mental illness), a study looking at the effectiveness of CMHN delivered problem-solving compared to usual GP care in reducing symptoms, alleviating problems and improving social-functioning and quality of life, found specialist mental health nurse support to be no better than support from GPs for patients with anxiety, depression and reactions to life difficulties (Kendrick et al., 2005, 2006). However, the use of mental health clinics in GP practice (PCMHC), a service that provides access to treatment for clients with mild to moderate mental health problems (mild/moderate depression and anxiety disorders including post-traumatic stress disorder, obsessive compulsive disorder, phobias, panic disorder and generalised anxiety disorders), staffed by two community psychiatric nurses, have reported positive results citing reductions in referral to community mental health teams (CMHTs) for depression and anxiety-related problems. While 47% of those using the PCMHC were said to also taking psychotropic medication, brief interventions of between 1-3 sessions were found to be effective in the primary care setting and during the 12-month evaluation period only three clients were said to be re-referred (Ward, Walpole & Glover, 2007).

Since 2004, the National Institute for Health and Clinical Excellence (NICE) has produced clinical guidelines on the care and treatment of common mental health disorders, within these guidelines the use of psychotropic medication is not recommended in the treatment of common mental health, and yet the most

common method of treatment for common mental health disorders in primary care is psychotropic medication (NICE, 2011a). Guidelines, such as those provided by the National Institute for Clinical Excellence (NICE, 2007, 2011) advise general practitioners not to use antidepressants routinely to treat sub-threshold disorders (such as mild to moderate depression), as the risk-benefit ratio is poor. It is suggested that GPs consider using antidepressants for those who have a past history of moderate or severe depression or, where initial presentation of sub-threshold depressive symptoms have been present for a long period (typically at least 2 years) or, where sub-threshold depressive symptoms or mild depression persist(s) after other interventions (NICE, 2009).

The MaGPIe study (2006) found that GPs prescribed psychotropic medication for subclinical or undiagnosed disorders. Differences between the proportions of patients receiving different types of treatment according to diagnostic groupings were found, with over 80% of patients receiving psychotropic medication when a diagnosis was made of either anxiety or depression, while less than 70% received medication when the patient was given a diagnosis of substance use disorder. In addition, requests for further physical investigation (41.6%) and referral to mental health professionals (68.9%) were higher where GPs made a diagnosis of substance use disorder compared to those diagnosed with either anxiety or depression (MaGPIE Group, 2006). Prescribing behaviours are also said to be influenced by seasonality, such that peaks in prescribing occur during the autumn and the winter. Findings from Gardarsdottir and colleagues show the initiation of antidepressant use to be strongly related to more frequent presentation of

depressive symptoms during the winter and found a significant difference of 5-35% more patients initiating antidepressant drug use during the winter compared to the summer (Gardarsdottir et al., 2010). However, the severity of depressive symptoms were not reported in the study and the question is raised about whether general practitioners might see less reason for treating mild depression symptoms with antidepressant symptoms during summer months than during winter time.

An important issue with regards to the prescription of antidepressants is in relation to prolonged use or long-term antidepressant therapy and follow-up to ensure the appropriateness of treatment over time. A study by Cruickshank and colleagues (2008) found that of 61 study participants receiving tricyclic antidepressants (29%) and other types of antidepressants (71%) the majority of participants (57.6%) were found not to meet criteria for any current DSM-IV, HAM-D diagnosis, with 66% scoring within the health population range using the MADRS, and so were inappropriately receiving antidepressants. General practitioner and psychiatrist raters shared agreement amongst their judgment of those being inappropriately prescribed antidepressants, however these judgements still fell short of the proportion identified overall. Attitudes from patients on inappropriate prescriptions showed 50% reported if asked by their GP, they would be likely to stop taking their antidepressant.

The disease management framework of collaborative care shown to improve primary care has been shown to improve clinical outcomes for mental health (Katon et al., 1995, 1996, 1999), and has also been suggested to improve both quality of care and clinical and functional outcomes in primary care patients

suffering panic disorder. Collaborative care comprises a combination of education of the disorder, pharmacotherapy, consultation with a psychiatrist and telephone call follow-ups. Results from a study comparing usual care with collaborative care showed both groups improved over time, and results reported the greatest differences for collaborative care were demonstrated in the first 6 months of treatment congruent with the more intensive nature of the disease management intervention during this period as well as greater rates of and adherence to antipanic medications regimens during the same phase (Roy-Byrne, Katon, Cowley & Russo, 2001).

Practice locality and access to various forms of treatment provide a challenge for practitioners, rural populations are said to be underserved in terms of psychiatric services, in that primary care providers in rural areas report having inadequate skills to manage mental health issues as they would (i.e. consultation-liaison) (Geller, 1999). Therefore, the use of multi-media (videoconferencing, secure e-mail and telephone interventions) have been used to link psychiatric specialists in academic centres with those practicing in rural locations (Hilty et al., 2006). The use of telepsychiatry consultation assistance has been said to provide positive benefits to general practitioners, by reducing isolation, decision support around medication and dosing, and facilitating enhancement of skills and knowledge, suggested to be reflected in changed referral patterns and needs overtime (Hilty et al., 2006).

Table 2-3: Updated NICE (2011) clinical guidelines: suggested treatment for common mental health disorders*

Level of intervention			
Low intensity intervention:	• Brief psychological interventions with reduced contact with a trained practitioner. • The practitioner facilitates and supports the use of self-help materials. Role taken by the practitioner is one of a coach of facilitator.		
	Intervention	Focus of intervention	Intervention description
	Facilitated and non-facilitated self-help	Focus is on a shared definition of the presenting problem.	Facilitated self-help (also known as guided self-help or bibliotherapy) is defined as a self-administered intervention, which makes use of a range of books or other self-help manuals and electronic materials based on the principles of CBT and of an appropriate reading age. A trained practitioner typically facilitates the use of this material by introducing it and reviewing progress and outcomes. The intervention consists of up to six to eight sessions (face-to-face and via telephone) normally taking place over 9 to 12 weeks, including follow-up.

	Non-facilitated self-help	Focus is on a shared definition of the presenting problem.	Non-facilitated self-help, also called pure self-help or bibliotherapy, is defined as a self-administered intervention and makes use of written or electronic materials based on the principles of cognitive behavioural techniques that are of an appropriate reading age to the patient. This intervention usually involves minimal contact with a practitioner (e.g. an occasional short phone call of no more than five minutes) and includes instructions for the person to work systematically through the materials over a period of at least six weeks.
	Group-based peer support (self-help) programmes	Shared experience and feelings	A support (self-help) programme delivered to groups of patients with depression and a shared chronic physical health problem. The focus is on sharing experiences and feelings associated with having a chronic physical health problem. The programme is supported by practitioners who facilitate attendance at the meetings, have knowledge of the patients' chronic physical health problems and their relationship to depression, and review the outcomes of the intervention with the individual patients. The intervention consists typically of one session per week over a period of 8 to 12 weeks.
	Computerised Cognitive Behavioural Therapy (CBT)	Behavioural change: thought-challenging to effect thought patterns and outcomes	A form of cognitive behavioural therapy that is provided via a stand-alone computer-based or web-based programme. It should include an explanation of the CBT model, encourage tasks between sessions, and use thought-challenging and active monitoring of

			behaviour, thought patterns and outcomes. It should be supported by a trained practitioner who typically provides limited facilitation of the programme and reviews progress and outcome. The intervention typically takes place over 9 to 12 weeks, including follow-up.
	Physical activity programmes	Structured group-based physical activity programmes	Physical activity programmes are defined as structured and group-based (with support from a competent practitioner) and consist typically of three sessions per week of moderate duration (24 minutes to 1 hour) over 10 to 14 weeks (average 12 weeks).
	Psychoeducational groups	Knowledge/information about condition to bring about greater understanding and aid self-management	A psychosocial group-based intervention based on the principles of CBT that has an interactive design and encourages observational learning. It may include presentations and self-help manuals. It is conducted by trained practitioners, with a ratio of one therapist to about 12 participants and usually consists of six weekly 2-hour sessions.
Targeted interventions for Persistent sub-threshold symptoms	Persistent sub-threshold depressive symptoms or mild to moderate depression that has not responded to a low-intensity intervention; initial presentation of moderate or severe depression; GAD with marked functional impairment or that has not responded to a low-intensity intervention; moderate to severe panic disorder; OCD with moderate or severe functional impairment; PTSD *Persistent Sub-threshold: refers to symptoms and associated functional impairment that do not meet full diagnostic criteria but have a substantial impact on a person's life, and which are present for a significant period of time (usually no less than 6 months and up to several years).*		

Intervention	Disorder	Description of intervention
Cognitive Behavioural Therapy (CBT)	Depression, Generalised Anxiety Disorder (GAD), Panic Disorder, Obsessive-Compulsive Disorder (OCD), Post-Traumatic Stress Disorder (PTSD)	A psychological intervention where the person works collaboratively with the therapist to identify the effects of thoughts, beliefs and interpretations on current symptoms, feelings, states and problems areas. They learn the skills to identity, monitor and then counteract problematic thoughts, beliefs and interpretations related to the target symptoms or problems, and appropriate coping skills. Duration of treatment varies depending on the disorder and its severity but for people with depression it should be in the range of 16 to 20 sessions over 3 to 4 months; for people with GAD it should usually consist of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting 1 hour.
Interpersonal Psychotherapy (IPT)	Depression	A psychological intervention that focuses on interpersonal issues. The person works with the therapist to identify the effects of problematic areas related to interpersonal conflicts, role transitions, grief and loss, and social skills, and their effects on current symptoms, feelings states and problems. They seek to reduce symptoms by learning to cope with or resolve such problems or conflicts. The intervention usually consists of 16 to 20 sessions over 3 to 4 months.

		Behavioural activation	Depression	A psychological intervention for depression that aims to identify the effects of behaviour on current symptoms, mood and problem areas. It seeks to reduce symptoms and problematic behaviours through behavioural tasks related to reducing avoidance, activity scheduling, and enhancing positively reinforced behaviours. The intervention usually consists of 16 to 20 sessions over 3 to 4 months.
		Behavioural Couples therapy Counselling	Depression	A psychological intervention that aims to help people understand the effects of their interactions on each other as factors in the development and maintenance of symptoms and problems, and to change the nature of the interactions so that the person's mental health problems improve. The intervention should be based on behavioural principles and usually consists of 15 to 20 sessions over 5 to 6 months.
		Short-term psychodynamic therapy	Depression	A psychological intervention where the therapist and person explore and gain insight into conflicts and how these are represented in current situations and relationships including the therapeutic relationship. Therapy is non-directive and recipients are not taught specific skills (for example, thought monitoring, re-evaluating, and problem solving.) The intervention usually consists of 16 to 20 sessions over 4 to 6 months.

	Antidepressants/drug treatment	Depression, Panic Disorder, GAD, PTSD	
	Combined interventions	Depression, GAD, OCD (combined interventions and case management)	
	Collaborative care	Depression	A coordinated approach to mental and physical healthcare involving the following elements: case management which is supervised and has support from a senior mental health professional; close collaboration between primary and secondary physical health services and specialist mental health services; a range of interventions consistent with those recommended in this guideline, including patient education, psychological and pharmacological interventions, and medication management; and long-term coordination of care and follow-up.
	Self-help groups	Depression, GAD, Panic Disorder, OCD,	A support (self-help) programme delivered to groups of patients with depression and a shared chronic physical health problem. The focus is on sharing experiences and feelings associated with having a chronic physical health problem. The programme is supported by practitioners who facilitate attendance at the meetings, have knowledge of the patients' chronic physical health problem and its relationship to depression, and review the outcomes of the intervention with the individual patients. The

			intervention consists typically of one session per week over a period of 8 to 12 weeks.
	Applied Relaxation	GAD	A psychological intervention that focuses on applying muscular relaxation in situations and occasions where the person is or might be anxious. The intervention usually consists of 12 to 15 weekly sessions (fewer if the person recovers sooner, more if clinically required), each lasting 1 hour.
	Trauma-focused CBT	PTSD	A type of CBT specifically developed for people with PTSD that focuses on memories of trauma and negative thoughts and behaviours associated with such memories. The structure and content of the intervention are based on CBT principles with an explicit focus on the traumatic event that led to the disorder. The intervention normally consists of 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).
	Emotional Response Prevention	OCD	A psychological intervention used for people with OCD that aims to help people to overcome their need to engage in obsessional and compulsive behaviours. With the support of a practitioner, the person is exposed to whatever makes them anxious, distressed or fearful. Rather than avoiding the situation, or

			repeating a compulsion, the person is trained in other ways of coping with anxiety, distress or fear. The process is repeated until the person no longer feels this way.
	Eye movement desensitisation and reprocessing (EMDR)	PTSD	A psychological intervention for PTSD. During EMDR, the person is asked to concentrate on an image connected to the traumatic event and the related negative emotions, sensations and thoughts, while paying attention to something else, usually the therapist's fingers moving from side to side in front of the person's eyes. After each set of eye movements (about 20 seconds), the person is encouraged to discuss the images and emotions they felt during the eye movements. The process is repeated with a focus on any difficult, persisting memories. Once the person feels less distressed about the image, they are asked to concentrate on it while having a positive thought relating to it. The treatment should normally be 8 to 12 sessions when the PTSD results from a single event. When the trauma is discussed in the treatment session, longer sessions than usual are generally necessary (for example 90 minutes). Treatment should be regular and continuous (usually at least once a week).

*Information drawn from the National Institute for Health and Clinical Excellence (2011) *Common mental health disorders: Identification and pathways to care*

2.4.5 Knowledge, education and training

Additional factors said to be associated with the management of individuals with common mental health problems are the individual characteristics of general practitioners themselves, such as knowledge and understanding of common mental health, some of which have already been alluded to. General practitioners' knowledge and understanding of common mental health problems are said to be an influential factor in the detection and management of these conditions. Medical education consists of limited exposure training for interviewing techniques and to psychiatric training, with the latter more often during inpatient experiences with severely dysfunctional patients (Smith, 2011). Weaknesses in current UK GP training have been identified in a number of specific clinical areas including care for those with mental health problems (Gofal, 2011; Lester, 2005). In response, calls for changes in medical education, by the Royal College of General Practitioners, have suggested extending GP training to include more training in three priority areas (enhanced clinical skills, enhanced generalist skills and enhanced leadership skills) and fourteen outcomes identified for enhanced GP training over a four-year period. It is suggested that the first two year period will include placements that provide all GP trainees with adequately-supervised exposure to: psychiatric problems, including common mental health conditions, psychosis and suicide risk assessment (Gerada, Riley & Simon, 2012). However, while there is recognition of the need for increased mental health training, it is suggested that the key focus will be on severe mental illness (Gregory, 2012). A blog response posted to the notion of secondary care placements, noted:

But I am not 100% sure that Anxiety and Depression recognition

and management skills would be best picked up in 2ndry care

environment. My feeling is that, GPs are dealing with disorders of

mental health which are much more subtle. Most of what we see is

of little or no interest to most psychiatrists.

(GP practitioner[1])

2.5 Discussion

General practitioners routinely see high numbers of individuals presenting with mental health and common mental health in their clinical practice. These types of consultations are challenging. Recognition and assessment of these conditions is said to be improving. However, it is clear that general practitioners are still experiencing difficulties, with a proportion of individuals not in receipt of adequate, appropriate, effective treatment and management.

Despite efforts over recent years to reduce stigma and increase access to treatment and various screening and diagnostic instruments being created to aid general practitioners in the effective and early recognition of common mental health in primary care, problems with symptom recognition and timely and effective intervention persist. The same can be said with interventions created to aid in the management and treatment of those with common mental health problems in

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[1] General Practitioner posting blog response to article 'Call for longer GP mental health training' in Pulse, 16 November 2012. Available at: http://www.pulsetoday.co.uk/your-practice/practice-topics/education/call-for-longer-gp-mental-health-training/20000888.article#.UkWw5FpwbIV

primary care, where the durability and effectiveness of such interventions appear to be various.

There appears to be a general consensus amongst health professionals that access to psychological care is difficult and limited, both in terms of demand outweighing service provision but also the lack of qualified specialists. It can be argued that GPs are best placed to take forward more psychosocial based assessments within the common mental health consultation, and that issues of trust that usually inhibit open disclosure can be reduced as GPs already maintain a relationship with their patients.

A plethora of individual differences and practitioner characteristics appear to influence how general practitioners recognise and manage patients with common mental health in primary care. General practitioners' knowledge and understanding of sub-threshold disorders is disparate, and so too is their confidence in treatments other than psychotropic medication.

Further investigation of individual differences and the understanding of common mental health and its management in primary care by general practitioners is required to assess to what extent these individual differences are impacting upon practice.

2.6 Summary of Chapter 2 and link to Chapter 3

The literature review, as outlined above, has endeavoured to present some of the main issues associated with the management of common mental health in primary care, including prevalence, treatment, recognition and assessment and general practitioner attitudes toward management in primary care. This review helped to inform the following studies as presented throughout the thesis. These studies attempt to look more closely at a number of the areas outlined within this literature review.

The first of these is presented in the following chapter. Chapter 3 describes a scoping study with working GPs at several general practices across Wales, facilitated via focus groups. This study was conducted to ascertain more generally what GPs understand to be common mental health problems and what, if any, difficulties they experience in the management of patients with common mental health problems.

Chapter 3: Exploring the complexities associated with the management of common mental health in Primary Care – A scoping study

This Chapter begins with some background, before moving onto describe the first study in the programme of research presented within this thesis. The scoping study explores the management of common mental health in primary care. This chapter concludes with a discussion of the study's findings and implications for the next stage of the research programme.

3.1 Introduction

At present there doesn't seem to be a clearly defined view of what the term 'common mental health problems' actually refers to though there is agreement in the fact that these problems are, in general, managed in primary care and refer to conditions such as, adjustment disorder, anxiety and depression that do not achieve caseness. They do not include the psychoses or those that fall into diagnostic categories.

In an average general practice population of 10,000 adults, approximately 1,200 people will have a common mental health problem, whereas only 25 people will have psychosis (Sainsbury Centre for Mental Health, 2007). In addition, 30% of the 280 million consultations undertaken by GPs each year have a mental health component (Royal College of Physicians, 2006). Therefore, the burden upon general practice is great, especially since mental health conditions are complex, can be long standing, and if left untreated are potentially disabling to the

individual. Common mental health disorders are said to affect one in six adults, at a cost to UK employers of £25 billion each year through lost working days (NICE, 2011).

The effective management of common health problems in general practice is of high importance. While it is suggested that GPs are key and best placed to recognise and manage individuals presenting with common health and common mental health problems it has been suggested that they find the management of these consultations challenging. However, while interventions and programmes are being introduced to address the suggestion of GPs experiencing 'difficulties' there seems to be a lack of literature and clear evidence pointing to exactly what it is that GPs are experiencing with regard to the consultation around common mental health.

The GP is usually an individual's first point of contact for general health care. GPs are there to help in the management of health and well-being and to prevent illness. Moreover, the GP also provides the link to further health services and other healthcare professionals. The GP's position is to also act as a patient's advocate, supporting and representing a patient's best interests to ensure they receive the best and most appropriate health and/or social care (RCGP, 2011). While, GPs are trained in all aspects of general medicine, they are said to experience difficulty in regards to the consultations relating to mental health (NICE, 2011b). However, while interventions and programmes are being introduced to address the suggestion of GPs' experiencing 'difficulties', there seems to be a lack of literature

and clear evidence pointing to exactly what it is that GPs are experiencing with regard to the consultation around common mental health.

3.2 Rationale

It is clear that common mental health within primary care accounts for a substantial proportion of a GPs clinical work. As previously discussed it has been suggested that GPs are having difficulties managing common mental health problems, however it is not clear what those difficulties are and to what extent such difficulties might impact upon the management of these. Therefore, proper assessment of the knowledge and relevant skills GPs have with regard to common mental health is required so that we can explore whether GPs are indeed having problems with the management of the common mental health consultation per se, or whether other more social/environmental, systematic or organisational factors are giving rise to management difficulties. In order to begin to look at these areas, a scoping study comprising focus group discussions with GPs would generate views and experiences regarding the management of common mental health in primary care. Data generated through such discussions will provide an insight to current thinking around the management of common mental health and areas requiring further investigation.

3.3 Method

3.3.1 Ethical Approval

Full ethical approval was obtained from the Research Ethics Committee for Wales, along with the appropriate research governance where necessary.

3.3.2 Sample

- Working GPs in Wales

- Sample size: five focus group interviews were conducted with between three and five participants at each location

- Focus Groups were located at GP practices across Wales: Cwmbran, Flint, Morlais, Narbeth and Presteigne

3.3.3 Recruitment

- General practices were purposively sampled for the study

- Practice managers and GPs were sent an email inviting them to take part in a study which formed part of a PhD programme of research looking at the management of common mental health in primary care, the data from which would be used to inform the construction of a questionnaire that was to be sent to working GPs in Wales. For GPs who expressed an interest in taking part in the study, contact details were provided and further information about the project, consent, data protection and complaints and distress procedures were sent out before being able to progress further.

3.3.4 Research Design

- A semi-structured focus group was conducted

- Participants received information about the project, data protection and consent procedures. Informed consent was given before commencement of the discussion group (see Appendix 3-1)

- All data were held/stored/received anonymously

- Data generated from the discussion groups was to inform the construction of an online questionnaire that would be sent to working GPs in Wales, regarding the management of common mental health in primary care

- Areas listed for discussion were:

    o Management of common mental health problems

    o Prevalence of common mental health problems

    o Challenges to management

    o What constitute common mental health problems

    o How management of common mental health in primary care can be improved

3.3.5 Data Collection

- During the winter of 2008 five focus group interviews were conducted at GP practices across Wales (Cwmbran, Flint, Morlais, Narbeth and Presteigne)

- The group discussion took no longer than one hour

- The discussion group was recorded and subsequently transcribed

- All data were anonymised during the transcription process

3.3.6 Analysis

- Qualitative data generated through the discussion group interviews was transcribed

- Qualitative data were organised and analysed using the Nvivo 8 software package for qualitative data

- Thematic analysis was the analytical tool chosen for these data

3.4 Results

This Scoping Study used focus groups as a way to explore what, if any, issues were present for GPs around the management of common mental health problems in primary care. More specifically, the focus groups employed a semi-structured interview approach, where key questions or points for discussion were presented, namely with regard to common mental health problems, its prevalence and issues the around management of common mental health in primary care. This format helps to define the areas of interest, whilst also allowing both the interviewer and interviewee to diverge in order to pursue an idea or a response (Silverman, 2000). This approach is a well-established method in healthcare research (Britten, 1996). The purpose of the research interview can be described as exploring the views, experiences, beliefs and/or motivations of individuals on a specific matter (Gill, 2008).

A Thematic Analysis approach was used to analyse data generated through the course of the focus groups. This methodology shares the concept of supporting assertions with data from grounded theory, which is designed to construct theories that are grounded in the data themselves, paying particular attention to the perceptions, feelings and experiences of participants. The view from the perspective of this research was that analysis was conducted from an inductive perspective – that is to say, the process of coding is not linked to previous

assumptions, but instead is data driven. The process of analysis using this approach follows seven stages, through which the identification of themes is achieved (preparing the data, familiarisation, coding the data, defining identified themes, re-examining relevance of data, final form construction for theme and report each theme).

Through the course of analysis four major themes emerged. Results will be organised and presented under each of these headings: common mental health problems; consultation difficulties; the issue of work; and training.

3.4.1 Common mental health problems
3.4.1.1What are considered common mental health problems?
The GPs taking part in the discussion groups suggested that they understood the term 'common mental health problems' to refer to conditions such as: mild stress, anxiety, depression, social phobia, chronic fatigue and being unable to cope with life.

3.4.1.2Nature of common mental health problems
GPs considered those conditions representing common mental health not to be serious mental health problems:

> *F2: [...] a lot of these people haven't got serious mental*
>
> *health problems they just need help and support [...]*
>
> (F2 General Practitioner, Morlais)

Across the group discussions, common mental health problems were referred to those that were short term or those that were generally reactive states:

> *F2: depends what it is I suppose, if it's depression I mean*
>
> *a lot of it can be reactive to situations and sometimes*
>
> *they just need a bit of time to get...their head round the*
>
> *situation...*

<div align="right">(F2, General Practitioner, Narbeth)</div>

Difficulty was raised around being able to find labels for individuals who suffered from mental health problems, in that the complex nature of complaints meant that presentations were not always clear cut, by way of being able to slot individuals into labels:

> *There was one guy who was seeing the other [name of*
>
> *GP] and she said you can't have a sicknote...and we went*
>
> *back through his history and he didn't have any...no-body*
>
> *had ever been able to find a psychiatric label for*
>
> *him...but he'd been off for years and years and years with*
>
> *ah I can't remember...I forgot what the term*
>
> *was...something like an odd chap or unable to cope with*
>
> *society so he'd been signed off for ages without actually a*
>
> *diagnosis...but in a way it was right that he was signed*
>
> *off because he COULDN'T cope with society you could*

see why he couldn't work...but it was hard to say 'yes' you

are depressed or he was psychotic or this that and the

other...and er it's just very difficult people like that...it's

hard to put down and fill in a box and put clearly this is

the reason

(M1, General Practitioner, Flint)

The assessment of impact upon individuals is something that GPs voiced to be difficult. Patients would sometimes present with physical conditions to cover mental health complaints. General Practitioners were aware of stigmatising attitudes and would code such complaints as 'stress at work' or more preferably a physical condition, so as to remove a 'label' and help the patient, in these instances patients were referred to as 'dual pathology' patients. The following excerpt serves to highlight this practice:

M1: hat about the dual pathology issue...do you ever get

that...I've got a lady at the moment who...I think she's

officially off work because of shoulder pain, but I think

unofficially she's off work because of depression anxiety i

don't know...

F: oh so there's 3 or 4 different complaints going on

M1: and you sometimes writing and you think well this

really isn't going to stop you going to work

M2: it's usually they want the physical diagnosis rather

than the mental diagnosis

M1: you can't blame them for that

(General Practitioners, Flint)

It was clear that there was an understanding of when mental health conditions were considered to be chronic, but for those that were ongoing problems and not meeting diagnostic caseness, these proved difficult. It seems evident that there is a complexity in management and understanding by way of dual directionality with regard to assessing for impact upon the individual, from the perspective of the doctor:

M4: well sometimes it can be difficult to assess how that's

impacting on their work or they....I mean it's fine again

when they're CLEARLY CLEARLY DEPRESSED but

people with sort of ongoing sort of chronic levels of

anxiety and a bit of social phobia and...you kind of think

well actually biting the bullet and being in work and

getting over that hum will probably be good for you

[ahh]

F18: equally some it's difficult to imagine them holding

down a job

(General Practitioners, Presteigne)

74

And that of the individual, toward their problem, in so far as the individual is acknowledged as having a CMHP that the GP feels should not impact upon the individual in the way that the individual is presenting, the difficulty then for GPs is around how to manage the individual in this situation and presentation of esoteric symptoms:

> *I have a problem with that though - in that...it's about*
> *how those symptoms...erm impact on that*
> *patient's...LIFE...erm and the slightly more esoteric ones*
> *you just deal with them differently...we have lots and lots*
> *and LOTS patients with chronic fatigue syndrome in this*
> *part of the world because there's a...erm mad alternative*
> *doctor who lives up in the hills and they tend to sort of*
> *gravitate towards her - but they perceive themselves as*
> *COMPLETELY...incapacitated and I have no problem*
> *with that because you just gradually move them*
> *towards... erm INDEPENDENCE...you know they have*
> *been investigated and NO abnormalities found, but there*
> *are these women in wheel chairs and not able to do*
> *anything...*
>
> (F11, General Practitioner, Presteigne)

3.4.1.3Treatment/interventions

GPs discussed the difficulties they found in managing common mental health in terms of providing treatments to patients and where the condition was in terms of its nature. It was presented by GPs that they felt the earlier a condition was recognised the better the chances were that it could be treated, so as to achieve a successful outcome.

> *[...] because they came you early on in the process you*
>
> *were able to deal with it and give them sensible advise*
>
> (F2 General Practitioner, Narbeth)

The availability of services to which GPs were able to refer patients for appropriate help was also an issue:

> *people who are on incapacity say with depression and*
>
> *trying getting them back into work is very difficult*
>
> *really...cos there really aren't the services available*
>
> *to...cos help building their confidence...you know services*
>
> *aren't available really*
>
> (M2, General Practitioner, Flint)

General practitioners spoke about using different approaches to treatment toward those having or exhibiting common mental health problems. It was commented by one GP that 'they [the patient] just need time and sympathy and support':

Depends what it is I suppose, if it's depression I mean a

lot of it can be reactive to situations and sometimes they

just need a bit of time to get...their head round the

situation in which case, sometimes counselling will help

them, occasionally they do need to have antidepressants

to actually help LIFT their mood to help deal with the

counselling...I suppose they're not difficult consultations

they just need time and sympathy and support – and the

great majority of those with that will pick up...

(F2, General Practitioner, Narbeth)

Early intervention was also explained to result in reducing the negative impact to the day-to-day living of the individual, while the delay of intervention was stated to directly result in the probability of non return-to-work for individuals. In part, the delay to the provision of an intervention was linked to system processes of acquiring interventions, an example of which we can see in the following excerpt:

Firstly, it's often long winded isn't it, secondly it's often

way down the track when these people are probably not

going back anyway...it's more the...I suppose the

intervention's too late usually. The trouble is, is that sort

of letter is...late so they're unlikely to return to work...all

these issues about confidentiality and it just gets later

by...the amount of time it takes to process it...

(M16 General Practioner, Cwmbran)

The ability to treat was also raised during discussions, so for some GPs (as discussed above) there was a concern over waiting times and the window of opportunity to treat (as they saw it), while for another group of GPs and with regard to their practice surgery, they spoke positively of their surgery's provision for patients' with mental health needs, such that they had recently been able to offer patients counselling (run by a psychiatrically trained nurse) and that there were links between the surgery and the community mental health team. The example below describes the positivity of being able to offer help to those individuals that would otherwise not be in a position to afford it, this excerpt also displays a sense of confidence in being able to manage patients with non-serious mental health problems:

CBT to base to giving them some anxiety

management...or some...giving them some basic tools to

help them move on in their lives and we found that's been

of great...of quite great benefit because I mean, a lot of

these people haven't got serious mental health problems

they just need help and support and I mean certainly a lot

of people in this area couldn't afford to have private

counselling or anything ... so from that point of view I

think we cope quite well with that...I mean...we only had

this service for 18 months 2 years and we coped with

most of it ourselves before

<div align="right">(F2, General Practitioner, Narbeth)</div>

Many GPs suggested using the internet to print off self-help leaflets for patients, as well as using the internet to look up information on things they were unsure of. Some GPs spoke of doing this with the patient present – there was a differing of opinion in this area, in that some GPs felt this would unnerve patients and others suggesting that they felt it impressed patients. The excerpt below provides an example of this, where one GP begins to explain that it's how information is accessed in front of the patient that makes the difference:

F11: in terms of accessing the website something to do

with the information you get there it's in terms of how to

get there... 'oh dear I've pushed the wrong button' and

it's like any resource...erm...for example...it's exactly the

same as using a book...if you use a book constructively

and say I'm going to look up the data because you're a

little bit underweight and da da da and explain what

you're doing they are positively impressed...if you look

and 'hang on oh what shall we give you?' they're

thinking this doctor has no idea what they're talking

about so it's EXACTLY the same...it's the expertise with

which you assess that information

M4: but the idea that you're looking something up in a

book on a web doesn't faze patients [

F11:   [if you do it properly

it doesn't faze patients no [

M4:   [at all they're used to us not

knowing things you know

<div align="right">(General Practitioners, Presteigne)</div>

Furthermore, through discussions it was raised that the provision of patient leaflets was something that was recorded into patient notes, mentioned to be useful on 'medico-legal' grounds, and importantly ran in line with the QOF which would lead to financial remuneration. It was further stated that GPs were actively encouraged, through appraisals, to demonstrate that they were providing people with advice; therefore information leaflets were suggested to be a straightforward and easily recordable way of doing this through their information technology systems. However, issues were raised around whether or not patients were fully appraised of the information within the leaflets or whether the GP just handed them out without communication:

I was told that I needed to be doing more in terms of

demonstrating that I had actually given people advice...so

it's a relatively straightforward way of doing it....so of

course there is a difference between giving them a leaflet

and working through the leaflet with them to make sure

they've understood it

<div align="right">(M10, General Practitioner, Morlais)</div>

In addition, there were issues in some practice localities with regard to poor internet connectivity and computer hardware provision, this was said to be due to the local health board taking over the maintenance of internet services for practice surgeries. An example of the significance of this situation was expressed by one of the practices taking part in discussion, where it was said their computer service and network once updated, due to the lag, would still be out of date:

practices used to be responsible for their own IT, so we

would upgrade and maintain but we are no longer

responsible for our own IT it's now maintained by the

health board...so since that's happened which is now 2

years we've had no maintenance...so there...there used to

be some funding that came to us so we could look after

our own and we're no longer given that funding and the

LHB keeps it and we are no longer able to maintain our

computers and consequently they don't get any...we've

said well shouldn't we be getting an upgrade and they've

said 'yes' they're going to upgrade da da whenever it

was...probably within the next 3 to 4 years...but they're

expecting to upgrade us in 3 to 4 years to XP rather than

to Vista so we'll be upgraded to something that will

already be 8 years out of date

(M4, General Practitioner, Presteigne)

As well as issues around connectivity and workable computer hardware, there were also issues raised around the use of internet-based information for learning and confidence in the information presented therein. However, credible sources such as those trusted, initially from their paper format, and timely information were deemed a valued resource:

[...]websites for learning is a sort of burgeoning

erm...rapidly progressive source of learning...it is in a

really interesting phase at the moment...particularly

[name of colleague] and i have done things a bit...a bit

younger but we've...not been used to it

historically...combine with the fact that a lot of them

haven't been terribly fit for purpose at the outset – so

they're a bit unwieldy and a bit slow and it's all

progressing slowly...it is an EXTREMELY rapid and if

you find THE RIGHT website incredibly useful way of

learning

(F10, General Practitioner, Presteigne)

M4: trust in the content...so the BMJ one the WeMeReC

one for example they're ones that...and the DTB are ones

which historically have been TRUSTED partly because

they're independent of industry – so they're not funded by

industries, they're not full of adverts so that helps

F18: and they have a good track record

F11: yeah...prominence and track record...so you can

trust that it's going to be a good space

<div align="right">(General Practitioners, Presteigne)</div>

3.4.1.4 Management and Consultation difficulties

The management of mental health problems were coined as 'bread and butter GP issues', whilst it was also discussed that the management of individuals with mental health complaints were more problematic and difficult to manage, compared to other presenting conditions. Aside from the complexities associated with assessment, recognition and treatment already discussed, GPs commented upon the difficult nature, of mental health, in that it's difficult to measure and evaluate:

M1: our trickiest cases are the usually they're not that

bad are they, it's not minor complaints

M2: it's the chronic back pain isn't it that you can't

measure

M1; and the chronic depression or anxiety isn't it

<div align="right">83</div>

I: they're more difficult

M1: yeah

I: in relation to work and health they're more difficult

M1: I think so yeah that's where the problem is cos

they're the people who are off the longest and the

hardest[

M2:   [to measure

M1: and to evaluate

(General Practitioners, Flint)

3.4.1.5 Assessment of common mental health problems

Difficulties were also presented during discussion groups regarding what was referred to as the 'agenda' or 'subplot' of some individuals to avoid returning to work or the acquisition of or retention of state benefits.

I think though that we're not talking about people with

mental health – we're talking about people

with...probably mild stress and anxiety however the

subplot is that they don't want to go to work...and I think

that that's what we find difficult...is where somebody

comes in who is...not on medication has PERHAPS had

some contact with er mental health services in the past or

more than likely NOT and they can't go to work cos

they're too anxious or stressed and...we're not 100% sure

84

that that is the case...I mean certainly not even at the

moderate side of mental health issues...you know I've no

issues at all with people with with...either acute or long

term depression or other mental illnesses erm...FINE and

you know a lot of these...once you've actually sort of

treated the root cause are ACTUALLY anxious to go back

to work, they're ANXIOUS ABOUT going to work and

this is where you...we're probably talking about...the

small proportion of people but who are chronically on

the sick leave on an annual basis...and those are difficult

or well nigh on IMPOSSIBLE to deal with...

(M3, General Practitioner Cwmbran)

However, this situation or 'playing' the system is one that seemed to benefit some while measures put in place to try and prevent this sort of practice by the state resulted in circumstances where those, who were said to genuinely suffer with CMHPs were said to actually suffer as a result. This example from a discussion groups highlights just such a dilemma, and illustrates where the GP find themselves in relation to trying to gain the appropriate help for their patient:

M3: I think there are a couple of things...and what i seem

to find is that the genuine people who have got

GENUNINE...stress anxiety and depression get KICKED

back to work by...the er...the medical...whereas the ones

that are on it for years [benefits] and years and years

seem to get AWAY with these medicals and it just really

doesn't make sense...i can remember one patient who was

SO agoraphobic that she couldn't go for the medical and

it just took me...about four letters to sort this out...erm no

she CAN'T attend because she's got agoraphobia and

...well

F10: perhaps then the other ones are better at playing

(General Practitioners, Cwmbran)

I think perhaps it right about the medical certificates in

relation to people who've got...where work is an issue -

they can be quite challenging can't they those...because

basically you very often feel this person is going to be

well when they find a new job...that's what you're sitting

there saying but you're in...that's when you can get into a

catch 22 [...]

(F1, General Practitioner, Narbeth)

The binary of condition recognition and, therefore for some due to being unable to work, the link with this to state benefit was a complexity within the consultation and a difficulty GPs resigned themselves to:

[…] as you say I mean it's ...actually IMPOSSIBLE to influence it to any...meaningful extent because its CULTURALLY determined...essentially it's not about the individual...and we can't influence the culture

(M1, General Practitioner, Cwmbran)

However, this difficulty though present was apparent to varying degrees for the practices interviewed (supporting the suggestion of the extent to which the culture or social environmental issues are influential), as this excerpt around sick notes illustrates:

M4: I don't think that's necessarily about us as GPs it's about – there is a VERY VERY high level of self-employed folk around here

F11: and employed poor...many people are in employment but its rural employment below...legal wage

M4: sick notes don't make a difference to them...you know it's just NOT an issue for a lot of folk, they either don't want them or it's not gonna help them...and so we don't get a lot so...IT DOES MEAN that the ones we DO end up doing...often are slightly more […] slightly more complex

(General Practitioners, Presteigne)

3.4.1.6 Doctor/Patient interaction

The interaction with the patient was regarded as difficult in terms of managing the condition, in that the patient's awareness of their problem was not helpful to the general practitioner:

> *I mean as far as SERIOUS mental health problems are*
>
> *concerned I mean...they're I mean, I suppose the main*
>
> *time they're a problem is when it gets acute really and*
>
> *erm...the lack of insight...and...you know sometimes they*
>
> *can be a bit awkward from the consultation point of*
>
> *view...*
>
> (F2, General Practitioner, Narbeth)

Difficulties around mental health problems were almost expected by GPs and normalised, in that difficulties seemed expected around certain areas:

> *M1: well you know the guy that breaks their knee or*
>
> *something sees the orthopaedic surgeon a few times...it is*
>
> *the backs and the what's on your website?...the backs and*
>
> *the mental health people are the...ones that DRAG ON*
>
> *and they're hard to evaluate*
>
> *I: why is that cos there's not sort of*

M2: well for instance there's no...you can't measure it

can you...you can only go on patient symptoms and their

perception of their symptoms

F: and it's their perceptions about how much their work

effects them as well...people who...you know stress at

work or depressed things like that there's no one willing

to...go back

(General Practitioners, Flint)

However, it also became apparent that the condition a patient suffered was conflated with the patient themselves:

F1: quite time consuming some...wouldn't you say?

F2: it's really difficult to say I mean YES

technically...well, every now and again I mean we'll

have a right difficult one [chuckle] ...if you see what I

mean or there are patients...

I3: what is that makes it difficult

F2: well... I don't think it's really any WORSE with

mental health to any of the other than the quick the

obvious quick ones the people who come to you for...but

if it's a...ongoing chronic problem I think you're as

likely to encounter a difficult one really, I don't know

M1: yes

F2: it's usually around medication that the problems

arise far more... than...I would've have said it's more

around the medication rather than the time off wouldn't

you say?

F1: well I would've thought so yeah...I mean are you

thinking about just general conflict in a consultation,

about dealing with a patient or are you talking about

dealing with their sickness or their sick notes

(General Practitioners, Narbeth)

3.4.2 Consultation length

Many of the GPs across the groups suggested one of the prevailing difficulties they encountered to be of consultation length, due to the difficulties or complexities surrounding the problem. It was suggested that this type of consultation (in general practice) was time consuming and in conflict with general practice clinic management time of between seven and ten minutes per consultation. This accepted, the example below shows, for some individuals, time spent in consultation was in itself an effective intervention:

Every now and again I've said to them...and i think the MOST

successful one I've had about this - I gave her a brief time off we'd

had a LONG LONG chat and I said look I think you need to go

away and think about this and I...I think I think you have to take on

board that you can tackle this but may be the best thing for you is

to is to leave…to get a new job...and she took two weeks off and she

came back to see me six weeks later having resigned and having

found a new job - without actually ...getting herself TRAPPED in to

trying to deal with this bullying problem...because the person who

was bullying her was her IMMEDIATE SUPERIOR she had not a

CAT IN HELL'S chance ...of getting through that situation...and

ACTUALLY that was one of my most successful therapeutic things

we...we spent a long time talking about it and she said 'well I like

the job', I said 'yeah but okay let's...just go away take two weeks

have it at home and think about it' but...but cos other people I've

given longer off and they've been off for a long time and then

they've got caught in not being able to get a job because they're on

the sick ....and it's very difficult.....

<div align="right">

(F1, General Practioner, Narbeth)

</div>

3.4.3 The issue of work

Another theme raised through analysis of discussions was that of 'work'. This was seen by many as an important influence or factor in relation to the difficulties or complexities of the management of common mental health. Significantly, there was a conflict between the doctor wanting to protect or act on the patient's behalf as an advocate, (1) in relation to the negative influence of particular work or working situations to an individual, and (2) between the doctor and the patient

when views were opposed in relation to the individual's ability to continue in work. More specifically, this aspect is related to the link between a doctor's diagnosis and the acquisition or retention of state benefits. Work was also viewed as being the linchpin to stabilising and aiding in the recovery of the individual.

Depression and things like that obviously in some cases

actually being in work and having some sort of normality

helps the patient recover

(F13, General Practitioner, Morlais)

In relation to the above example, 'work' was also seen as a causal attribute to the mental health problem, this was recognised by the GPs participating across the groups:

[...]I have a couple of patients who... has been sort of

bullied at work for example which has created...a acute

mental health problem where they've not had a mental

health problem before and it's exactly that and...the way

its dealt with at work...will influence how they how they

are recovering [...] because unless you resolve the issues

which...have caused it then to go back to work is not

going to change anything they will be in EXACTLY the

same situation and that's the difficulty isn't it and

then...they you know....

(M1, General Practitioner, Narbeth)

It was also recognised that, for the majority of individuals, financial dependence and a shortage of employment left little choice. In this double bind, there is a realisation that for those with common mental health it can be difficult to move forward into work, while being off of work for a long period can in itself serve to compound aspects of the condition. However, as previously discussed GPs felt that there were no services available to aid individuals in this respect:

> *It's only relevant to mental health problems isn't it...we*
>
> *see these people who have become DEPRESSED and*
>
> *DEMOTIVATED by...by you know and lacking in*
>
> *confidence by being off work for years and don't feel*
>
> *confident enough to ever think about getting going back*
>
> *into employment*

<div align="right">(M2, General Practitioner, Flint)</div>

3.4.4 Training

In terms of knowledge and training, time was a salient factor with regard to additional learning. Many of the GPs said that they would like more and better education and training in the area of mental health. It was further commented that the area of mental health was lacking when compared to others:

> *It's a bit of a Cinderella, I mean similar to mental health*
>
> *isn't it...there seems to be lots of research into*

CARDIOVASCULAR stuff and DIABETES and all

that...but it's like mental health and occupational health

say...are really Cinderella areas where there really isn't

much education available or...where it's needed really

(M2, General Practitioner, Flint)

It was suggested, that the difficult nature of common mental health was possibly the reason for this:

how could you...I mean there's nothing to measure is

there...you were saying about back pain you can't...so

how do you research something that's hard to measure

and that's the problem isn't it

(M1, General practitioner Flint)

It was voiced that time constraints of the working day meant, that if additional learning did take place, this would be done at home. Access to the internet, although present across all groups, was said to be somewhat slow in rural areas and was, in effect, a barrier to information access. GPs also spoke about having different preferences to learning: seminars, papers and online learning modules. Internet modules were clearly preferred over books and journals, however the long term effectiveness and retention of such modes of learning compared to actual interaction was doubtful:

M10: but in terms of actually learning...the...my own

experience has been not all that great when where you go

to something like the BMJ learning website when you

actually then have a pre-course assessment you tick

boxes you work through a module you tick boxes at the

end of it...I mean I DO IT because it earns me brownie

points for when it comes to my accreditation but whether

I've actually LEARNT a great deal from THAT process

because for me...I'm a quick reader so I just quickly go

through quickly read it, quickly get the points but then I

don't know that I retain very much so...as an actually

learning...I think I learn more if a patient comes in and I

really don't know what's going on then you actually

relate it to the patient and you remember then

F13: yes if you've had an experience that sticks in your

mind a lot better

F16: I mean I enjoy using the BMJ modules...but how

much of it STAYS in your head...you know

(General Practitioners, Morlais)

3.5 Conclusion

It can be concluded from this study that the prevalence of mental health in consultations is high and that GPs see the common mental health and mental health

consultation challenging. It is evident from the findings in this scoping study that there is a lack of confidence in managing such consultations and to some extent apathy, a kind of knowing expectancy, that these type of consultations and patients are 'difficult', that they 'drag' and that the GP doesn't make a difference. This apparent conflation of the individual and the condition is of significance and is in itself a clear display of GPs' lack of awareness and education in this area.

The area of training and education for GPs is of key importance; it seems that to a large extent the basis for their knowledge on mental health and common mental health problems is vague, out-dated and by no means solid. It seems clear from the findings of this study that their confidence in managing patients with common mental health problems is not high and that there are significant gaps in learning and awareness.

It is also clear from findings discussed above that there are a multiplicity of challenges for the GP with regard to this type of consultation – which in many cases seem difficult to disentangle. There seems to be confusion for GPs, both in terms of understanding about conditions beyond chronic depression and anxiety (what they are and their nature) and how to manage them. The latter not just being confined to the aspect of treatment management, but also in terms of the complexities around the individual and their social environment. For instance, issues relating to stigma, the sick role, work (whether in or out of work) and the impact upon state benefits and financial security. In addition to, and related to these was the conflict for the GP around their role, their responsibility to the patient as

the patient's advocate and to the state in terms of being an independent assessor of health, in effect a gate keeper toward financial provision.

GPs have a key role and a huge responsibility in dealing with individuals with mental health and common mental health problems. It is clear from this study that GPs need help and assistance in being able to deal effectively within these areas. Further research needs to be conducted to better understand the areas of need and where the gaps are so that more targeted education, training and awareness can be introduced.

3.6 Limitations

Although Thematic Analysis is one of the most popularly used qualitative approaches to analysis (this is in no small part linked to the ease of accessibility to researchers from all backgrounds), in that it is not driven by specialist theory, compared for instance to Discourse Analysis, which has a strong Social Constructivist underpinning and which is executed in line with specific conventions. Therefore, a limitation associated with using Thematic Analysis is its reliability. The concern here is seen as the wide interpretation that can be drawn from themes, in addition to the possibility of applying themes to large chunks of texts. So too, due to the style of this particular method, there is the likelihood that fine distinctions in data will be missed, that the discovery of and verification of themes are interrelated, and that due to the coding practice there is an inherent difficulty in the maintenance of individual accounts. And importantly, due to method's lack of sensitivity to detail it does not allow for making claims about

language use. That said, this particular method was deemed appropriate of scoping what, if any, difficulties GPs were experiencing in the consultation with patients presenting with common mental health disorders and indeed what they thought constituted common mental health in the first instance. This method enabled the identification of issues and provided signposts for further detailed exploration.

3.7 Summary of Chapter 3 and link to Chapter 4

The chapter above describes the GP Scoping Study which aimed to explore what if any difficulties GPs were experiencing in practice. Findings show that GPs experience many challenges to the management of common mental health problems and understand the term common mental health to refer to a broader set of conditions than those that are posited within public health literature.

The challenges raised during the GP Scoping Study informed the following study, the GP Survey, presented in the following chapter (Chapter 4). Chapter 4 describes the GP Survey, along with its findings in more detail.

Chapter 4: A study of GPs' perceptions and knowledge of common mental health and their management - The GP Survey

Informed by the focus groups with General Practitioners (GPs), the GP Survey was developed. This chapter presents the GP Survey which investigated how GPs across five Local Health Boards in Wales, during 2009-2010, managed common mental health in primary care. Areas covered in the survey include education, prevalence, confidence, and experience. Firstly the chapter will present a topical background, followed by aims, method, results and conclusions from the GP Survey.

4.1 Introduction

Mental health issues affect ever greater numbers of people, with one in three GP consultations said to have a mental health element to it (NICE, 2011a), with common mental health disorders affecting one in six adults. However, there does not seem to be a concrete definition for what the term 'common mental health problems' refers to. The British Occupational Health Research Foundation review, defined common mental health problems as those conditions that: occur most frequently and are more prevalent; are most successfully treated in primary rather than secondary care setting and are least disabling in terms of stigmatising attitudes and discriminatory behaviour (Seymour & Grove, 2005). This means that common mental health problems are said to refer to conditions such as, anxiety and depression that do not achieve caseness (NICE, 2007). Excluding those conditions

within diagnostic categories, and are considered as those problems that are able to be managed in primary care.

The effective management of common health problems in general practice is of high importance. Common mental health disorders can affect up to 15% of the population at any one time, with one in four said to experience a mental health problem every year (NICE, 2011b). Timely recognition and appropriate treatment management is key to successful outcomes. But despite acknowledging the prevalence of common mental health in primary care and the burden to general practice, real issues continue in regard to effective recognition and treatment of these conditions (Kroenke, 2000). And large numbers of individuals do not receive the help and support they need for their distress. So, while it is suggested that GPs are key and best placed to recognise and manage individuals presenting with common health and common mental health problems it appears that GPs' find the management of these consultations challenging.

It is clear that common mental health within primary care accounts for a substantial proportion of a GP's clinical work. However, proper assessment of the knowledge and relevant skills GPs have with regard to common mental health is required so that we can explore whether GPs are indeed having problems with the management of the common mental health consultation per se, or whether other more social, environmental, systematic or organisational factors are giving rise to management difficulties.

4.2 Rationale

The increase of prevalence with regard to mental health in primary care has cemented its position of high importance for GPs, governmental bodies and patients alike. More recently, the establishment of a 'gold standard' and 'best practice' with regards to the management of mental health and common mental health in primary care, akin to that of more traditional coronary and musculoskeletal care management, has been gathering great interest. This survey is part of a programme of research looking at GPs' management of common mental health and could, therefore, contribute significantly to the establishment of such a standard. Likewise, information gathered through this survey could potentially prove interesting for improvements to CPD for GPs in this area.

The purpose of this survey is to:

- Identify what GPs understand the terms 'common mental health problems' and 'common mental health disorders' refers to

- More fully explore how GPs manage the common mental health consultation – what works and what doesn't work

- Identify factors influencing general practitioner management of the common mental health consultation

- Assess the level of knowledge and relevant skills GPs have about common mental health

4.3 Method

4.3.1 Ethical Approval

Full ethical approval was awarded by the Multi-Research ethics Committee for

Wales, along with research governance from Blaenau Gwent LHB, Caerphilly

LHB, Monmouthshire LHB, Newport LHB and Torfaen LHB.

4.3.2 Participation

The National Public Health Service for Wales (NPHS) was interested in the GP

survey and agreed to support the distribution of blank surveys to all GPs in the

Gwent Health Authority region in Wales (Blaenau Gwent LHB, Caerphilly LHB,

Monmouthshire LHB, Newport LHB and Torfaen LHB).

4.3.3 Sample

- All working GPs within the Gwent Health Authority region in Wales
  were eligible to take part

- Sample size: 395 GPs working within the Local Health Boards of
  Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen

- GP data will be grouped as:

  - o Partner

  - o Salaried

  - o Registrar

  - o Locum

  - o Retainer/assistant

4.3.4 Recruitment

- Names of GPs working out of practices across the five local health boards making up the Gwent Health Authority region (Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen) were sourced via the HOWIS directory and were cross-referenced against practices' own websites

- GPs were sent a letter, citing support from the NPHS, along with an information sheet (see Appendix 4-2) explaining the research, informed consent (see Appendix 4-1) and an invitation to complete the short-item questionnaire (see Appendix 4-2)

- In order to increase response rates a reminder letter was sent after three weeks

- GPs were provided with the opportunity at the end of the short questionnaire to opt-in to take part in further research and to receive written results from the survey upon completion

4.3.5 Data collection

A short item paper and pen survey was developed.

4.3.5.1 Questionnaire Development

- A short-item paper and pen questionnaire was developed from information gathered through informal discussion with GPs, the literature and consultation with experts in the field

- A small pilot study was carried out with an opportunistic sample of GPs

- Changes to questions were addressed in light of this feedback

- Upon completion of amendments and after favourable review from the research team, the questionnaire was then distributed across the

Local Health Board	Number of GPs
Blaenau Gwent	48
Caerphilly	121
Monmouthshire	67
Newport	84
Torfaen	75

Gwent Health Authority region (see Appendix 4-3).

4.3.5.2 Pilot Study

- A small pilot study was carried out with an opportunistic sample of GPs (n=4) from outside the proposed sample population. GPs were asked to complete the short questionnaire. The GP was then contacted by the researcher (at a time convenient to the GP) who took them through a short cognitive debriefing exercise (see Appendix 4-4) regarding the content and structure of the questionnaire and for any additional comments or suggestions they may have

4.3.5.3 Distribution

- A total of 395 survey packs were distributed between May and June 2009

- In order to increase response rates a reminder letter was sent 3 weeks after initial distribution

4.3.6 Analysis

4.3.6.1 Qualitative analysis

Thematic content analysis was employed (Silverman, 2004) to analyse the data.

4.3.6.2 Quantitative analysis

All data was converted into Excel. Data was then imported into the SPSS statistical package for analysis (SPSS v.16).

4.4 Results

4.4.1 General Practitioner Sample

Overall, 122 responses were received for the GP survey sent out between May and June 2009, equating to a response rate of around 31%. Of these, six were notifications of retirement, change of practice and feedback. General practitioners (GPs) who took part in this study ranged between 28 and 64 years. Respondents were all working GPs in the Gwent Health Authority region of Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen situated in Southeast Wales. The resulting sample of 116 GPs who completed the questionnaire comprised of 92 Partners (79.3%), 17 Salaried (14.7%), 1 Registrar (0.9%), 3 Locums (2.6%) and 3 Retainer/Assistant GPs (2.6%). They averaged 44.31 years ($\pm$ 9.02) and were fairly evenly split by gender; 64 male (55.2%) and 52 females (44.8%). The majority of GPs (44%) reported practicing in general practice for over 15 years.

4.4.2 The Practices

Of the sample, 59 (50.9%) GPs practiced in an urban practice, 49 (42.2%) semi-rural and 8 (6.9%) practiced in a rural practice (*see* fig 4-1); 27% of all GPs indicated their practice received remuneration for practicing in an area of deprivation, the majority of which practiced in semi-rural and urban areas, 38.71% and 48.39% respectively. As would be predicted, practice size was significantly correlated with practice type ($p < .018$, 0.05 level). The majority of GPs (79%) reported working in practices with a list size greater than 5, 000, with 32% reporting working in a practice serving between 7, 001 and 10, 000 patients. The greater number of which were situated in urban settings. Larger practices, as well as being associated with greater number of partners ($p < .01$ level), were also correlated with being training practices (n=51, 44%; $p < .001$). GPs (60%) reported working between seven and nine clinical sessions per week, with a sizeable sample (38%) working under six sessions per week; 6.1% working less than three sessions per week.

Figure 4-1: Respondent distribution by Local Health Board

GP Survey (N = 122)

Key	
LHBs	***n%**
☐ Blaenau Gwent	8.3
☐ Caerphilly	26.4
☐ Monmouthshire	33
☐ Newport	50
☐ Torfaen	35

- **% reflects the level of response in relation to the population sampled from the LHB indicated**
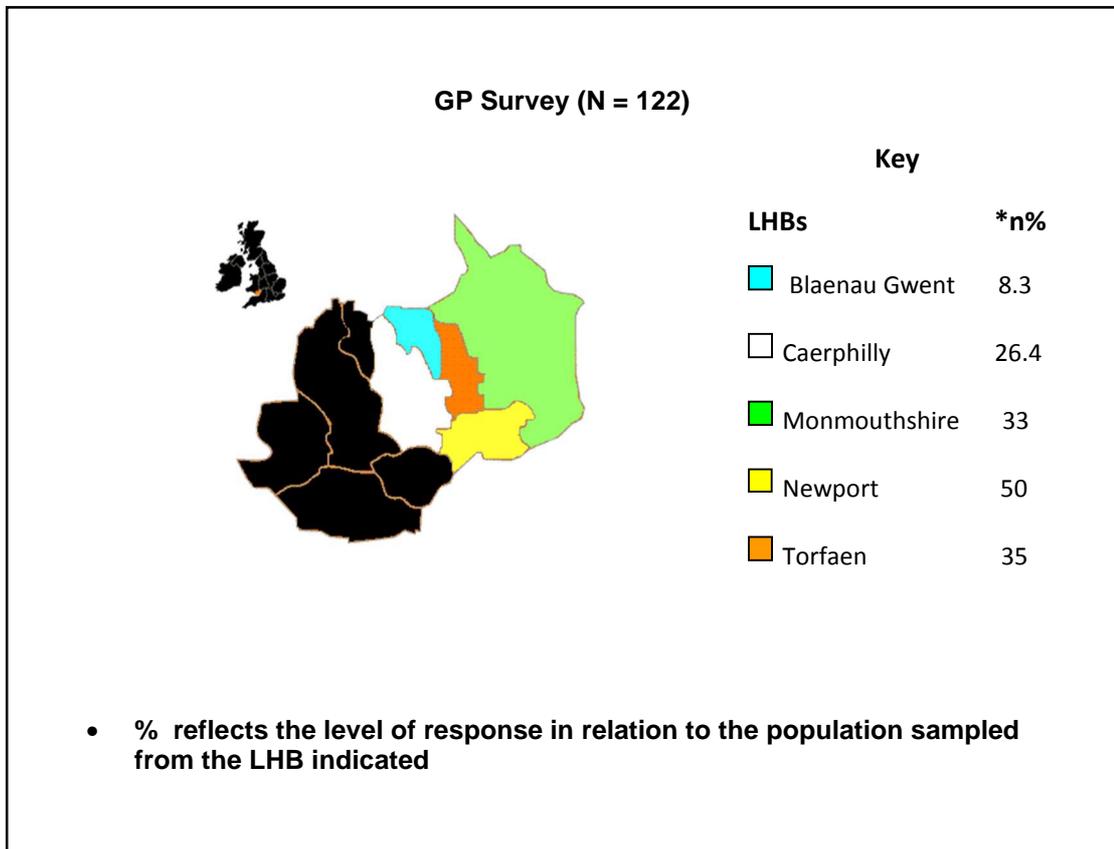
4.4.3 Defining Common Mental Health

One of our primary research questions was to identify what GPs understand the term 'common mental health problems/disorders' refers to (see figure 4-2). To determine this we asked GPs if they agreed with a statement which encompasses the more popularly cited expression; 22.4% (n=26) of GPs agreed and 75% (n=87) of GPs disagreed with this statement respectively.

Figure 4-2: Example of question asking GPs how they understand the definition of common mental health problems

---

2.1 The following question focuses on what you think the term 'common mental health problems/disorders' refers to. Please read this statement below and indicate whether you agree or disagree with this statement: Please tick ONE box

'Common mental health problems/disorders' do not refer to conditions other than depression and anxiety and are not short term.

Do you agree with this statement? Please tick ONE box

Agree

Disagree   (please provide an example of what you think below)

_____

_____

_____

GPs were also asked to provide examples of what they thought the term common mental health problems/disorders refers to, and it was revealed that GPs believe common mental health problems to encompass a much wider range of mental health conditions/symptoms (see Table 4-1). GPs also provided examples of what they thought about the term and factors constituent of a common mental health problem/disorder, i.e. time and severity (see Table 4-2).

Table 4-1: Symptoms and conditions GPs' believe common mental health problems refer to

Symptoms/Conditions		
Environmental/lifestyle Issues	**Bodily Reactions**	**Psychoses**
Adjustment Reaction	Burn out	Psychosis
Abnormal/prolonged bereavement	Low mood	Schizophrenia
reactions	Somatisation	Manic depression
Stress due to life circumstances	Phobic symptoms	Personality disorder
Stress due to work		
Anxiety	**Obsessions/compulsions**	**Social/conduct problems**
Longer term anxiety	Alcohol and drugs	Relationship breakdown
Chronic anxiety	OCD	Psychosexual problems
Short term anxiety	Substance misuse	Social phobia
	Eating disorders	Behavioural disorders
Post Traumatic Disorder	Phobic disorder	Personality issues
	Addiction	Anger
	Insomnia	
	Panic disorders	

Table 4-2: About the term and constituent factors of a common mental health problem

What GPs think about common mental health problems and the term
What common mental health problems are:
- Long-term perhaps not severe   - Short-term (i.e. acute NOT chronic)   - Short-term reactions   - Short-term especially if triggered by life events   - Reactive states   - The full spectrum of mental health issues
What common mental health problems are NOT:
Severe
What common mental health problems do:
Contribute to a large proportion of all other ills seen by GPs
About the term common mental health problems:
- Nebulous term, could mean anything   - Common mental health problems by the very title are "common"   - Mental health has a much wider scope than anxiety and depression   - Don't know what a common mental health problem is   - Referring to anxiety and depression is too limiting

4.4.4 Common mental health in primary care

As predicted, common mental health in primary care is a big issue. GPs indicated high prevalence in consultations focused upon common mental health problems in the previous seven days; 65% (n=75) of GPs indicated they spent over 10 consultations focused on a CMHP in the last week, of these a further 33% (n=38) stated this to be over 15 consultations. Unfortunately due to ambiguity of the category (15+) we are unable to know just how many more than 15 these GPs were experiencing. However, we do know from these data that prevalence is high and therefore this is indicative of the significant impact of common mental health problems on GP time spent per week (see Figure 4-3).

Figure 4-3: Number of consultations focused around a common mental health problem in the last seven days
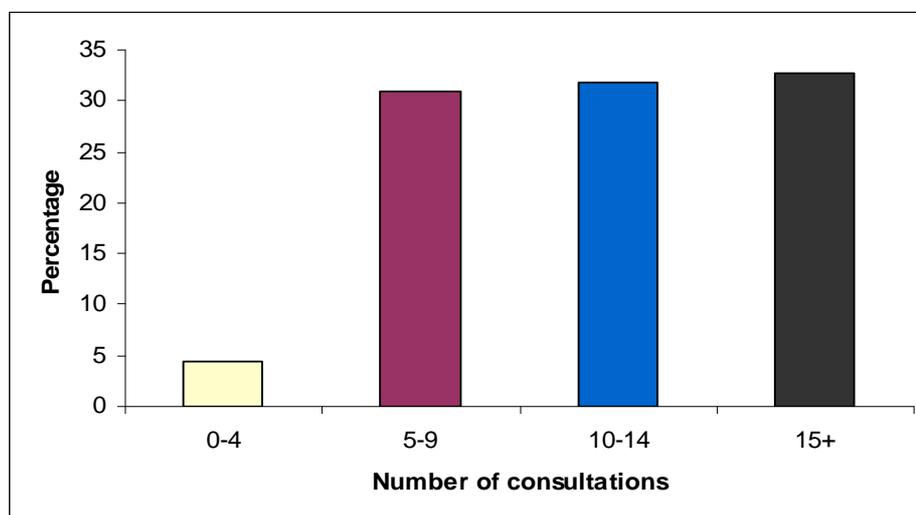
Although 75% (n=87) of GPs disagreed with anxiety and depression as the sole explanation for common mental health problems, when asked "of those you consider to be common mental health problems, which would you say were the

four most common complaints" (number ONE being the most common),
depression and anxiety did factor heavily within the top two positions; 45.7% and
51.7% respectively for position one and two. However, when all positions were
collapsed and the overall frequency was calculated (*see* Figure 4-4), both
depression and anxiety levelled to parity accounting for 21.8% of the variance
equally. Furthermore, this was closely contended by the presence of obsessions
and compulsions accounting for 15.1% and poor coping at 8.4% of the variance.
More surprisingly, GPs ranked psychosis (7.3%) above stress (7.1%). Overall,
stress ranked in sixth place out of a possible twelve, closely followed by
somatisation (4.1%) and adjustment disorders (3.9%).

Figure 4-4: Overall ranking of what GPs' perceived to be common mental
health problems
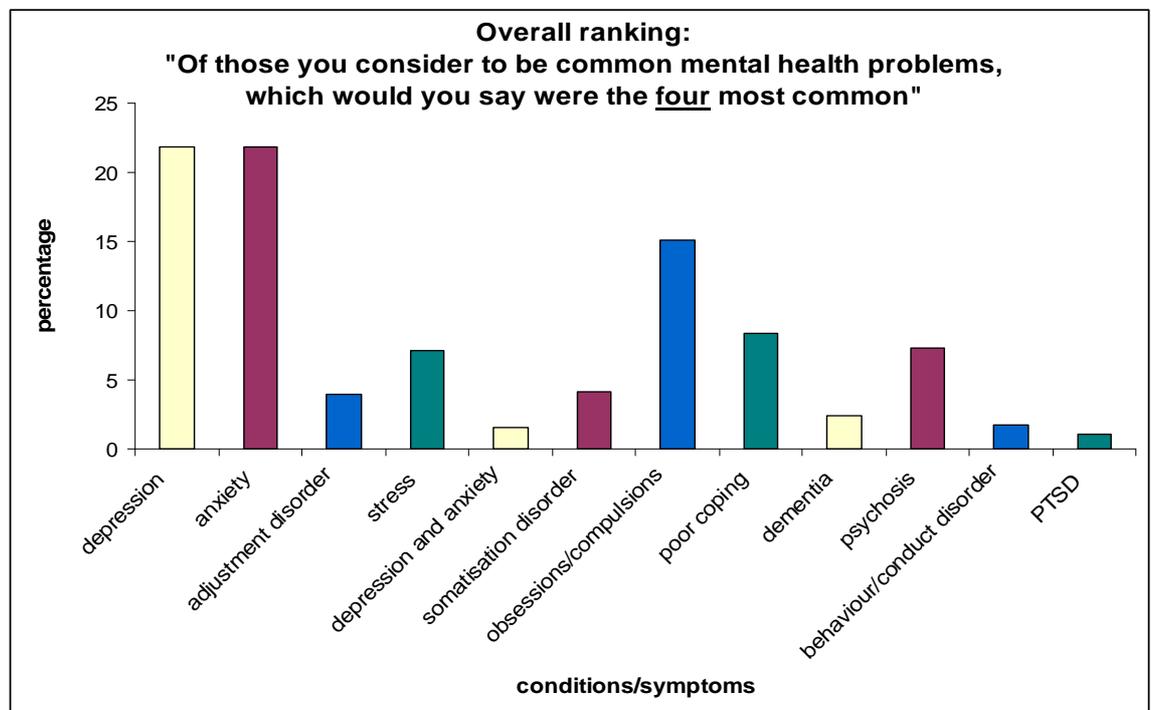
4.4.5 Management of common mental health problems

In order to tease apart factors associated with the management of common mental health problems we included items around recognition, confidence, training and personal experience, as we know that these factors can be influential with regard to clinical decision making. Consistent with the majority of the survey items, categorical scales were presented requiring respondents to choose a single position. GPs were asked to think back over the previous seven days and indicate what percentage of consultations had a common mental health problem as a secondary component, that is to say the patient's presentation of a common mental health problem can be associated with a prior condition. The categorical scale included a possible nine positions, ranging from 0-100%. Over 73% (n=85) of GPs indicated that between 21-50% of consultations undertaken in the last seven days had a common mental health problem as a secondary component to a primary condition (see Figure 4-5). Conversely, 61.2% (n=71) of GPs stated of those consultations taken in the last seven days, between 11-40% had a CMHP as a primary condition (see Figure 4-6).

GPs were asked to indicate how straightforward they found consultations around common mental health (on a scale of 1-4, where 1 is very straightforward and 4 is not at all straightforward), 81.8% (n=95) of GPs nested between positions two and three on the scale. Just over a third of respondents indicated that they didn't find the management of common mental health problems straightforward.

Figure 4-5: Percentage of consultations over the last 7 days: CMHP as a
secondary condition
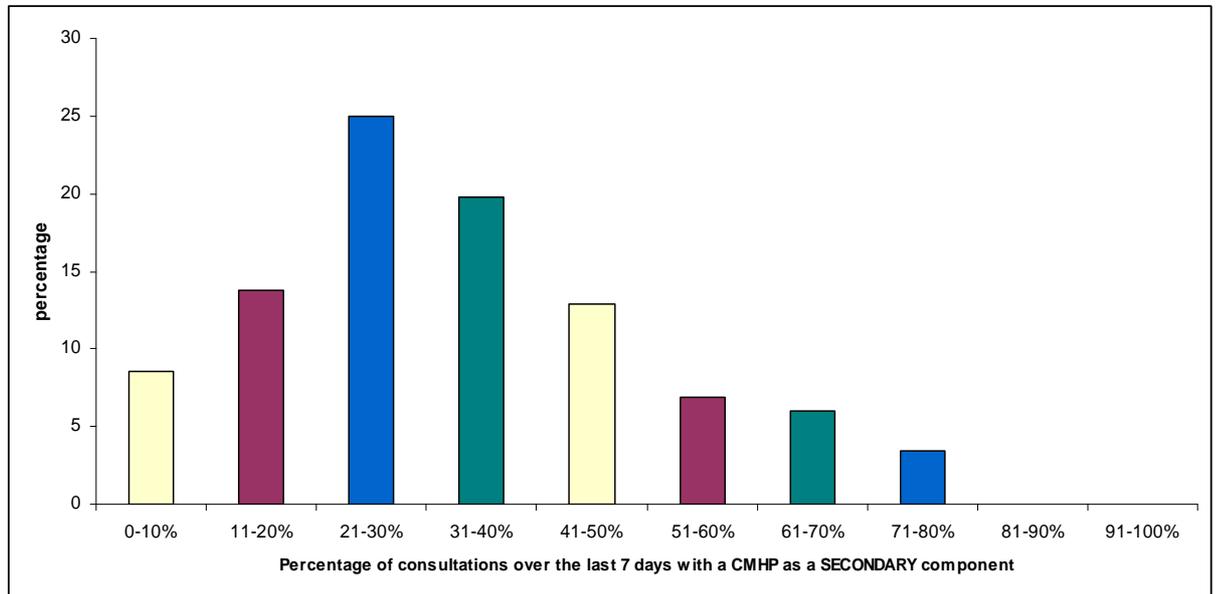
Figure 4-6: Percentage of consultations over the last 7 days: CMHP as a
primary condition
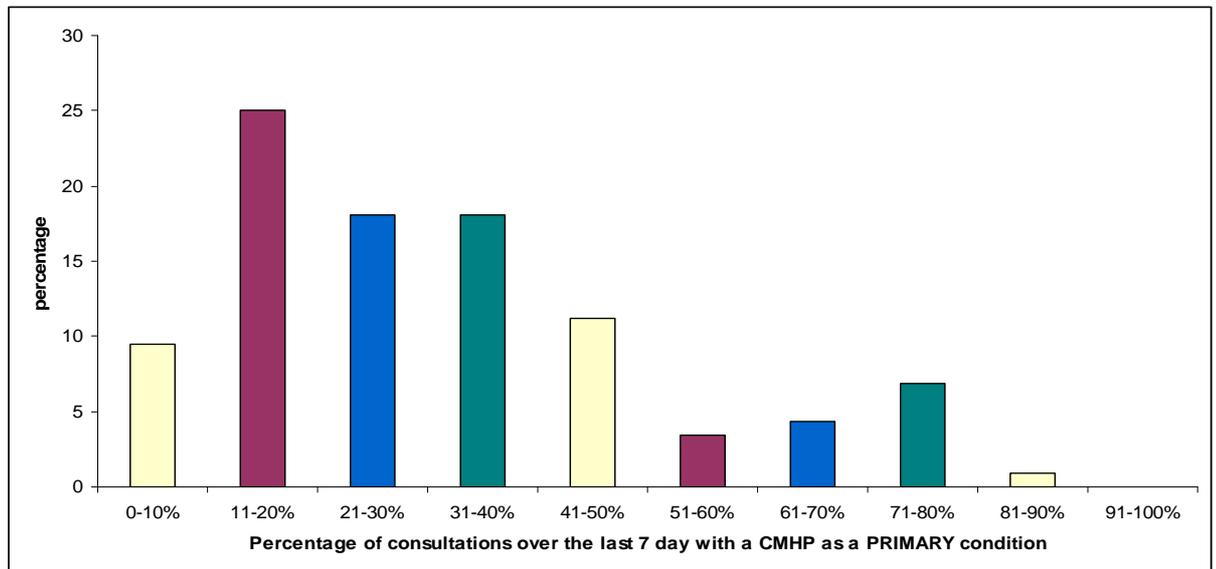
When GPs were asked to indicate with whom they found the management of
common mental health problems more straightforward, 88.9% (n=103) of GPs

indicated consultations with patients they were familiar with were more straightforward, while 85.3% (n=99) indicated consultations were less straightforward with those they were unfamiliar with. Explanations in support of familiarity were rapport, prior knowledge of patient's health history and familial and work circumstances. However, GPs also indicated a tension between openness and patient expectation, citing that communication with patients unfamiliar to them did offer the opportunity to speak more plainly.

Effective management of common mental health in primary care is of high importance and is crucial for positive outcomes, patient confidence and engagement. Initial consultations are therefore key with regard to recognition and the assignment of appropriate treatment. We asked GPs to tell us the course they generally take when a patient presents with a common mental health problem on their first visit. Categorical items were presented (*ask to see them again, prescribe medication, refer to a specialist, use a screening tool* and *other*) and GPs were able to indicate those that applied to them. In addition, space was provided alongside each option to allow for qualitative comments. Of the GPs within the sample, 84.2% indicated they would request to see the patient again on their first visit, of these, 66.3% would use a screening tool. Furthermore, over a third of the total sample indicated prescribing medication to a patient on their first visit. Data were further analysed using Pearson Chi-square, including Yates' correction for continuity to compensate for the overestimation of the chi-square value when used with a 2x2 table. Of those prescribing medication on a first visit, 97.5% of GPs indicated requesting to see the patient again ($p = .011$). However, nearly 60% of

GPs do not administer a screening tool prior to the prescription of medication (*p* = .041).

As would be predicted, GPs ranked their confidence of simple therapy (1 medication) management of anti-depressant therapy as high (71.6% very confident). However, GPs rated their confidence of managing complex therapy (2 or more medications) as significantly lower with 57% of GPs marking downward of position 2 on the scale. GPs confidence in managing psychological therapies also displayed a difference across the sample (see Figure 4-7).

Figure 4-7: GPs' confidence of using/managing psychological-based interventions
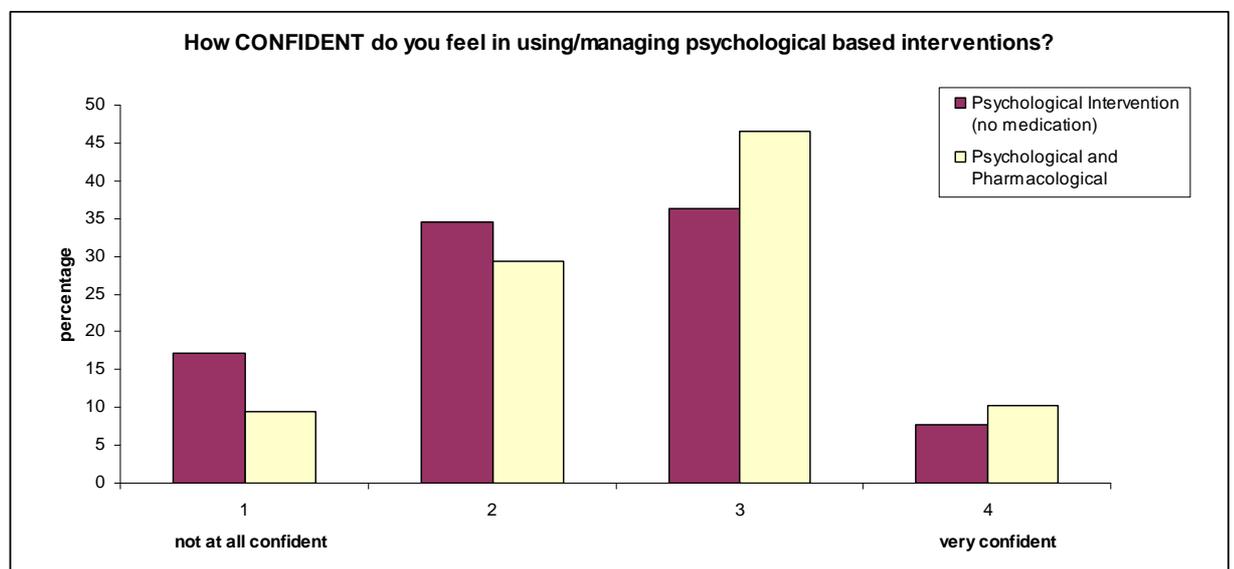
Pearson (r) correlation coefficients between variables were calculated. Strong (r) value associations were found between GPs high confidence managing simple

antidepressant therapy and confidence managing complex (2 or more medications) therapies ($p < .001$). High confidence in the management of simple therapy was significant at the .05 level compared to confidence in managing and using psychological interventions with no medication. However, there was no significant association between confidence of managing simple therapy with the management of psychological and pharmacological interventions. Confidence of managing complex antidepressant therapies (2 or more medications) was related to the confidence of managing psychological interventions displaying a strong relationship significant at the .01 level for both psychological and psychological and pharmacological, $p < .001$ and $p < .01$ respectively.

Access to treatment is considered an influential factor in the decision making process. Therefore, we asked GPs to indicate how soon a patient who is referred for evaluation of moderately severe depression is typically seen by a mental health professional. Five options were presented ranging from '*within 24 hours*' to '*usually unable to obtain access*'. Over 47% reported it taking over 4 weeks. Notations provided by some of the respondents were critical of successful access being determined by severity (only the most severe filtering through), some stated they had given up referring due to patients not being seen or that it would take months. To explore whether the negative experience of referral to a mental health professional influenced decision making at a patient's first visit a correlation coefficient was calculated. There was no relationship between GPs negative experience of referral to a mental health professional and management of a patient at first visit.

4.4.6 Education and training

To assess the level of knowledge and relevant skills GPs have with regard to common mental health we asked GPs about previous training and experience. Of the GP sample, 68.1% had undertaken a refresher course in the last three years (not necessarily related to mental health, (i.e. CPD sessions, BMJ masterclasses), 25.9% had experienced training in mental health or mental illness (i.e. specialist courses) and 33.6% of the sample indicated they had had a psychiatry and/or psychology related job. Of the total sample only 18 (16%) GPs checked all three of the options.

GPs were asked to indicate (by checking either *Yes* or *No*) whether or not they believe they receive appropriate training/education covering common mental health issues and their management, 47.4% of GPs indicated they felt they did not receive appropriate training/education. A cross tabulation was performed to explore whether there was any relationship between prior training and whether GPs feel they receive appropriate education and training. Of those who indicated prior training around half (48.7%, 50%, 48.7% across all categories respectively) indicated they felt GPs did not receive appropriate training or education with regard to common mental health and their management, however those who had not undertaken any prior training (refresher courses, mental health training, psychiatry/psychology related job) indicated in greater numbers 52.8%, 52.4%, 52% respectively, that they felt they had received appropriate training and education. A correlation coefficient was performed with data generated from the definition statement question to explore if training bears any relationship to

whether or not GPs agreed or disagreed with the definition statement question. Results show a significant negative relationship (-.209, $p < .028$), this means that those who indicated they feel GPs receive appropriate training and education also disagreed with the statement that common mental health problems refer to just anxiety and depression and vice versa.

4.4.7 Personal Experience

We also asked GPs whether they, an immediate family member, or a close friend had ever been treated for symptoms of depression. GPs were provided with four options (*no experience, some experience with depression in personal life, treated with medication only, some experiences with depression in personal life, treated with Psychotherapy, without medication and some experiences with depression personal life, treated with bo*th *Psychotherapy and medication*), of the sample 38% (n=44) indicated that they, an immediate family member or a close friend had been treated for symptoms of depression. The greater proportion had been treated with medication only (21.1%). We then asked those who had experience to rate the results of treatment, from excellent (21.3%), good (46.8%), fair (27.6%) and poor (4.2%). A correlation coefficient analysis was performed to ascertain whether experience impacted on management of different therapies. Results display a significant negative relationship between the personal experiences of results of treatment and confidence managing simple (single medication) antidepressant therapy (-.417, $p < .004$), that is to say high confidence managing antidepressant therapy is associated with lower scores of personal experience with results of treatment. No relationship was found between personal experiences of the results

of treatment and confidence managing complex (2 or more medications) antidepressant therapy. A significant negative relationship was found between personal experiences of the results of treatment and confidence managing psychological-based interventions (-.458, $p < .002$) and confidence managing psychological and pharmacological interventions (-.463, $p < .001$). Those GPs with personal experience of treatment for depression, and those who had an immediate family member or close friend who had been treated for symptoms of depression, had lower confidence in managing psychological-based interventions and lower confidence in the management of psychological and pharmacological interventions.

When figures of personal experience were cross tabulated to explore whether there was a difference associated with gender and experience there was a fairly even split between males and females, 36.5% and 42% respectively.

4.5 Discussion

This study aimed to identify what GPs understand the term 'common mental health problems/disorders'. Our results demonstrate that GPs understand common mental health problems to encapsulate a much broader range of conditions aside from anxiety and depression. Furthermore, though GPs acknowledge the prevalence of anxiety and depression, GPs did not rate them as exclusive, obsessions and compulsions were closely rated for prevalence. More surprisingly, findings place stress below psychosis in sixth place within the overall rankings. This could be explained with GPs' use of the term 'common mental health problems', as many

GPs rated symptoms or outcomes rather than umbrella terms such as 'stress' which can account for a range of different experiences. One of the main findings from this study is the dissonance related to the use of the term 'common mental health problems', as GPs understand the term very differently to that which is popularly cited. The way in which terms are used and their meaning is of real importance. The binary of how terms are used within policy and primary care mean that this could have significant implications with regard to the targeting of appropriate knowledge and education which GPs feel they are in need of, the availability of resources and the framing of patients' complaints.

Results from this study indicate the complexity of managing common mental health in primary care. Figures demonstrate that GPs find the management of common mental health with patients they are familiar with more straightforward than those they are unfamiliar with. It is also clear that much of GPs time is bound up with dealing with common mental health, whether as a primary condition or as a secondary component to a prior condition. Results also show that GPs confidence in using/managing single antidepressant therapy is high, while their confidence in using/managing therapies alternative to prescribing single antidepressants is not. While many of the GPs indicated they would ask a patient to come back, in accordance with 'watchful waiting' recommended within recent NICE guidelines (NICE, 2007), over a third of the sample indicated they would provide an antidepressant on a patient's first visit with 60% of those not administering a screening tool. This is in conflict with recent NICE guidelines

(NICE, 2007) which state that antidepressants are not recommended for the initial stages of treatment as the risk-benefit ratio is poor.

GPs that indicated having personal experience (themselves, an immediate family member or close friend) of mental health issues and had experienced positive outcomes with treatment were shown to have higher confidence managing both simple antidepressant therapy and psychological and psychological/pharmacological interventions. Likewise, those who had experienced less favourable or positive outcomes of treatment were associated with lower levels of confidence in using or managing these therapies. We can imply therefore, that an individual's prior experience of treatment, on a personal level, will have an impact on an individual's working practice. This is an important consideration with regard to educating and scaffolding GPs experience and training across the spectrum of mental health issues and their appropriate therapies.

Furthermore, our study aimed to assess the level of knowledge and relevant skills GPs have about common mental health. GPs who participated in this study indicated a range of different education and training experiences not specific to mental health. It is interesting to note that only a third of our GP sample had experienced any form of mental health training. Those who indicated having had a psychiatry and/or psychology related job cited working as an SHO during their GP training, usually for around six months. However, when we consider the majority of our sample have been in practice for over 15 years (44%) there is a

question over the reliability and stability of this prior training. A study by Williams (1998) looking at clinical competence of general practitioners trainees before and after a six-month psychiatric placement show training received as a psychiatric SHO tends to be weighted towards problems commonly encountered within a hospital setting, at the expense of skills relevant to dealing with neurotic and other primary care issues. This is further supported by Gask (1994) who commented that the needs of psychiatric and GP trainees are different and that training received by many GPs does not necessarily prepare them for future work in primary care.

Findings from this study show that significant numbers of those who previously experienced some form of training or education in mental health indicated that they did not feel GPs received appropriate education or training covering common mental health issues and their management. Also, those who had experienced further training/education were also more likely to disagree with the assertion that common mental health can mostly explained by depression and anxiety. Those who had no further training or experience with regard to mental health indicated that GPs did receive appropriate training covering common mental health issues and their management and were more inclined to agree that common mental health problems refer only to depression and anxiety. The implications of these findings may be that those who do not undergo further training in mental health related issues have a much narrower focus of what constitute mental health problems and their symptoms. Therefore this could have implications on their ability to effectively recognise and treat mental health problems in presenting patients.

In summary, this survey has shown that GPs understand common mental health in a very different way in their everyday practice to that posited with literature and policy. Furthermore, GPs express a need for more appropriate education and training and the need for resources. Further research needs to be conducted to investigate the factors associated with individual differences that could not be accounted for within this survey. Findings from this study may have implications for many areas, such as public policy, GP training, medical communication with the public and advertising.

4.6 Limitations

Due to the limited time frame and issues around sample access, only GPs listed on HOWIS or on practices' own websites were sampled. Therefore, this excludes all those freelance locums who are not permanently based within practices. In addition, this study relied upon the self-selection of participants. As a result there are issues in regard to the representativeness of the sample within this study and therefore results need to be considered with caution.

4.7 Summary of Chapter 4 and link to Chapter 5

Chapter 4 describes the GP Survey which shows in more detail the issues that general practitioners are experiencing in their practice when managing patients with common mental health problems. This study has shown the plethora of complexities surrounding and bound up in the assessment, recognition and management of patients with common mental health. In particular, the importance of education and knowledge. Results also revealed GPs' confidence in managing

treatment varied depending upon whether the treatment in question was pharmacologically or psychologically based. Furthermore, findings also showed that treatment management decisions were influenced by prior personal experience of treatment.

The issue of GPs' prescribing and referral behaviour is one that is focussed upon within the next study, as presented in Chapter 5. This study employed the Theory of Planned behaviour, a well-established theoretical model, to explore factors and predictors to a given behaviour – in this case the prescription of antidepressants or the referral to psychological-based treatment of patients with common mental health problems. The following chapter describes and discusses this study in more detail.

Chapter 5: Theory of Planned behaviour: General Practitioners' prescribing and referral behaviour

Beginning with some background, this chapter outlines the rationale for conducting the study which investigates General Practitioners' (GPs') prescribing and referral behaviours. It first presents the theoretical propositions of the Theory of Planned Behaviour (TPB) model and its application to the study of GPs. It then goes on to outline the aims, methods and results of this component of the programme of research (which looks at GPs management of common mental health in primary care), in the context of using the Theory of Planned Behaviour as a mode of study. The chapter concludes with a discussion of survey results.

5.1 Introduction

The Theory of Planned Behaviour (TPB) (Ajzen, 1985, 1991) is the theoretical basis for 970 studies published in the OVIDSP database (Medline, PsychINFO, Embase and the Cochrane Library) from 1985 to 2009. The TPB is a psychological model of behaviour change, in which cognitive self-regulation plays an important role in terms of a dispositional approach to behaviour. The TPB extended the Theory of Reasoned Action (TRA) (Fishbein, 1967). The earlier TRA proffered a model of attitude structure; according to this model behaviour is driven by the intentions of individuals, that is to say their explicit plans or motivations to perform a particular act. This theoretical model has been applied to predict intention and behaviour within many areas: coupon usage (Shimp & Kavas, 1984),

family planning, (Jaccard & Davidson, 1972; Davidson & Jaccard, 1975) and nutrition (Sheperd & Towler, 2007).

Behavioural intention can be described as encompassing two factors. Firstly, the attitude to the behaviour, such as the degree to which an individual perceives an intended behaviour to be desirable. Ajzen (1991) further describes the construct of intentions as capturing the motivational factors that influence behaviour, for instance how hard a person is willing to try or how much of an effort they are planning to exert in order to perform a particular behaviour. The second factor is the subjective norm, which can be understood as the social component, or more specifically, the extent to which significant individuals, such as relatives, friends or colleagues condone this act (Ajzen, 1985, 1991; Ajzen & Fishbein, 2005). Attitude to behaviour and subjective norm are in turn regarded as being predictable from measures of the beliefs which underpin them, each belief being weighted by its significance to the individual (Parker, Manstead et al., 1995).

Behavioural intention can only be born in behaviour if the behaviour under consideration is within volitional control, i.e. if the person can decide at will to perform or not perform the behaviour (Ajzen, 1991). The TPB further extended the TRA by the inclusion of perceived behavioural control. This perspective suggests that behaviour is propagated not only by the individual's attitude toward behaviour and the subjective norm, but it is further influenced by a sense of control, that is, the extent to which individuals feel they can engage with the behaviour; so called perceived behavioural control (Ajzen, 1991). Perceived

behavioural control is described as possessing two main factors. Firstly, whether the individual perceives they have the relevant knowledge, discipline or skills to perform a particular behaviour, called internal control (Kraft, Rise et al., 2005), a factor which also relates to the concept of self-efficacy. Secondly, perceived behavioural control relates to external control, that is, the extent to which the individual perceives other factors could inhibit or facilitate the behaviour, such as resources, the cooperation of colleagues, or time (Kraft, Rise et al., 2005). The concept of perceived behavioural control is distinct from other conceptions of control (see Rotter (1966) *perceived locus of control*) in that it refers to a specific behaviour in question and concerns the individual's perception of the easiness or difficulty of performing a particular behaviour. The element of perceived behavioural control is closely aligned to self-efficacy (Bandura, 1977) which focuses on the judgments of the individual toward the performance of actions required of potential situations. The TPB acknowledges the role of self-efficacy beliefs within people's behaviour toward an activity, and that they can influence their choice of activities, preparation for an activity, effort expended during performance, as well as thought patterns and emotional reactions (Azjen, 1991; see also Bandura, 1982, 1991).

According to the TPB, performance of behaviour is a joint function of intentions and perceived behavioural control (Ajzen, 1991). That is to say, the more positive the attitude and subjective norm toward a specific behaviour, and the greater the perceived behavioural control, the stronger an individual's intention to perform the particular behaviour of interest should be (Ajzen, 1991). Predictability is high

using this approach where individuals are able to make choices over actions within a given situation.

5.1.1 Predictive accuracy

Ajzen (1991) posits that for accurate predictions to be made of behaviour then several conditions must be met:

1. Intentions and perceptions of control must be assessed in relation to a particular behaviour and the specified context must be the same as that in which the behaviour is to occur.

2. Intentions and perceived behavioural control must remain stable in the interval between their assessment and observation of the behaviour. Intervening events can produce changes in intentions or in perceptions of perceived behavioural control. This would result in the original measures of these variables unable to produce accurate prediction of the behaviour.

3. Predictive validity is concomitant on the accuracy of perceived behavioural control. That is, prediction of behaviour from perceived behavioural control should improve to the extent that perceptions of behavioural control realistically reflect actual control.

(Azjen, 1991, p. 185)

Common mental health problems account for a large percentage of GPs' time (Marsh, 2009). However, GPs find the management of these challenging, not least because they recognise common mental health as concerning a raft of mental health issues (obsessions and compulsions, psychosis) not just depression and

anxiety (Marsh, 2009). Effective management and recognition of common mental health problems is therefore of high importance to GPs. The GP Survey looked to explore what GPs perceptions of common mental health issues were, factors associated with their management and to assess the level of knowledge and skill they have with regard to common mental health (Marsh, 2009). Data from the survey raised many interesting questions around individual differences of GP management of common mental health within primary care (i.e. prescription of medication at first visit, confidence with psychological based management, training and skills difference) which need further investigation. The importance of appropriate management with regards to common mental health, especially in the early stages is well documented (RCGP, 2006; SCMH, 2007). As referenced earlier, the application of the TRA framework and the TPB has been used in many areas. More notably with reference to the locus of research conducted within primary care. This perspective has underpinned much work within the primary care arena, such as breast feeding, (Manstead, Proffitt et al., 1983), familial management in primary care (Braithwaite, Sutton et al., 2002), and pharmacists beliefs and intentions with non-prescription medicines (Walker, Watson et al., 2004). This psychological theory-based framework is therefore deemed an appropriate model by which to take forward the GPs Survey and further explore GPs' attitudes toward the management of common mental health in primary care.

5.2 Aims

GPs understand the term common mental health to refer to a broad range of mental health symptoms and conditions, not just the depression and anxiety more commonly referred to in many guidelines, literature and health literacy information. GPs spend vast amounts of their time managing patients with common mental health issues and the effective management of these is therefore of high importance for GPs. However, as shown through the GP Survey, GPs find the management of common mental health difficult. As a result there is great variability in management of these conditions, supported by a host of contributory factors (e.g., environment, access and availability of support, system issues, ethos of the practice, time constraints, patient expectation), which inevitably leads to outcome variability. It has been proposed that the possibility for success variability could be that 'knowledge is only one factor affecting practice' (Walker & Watson et al., 2004, p.671). Therefore, the present study, informed by the GP Survey, sought to further explore this variability so that we are able to better target information and resources which GPs have already mentioned they would like to see. This study used the TPB, an established framework which has been widely used to investigate factors associated with the beliefs and attitudes of health professionals' health-related behaviour (Conner & Norman, 1996; Walker, Grimshaw et al., 2001; Walker, Watson et al., 2004). The model was employed to explore the relationship of several components of management, namely: diagnosis and treatment (medication v. referral). A similar study by Walker, Watson et al looked at the attitudes and beliefs of pharmacists with regards to non-prescription medications (Walker, Watson et al., 2004). This study examined GPs prescription

of antidepressants and referral to psychological-based treatment for individuals with common mental health problems. The psychological theory-based framework of the TPB was deemed an appropriate model by which to do this.

The hypothesis was that GPs behaviour is moderated by many factors. The study explored GPs' intentions with regards to components of management (diagnosis and treatment (medication v. referral)) and examined the relationship between beliefs, attitudes, perceived behavioural control and behavioural intention.

5.3 Method
5.3.1 Ethical Approval
Full ethical approval was obtained from the Research Ethics Committee for Wales, along with the appropriate research governance where necessary.

5.3.2 Framework of study
- The Theory of Planed Behaviour, a well-established framework, was used to explore the relationship between behaviour and intentions
- Several components of management were investigated which relate to different elements of the TPB model:
    - Diagnosis
    - Treatment (medication v. referral)

5.3.3 Sample
- All Working GPs in Wales

- Sample size: While a relatively small sample of around 100 GPs allowed testing of the TPB model, numbers exceeding this allowed the testing of other variables to address secondary issues (experience, type of practice, etc)

5.3.4 Recruitment

- All GPs working in Wales were eligible to take part

- GPs were sent an email (see Appendix 5-1) inviting them to take part in a study where attitudes towards the management of common mental health will be explored. For GPs who expressed an interest to take part a hyperlink directed them to the anonymous electronic online questionnaire where they were presented with further information about the project, consent, data protection and complaints and distress procedures before being able to progress further. At the end of the questionnaire, participants were presented with a debriefing sheet including the full contact details of researchers, which they were able to print off

- A reminder email was sent 3 weeks later in order to maximise response rates

- To further boost responses, paper and pen versions of the questionnaire were sent to 500 randomly selected GPs from across Wales

5.3.5 Research Design

- An online questionnaire developed using the TPB model focused on common mental health and its management by general practitioners within primary care (see Appendix 5-2)

- The questionnaire took no more than 20 minutes to complete

- Data were automatically submitted upon completion of the questionnaire

- Part finished questionnaires were unable to be submitted or received

- All data were anonymous

- Items were generated to assess all components specified in the TPB:

  - Behavioural Intention

  - Attitude

  - Subjective Norm

  - Perceived Behavioural Control

  - Behavioural Beliefs and Outcome Evaluations

  - Normative Beliefs and Motivational to Comply

  - Control Beliefs and perceived Power

- Responses to all items were rated on a 7-point scale

5.3.6 Data Collection

- An online questionnaire developed using the TPB model was distributed (date: January to December 2010)

- In an attempt to increase respondent rates after online distribution, a further 500 paper versions of the questionnaire were sent to practices which were randomly selected (June to July 2010)

- A small pilot was carried out (prior to distribution) with an opportunistic sample of GPs and experts in the field (n=5). GPs/experts were asked to complete the short questionnaire, and the individual was contacted by a researcher at a time convenient to the GP/expert. At this time they were asked a few short questions regarding the content and structure of the questionnaire and for any additional comments or suggestions they may have. Changes to questions or format were addressed in light of this feedback

5.3.7 Analysis

- Quantitative survey data was collected automatically via the survey software package

- Data retrieved from the paper and pen versions were manually uploaded to SPSS 18

- Numerical data were organised and converted into the Excel 2007 software package before being imported into SPSS 18

- Appropriate statistical tests and analysis were performed with these data using SPSS 18

5.4 Results

5.4.1 General Practitioner Sample

Overall, 127 responses were received for the TPB survey sent out between December 2009 and the end of August 2010. General practitioners (GPs) who took part in this study ranged between 29 and 64 years. Respondents were all working

GPs sampled from across the seven Local Health Boards in Wales (Abertawe Bro Morgannwg University Health Board, Aneurin Bevan Health Board, Betsi Cadwaladr University Health Board, Cardiff and Vale University Health Board, Cwm Taf Health Board, Hywel Dda Health Board and Powys Teaching Health Board). The sample of 127 GPs who completed the questionnaire comprised of 113 Partners (89.7%), 11 Salaried (8.7%), 1 Registrar (0.8%) and 1 'Other'; no Locums or Retainer/Assistant were indicated in this sample. Respondents averaged 46.45years (± 8.66) and were fairly evenly split by gender: 65 male (51.6%) and 61 females (48.4%). The majority of GPs (67 (53.2%)) reported practicing in general practice for over 15 years.

5.4.2 The practices

Of this sample, 52 (41.3%) GPs were in an urban practice, 50 (39.7%) semi-rural and 24 (19%) in a rural practice. The majority of GPs (96 (76.2%)) reported working in practices with a list size fewer than 5,000, with 39 (31%) reporting working in a practice serving between 7,001 and 10,000 patients. Only 50 (42%) GPs indicated theirs was a training practice, compared with 69 (58%) indicating theirs was not. Larger practices, as well as being associated with a greater numbers of partners ($p < .001$), were also correlated with being training practices (n=39; $p < .001$). Seventy-nine GPs (62.7%) reported working between seven and nine clinical sessions per week, with a sizeable sample (n=31, 24.6%) working under six sessions per week.

5.4.3 Indirect and direct measures

The Theory of Planned Behaviour model investigates predictors to intention.

Therefore, to predict whether a person *intends* to do something, we need to know:

- Whether the person is in favour of doing it ('attitude')

- How much the person feels social pressure to do it ('subjective norm')

- Whether the person feels in control of the action in question ('perceived behavioural control')

(Francis et al., 2004)

Aside from behaviour, the variables used within the Theory of Planned Behaviour model are psychological constructs (internal). The model utilises both direct and indirect measurement approaches, such that each predictor variable can be measured directly (e.g. asking respondents about their overall attitude) or indirectly (e.g. asking respondents about specific behavioural beliefs and outcome evaluations). By using both direct and indirect measurement approaches to tap into the same construct, we hoped to offset the problem of the differing measurement approaches which make different assumptions of the underlying cognitive structures (Francis et al., 2004).

5.4.4 Direct measures

Firstly, direct measures were analysed by way of a multiple regression. 'Intention' was used as the criterion with the direct measures of attitude, subjective norm and perceived behavioural control as predictor variables. Multiple regressions were

carried out separately for 'antidepressant prescribing' and 'referral for psychological-based treatment'.

5.4.4.1 'Anti-depressant prescribing' – direct measures

Using the enter method, a significant model emerged ($F_{3,123} = 3.461$, $p < .05$. Adjusted R square = 0.55). Output from the model is shown below:

Predictor variable	Beta	*P*
Attitude	.076	.382
Subjective Norm	.205	.022
Perceived Behavioural Control	.140	.116

Significance was achieved for Subjective Norm ($p = .022$), while Attitude and perceived behavioural control were not significant ($p = .382$ and $p=.116$ respectively).

5.4.4.2'Referral for psychological-based treatment' – direct measures
Using the enter method, a non-significant model emerged ($F_{3,123}$ = 0.986, p=.402.

Adjusted R square = 0.000).

Predictor variable	Beta	*P*
Attitude	-.038	.709
Subjective Norm	.066	.041
Perceived Behavioural Control	.113	.269

For referral to psychological therapies, Subjective Norm was shown to be just

within significance (P = .041), while both Attitude and Perceived Behavioural

Norm were shown to be non-significant (p = .709 and p = .269 respectively).

5.4.5 Indirect measures
Secondly, indirect measures were analysed by way of a multiple regression. The

direct measure of 'Attitude' was used as the dependent variable with the indirect

measures of attitude, subjective norm and perceived behavioural control as

predictor variables. Multiple regressions were carried out separately for

'antidepressant prescribing' and 'referral for psychological based treatment'.

5.4.5.1 'Anti-depressant prescribing' – indirect measures

Using the enter method, a non-significant model emerged ($F_{3,122} = 1.943$, $p=0.126$.

Adjusted R square = 0.22). Output from the model are presented below:

Predictor variable	Beta	*P*
Attitude	.200	.029
Subjective Norm	-.018	.848
Perceived Behavioural Control	-.096	.309

Significance was achieved for Attitude as a predicting factor to anti-depressant prescribing, while both Subjective Norm and Perceived Behavioural Control were non-significant.

5.4.5.2 'Referral for psychological-based treatment' – direct measures

Using the enter method, a significant model emerged ($F_{3,123} = 5.543$, $p < .001$.

Adjusted R square = 0.098). Significant variables are shown below:

Predictor variable	Beta	*P*
Attitude	.298	.001
Subjective Norm	-.025	-.278
Perceived Behavioural Control	.231	.010

Both Attitude and Perceived Behavioural Control Achieved significance, while Subjective Norm was shown to be non-significant.

By following the model and by employing multiple regressions to both the direct and indirect measures one can look to explain the variance in the level of one variable on the basis of the level of one or more other variables. The findings of the present study, though not conclusive, do show that the TPB model is an appropriate model for investigating how GPs prescribing and referral behaviour is guided.

Findings from this study suggest that GPs' behaviour regarding the management of individuals with common mental health problems is indeed moderated by many factors. Factors determining whether a GP will prescribe antidepressants or refer an individual to psychological-based treatment for a common mental health problem are different.

These findings demonstrate that whether or not GPs prescribe antidepressants to patients with common mental health problems is significantly influenced by both their attitude and their subjective norm. Perceived behavioural control was not found to be a significant factor in their decision to prescribe anti-depressants to patients with a common mental health problem.

When we analysed data for 'referral to psychological-based treatment' both attitude and perceived behavioural control were shown to be significant factors. However, the model did not perform as expected for both direct and indirect measures with direct measures not achieving significance and the model only proving significant with indirect measures.

5.4.6 Further analyses

To determine the specific beliefs that have the greatest influence on intention to prescribe anti-depressants to patients with common mental health problems, a median split was executed and a series of t-tests were used to identify differences between the two groups. Both 'attitude' and 'subjective norm' were significant at $p = .044$ and $p = .001$ respectively. Perceived behavioural control was shown to be non-significant at $p = .942$. To explore this more closely a crosstab was conducted (putting zero at 2 in a range from -32 to +42) which showed a fairly even split between those who do not feel in control of prescribing antidepressant medication to patients with common mental health problems (n=66) and those that did feel in control of prescribing anti-depressant medication (n=61).

This process was repeated for 'referral to psychological-based therapy', which showed attitude to be a significant influence upon intention to refer ($p = .011$). A crosstab was conducted to look more closely at perceived behavioural control, showing that 62 of the participants do not feel in control of referring patients with common mental health problems for psychological-based treatment, while 65 feel in control of referring to psychological-based treatment.

5.5 Discussion and conclusions

As has been previously mentioned, the intention was to look more closely at the behaviour of GPs regarding the prescription of antidepressants and referral to psychological-based treatment for individuals with common mental health problems. Our hypothesis was that GPs' behaviour is moderated by many factors.

The study aimed to explore GPs' intentions with regard to components of management (diagnosis and treatment (medication v. referral)) and to examine the relationship between beliefs, attitudes, perceived behavioural control and behavioural intention. Our approach used the Theory of Planned Behaviour as a model by which to investigate the key influential factors operant in this decision making process in order to extrapolate predictors of said prescribing behaviours, as the TPB model predicts the occurrence of a specific behaviour provided that the behaviour is intentional. Our mode of study, that of using survey design and including scenarios, fulfils the propositions made by Azjen (1991) in ensuring predictive validity of results from the model. Findings from our study suggest that GPs' behaviour regarding the management of individuals with common mental health problems are indeed moderated by many factors.

Results from this study show that a GP's decision to prescribe antidepressants to patients with common mental health problems is significantly influenced by both their attitude (that is to say the degree to which an individual perceives intended behaviour to be desirable), summarised by Ajzen (1991) as, how hard a person is willing to try, how much of an effort they are planning to exert in order to perform a particular behaviour. And by their subjective norm (which is understood to be the social component), described by Ajzen as the extent to which meaningful individuals, such as relatives, friends or colleague condone this act (Ajzen 1985; Ajzen, 1991; Ajzen & Fishbein, 2005). 'Attitude' was the stronger predictor of the two variables, reaching significance on both direct and indirect measures of the model. The theory holds that these two constructs, attitude and subjective norm,

are regarded as being predictable from the measures of the beliefs underpinning them, with each belief being weighted by its significance to the individuals (Parker, Manstead et al., 1995).

These results are interesting not least because they raise questions around practice culture and expectations. The coupling of attitude and subjective norm is a strong binary. Firstly, the role of the subjective norm within the arena of general practice and primary care is possibly an area that is most compelling. General practices differ in how they operate, although they rest within the domain of primary care and therefore function within guidelines metered out by its governance and regulators; they also sit below this and within the local authority and its guidelines and regulators. Furthermore, general practices themselves seem to vary greatly, not only in terms of geographical locality and socioeconomic status, but also with regard to the types of resources available, the size of patient lists and also type of patient. Therefore, the realisation then of general practices potentially being further separated by their own culture or way of doing things is one that needs to be a key factor when considering how GPs are trained or how processes are evaluated. That said it is possible for a newly qualified doctor to enter into a general practice with updated and advanced skills with regard to the management of common mental health problems, but for these skills and practices to be dissolved or dissuaded over time within the overall ethos or practice philosophy of said general practice. Such potential can give rise to a concern for improvements in standards wholesale, as individuals enter the profession year on year, likewise

raising questions of how to initiate long lasting change of practices to those that are potentially resistant.

This notion is given increased weight when considering that results from this study have also shown the significance of 'attitude' toward the intention to prescribe. These results further support one of the conclusions from the GP Survey, where personal experiences of GPs influence working practice. This study showed significant relationships between personal experience and results of treatment with confidence in managing treatments for both antidepressant and psychological therapies, respectively (*see* Chapter 4: the GP Survey, p.103). It can be suggested that such elements are of key importance when considering and scaffolding GPs' personal experiences with regard to training across the spectrum of mental health and its appropriate management.

The component of perceived behavioural control within the TPB model is a factor that relates to the concept of self-efficacy. It is also described in the literature as comprising two main factors, whether the individual perceives they have the relevant knowledge, discipline or skills to perform a particular behaviour, called internal control (Kraft, Rise et al., 2005), and that PBC relates to external control or the extent to which the individual perceives other factors could inhibit or facilitate the behaviour, such as resources, the cooperation of colleagues, or time (Kraft, Rise et al., 2005). Analysis in relation to GPs' prescribing behaviour showed that perceived behavioural control was not a significant feature within this model of GPs intention to prescribe antidepressants to patients with common

mental health problems. However, what we did find by conducting a median split was that around half the GPs did not feel in control of prescribing antidepressants to those with common mental health problems. When we consider the aforementioned findings in relation to Attitude and Subjective Norm, it is possible to see this result as a potential link between individual GPs in some practices not feeling in control to prescribe and the status and nature of the practice itself. Equally, if we understand that the position of control, as mentioned above, is in relation to an individual's possession of knowledge and skills then this result can also be seen as further support for findings from the GP Survey. Within this study, the divide between those GPs indicating that they needed more training and education in the management of common mental health was similar, with just over half of respondents indicating they needed more training and education in the management of common mental health problems (see Chapter 4: The GP Survey).

Perhaps not surprisingly, based on previous study, results for GPs referral to psychological-based treatment was shown to be different compared to that for prescribing behaviour. Our results showed that GPs' intention to refer for psychological-based treatment was significantly influenced by practitioner's attitude. Therefore, as has been shown with results from analysis of GPs intention to prescribe, practitioner's attitude significantly influenced whether they referred for psychological therapy. This is concomitant with findings from the GP survey (see Chapter 4). However, further analysis showed that around half of the sample did not feel in control of referring patients with common mental health problems for psychological-based treatment. As mentioned earlier, PBC relates to an

individual's perception of their own knowledge and skills to perform a particular behaviour and also to external control. This is an important finding for beginning to understand factors influential in GPs referral behaviour. More generally there have been questions over the availability of psychological therapies in matching demand and also that such referrals are predominantly dependent on whether presentations by patients meet a certain level of severity. The availability of psychological therapies to individuals and practices vary across Wales and the UK as a whole and have for some time been a cause for concern, such that a programme was introduced by the Government in England in 2007 following a paper by Lord Layard and general election manifesto in 2005. Programme aims were to promote an increased person-centred approach to therapy in general and to investigate ways to improve the availability of psychological therapies, with particular focus on those suffering from depression or anxiety disorders. However, there have been questions over the success of this programme in achieving its objectives. In 2009, an article in the Observer 'Flagship Mental Health Scheme faces cutbacks' (Guardian, 2009) printed that the IAPT Expert Reference Group – the body that oversees the programmes implementation – was told that only 400 out of an expected 3,600 therapists needed to run it were fully trained. Further, that the government's target of 25,000 people coming off benefits by 2010/2011 would be difficult to achieve as only 2,000 patients who had completed the course had succeeded in coming off benefits (Guardian, 2009). For Wales, this year sees the launch of policy implementation guidance for Psychological Therapies in Wales (National Assembly for Wales, 2012), which aims to help improve the nation's health and well-being by considering an all-

147

round care approach. So as to improve access and availability of appropriate access to services, that are both, psychologically minded and psychologically therapeutic (Welsh Assembly Government, 2012).

It is possible to conclude from this study that the position of an individual's experience toward therapeutic results is something that could be seriously considered in the delivery of training courses and information packages, which refer to services available to GPs with regards to psychological therapies. Furthermore, information including success rates and potential outcomes may also prove beneficial. The presence of personal experience as a feature of a predictor of prescribing and referral behaviour is something that could figure more prominently within early phases of medical training. More usually, it would not seem obtuse to accept that personal experience would in some way influence ones intention to perform a given behaviour. However, when we talk about this in relation to personal experience influencing the likelihood of a GP deciding what sort of treatment to offer an individual, then this same consideration gathers more gravitas.

Our finding of the social component within the prescribing behaviour of GPs is of similar importance. In spite of general guidelines which suggest a stepped care approach with watchful waiting, it is clear from our respondents that prescription of medication is an approach that is more freely taken than suggested by such guidelines. It may be possible to suggest, from the position of the subjective norm as a predictor of GPs' prescribing behaviour in our results, that this could

potentially be, in part, due to practice culture and general expectations about how certain conditions are treated. Should this be the case, perhaps policy and guidance and more importantly evaluation of behaviour change could be more focused at practice level, rather than at the individual level. More simply, by altering these three predictors, we can increase the chance that the person will intend to do a desired action and thus increase the chance of the person actually doing it (Francis et al., 2004).

5.6 Limitations

Limitations of this study were associated primarily with sample size and so there is an issue with the representativeness of this study's sample, and therefore results do need to be appreciated with caution. Another limitation was the function of ethical application procedures, namely delayed responses from individual Local Health Boards. These delays meant that time scales of recruitment had to be extended to accommodate these delays. In addition, the method of online surveys did not achieve a good response during the first wave of distribution (n=16) and, as a result it was decided to distribute a paper and pen version of the survey to 500 GPs randomly selected from practice staff lists hosted by HOWIS, a publicly available NHS general practice directory. During this recruitment stage and including online reminders informing of the link to the online survey, responses totalled 27 for the online survey and 100 for paper and pen responses. However, when one considers that there was no monetary incentive for those taking part in this study, aside from the inclusion of a freepost envelope for ease of response, the response rate (20%) for the paper and pen distribution can be seen as encouraging.

5.7 Summary of Chapter 5 and link paragraph to Chapter 6

This chapter has described a study which was conducted to look more closely at GPs' prescribing and referral behaviours using a well-established theoretical framework – the Theory of Planned Behaviour model - to investigate key influential factors operant in the decision making process. Results show GPs' prescribing and referral behaviour to be moderated by various factors. GPs' decision to prescribe antidepressant medication to patients with common mental health problems is significantly influenced by both their attitude and subjective norm, while GPs' referral behaviour were shown to be significantly influenced by GPs' attitude. Furthermore, around half the GP sample did not feel in control of referring patients to psychological-based treatment.

This and previous chapters presented so far have dealt with the position of the general practitioner in the management of those with common mental health problems, however it is important to consider the position of the patient. To address this consideration a study was conducted with lay people and is presented in the following chapter. Chapter 6 presents the Mental Health Literacy study which was conducted with members of the general population looking at their perception and experience of common mental health and its management.

Chapter 6: People's perceptions of GP management of common mental health problems - Mental Health Literacy Study

Having looked at GPs' management of common mental health from a variety of angles in the previous chapters, it is important to consider the position of the patient in this equation. This chapter presents a study which sought to look more generally at how lay people understand and perceive common mental health and its management in Primary Care. An outline of the study and its results are presented, concluding with a discussion of the same.

6.1 Introduction

Understanding how health professionals recognise and manage common mental health, while being of pivotal importance, is only one side of the coin. How individuals recognise and understand their own health symptoms is of equal importance, as not only can it influence when and with whom individuals seek help, but also how they present themselves during the consultation. This is known as 'health literacy': the ability to gain access to, understand, and use information in ways which promote and maintain good health (Nutbeam et al., 1993). This conceptualization of health literacy was further expanded following the 5th *WHO Global Conference on Health Promotion,* to expand the glossary definition to include among others: "to understand health literacy not only as a personal characteristic, but also as a key determinant of population health" (Kickbusch, 2001). Focussing on the area of mental health and its very particular set of issues,

this term was extended by Jorm (1997a) to 'mental health literacy' and defined as "knowledge and beliefs about mental disorders which aid their recognition, management or prevention" (Jorm, 1997a, p.182). Furthermore, mental health literacy is said to consist of several components including:

a) The ability to recognise specific disorders or different types of psychological distress;

b) Knowledge and beliefs about risk factors and causes;

c) Knowledge and beliefs about self-help interventions;

d) Knowledge and beliefs about professional help available;

e) Attitudes which facilitate recognition and appropriate help-seeking; and

f) Knowledge of how to seek mental health information

(Jorm, 2000, p. 396)

Appraisals and understanding of mental health is something shaped by many factors. Research has suggested that while professionals have expert knowledge, largely based on scientific evidence and expert consensus, the public or the lay persons' knowledge is based on a range of beliefs based on personal experience, anecdotes and media reports (Jorm, 2000). A recent review looking into Mental Health Literacy described the media as having a negative effect upon individuals' beliefs, particularly on perceptions of dangerousness related to serious mental illnesses like schizophrenia. Negative media images are said to be of concern because they increase psychological distress and fear of stigma for persons with mental disorders (Canadian Alliance on Mental Illness and Mental Health, 2007).

In recognition of the importance of mental health literacy in benefiting the individual, a broad range of information programmes have been introduced, for instance the Beyond Blue programme in Australia which involves multiple targeted initiatives to lift community awareness along with the promotion of prevention and early intervention. This programme also targets health care management by way of promoting primary care training and partnerships for service reform and to increase targeted and applied research. A further example is Depression Busting in the UK, a self-management of depression course developed, written and delivered by those who have a history of depression. Their success supports the notion of a broad, multi-level approach across several domains.

A narrative review of public knowledge and beliefs about mental disorders (Jorm, 2000), discussed amongst other things, knowledge and beliefs held about professional help. Research suggested that while there was an absence of one overarching general factor for mental health literacy, there were a number of factors representing general belief systems that illness is best handled by medical, psychological, or lifestyle interventions (Jorm, 1997b). General practitioners were also suggested to be rated very highly in many countries, particularly for depression (Priest et al., 1996; Wolff et al., 1996; Jorm et al., 1997). In developed countries, for depression, psychiatrists and psychologists were rated less highly than GPs, but were more likely to be seen as helpful for schizophrenia (Jorm et al., 1997a; Angermeyer et al., 1999).

6.2 Rationale

To further explore the complexity surrounding the management of common mental health it is essential to try to understand how lay people understand common mental health problems and the management of these in primary care. Therefore, this phase of the research programme was to look more generally at people's understanding of CMH and what they thought about GPs management of CMHP. To this end questions were included within an online survey to explore individuals' perception of common mental health, the definition thereof, GPs' management and the role of knowledge in relation to the consultation and treatment management.

6.3 Method

The mental health literacy study was conducted from 28th March 2011 to 20th April 2011. Questions were added to a survey being rolled out to Cardiff University staff, the 'Well-being in University Staff Survey'.

6.3.1 Ethical Approval
Full ethical approval was granted by the School of Psychology ethics committee.

6.3.2 Sample
The sample population for the study were staff members of Cardiff University.

6.3.3 Recruitment
Participants were invited to take part in a paid online study looking into 'well-being in University staff', via a notice posted on the Cardiff University Intranet notice board. Interested individuals were asked to contact the researcher who then replied providing a link to the online questionnaire (see Appendix 6-1).

Participants received £10 for completed questionnaires and were automatically entered into a prize draw where there were three top prizes of £100. Individuals were not directly asked to provide their job, however in order to receive payment individuals were asked to provide contact details.

6.3.4 Design

The online questionnaire was developed looking at the well-being of University staff. Eleven items relating to Mental Health Literacy (see Appendix 6-2) were embedded into the questionnaire which also included items from the: WHO-5, AIOS, Warwick Edinburgh, ERI, DCSQ, Bullying, HSEMS, LMX, PANAS, LOTR, GSES, Rosenburg Self-Esteem, SWLS, ENRIHD, WCCL-R, ASQ, Mini Markers, OHQ, HADS, PSS, PHQ, which also measured subjective well-being, work circumstances, personality, etc. Interested individuals were provided with a direct link to the online questionnaire which was anticipated to take an hour to complete, because of the online methodology individuals were able to complete it in their own time.

6.3.5 Analysis

Data from the 11 mental health literacy questions were organised using Excel and then uploaded to SPSS 18 for appropriate statistical analysis.

6.4 Results

A total of 120 staff members participated in the study. Descriptive analyses of the data showed the age range for respondents 21 years to 64 years, with a mean age of 36.81. Of those participants who indicated their gender the greater percentage

of respondents were shown to be female (n=87, 75.7%), while male respondents were shown to account for 24.3% (n=28) of the sample.

Respondents were asked to indicate their marital status, while all available options were represented, results showed that the proportion of single, living with partner and married were closely matched (31.7% (n=38); 25.8% (n=31) and 36.7% (n=44) respectively). The proportion of those indicating themselves to be separated or divorced was much lower (2.5% (n=3) and 33% (n=4) respectively).

Respondents were also asked to indicate their level of educational attainment. Available options ranged from None to Higher Degree/Professional Qualification level. The greater proportion of the sample indicated possessing an educational level at Degree and Higher Degree/Professional Qualification (35% (n=42) and 38.3% (n=46) respectively). While those indicating GCSE/'O' Level, AS level/SCE Higher/Matriculation and City and Guilds/National Diploma were markedly lower (8.3% (n=10); 10% (n=12) and 6.7% (n=8) respectively). Only two (1.7%) respondents indicated not having any of the educational levels offered.

In terms of ethnicity, respondents were asked to identify themselves as being either: White; Black African, Black Caribbean, Black neither Caribbean nor African, Indian, Pakistani, Bangladeshi, Chinese or Other. Of those responding, n=118 (98.3%) of the sample identified themselves as White, while only one respondent (0.8%) identified themselves to be Indian and one (0.8%) as being Bangladeshi.

Respondents were also asked to indicate their annual salary (£0- £9,999; £10,000 - £19,999; £20,000 - £29,999; £30,000 – £39,999; £40,000 - £49,999 and £50,000 or more). The greater number of respondents indicated their salary to be between £10,000 – 19,999 (n=40, 33.3%) and £20,000 - £29,999 (35%, n=42,). While few respondents indicating receiving salaries below £10,000 (7.5%, n=9), and n=29 (24.2%) indicated earning in excess of £30,000 of those n=4 (3.3%) indicated receiving £50,000 or more.

Participants were not required to provide a job description, however in order to receive a participatory payment they were required to provide contact details. Information gathered from payment information showed that the University staff responding sample was broad, indicating individuals participated from within the staffing sectors of security, administration and included staff from various sectors on the Heath campus (located at the University Hospital site and the School of Medicine).

6.4.1 Mental Health knowledge questionnaire
With regard to the definition of common mental health, respondents were asked whether they agreed or disagreed with a statement that encompassed the more popularly cited expression of what common mental health problems refer to: 'common mental health problems do not refer to conditions other than depression and anxiety and are not short-term'. The majority of respondents disagreed with the popularly presented view of common mental health, 89.7% (n=105). This

157

finding supports the finding from the GP survey, where 75% of GPs also disagreed with this definition of common mental health (see Chapter 4: The GP Survey).

Respondents were asked to indicate what they considered to be the four most prevalent common mental health problems, on a scale from 1 to 4 (with 1 being the most prevalent). Respondents indicated a range of conditions they considered to be common mental health problems/disorders apart from the well-recognised conditions of depression and anxiety, these included conditions such as stress, psychosis, dementia, affective disorders, eating disorders, addiction (substance and alcohol), compulsions and also included, autism and human behavioural traits (jealously, confidence (lack of)).

Depicted in Figure 6-1, are those conditions considered to be most prevalent common mental health problem/disorders (11 entries). The most prominent of all those suggested by respondents are that of depression, stress and anxiety (n=70, 58.3%; n=22, 19% and n=12, 9.9% respectively).

For the second most important condition/symptom considered to be a common mental health problem respondents indicated 25 symptoms/conditions (alzheimers, bipolar disorder, neuroses, schizophrenia and dementia (n=3, 2.6%; n=5, 4.3%, n=2, 1.7%, n=3, 2.5% and n=5, 4.2% respectively) (see Figure 6-2). However, anxiety, depression and stress remained most commonly represented (n=41, 34.2%; n=25, 20.8% and n=13, 10.8% respectively).

Figure 6-1: Position One: most cited 'Common Mental Health Problem'
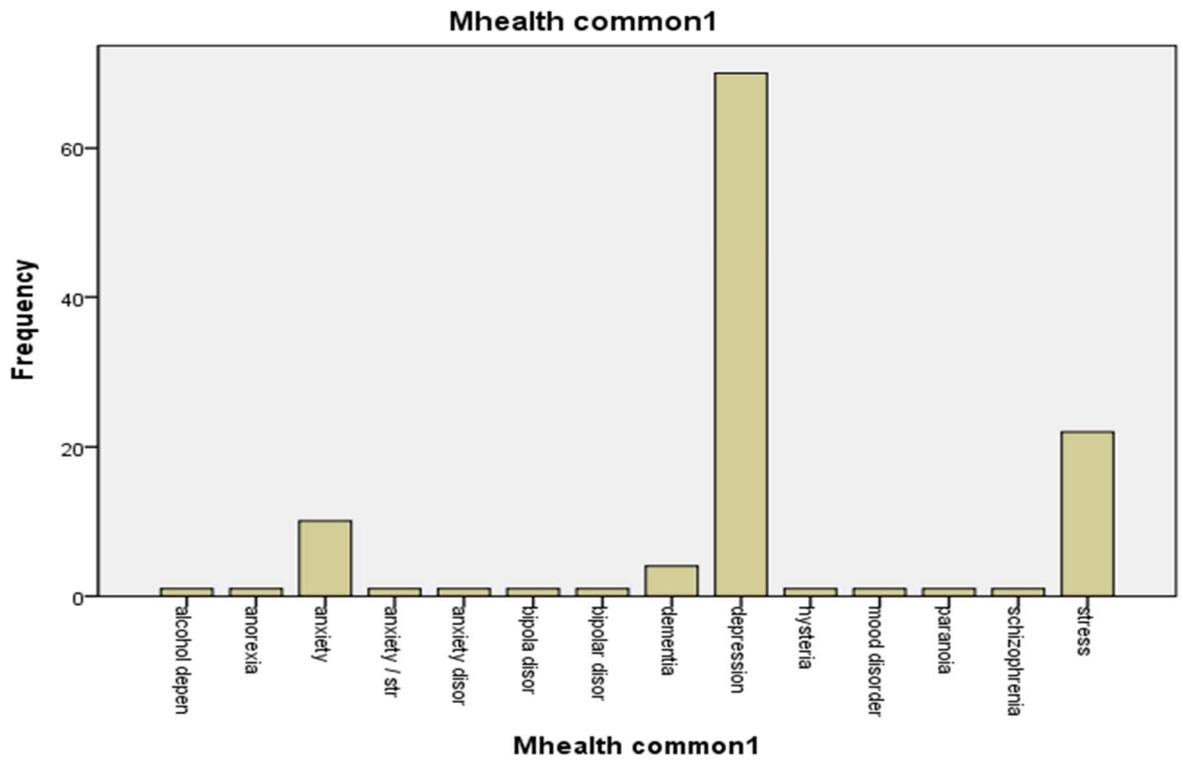
Figure 6-2: Position Two: most common 'Common Mental Health problem'
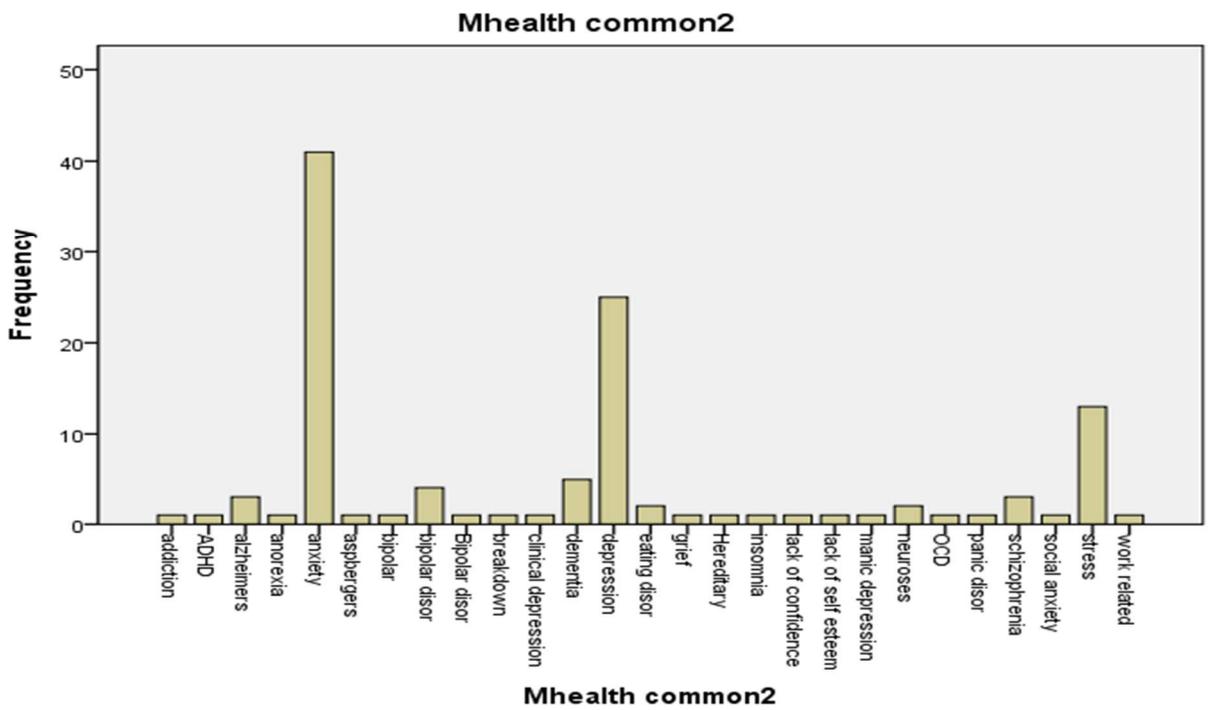
For the third most important condition/symptom cited by GPs, anxiety (n=18, 16.2%) was the most highly cited, amongst broad list of entries from respondents, while bipolar disorder, schizophrenia, OCD, autism, eating disorder, paranoia and stress were the next most commonly cited (n=13, 11.7%; n=8, 7.2%; n=6, 5.4%; n=5, 4.5%; n= 5, 4.5%; n=4, 3.6% and n=9, 8.1% respectively).

Figure 6-3: Position Three: most common 'Common Mental Health problem'
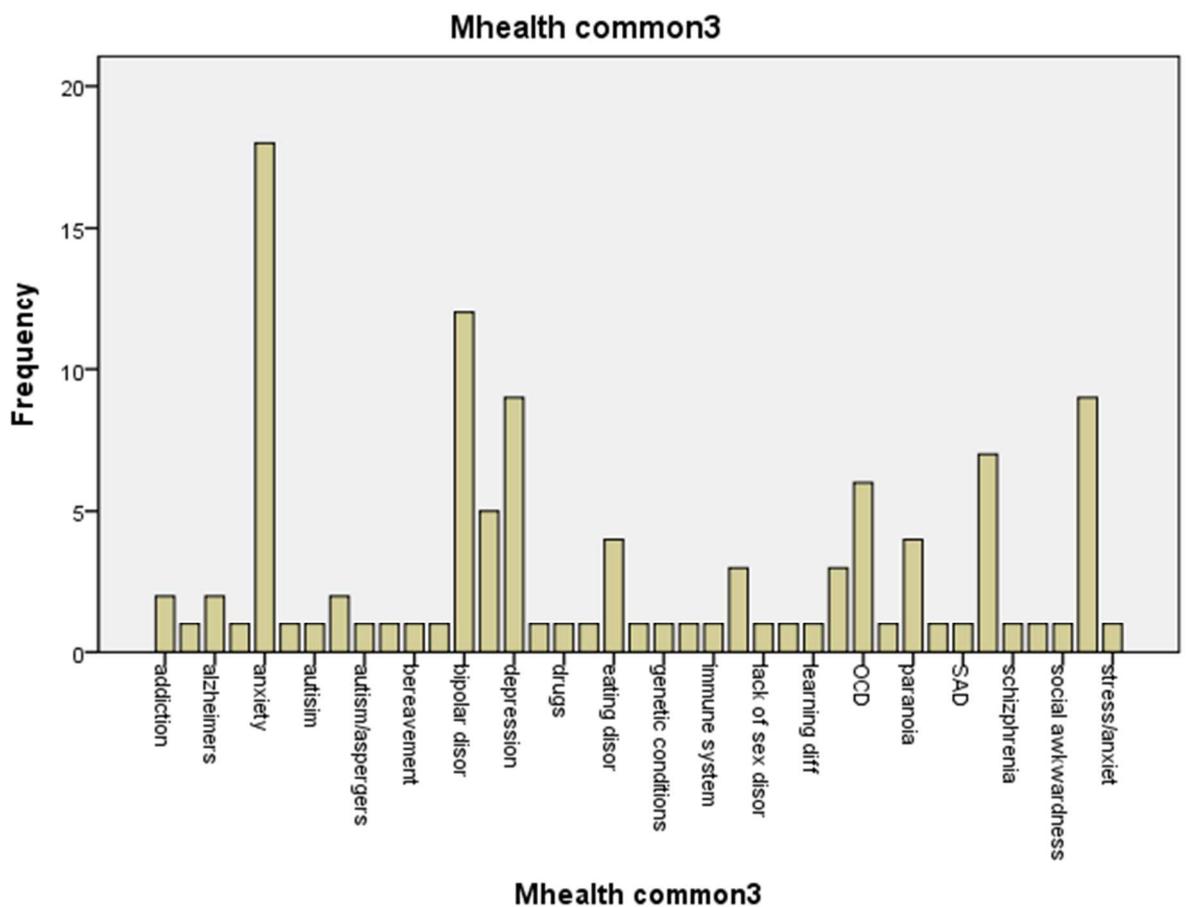
Respondents provided 37 conditions they considered as the fourth most common mental health problem considered most important (see Figure 6-4). Of those entries provided, the most commonly cited conditions were bipolar disorder (n=15, 15.3%), schizophrenia (n=13, 13.3%), alzheimers (n=6, 6.1%), eating disorders (n=5, 4.2%), anxiety (n=5, 4.2%), phobias (n=5, 5.1%) and personality disorders (n=4, 3.3%).

Figure 6-4: Position Four: most common 'Common Mental Health problem'
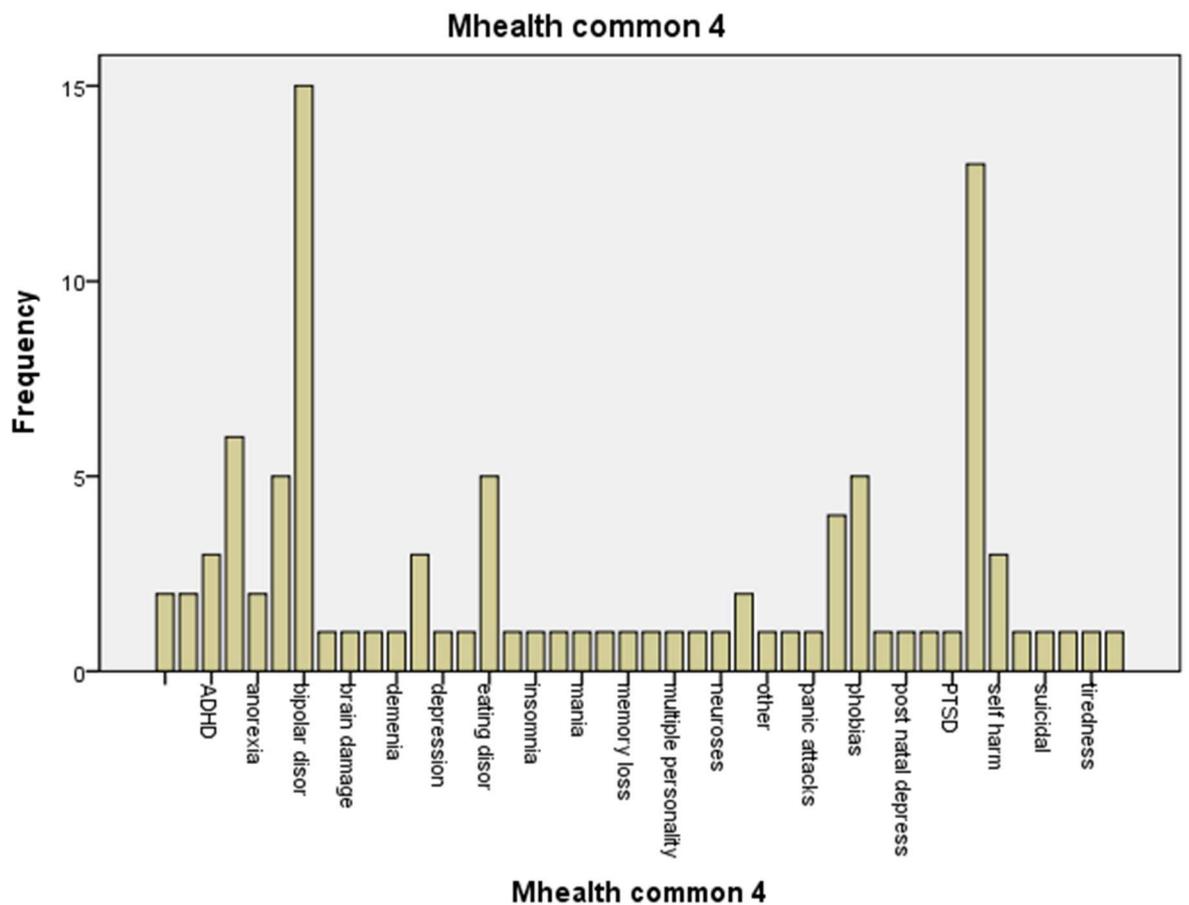
When respondents were asked whether they had personal experience of a common mental health problem, 52.5% (n=62) of respondents indicated they had while 47.5% (n=56) indicated they hadn't.

In terms of knowledge, when respondents were asked to state how good their knowledge of common mental health problems was (good, average or poor), the greater proportion of respondents indicated their knowledge as 'average' (n=73, 60.8%), while the number of those indicating their knowledge to be 'good' or 'poor' were evenly matched (n=24, 20% and n=23, 19.2% respectively).

Sixty-five respondents (54.2%) indicated that they felt they could identify common mental health problems in other people, while 45.8% (n=55) indicated they could not.

Respondents were asked whether they felt they were able to help people with common mental health problems, 52.5% (n=62) indicated they could not, while 47.5% (n=56) indicated they felt they were able to help others.

The majority of respondents didn't feel that GPs receive appropriate training/education covering common mental health and their management, 67.5% (n=79), while 32.5% (n=38) indicated they felt that GPs did receive appropriate training/education.

Respondents indicated, along a four-point Likert scale (anchors described as: 1 'very straightforward' and 4 'not at all straightforward'), how straightforward they thought consultations with the GP around common mental health problems are. The majority of respondents indicated that the consultation was not straightforward (a combination of scale positions 3 and 4, n=81, 70.5%)

Respondents indicated strongly that they thought treatment for a patient with common mental health problems depended upon their knowledge of their problem (81.2%, n=95), compared to those (18.8%, n=22) who indicated they thought it did not.

When asked about treatment for common mental health problems (medication, psychological therapy or both), respondents indicated that they thought treatment should be the combination of psychological therapy and medication, 83.1% (n=98). Psychological therapy on its own was endorsed by 16.2% (n=19) and only 0.8% (n=1) indicated the use of medication only. Respondents believed that psychologists or psychiatrists should be more involved in the treatment of common mental health problems, 95.7% (n=111), while only 4.3% (n=5) indicated they should not.

6.4.2 Further analysis – associations between variables

In order to explore associations between results cross tabulations were calculated (see Appendix 6-2 for questions). A Pearson Chi-square test was conducted on the data to analyse for associations between items.

In the first instance, we looked at the role of knowledge and experience. As you might expect, individuals' experience and knowledge of common mental health problems were found to be significantly associated, $\chi^2(2) = 21.348$, $p = .000$. The effect size was .425 (see Table 6-1). That is to say that, within our sample, those who had experienced common mental health problems, also rated themselves as having between good and average knowledge of common mental health problems.

Table 6-1: Crosstab - The role of knowledge and experience

		Knowledge of CMHPs			Total
		average	good	poor	
Experience of CMHPs	no	35	3	18	56
	yes	38	20	4	62
Total		73	23	22	118

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	21.348[a]	2	.000
Likelihood Ratio	23.527	2	.000
Linear-by-Linear Association	2.828	1	.093
N of Valid Cases	118		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.44.

In terms of being able to identify common mental health problems in others, analysis showed that respondents who indicated that they had experienced a common mental health problem were significantly more likely to be able identify

common mental health problems in other people $\chi^2(1) = 12.029$, $p = .001$. The

effect size was .319 (see Table 6-2).

Table 6-2: Crosstab - Identification of CMHPs in others

		Able to identify CMHPs in others		Total
		No	Yes	
Experience of	no	35	21	56
CMHPs	yes	19	43	62
Total		54	64	118

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	12.029[a]	1	.001		
Continuity Correction[b]	10.780	1	.001		
Likelihood Ratio	12.226	1	.000		
Fisher's Exact Test				.001	.000
Linear-by-Linear Association	11.927	1	.001		
N of Valid Cases	118				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 25.63.

b. Computed only for a 2x2 table

Those who had experienced a common mental health problem also felt that they could help people with common mental health problems, $\chi^2(1) = 9.048$, $p = .003$. The effect size was .279 (see Table 6-3).

Table 6-3: Crosstab: Experience and helping others with CMHPs

		Able to help people with CMHPs		Total
		No	Yes	
Experience of CMHPs	No	37	18	55
	Yes	24	37	61
Total		61	55	116

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	9.048[a]	1	.003		
Continuity Correction[b]	7.963	1	.005		
Likelihood Ratio	9.182	1	.002		
Fisher's Exact Test				.003	.002
Linear-by-Linear Association	8.970	1	.003		
N of Valid Cases	116				

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 26.08.

b. Computed only for a 2x2 table

Looking from the view of having poor, average or good knowledge of common mental health problems, the association with experience was the same. However, although still significantly associated, figures differed slightly in regard to the identification of common mental health problems in others ($\chi^2(2) = 29.273$, $p = .000$). The effect size was .494 (see Table 6-4).

166

Table 6-4: Crosstab - Knowledge of CMH and identification of CMHPs in others

		Able to identify CMHPs in others		Total
		No	Yes	
Knowledge of CMHPs	Average	33	40	73
	Good	2	22	24
	Poor	20	3	23
Total		55	65	120

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	29.273[a]	2	.000
Likelihood Ratio	33.414	2	.000
Linear-by-Linear Association	5.226	1	.022
N of Valid Cases	120		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.54.

In addition, when knowledge was cross tabulated with whether they felt they were able to help people with common mental health problems, the relationship while still significant ($\chi^2(2) = 5.786$, $p = .055$, effect size.221) was weaker compared to that of experience ($\chi^2(1) = 9.048$, $p = .003$, effect size .279) (see Table 6-5).

Table 6-5: Crosstabulation - Knowledge of CMH and ability to help others with CMHPs

		Able to help people with CMHPs		
		No	Yes	Total
Knowledge of CMHPs	average	39	33	72
	good	8	16	24
	poor	15	7	22
Total		62	56	118

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	5.786[a]	2	.055
Likelihood Ratio	5.891	2	.053
Linear-by-Linear Association	.282	1	.596
N of Valid Cases	118		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 10.44.

To explore whether knowledge or experience was the driving factor, further analysis was conducted. A new variable was created which combined both experience and knowledge of common mental health problems to try to pick out and investigate the different elements in order to explore if there were any particular drivers. A cross tabulation was then performed with all other variables.

A cross tabulation between the combined knowledge/experience variable and being able to identify common mental health problems in others, demonstrated some interesting differences. Analyses showed that the presence of knowledge was a significant associative factor ('no experience and good knowledge' 100% (n=3)

and 'experience and good knowledge' 90% (n=18)). So too, the presence of experience was shown to play a role in being able to identify common mental health in others ('no experience and low knowledge' and 'experience and low knowledge', 34% (n=18) and 60% (n=25) respectively). However, it was demonstrated that the combination of having both 'experience' and 'good knowledge' made individuals more able to identify common mental health problems in other people (see Table 6-6 and Figure 6-5).

Table 6-6: Crosstabulation: Combined knowledge and experience and ability to identify common mental health problems in others

		Ability to identify CMHPs in others		
		no	Yes	Total
Combined	No experience low knowledge	35	18	53
	No experience good knowledge	0	3	3
	Experience low knowledge	17	25	42
	Experience good knowledge	2	18	20
Total		54	64	118

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	22.088[a]	3	.000
Likelihood Ratio	25.117	3	.000
Linear-by-Linear Association	17.698	1	.000
N of Valid Cases	118		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.37.

Figure 6-5: Combined knowledge and experience and ability to identify common mental health problems in others
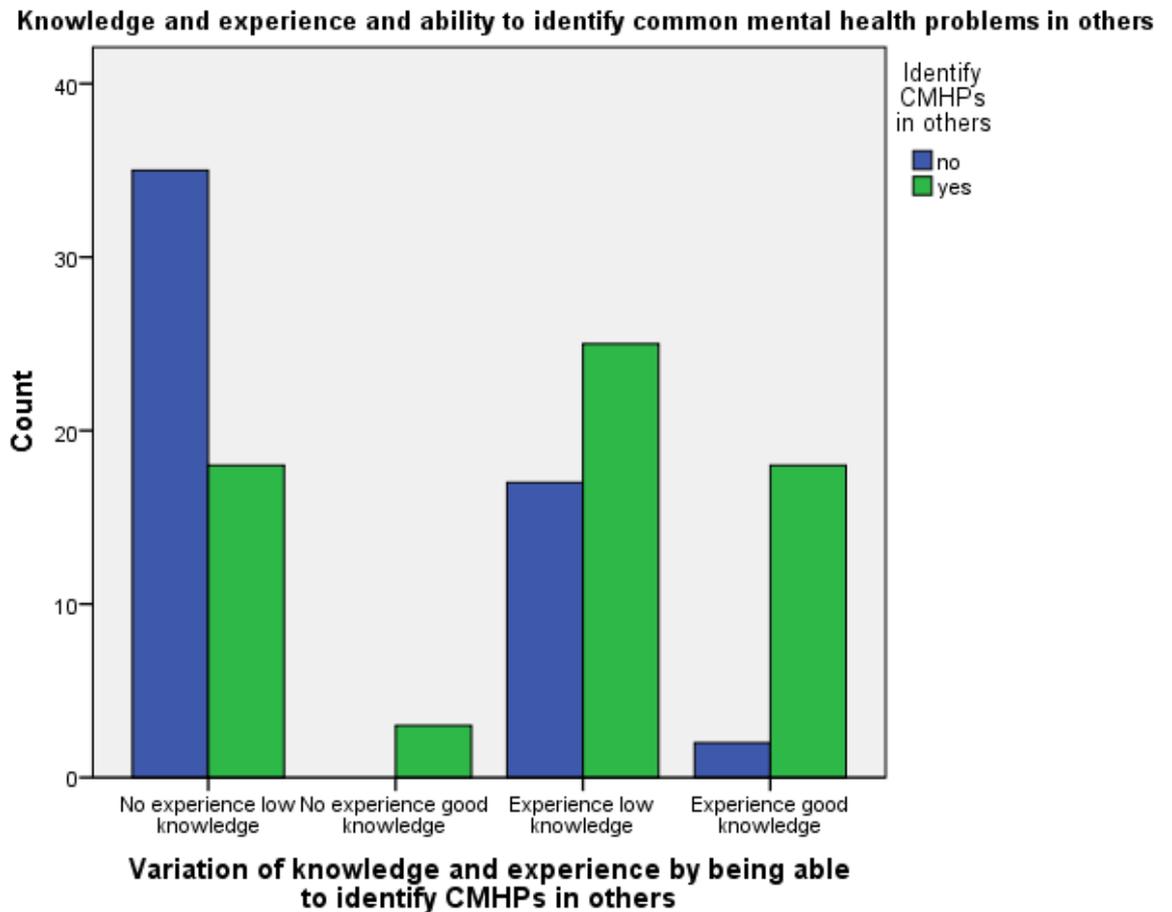
The knowledge effect was still present when a cross tabulation was performed with combined knowledge/experience and whether individuals felt they were able to help people with common mental health problems ($\chi^2(3) = 10.739$, $p = .013$, effect size .304) (see Table 6-7). Better knowledge was associated with whether an individual felt they were able to help other people. However analysis did show that if you had 'poor knowledge' of common mental health problems, it was having the 'experience' of common mental health problems which made an individual

more likely to feel they could help other people with common mental health problems.

Table 6-7: Crosstabulation - Combined knowledge and experience and ability to help others with CMHPs

		Treatment dependent on patient knowledge		
		No	Yes	Total
Combined	No experience low knowledge	36	16	52
	No experience good knowledge	1	2	3
	Experience low knowledge	17	24	41
	Experience good knowledge	7	13	20
Total		61	55	116

Chi-Square Tests

	Value	Df	Asymp. Sig. (2-sided)
Pearson Chi-Square	10.739[a]	3	.013
Likelihood Ratio	10.952	3	.012
Linear-by-Linear Association	9.837	1	.002
N of Valid Cases	116		

a. 2 cells (25.0%) have expected count less than 5. The minimum expected count is 1.42.

6.5 Conclusions

This study aimed to look more generally at what members of the public understand common mental health to be and their management of these in primary care. Results demonstrate that the public understanding of common mental health

problems is much broader than the more frequently spoken of depression and anxiety. This finding is in support of that found in the GP survey, where they too believed common mental health to encapsulate a broader reach of conditions/symptoms. Similarly, the general population acknowledged anxiety and depression to be prevalent, ranking depression in position one of their four most commonly presented 'common mental health problems' achieving 60.3% (n=70) of the sample, while depression achieved a total score of 92.9% across all four positions. However, respondents rated stress as more prevalent compared to anxiety (n=22, 19% and 12, 9.5% respectively) within position one. That said, anxiety in total achieved 70.7% across all four positions, with stress achieving 39.3%. Markedly, amongst the plethora of conditions indicated by the general population sample, those with larger ratings overall across all four positions were bipolar disorder (39.6%), schizophrenia (17.7%), dementia (16.3%), addiction (12%), anorexia (10.6%) and alzheimers (10.5%). In line with respondents' proposition of common mental health conditions being wide and varied, the sample rejected (89.7%, n=105) the more commonly referenced description of common mental health as represented in the statement. Again this mirrored GP results from the GP Survey, where 75% of GPs also disagreed. In addition, these findings support those of the GP Survey, in that the way that individuals understand common mental health problems to be is different to that which has been proffered more recently. As has been previously discussed (*see* Chapter 4: The GP Survey) the way in which terms are used and their meanings are of high importance not only for targeting appropriate knowledge and training of health

professionals, but also for the availability of resources to help treat conditions both present and prevalent in the general population.

In terms of an individual's knowledge and experience, results from the sample showed that knowledge and experience were significantly associated ($\chi^2(2) = 21.348$, $p = .001$). That is to say that those who had personal experience of a common mental health problem also rated themselves as having between good and average knowledge of common mental health problems. This finding is commensurate with research that suggests that 33% of respondents indicated personal experience of someone with a mental disorder as their main source of information, with a further 10% citing friends and relatives (Wolff et al., 1996). In terms of feeling able to help others with common mental health problems, around half the sample indicated that they felt they were able to do so (52.5%, n=62). Experience was also found to be a significant factor when being able to recognise common mental health in others and a person's sense of being able to help others with common mental health problems ($\chi^2(1) = 12.029$, $p = .001$). This is important when the Working Minds Survey, found that over 30% of people with mental health problems felt they have been dismissed or 'forced to resign' because of discrimination (Challis & Wilkinson, 2010).

Furthermore, findings from this study showed that people felt treatment of someone with a common mental health problem was dependent upon their knowledge (81.2%, n=95). This finding is in line with research which suggests that the likelihood of receiving effective treatment and recognition is dependent upon

appropriate interaction with the GP during the consultation, appropriate interaction being the presentation of symptoms in a way that GPs understand. This factor is of crucial importance for providing someone with a greater chance of appropriate help, especially when it has been estimated that as many as 50% of cases go undetected in the GPs surgery (Goldberg & Huxley, 1992). For example, detection and recognition of mental disorders is greater if the patient presents his or her symptoms as reflecting a psychological problem (Herran et al., 1999; Kessler et al., 1999) and also explicitly raises the problem with the GP (Bowers et al., 1990; Jacob et al., 1998). Weich et al (1995) showed that GPs detected about 20% of the cases of psychiatric morbidity who presented with physical symptoms, 53% of those presenting with both emotional and physical symptoms, and 100% of those who complained of emotional problems.

The unreliability of consultation outcomes is something discussed within a study looking at lay attitudes to professional consultations for common mental health disorders. This study by Pill (2001) found that most people felt that GPs had little time to devote to an analysis of personal problems, and some suspected that GPs might not be too tolerant of a presentation with emotional symptoms. The GP was seen as having little option other than to prescribe an antidepressant. Unfortunately, the latter were regarded as being potentially addictive, or otherwise harmful, and, in any event, as mere palliatives in place of something that could really get to the root of a person's problems (Pill, 2001). Results for beliefs of treatment method, in our study, displayed that the vast majority of this sample indicated that they felt common mental health should be treated with both

medication and psychological therapy (n=98, 81.7%), while only one person indicated medication only. This finding is in contrast to other earlier research showing, that in developed countries, for depression, psychiatrists and psychologists were rated less highly than GPs. The use of combined pharmacology and psychological treatments is favoured by psychiatrists and is generally accepted among health professionals, though some doubt has been expressed about the efficacy of treatment for the mild/moderate cases often seen in primary care (Kendrick, 1996). It was also clear from the findings that respondents felt that psychologists and psychiatrists should be more involved in the treatment of those with common mental health problems (n=111, 95.7%). However, in reality the availability of psychological-based therapy in general practice is patchy and weighted by severity, such that only those with severe and enduring mental health problems are referred by GPs.

Findings from the present study suggest that there is a lack of confidence and issues with expectation regarding consultations with GPs regarding common mental health problems by members of the public. Findings showed that the general population do not find the consultation around CMHPs straightforward, mirroring the position of GPs (see Chapter 4: GP survey), and also that they felt GPs did not receive appropriate training/education covering common mental health problems (67.5%, n=79).

It can be understood from the results presented, that people feel that the prospect of going into a consultation about a common mental health problem as being

shrouded by uncertainty. Within this construct it may be that the belief that the level of knowledge possessed by an individual as being influential to the receipt of effective appropriate treatment gains more weight and validity. The notion that an individual's knowledge about their problem being a key factor in the GP/patient interaction and in the attainment of effective outcomes, is borne out by research as previously discussed. Further, this notion as being a pervading factor may be given further weight, when we consider the combination of factors that lead to a sense of uncertainty with GPs within the consultation around common mental health problems. Such as a particular level of knowledge about specific problems/symptoms, the availability of treatments for these. Therefore, the presence of the individual's knowledge can help to pull together and signpost precarious factors that might otherwise be present (as findings from this research programme suggest), such as GPs lack of confidence in recognition of CMHPs, the self-professed lack of training and education, the difficulty inherent in this type of consultation not being straightforward, coupled with the time constraints of practice clinical session times.

The increase of people's appropriate knowledge into mental health issues and language of the same is shown to be key in presenting one's problems and thereby aiding in achieving an appropriate and desired outcome. This aspect of individuals' understanding of appropriate language to present or describe their symptoms or condition to health professionals, is something that would be beneficial across the board considering the time constraints of any consultation.

6.6 Limitations

There were shortcomings associated with this study, such as the population sample, the number of respondents and the diversity of the respondents. Therefore, issues around representativeness exist and as such results must be taken with caution. A broader sample population, which includes individuals from across the social strata is something that would be extremely beneficial to this study. Another limitation can be understood as the strategy employed to distribute the questions from this study. While it seemed an appropriate route to take, the embedding of questions within a much larger study lead to the probability that responders experienced survey fatigue. It is also possible that response numbers may have been larger had these questions been distributed separately, so that respondents had a clearer understanding of the topic under investigation. Furthermore, a qualitative methodological approach to investigate perceptions and understanding of common mental health and its management with the general population would provide an opportunity to gather more detailed data.

6.7 Summary of Chapter 6 and link paragraph to Chapter 7

Chapter 6 describes and discusses The Mental Health Literacy Survey. Results from this survey also provide support and agreement to those found through the GP Survey (Chapter 4), in that the general population also believe the term common mental health problems to encompass a wider range of conditions and that the common mental health consultation is not straightforward. The study has also shown the importance of education, knowledge and experience in recognition, access to treatment and aiding others. Results also showed the general population

to believe that GPs lack appropriate education and training and furthermore that psychologists should be more involved in the treatment of common mental health problems.

The chapters presented in this thesis thus far have chronicled various studies that have aimed to investigate the management of common mental health. While the various findings have served to provide both supportive evidence and new knowledge in this area, it is important to contextualise and validate our findings in relation to other key health professionals within primary care who also have involvement with patients who have mental health and common mental health problems. Therefore, Chapter 7 (the following chapter) presents a triangulation study conducted with GPs, Primary Care Counsellors and Clinical Psychologists, where all findings from the previous studies are discussed.

Chapter 7: Triangulation of findings – a validation study with GPs, Primary Care Counsellors and Clinical Psychologists

This chapter discusses the perceptions and opinions of GPs, primary care counsellors and clinical psychologists towards the findings of this programme of research that investigated GPs' management of common mental health in primary care. Firstly, it discusses the rationale for conducting the validation study, before going onto outline the study itself: aims, methods and results.

7.1 Introduction

During the course of investigating GPs' management of common mental health (CMH) in primary care, the programme of research has used a multi-method approach: cognitive debriefing exercises, focus groups with GPs, GP survey, interviews with experts, a study using the theory of planned behaviour (a survey of prescribing/referral behaviours) and a general population mental health literacy survey. Multi-method approaches, utilising quantitative and qualitative methodological approaches, allow for the examination of a particular phenomenon or topic on several different levels (Brannen, 1992).

As has already been discussed within the previous chapters, data collected during this programme of research has identified many aspects and influential factors associated with CMH management. As part of a validation process and in order to contextualise and to gauge further the representativeness of the findings produced from this research in regard to the management of common mental health in

primary care, a triangulation study was conducted. The study invited GPs, Primary Care Counsellors and Clinical Psychologists to take part in focus groups to discuss the findings and issues around the management of common mental health problems in primary care.

As reported within this thesis, general practitioners are reluctant to refer patients who present with mental difficulties to psychologists (Beel, Gringart & Edwards, 2008; Meyer, Fink & Carey, 1988; Sigel & Leiper, 2004). Strong evidence is presented in the literature reporting that the use of mental health care providers in collaborative practice is not only cost effective but also in the best interests of patients (Beel, Gringart & Edwards, 2008; Hemmings, 2000; Vines et al, 2004). Findings presented throughout this thesis display various barriers to general practitioner referral to psychological-based treatment. These findings are supported by the literature, such as GPs' assumptions regarding treatment, interaction styles and differences in theoretical languages (Beel, Gringart & Edwards, 2008), and with regards to communication where GPs' found that communications from psychologists were not very informative (Sigel & Leiper, 2004).

Therefore, the opinions and experience of those who work closely with, or having experience of the management of common mental health (GPs, Primary Care Counsellors and Clinical Psychologists) are considered vital to the project in terms of a robust research evidence approach. The technique of using the focus group in order to generate this kind of data is built on the notion that group interaction encourages respondents to explore and clarify individual and shared perspectives

(Gill et al., 2008; Morgan, 1988). Focus groups are an established method used to explore the views of individuals on health issues, programs, interventions and research.

7.2 Aims

The study involves key health professionals taking part in a focus group discussion to talk about the findings and issues surrounding the management of common mental health, more specifically prescribing and referral of those with a common mental health problem. The objective of the study was to try and triangulate the findings and to establish whether or not the GPs, primary care counsellors and clinical psychologists interviewed agreed with the findings presented from the previous investigations, and to provide an opportunity for further discussion and new insight.

7.3 Method

7.3.1 Ethical Approval

Full ethical approval was obtained from the Research Ethics Committee for Wales as part of the original study *Predictors of Prescribing and Referral Behaviour for Common Mental Health Problems* (see Chapter 5).

7.3.2 Sample

Three focus groups:

- GPs

- Primary Care Counsellors

- Clinical Psychologists

- Sample size: Each group will consist of between 3-6 people

7.3.3 Recruitment

- Participants (GPs, Primary Care Counsellors and Clinical Psychologists) were recruited via purposive sampling

- Participants were contacted via telephone and email (see Appendix 7-1) and were also sent further information about the project, consent, data protection and, complaints and distress procedures before they were able to progress further

7.3.4 Research Design

- The focus group discussions would be led by (KW) and would take no longer than one hour

- Discussion groups were held at a location suitable to those participating

- To ensure participants were able to comment fully upon the findings from the research programme, participants were sent a document listing the main findings from the previous studies a week before the focus group was due to take place (see Appendix 7-2)

- At the end of the discussion group all participants were presented with a debriefing sheet including full contact details of the researchers (see Appendix 7-3)

- All data generated was anonymised

7.3.5 Data collection

- Issues around consent and participants' right to withdraw were explained prior to the commencement of the discussion group

- Consent was also sought for the recording of the discussion group prior to its commencement (see Appendix 7-4)

- Group discussions were recorded and transcribed

7.3.6 Analysis
Qualitative Analysis

- Transcribed data was organised and coded using the Nvivo 8 qualitative software package

- Data underwent thematic content analysis

7.4 Results and Discussion

Prior to the focus group interviews, interviewees were sent a pre-focus group document which provided key messages drawn from the studies conducted during this programme of research (Scoping Study, GP Survey, Theory of Planned Behaviour Study (referring and prescribing behaviours) and the general population Mental Health Literacy Study) which aimed to look into the management of common mental health in primary care.

These key messages were presented in the pre-focus group document (received by participants prior to the group discussion) and were grouped into categories: consultations around common mental health; management of common mental health; and training (for pre-focus group document see Appendix 7-4). With this in mind the results from these validation focus groups will be presented under each of these headings and responses from the various groups (GPs, primary care counsellors and clinical psychologists) will be presented alongside each other.

Further, themes identified within the data will be presented alongside and following the main themes identified from the studies.

7.4.1 Participants' understanding of the term 'common mental health'

Interviewees agreed with the findings presented from the previous studies around common mental health being broader than anxiety and depression (although recognising too that they would be seen as most commonly presented) and that common mental health disorders were non-chronic disorders that did not meet caseness. However, there was a debate from the clinical psychologist group surrounding the finding that common mental health conditions were considered short-term and reactive states:

> ....mainly I'm comfortable not so much with it being a non-chronic disorder but more about the severity of it perhaps...and may be the complexity of the mental health...the common mental health problems so I would be in agreement that anxiety depression disorders would be THE most common mental health problems somebody would see and all the it's...the sort of studies would support that i think...but it would be about...cos I think it is possible to be a common mental health problem but still be a low level you know something totally appropriate for primary care despite it being something that somebody might have struggled with for decades but if they're still...you know may be going to work

and upholding some other areas of function so it...maybe it's

about the impact of it with regards the severity and then

the...complexity of it you know...there's something about a

simple phobia a spider phobic... you know not necessarily

particularly complex whereas more generalized anxiety

disorder could be quite complex so...I don't know that it's

quite as quantifiable as just a reactive thing that's transient

and therefore will PASS with some relatively straightforward

intervention...I think GPs probably see common mental health

problems more than that to be honest to be fair to the...

(GF11WBHCP, Clinical Psychologist)

Further, GPs commented upon the presence of coping mechanisms and that these, as experienced by them in practice, seemed to be either effective or dysfunctional and therefore resulted in either positive or negative responses to the social and environmental factors which also impacted upon health:

...you would speak to a young woman and say what does

your mother do when she's worried...'she goes to bed for

two days'...'what do you do when you're worried' 'oh i go

to bed for two days'...and then so in that sense when

you're left thinking well these are some behavioural

techniques you might want to use or here are some

cognitive techniques or some mindfulness...in the context

of actually anybody in my family you know they either

turn to alcohol..street drugs...go to bed whatever you

know they've got if you like COMPLETELY dysfunctional

coping or un...ineffective coping mechanisms we're then

starting from a very different starting point...but

paradoxically the other side of that of course for me is

that actually people survive in [place name] because they

they've got endurance they've got inner strength and

resilience

(GM4MGP, General Practitioner)

7.4.2 Consultations around common mental health

7.4.2.1 Assessment and recognition of common mental health

Agreement was found across groups for findings around GPs experiencing

difficulties in the assessment of common mental health. This issue was further

discussed by all groups. There was consensus around the difficulty of common

mental health being bound up with other chronic problems (73% GP Survey), and

that the picking apart of these was troublesome.

GF7MGP...because we're dealing with an individual with

complex - often with chronic disease issues social issues

as well as mental health things...so working within that

context separating it out is...not helpful for anybody

GM5MGP: all those people have personality disorders

anyway so they hide prevalence of personality disorder

which perhaps then gets tied up into diagnosis of

depression...then peoples' social circumstances alone if

you put anyone without ANY mental health problems into

that situation they'd quickly developed signs of

depression

(General Practitioners)

Additionally, in terms of difficulties associated with assessment, it was suggested by clinical psychologists that perhaps this was another aspect of confidence, that GPs 'didn't ask' questions that would then place them in a situation where they would have to deal with the answers:

...into the assessment of risk you know sometimes people

won't ask a question because they're anxious about well I

don't know actually what to do about it if I get that

answer so maybe somebody won't ask about someone's

eating cos they think really don't want to mess there and

YOU KNOW and if you look relatively a healthy way I'll

leave that for another day...cos you can't ask all of it in

a...you know a very long consultation and assessment for

mental health issues things WILL NOT get asked...it's not

a fault finding thing it's just...peoples' priority i guess is

lets treat what's in our faces really

(GF11WBHCP, Clinical Psychologist)

This issue is perhaps supportive of and in line with issues around presentation of conditions within the consultation, recognition was said to be further hampered by patient expectation and the social construction of illness within the locality of the general practice served the GPs taking part in the validation focus group.

> *well I think in ours...we serve a deprived community*
>
> *where there's a very high prevalence of common mental*
>
> *health problems but there's a paradox because...there are*
>
> *some people there – for example thinking about post*
>
> *natal mood disorders – EVERYBODY they know ALL*
>
> *their friends have post natal low mood or depression so*
>
> *it's just part of being a new mother...and some people*
>
> *then...don't think it's even a problem when you mention it*
>
> (GM4MGP, General Practitioner)

7.4.2.2 Labelling

In terms of diagnostic labelling, it can be understood through the discussion with GPs that diagnostic labelling in practice is exercised creatively, or more specifically is manipulated for the good of the patient. This creative manipulation is said to take various forms, working within or using the system to achieve outcomes that are in the best interest of or requested by the patient. For instance, that they would make a diagnosis of 'depression' instead of 'bereavement' to 'play the game' and enable access to treatment said to otherwise be unavailable; or

conversely by way of evasion, in that the use of it could be stigmatising for the individual:

> *to make a diagnosis you have to think about the person in*
>
> *their social context, their family context...you know what*
>
> *the label, the word means to them and for some people I*
>
> *might never use the word 'depression'*

<div align="right">(GM4MGP, general practitioner)</div>

> *another thing about depression screening is that is going*
>
> *to made anonymous...our depression scores are low*
>
> *because we just don't (indeciferable) one way to get*
>
> *round having to do a PHQ is to code someone as low*
>
> *mood so you don't code them as depression so i suspect*
>
> *that if you looked at our prevalence it would be...well*
>
> *figures are actually quite HIGH still on the prevalence*
>
> *cos it is actually so high...if we coded everyone that we*
>
> *thought did have depression but we've actually coded as*
>
> *low mood I think our prevalence would be much higher*

<div align="right">(GF7MGP, General Practitioner)</div>

Also, diagnostic labelling was said to be linked to and important for financial and familial security, as one participant explains a strong link between a 'doctor's diagnosis of something and entitlement to benefit or time off work or *support* from

the council' (GM4MGP), and that this then builds upon the complexity of assessment and diagnosis.

This sense of GP responsibility and patient expectation is of significance with regard to the patient/doctor interaction. General practitioners frequently cite their 'role' as the patient's advocate. Therefore, this is a key pervasive factor during the consultation and management of the individual. Patient expectation will be discussed in more detail in the following section.

The issue of financial remuneration was not solely discussed in terms of patients, but was countered by GPs and clinical psychologists as they discussed returns for practices from the QOF, such that, 'if we use certain words in the medical record it impacts our income through QOF' and the take up of medications for drug companies.

There was also debate from both clinical psychologists and primary care counsellors regarding conditions of bereavement and its inclusion as a common mental health problem. Despite being in agreement with the findings from GPs and the general public around bereavement being considered as common mental health problem, the debate between participants in this study centred upon the appropriate recognition of conditions and the issue of severity and co-morbidity. From the clinical psychologist perspective, this concern was specifically set with regard to eating disorders:

...I think that's the important word the co-morbidity as

well as to whether that's something that encourages GPs

to start thinking oop this is getting a bit messy and we

ought to bump it up because the anxiety might be

relatively...you know mild to moderate the eating

disorder might be relatively mild to moderate but when

you put the two together and is it at that point that may

be a GP feels that it needs to go up a level...whereas I

don't necessarily think it would have to it's

just...understanding the formulation of how to manage it

(GF11WBHCP, Clinical Psychologist)

7.4.2.3 Screening

Findings from the GP Survey indicated that over half of the sample prescribed on a first visit and, of those that prescribed, 60% indicated that they do not administer a screening tool prior to the prescription of medication - a finding that is in conflict with NICE (2007, 2011) guidelines. GPs agreed with this finding and expanded on it, providing their opinions and experiences of using and implementing screening tools. Despite the NICE (2007) guidance on the management of common mental health, citing that during initial phases of management that GPs should administer a screening tool prior to the prescription of medication. The GPs in the discussion group qualified this advice in terms of how screening and the prescribing of medication was viewed in practice and this, they strongly felt, was that screening and the prescription of medication should be viewed separately:

191

...a screening tool is not the right tool for making a

diagnosis it's not even a prescribing guidance tool...a

screening tool is for screening and then prescribing is

about clinical decision making...which is a completely

different process

(GM4MGP, General Practitioner)

In the following example, and further supporting the finding that screening tools were not being administered, a GP explains not having used one and also alludes to the issue of the receiving of financial reward if not fulfilling practice:

Equally 60% of doctors shouldn't be getting their QOF

money ((chuckling)) I'm sure isn't happening...that it's

one of the QOF indicators so...very interesting

((chuckling)) I personally have never used one...I'm sorry

everybody ((chuckling))

(GF7MGP, General Practitioner)

On the other hand GPs explained their use, or rather explaining their now lack of use as being bound up with the introduction of the QOF and that this system and the process-led approach, did not take into account the nature of the conditions (e.g. coronary heart disease and diabetes) with which it was instructed to be used. Couched in terms of a narrative of experience, the GP speaks about the use of screening tools by health care staff and reflection on that of own health condition:

[...] when the QOF depression came in and all patients

with coronary heart disease and diabetes were supposed

to be asked the two screening depression questions...that

our nurses commented well people have...you know when

we're doing a regular check up people have so many

horrible things happening in their lives that that of

course they have time when they feel a bit hopeless...well

of course they have times when they feel their life isn't

worth living but then if you say to them...OH that means

you may be depressed...they say NOT AT ALL this is just

my life

[...] if you then put that into the context of - because i live

with diabetes and if you did the PHQ on me on Monday

when I was on call I can ASSURE you it would have been

HIGH score...but then if you said to me right [name]

because your PHQ score is 20 or whatever it would have

been therefore you now have a label of depression here is

your Prozac..that would have been entirely inappropriate

((chuckling))

(GM4MGP, General Practitioner)

7.4.2.4 Straightforwardness of consultations
The validation groups agreed with the findings presented from the GP Survey

showing that GPs and the general population (see Mental Health Literacy Survey)

did not find consultations around common mental health straightforward. An
example is presented of what this means for general practitioners was provided
through discussion with GPs - citing issues around expectation, responsibility and
role – couched in terms of a general incident narrative of a recent consultation
experience:

GF7MGP: that's the worse thing about them they're

complicated so they often go on for longer time...cos they

often don't...you just don't want anything to happen while

they're there really...they discuss their life problems as

well as their actual health problems then...a feeling that

doctors can sort everything out they can provide a sort

of...whether they should leave their husband or not you

know...so that can take ages can't it

GM4MGP: they almost come to us for a counselling

service don't they

[agreeing]

GM4MGP: they use us for a counselling service which

isn't really what we're trained as or ought to do to be

honest

GF7MGP: you had a gentlemen for an hour didn't you

because he was going through a very very stressful life

event which you know

> *GF1MGP: I don't think it was quite that long*
>
> *((chuckling))*
>
> *GF7MGP: it was a long time yes yeah it wasn't quite that*
>
> *GF1MGP: and you know these... life events are awful*
>
> *sometimes and terrible and you can't just stick to the 10*
>
> *minute consultation and throw them out into it you know*
>
> <div align="right">(General Practitioners)</div>

7.4.3 Management of common mental health

In terms of managing those with common mental health problems in primary care, findings from the previous studies suggested that GPs felt it was difficult to manage inherited patients, meaning patients who had or were already being treated by another GP, and that interventions were more effective and had a better chance of success closer to the point of condition recognition. These findings were met with some questions. It was understood too that there were many types of general practice (urban, rural) where GP turnaround or patient population were transient to differing degrees and that this would/could add to management complexity.

This excerpt from the clinical psychologist discussion group shows their response to these findings and suggests that it could be that it is about lacking good management of the problem in the eyes of the patient, and perhaps a lack of motivation to manage properly by GPs, because of the complexities of a patient seeing or being seen by different GPs:

NT: so is that about them [GPs] feeling that a) there's

that optimum window that's been lost but also that may

be the client has decided nobody can help me this is just

going to be something I'm stuck with or you know here i

am at the GP again and they're prescribing this again or

suggesting this group or something you know their...their

hopefulness about it is waning I suppose and I guess it

fits in with the idea that...if their belief that the common

mental health problem is a reactive thing then that

suggests to me that it's not long...it's short duration as

well so if you combine their expectation of it being a

reactive thing WELL that's...not the case if it's a long

term inherited problem you know...you know because by

the time it's that it's morphed into other things by

then...and it's no longer as pure as it was in the initial bit

that they're understanding so...maybe that's where it

starts become oh hang on...I DON'T KNOW if that's

about inherited patients or if that...you know it is about

people's longevity so naturally it's going to be somebody

perhaps you'll inherit because GPs will come and go

from a practice or locums might come and go..so it might

not be about the inheritedness it's just that they're around

long enough to see several GPs...you know rather than be

one...one person's baby for a long length of time so I

196

don't know if there's two different things going on

there...perhaps

BL: yeah and again if they are seeing different people as

well because of locums and that kind of thing I would

imagine then GPs having patients who have seen a lot of

different people...people come at things from a different

point of view as well they'll each have their own special

interest and background so that could..inadvertently add

to the complexity of it because you could be

reading...other correspondence that previous GPs have

written and it could be kind of like oh well we're just

trying to go with that...so it could be quite it can add to

the confusion I suppose

(Clinical Psychologists)

This issue was taken further by primary care counsellors describing the potential state of a patient's condition that has progressed to something more chronic, enduring and complex as a result of not being picked up and the difficulties this would hold for the GP who is then tasked with trying to help:

JD:...that might just be that it is chronic depression...that

it is harder to kind of almost provide an intervention

because it can have lots of layers to it and you know the

fact that it is chronic...you know might just be more

difficult to...to provide an intervention so whether that's

just because it's been passed on to them or whether it is

because it's chronic and enduring that it is more difficult

to manage

KM: because of that's the case it does also impact on so

many other areas then on that patient's life that...you're

no longer just dealing with the depression and that, you

know it's all the other areas that are being impacted

upon...as you say all these layers it's hard to kind of step

in to, it's deep progressed impacted so far, to then start

(Primary Care Counsellors)

For the GPs in the discussion groups, this issue of inherited patients and early intervention was discussed in such a way that it was evident, in support of the previous findings, that there are inherent difficulties and complexities associated with the management of patients with common mental health problems which impact both upon motivation and the GPs' sense of ability to make a difference in practice. The following excerpt encapsulates this talk and depicts an obvious waning of motivation in the GP's management as a result of their own personal experiences of managing patients with common mental health problems:

...yes...I mean I can remember one patient who has

responded dramatically to bibliotherapy because...

reading the book AT THAT moment in her life she

suddenly realised why her normal response was panic

198

attacks followed by depression...sadly two years later

she's forgotten all the lessons that she's learnt and she's

back to square one...my own feeling is we support people

from crisis to crisis and there are particular you know

inherited or chronic patients...and it's difficult because

you know - the hours I used to spend trying to think

because I was trained to think and the next time you see

them is the time you'll make a difference in their lives and

I used to give people hours and hours and hours until I

learnt oh no actually... for a whole load of reasons

they're...it's up you know it's not a good use of my time

and skills basically

(GM4MGP, General Practitioner)

Importantly, what the preceding discussions do show, along with support for earlier findings presented in this programme of research around the need for education and training of GPs in the area of common mental health and it's management, is the importance of picking up or recognising these issues for patients and managing them effectively in the first instance, so as to avoid and prevent the damaging impact for patients and GPs if this is not achieved.

7.4.3.1 Patient knowledge

Findings from the studies suggesting patient knowledge as being a pervasive factor in the management of their condition was agreed by all those taking part in the validation study. For instance the general population study (Mental Health

Literacy Study) found that 81.2% thought treatment depended upon knowledge of their problem. For the clinical psychologist this was understood as being or referring to 'their [a patient's] level of insight isn't it' (GF12WBHCP), primary care counsellors spoke about it in terms of patients being able to provide a clearer message to GPs and therefore aiding with the direction of the approach to management, albeit dependent upon further options are available to them:

GF9WHPCC: yes may be in a sense that if a client goes

in and says you know I've been feeling extremely anxious

and i think i need some CBT[

GF8WHPCC: [or how things have been so

stressful [

GF9WHPCC: [I think may be sometimes...I think that GP

would clearly think okay yes we have that available and

this...and i suppose if they don't have if they're not too

sure what are the clients presenting issues or...maybe

they're a bit unsure about would work best for

them...maybe they don't even know enough about

psychological therapy to have confidence in it and how it

might work

(Primary Care Counsellors)

The suggestion has been raised within the thesis of improved consultation outcomes being related patients that present at the consultation with more understanding or knowledge about their condition, and as a result are more likely to receive from their GP what it is they have asked for. The position of the informed patient has also been discussed as aiding the GP in what GPs' see as a difficult consultation situation. This is evident from the following excerpt taken from the GP discussion group:

> *GF6MGP: definitely*
> *GF1MGP: I think it definitely can...I saw somebody with*
>
> *in inverted commas post natal depression and basically*
>
> *her problem is she didn't get maternity pay so she went*
>
> *back to work a week after the baby was born...and that's*
>
> *her problem she's tired stressed drained because*
>
> *she's...one of our higher social class patients and she's*
>
> *related to somebody who works in the practice or*
>
> *because she's seen a health visitor and they said well we*
>
> *think you're depressed so she came in this morning for*
>
> *antidepressants...even though I...cos she's read up on*
>
> *it...even though I don't feel well she probably...I and I*
>
> *said you know what the problem is it's cos..you're just*
>
> *tired it's an exaggeration of total normality and this isn't*
>
> *going to change things...but I think if the antidepressants*
>
> *can help her get to January.. January she can speak to*

her boss who's her brother-in-law to sort everything out

so that...she's fine though she loved her antidepressants

we do but...that's what she came for and that's what she

was leaving with

GF2MGP: she had made up her mind

GF1MGP: yeah she knew the ones she wanted...and er

yeah

GF6MGP: and equally if somebody has had any sort of

exposure to psychological therapies then...they're much

more into self-help aren't they...this or...this will work

read this book...you might get something out of it

((chuckling))

(General Practitioners)

It is clear from the above excerpt that although the GP did not feel it was appropriate to prescribe antidepressants for this case, she did anyway because 'she [the patient] had made up her mind'. Unaware of the content in the GP discussion but recognising there exists a difference in attitude to management in practice, this suggestion around patients being able to request and receive treatments from the consultation was met with resistance by one of the clinical psychologists, who aligned this version of management behaviour by doctors to their management of other physical conditions, suggesting that there seemed practice differences perhaps emanating from a lack of confidence:

yes yeah well that's I'm wondering if there's quite so

much try to refuse if it's felt inappropriate or I've got a

slight tickle in my throat I think I might be getting

tonsillitis can you give me some antibiotics..well hang on

maybe we should wait a couple of days and actually have

some firm evidence of that to see if it does progress

because it could go away...whereas it...I don't know are

they...do they do it with the same umpf...you know or with

the same confidence i suppose is the word isn't it...to do

that watchful waiting behaviour as well....

...not wanting to rock the boat...but then it does kind of

pass the buck if it becomes a bigger issue and then that

person gets referred to secondary services...somebody's

got to say no at some point if it's inappropriate

(GF11WBHCP, Clinical Psychologist)

Furthermore, as has been previously discussed patients' knowledge or indeed patient expectation can be a strong influential driver for the doctor/patient interaction and this dynamic can occur to differing degrees whether it is the request for a sick note from work, the prescription of medication, or financial security. For some patients in some areas there is a social construction of illness and this not only is normalised amongst their peers but is also a means by which they achieve or rather maintain financial and familial security. For the general practitioner then,

the consultation around common mental health problems is no longer focussed on or set to the health condition but is also intrinsically linked to the individual's livelihood as a whole:

> *GF1MGP: well I saw somebody this morning who came*
>
> *in and said about how dreadful she was feeling and went*
>
> *through a whole list of symptoms and then said 'oh my*
>
> *DLA is up for review and I'm scared I'm going to lose my*
>
> *car' so by the end I'm thinking cor...it was a very long*
>
> *consultation...once I said I filled the forms in she seemed*
>
> *to brighten up a bit ((chuckling))*
>
> *GM4MGP: I mean are the consultation harming*
>
> *GF1MGP: oh we all know her very well...but you know*
>
> *she came in 'oh my pain worse than ever I'm more*
>
> *depressed that ever I have to do more for my*
>
> *parents...and I think losing my car...that's the one thing*
>
> *that keeps me going' and I thought...*
>
> *GF7MGP: it's probably right as well*
>
> *GF1MGP: I know absolutely*
>
> *GF7MGP: we'd hate to lose our cars wouldn't we*

(General Practitioners)

The presence of these socially interactive dynamics can mean that such issues result in the GP conducting consultations differently depending on who comes through the door. Consultations not only differ in terms of natural differences

associated with conditions and the needs of individuals on a case by case basis, as one would expect, but can also differ in terms of what the diagnosis and treatment management means to the individual and its impact upon their social placing as a whole.

we serve a deprived community where there's a very high prevalence of common mental health problems but there's a paradox because...there are some people there - for example thinking about post natal mood disorders - EVERYBODY they know ALL their friends have post natal low mood or depression so it's just part of being a new mother...and some people then...don't think it's even a problem when you medicalise it...whereas other people it's classed stressful or they're not coping there are other issues about like...WORK or...being a good wife or whatever or a good mother and for them then they come to us they almost WANT us to medicalise it...and if we then say but actually it's part of normal human life and I think you'll find and many people feel like that...it's almost as if we're not taking them and their worries and their concerns seriously and that can be...that can become because of then in [placename] there's such a strong like between A doctor's diagnosis of something

and entitlement to benefit or time off work or SUPPORT

from the council or whatever it might be...

(GM4MGP, General Practitioner)

7.4.3.2 Prescribing

As will be discussed shortly, all participants agreed with findings around confidence levels being high when managing antidepressants, and there being low confidence in the management of psychological-based therapies; albeit that agreement across the groups (clinical psychologist, primary care counsellors and general practitioners) was not resolute when findings suggested GPs felt more confident in the management of psychological therapies if they felt able to manage complex therapies (the prescription of two or more antidepressant medications). Responses from GPs within the discussion group, although accepting this finding, suggested that they did not routinely, if at all, administer more than one antidepressant medication. Having said that, an example of such an opinion was presented by one of the GPs along with a working practice example of a local psychiatrist in the area:

well I think in terms of more than one medication we one

of our two local psychiatrists is a great FAN of two

different...you know giving people two different

antidepressants...and I'm not at all sure it's safe or

effective

(GM4MGP, General Practitioner)

Response to the findings around GPs prescribing medication on a first visit (over a third) was one of surprise, as the actuality of first-meeting medication prescription sits in conflict with the suggestion by GPs that common mental health problems are short-term or reactive states. This comment also illustrates the possibility of not fully recognising the nature of a condition or state by prescribing too quickly:

yeah but if it truly is reactive and short term and transient and totally appropriate everybody's got a good understanding of it then you know the watchful waiting sort of premise would be a sensible way forward because...as we're getting to kind of see in this discussion somebody might present as quite depressed and there might be a very justifiable recent reason for it for example a bereavement etcetera...that actually if you don't take the time to enquire about that or to you know consult about that I suppose you wouldn't know so you might just merrily prescribe some medication but...actually if it's a normal response you might be more inclined to say actually you're having very appropriate although unpleasant response to your situation at the moment what can we do about it...let's have a little...a watch and a wait or signposts

(GF11WBHCP, Clinical Psychologist)

Findings presented from the Theory of Planned Behaviour Study, that GPs'
prescribing behaviour was influenced by both their 'attitude' (the degree to which
an individual perceives intended behaviour to be desirable) and their 'subjective
norm' (the extent to which significant individuals, such as relatives, friends or
colleagues condone this act) was met with agreement by the GPs in the discussion
group. An example of this as they understood it, shown below, describes working
to the systems of the general practice and the sense that 'own values' will influence
how they work to guidelines:

GF7MGP: I think so cos I think that within this practice

there is a philosophy that is more holistic perhaps than if

you went to other practices...but that's difficult to know

obviously because you haven't worked anywhere

else...but...certainly I think from the comments we get

from our secondary care of...services about the referrals

they receive then...have different thresholds of what they

think they should be dealing with it

GM4MGP: you know I think there is...as i said earlier

about you know the trying to fit in with guidelines you

know there is a sense in which some people will fit in with

guidelines some people are aware of guidelines and they

don't make very much difference...and so our own values

will have an influence on that definitely yeah

(General Practitioners)

Clinical psychologists were confused in response to findings around GPs' prescription of antidepressants, that many GPs apparently were not employing 'watchful waiting' in accordance with guidelines, and that the majority of GPs indicated they believed that common mental health problems are short-term or reactive states. During the GP discussion group, the practice of 'watchful waiting' or seeing a patient on consecutive weeks after the prescription of medication is suggested to be unsustainable. It can be argued that this apparent conflict of practice carries more weight given that the GP participant is, himself, involved in an official 'role' with the implementation of such guidelines:

> *I started this about a month ago and I it's just not*
>
> *sustainable as [GM5MGP] has said you know but*
>
> *it...because in one of my other roles I'm actually involved*
>
> *with how do we actually implement guidelines if I'm not*
>
> *trying to implement them ((chuckling)) you know...so if I*
>
> *find that they're...you know...there might be some patients*
>
> *that should be seen every week ...but the idea that every*
>
> *patient MUST be seen every week I think is bonkers*

(GM4MGP, General Practitioner)

7.4.3.3 Referral

Participants aired agreement to the findings from the studies around GPs' referral to psychological-based treatment, and more specifically that of GPs' general reluctance to refer (based on personal experience, effectiveness, confidence,

waiting times) for psychological-based treatment. In response to these suggestions, explanations were proffered around a managerial difference in level during the consultation, that is to say that GPs were 'probably more confident' in the assessment of mental health problems, but that more difficulty was experienced in managing at the next level:

yeah my sort of views of the sort of...the GP stuff as well is that...it's it's hard to describe really because I think they need to...they obviously have an awareness of what's out there and what's available but systems change and availability of how to treat and how to manage changes and while it's in their hands you know they're immediate sort of frontline first sort of approach I think they're probably more confident about sort of assessing mental health problems..when it comes to right what do I need to do to get it to the next level it it's quite a different ball game then...and so maybe it's about...their awareness of what's out there in the big...in the services and things and that will change across well within a health board you know between our localities...but also will obviously be hugely different between a rural locality and...a city locality as well...so there'd be big differences there about what's available to refer to...so if you're asking questions you know you in your head is perhaps thinking well what

is out there for me to refer to so I need to...I need to cater

to that so in some ways constructing where it's going

right at the very beginning...I think we all do it we do it in

our service as well...you know I think that might be

something that makes things complicated for GPs as well

having to stay up to speed on the ball with all those

things that are out there...it's not as straightforward as oh

Joe Bloggs needs a brain scan I know where that goes

you know...you know Joe Bloggs might need some help

with his mental health problem but I don't know what

specifically and that needs to go to the next level...

<div align="right">(GF11WBHCP, Clinical Psychologist)</div>

The suggestion above from the clinical psychologists that perhaps, in part, GPs are experiencing management decision difficulties - due to a lack awareness and knowledge about what is 'out there' to be offered to the patient - is supported by the following quote from the GP discussion group around whether they have something else to offer in terms of treatment. Importantly, it seems from this example that the GPs see themselves as part of the treatment or intervention, and not the means by which to access treatment:

GF2MGP: sometimes it's appropriate if someone's been

trying to cope with their symptoms for a long time

and...you know aren't sort of frequent attenders and

they've been inclined to deal with it themselves and...you

know obviously coming here is like the last...you know

pitch attempt you know at getting help

GF5MGP: I agree with you when I was younger you

wouldn't do it but now there are...it does seem the patient

thing that they expect [

GF2MGP: [yeah they come here wanting

something don't they...I suppose that's it's whether we

can offer them something else if we've got an alternative

<div align="right">(General Practitioners)</div>

In terms of referrals from GPs for psychologically-based treatments, it is feasible that there is a possibility that the presence of physical conditions within referrals are suppressed in order to achieve successful referrals for their patients. Such a prospect is probable in the light of findings showing the high prevalence of common mental health conditions bound up in more chronic conditions. As has been previously discussed, there is manipulation of coding practices, whereby GPs 'play the game' to achieve referrals for their patients. For instance, that 'bereavement' is coded as 'depression' so as to attain treatment for patients. This lack of physical condition information is noted during discussion with primary care counsellors:

yeah the...you know we're not...we don't have that

information available to us...it's up to you know the

doctor would know...it's what they initially present to the

GP ...so say the GP would complete the referral forms for

us telling us what the main presenting mental health

problem is they wouldn't necessarily give us information

about physical difficulties unless it WAS

relevant...something like chronic pain or something that

is NOW impacting on how they feel and now they are

feeling depressed or...whatever as a result of chronic by

health conditions...but generally it's the mental health

problem that we are privvy to rather than anything else

(GF8WHPCC, Primary Care Counsellor)

GPs suggested offering patients other means of treatment in accordance with NICE guidelines, but this was not met with universal agreement from other members within the group and was couched in terms of a sense of responsibility from the GP to provide these alternatives, due to being part of the development of mental health guidelines and also a sense of chastisement around antidepressant management. In terms of treatment effectiveness, feedback from patients was not encouraging and was coupled with a management dilemma. This is evident in the following example for participating GPs, around work and resilience:

I try now to recommend bibliotherapy to everybody

and...almost always...almost always recommend one

mindfulness book and one CBT book and...but then the

number of people who have said they've found it helpful

is not enormous but it's an attempt not to prescribe every

single time....and for me again because I'm involved in

the current mental health guidelines for [name of health

board] one of the issues is about stopping medication

after six months and again that is a REAL challenge

because after you've started something on it and it

appears to be helpful...the idea then that all GPs are

rubbish because they never stop prescriptions actually

when you're sitting in the consulting room it's....the idea

'oh because you've now been on it six months we've now

been told we mustn't prescribe it any more' it's

really...particularly if they're fearful of going back to

where they work it's a real challenge

(GM4MGP, General Practitioner)

Participants agreed with the findings around GPs' confidence with managing antidepressants and GPs' lack of confidence around managing psychological therapies. An example of 'attitude' was provided whereby GPs conflated the management of psychological therapies with their own execution of these practices and this quote provides further insight into the lack of motivation to engage, primarily due to the feeling of it not being their 'role':

GM5MGP: feel quite happy managing antidepressants

but I wouldn't probably wouldn't go down the...role of

managing psychological therapy myself...I can refer to

214

them but I don't have time and I don't have the interest

and i don't think it's really my....role...I MIGHT point

them in the direction of CBT or...may be a bit of online

stuff or self-help or [

GF7MGP: [we don't have any[

GM5MGP: [it's a occasional

bibliotherapy but...but not me sitting there [

GF1MGP: [we're not

trained as clinical psychologists [

GM5MGP: [doing it myself I'm not

really trained

(General Practitioners)

Findings from the general population Mental Health Literacy Survey showed that respondents thought that psychologists or psychiatrists should be more involved in the treatment of common mental health problems (95.7%). This finding was met with broad agreement by participants. However, discussion with primary care counsellors did raise the prospect that perhaps the role of psychiatrists and psychologists were not fully understood by the general population:

GF9WHPCC: very difficult to manage...and i guess the

psychiatrist just does a medication review so...so there's

not really very much [

GF8WHPCC: [psychologists no longer determine

their sort of...more kind of specialised areas but mild to

moderate common mental health problems and can be

managed if it can't be managed between GPs and

counsellors

(Primary Care Counsellors)

7.4.4 Training
7.4.4.1 Training and education
Within the area of training, responses were separated into the knowledge and the

awareness of common mental health problems and its management in terms of the

patient (as a factor), treatment and the consultation itself. Responses from the

Clinical Psychologists and Primary Care Counsellors were broadly similar, in that

they agreed with findings from the Mental Health Survey that over half of the

general population sample felt that GPs needed additional training (67.5%) (see

Chapter 6: the Mental Health Literacy Survey), and were surprised with the finding

that 47.4% of GPs had indicated they felt they did not receive appropriate training

and education with regard to common mental health problems (see Chapter 4: the

GP Survey) and that a third of the population from the GP survey indicated not

having undertaken any form of refresher training (mental health focussed or

otherwise) in the last three years. However, a Primary Care counsellor expressed

it as an 'encouraging' finding that GPs themselves felt they needed more training.

By way of training there is the issue surrounding knowledge, understanding and awareness of common mental health per se and also how to manage the patient with common mental health and the provision of treatment, execution of guidelines etc. With this in mind, the finding that GPs themselves felt they required appropriate education and training coupled with the finding that GPs were prescribing on a first visit was something that concerned the group of clinical psychologists:

> *Well to correlate...you've got half the GPs who receive*
>
> *who have said they don't receive education and training*
>
> *and you've also got the other half prescribing*
>
> *antidepressants at the same time*
>
> (GM10WBHCP, Clinical psychologist)

For primary care counsellors, although this issue was also one of concern, their outlook was one of acceptance and understanding for the position of the GP, rather than emphasis on management being outside of regulatory guidelines:

> *yeah I mean...I think it's something within primary care*
>
> *that's starting to HAPPEN because GPs get continuing*
>
> *professional development so...GPs at the practice where I*
>
> *am they have some training on eating disorders and*
>
> *maybe it's about bringing different things into their*
>
> *awareness and also signposting them to the particular*

questionnaires that might indicate that there is a risk...so

less about management but really about recognition and

signposting to relevant service...so I think they get quite a

bit of that but that could be different in different surgeries

and locality

<div align="right">(GF9WHPCC, Primary Care Counsellor)</div>

The responses from GPs toward the finding that GPs wanted more training in common mental health were more cynical, coupled with a reluctance to engage in more training that seemed to be viewed more as a burden and whimsical, and rather that they would like less:

GF7MGP: I mean it's interesting to talk the details of the

thing...but this stuff just gets rolled out...off loading some

of that is much more helpful to us

GM4MGP: particularly if what they're telling us to do is

motivated by their latest drug company sponsorship

GF7MGP: yeah and that's what de-motivates us most I

think

<div align="right">(General Practitioners)</div>

An example of the undertaking of a CBT course was provided by one of the GPs during discussion, from this quote it is possible to see that for this GP there is not a wholly positive approach to CBT in general and that their understanding of the technique as a result of going on the course is somewhat simplified. This is

interesting not least because it can be assumed that this level of learning will in some way influence their management of patients with CMHPs:

I think like...I think...like I did go on a CBT course about how to use techniques and I think we probably...all do...like...you just that sort of 'yeah you feel rubbish and you want to sit on the couch all day but it WILL help you to go for a walk' kind of that's sort of CBT isn't it like

(GF6MGPR, General Practitioner)

Another example of GP training and learning in how to manage and treat patients with a common mental health problem within a consultation, and how training impacts upon and fits with the real-world setting, this example was provided by one of the GPs within the validation study:

I don't know...it's quite an expectation...which may be my other training there wasn't quite the same and I...had felt quite confident like negotiating waiting and seeing and not starting medication but I have...quite often felt a bit of pressure to prescribe since I've been here I think that...because there's such a high prevalence of common mental health disorders in the population and because everybody else is on medication...that's almost the agenda of coming almost

This quote highlights the complexities surrounding the GPs' day-to-day management of those with common mental health problems, and provides further support to the other difficulties raised for GPs within the consultation (patient expectation, reluctance to refer, lack of training and education and awareness and confidence around available interventions and treatments).

An additional area of concern, suggested as requiring training and greater awareness, was raised by clinical psychologists around the issue of research and the statistical presentations therein. The clinical psychologists taking part in this validation study felt GPs lacked understanding and awareness in the area of research and statistical analysis and how they can be presented. It was suggested that this lack of understanding and awareness then led to a 'face value' acceptance of reported findings:

> *GM10WBHCP: one thing GPs as a general rule DON'T*
>
> *know anything...virtually anything about is the research*
>
> *and statistical analysis they can have a lot of...can get*
>
> *sold very easily on the latest stat without really*
>
> *understanding what that finding means or what the*
>
> *research or the context in which it was done...or actually*
>
> *there is controversy about this versus that versus that*
>
> *versus that...they have to take things at face value of*

what's been said from a book

GF11WBHCP: that if it's in the British Medical Journal

then it must be true

<div align="right">(Clinical Psychologists)</div>

Moreover, the clinical psychologists illustrated the relative danger of statistical persuasion and accepting the face value of statistical presentations, and stressed the importance of understanding findings adequately, including the broader considerations thereof:

GF11WBHCP: and it doesn't sort of highlight the idea

that may be...you know it was ineffective for 50% of

people you know...and even NICE guidelines are similar

I mean you know...nothing's ever 100% so...you know

they will be influenced...and the NICE guidelines say this

is you know but it's sort of like well hang on[

GM10WBHCP: [but it

doesn't say what it's contraindicating in its guidelines

GF11WBHCP: yeah yeah

GF12WBHCP: about the samples that were used...and

whether they have co-morbidity

<div align="right">(Clinical Psychologists)</div>

Within the area of training, it was accepted by both clinical psychologists and primary care counsellors that GPs were trained to work in a particular way –using the 'Medical Model'. It was suggested that this meant GPs' rationalised patient presentations within a consultation in a particular way using that paradigm. Further it was said that GPs were also constricted by general practice management systems, and were not in a position to consult for extended periods:

> *YES you do what you do best..you do what you're trained*
>
> *to do we would be the same...we would be useless as GPs*
>
> *or as mental practitioners we would be asking people*
>
> *how they felt...our consultations would go on too long*
>
> (GF11WBHCP, Clinical Psychologist)

With this in mind, a suggestion to improve GPs education and training was one around fine tuning and making appropriate use of existing systems:

> *we do diss the medical model but at the same time there*
>
> *are advantages to a medical approach to dealing with*
>
> *things so in some ways...to me it's about trying to help*
>
> *GPs manage common mental health problems based on*
>
> *their existing systems to some degree cos you don't want*
>
> *to try and re-invent the wheel entirely and have a*
>
> *completely different system yet... but you want it to be*

appropriate for that kind of a problem so there will be

limits to that

<div align="right">(GF11WBHCP, Clinical Psychologist)</div>

7.4.4.2 Impact of lack of referral
During discussion around GPs reluctance to refer, an important concern was raised by clinical psychologists around the area of condition prevalence and resource provision. Essentially, by GPs not referring those in need for treatment the by product is that statistics of prevalence do not represent a true reflection of the 'demand', this then has a direct impact upon resource provision:

...it's interesting that they sort of say oh no oh we won't

refer them cos it's a long waiting time...well if they don't

do that it doesn't generate...I mean trust me we've got a

waiting list...it doesn't generate a true reflection of the

DEMAND then so we can't then resource our services

appropriately similar even in primary care it wouldn't

reflect demand so you wouldn't say oh hang on we've got

HUGE numbers who are not being seen the waiting list

has shot through the roof so therefore we need to

recruit...and you know there's a problem here

<div align="right">(GF11WBHCP, Clinical Psychologist)</div>

The suggestion from clinical psychologists that actual numbers of individuals requiring psychological-based treatment are effectively being hidden due to the lack of referrals by GPs can be supported by and taken further, by comments made (separately and without prior knowledge of the topic in question) during the GP discussion group. The following example displays talk about GPs circumventing screening and coding practices:

> *…our depression scores are low because we just don't*
>
> *(indeciferable) one way to get round having to do a PHQ*
>
> *is to code someone as low mood so you don't code them*
>
> *as depression so I suspect that if you looked at our*
>
> *prevalence it would be...well figures are actually quite*
>
> *HIGH still on the prevalence cos it is actually so high...if*
>
> *we coded everyone that we thought did have depression*
>
> *but we've actually coded as low mood I think our*
>
> *prevalence would be much higher*

(GM5MGP, General Practitioner)

7.4.4.3 The treatment 'Gap' for those with common mental health problems
An important area for attention was the suggestion that a gap existed, whereby individuals could have conditions/symptoms that were not considered severe enough to be treated within secondary care settings, but were also not able to be adequately treated, if at all, in primary care:

...that doesn't meet both...either camp...yeah there's a

huge gap in with regard to the moderate level of people

definitely

(GF11WBHCP, Clinical Psychologist)

This proposition was further commented upon by the primary care counsellors. Furthermore, they explain about trying to 'pick most of them up' although it's outside the mild to moderate remit and how this is why their waiting lists are so long:

GF9WHPCC: there is a gap of people in the sense

that...don't fit into a primary care protocol and don't you

know...are not severe enough to fit into secondary care so

those are the ones that can kind of get batted back and

forward in as much no one is going to pick them up so

there aren't services sufficient for that...well I suppose in

a way we pick most of them up even though it's kind of

outside our [

GF8WHPCC: [that's why our

waiting lists are SO long really because we are still

trying to... manage outside of the mild to moderate you

know and...because as [JD] says you know where else

are they going to go...if they get referred to CMHT for a

psychologist well... you know they could be waiting over

a year but that's gosh something like that isn't it

<div align="right">(Primary Care Counsellors)</div>

7.5 Conclusion

This triangulation study was conducted to further contextualise and validate findings from the research programme. The findings presented above demonstrate that the groups involved (general practitioners, primary care counsellors and clinical psychologists) supported and provided agreement to the findings from the research programme, while also providing additional and contextual information in the areas of GPs' level of confidence, patient and GP knowledge and education, referral and prescribing behaviours. Participants taking part in this study further acknowledged a host of conflicting beliefs and behaviours in action within the management of common mental health in primary care.

Findings from the present study provide many implications for future research. For instance, while GPs declare common mental health to be short-term or reactive states, results show GPs' preference for prescribing antidepressant medication within initial consultations and without using screening tools to not only be in conflict with guidelines, but with the notion of a condition being short-term or reactive. Further, GPs' reluctance to refer was something that was a cause for concern for participants, in that statistical representation of prevalence could be masked and as such would impact upon the provision of resources and services.

Moreover, this study confirmed fractured collaboration and communication difficulties between services. GPs' lack of confidence and sense of control were suggested to be overarching factors that influenced GP management practices at all levels. Areas affected were suggested to be knowledge and understanding of conditions, referral to psychological-based therapy, the preference of antidepressant medication, and GPs' ability to engage effectively in consultation with patients with common mental health disorder. Participants also suggested a treatment 'gap' existed, whereby individuals whose conditions fell between primary and secondary care settings were not in receipt of appropriate treatment or condition management.

Each of these areas is worthy of future research. The findings from this study in combination with findings from some of the earlier studies in this thesis could provide a good background from which to conduct new research which could benefit patients, medical education, policy and practice.

7.6 Limitations

Shortcomings of this study are associated with participant numbers and sample brevity. This study would have benefited from greater numbers from each of the key professional areas, along with the inclusion of other key individuals associated with common mental health management. Therefore, the issue of representativeness exists in regards to this particular sample. As such, study results must be taken with caution. As with each of the other studies within this thesis,

delays in attaining ethical and research governance approval, due to process, did not help to achieve greater responses.

7.7 Summary of Chapter 7 and link paragraph to Chapter 8

The chapter above discusses the triangulation study conducted to contextualise and gauge the representativeness of findings presented throughout the thesis from the various studies comprising the research programme entitled 'The Management of Common Mental Health in Primary Care'. The triangulation study results showed participants taking part within the various groups (GPs, Primary Care Counsellors and Clinical Psychologists) agreed with findings generated from the various studies conducted through the research programme. Furthermore, the triangulation study provided additional depth to some of the difficulties experienced by GPs and patients alike, such as the role of the GP and the position and expectation of the patient. Moreover, the chapter discusses further areas for concern, such as the by-product of non-referral and a perceived gap in provision where a number of patients in need of care are not receiving appropriate treatment or management for their condition.

The next and final Chapter 8 concludes the thesis. This chapter presents summary conclusions for each of the chapters. These are followed by an overarching conclusion to the thesis and implications of the research and its findings in relation to recent changes in policy and guidance.

Chapter 8: General Discussion

8.1 Introduction

This chapter will outline the thesis and its development in relation to the aims and outcomes of each chapter. A brief summary is provided for each chapter which discusses how each study impacted upon and shaped subsequent work. This chapter will also provide an overall conclusion to the research programme, including possible implications for the literature. Future research and practice from the results of this research programme are also discussed. Findings within the thesis will also be discussed in the light of recent changes to policy and practice since the inception of the research, and how the findings reported within the thesis fit with these. Finally, limitations associated with the studies, more generally, will be presented.

8.2 Chapter Two: Literature Review

Chapter two presents an outline of the main issues within the literature in regard to the management of common mental health in primary care. This chapter includes literature around the prevalence of mental health across the world, and discusses the problems of recognition, assessment and management in relation to mental health, despite the creation of various screening, diagnostic instruments and management interventions. Furthermore, issues are raised within the literature around knowledge, education and individual differences from both the practitioner and patient perspective; cited as influential factors, these are discussed both in terms of barriers and facilitators to appropriate condition management.

8.3 Chapter 3: Exploring the complexities associated with the management of common mental health in primary care – A Scoping Study

The study described in this chapter is the first in the programme of research begun in 2007, looking at the management of common mental health in primary care. The present study was a scoping study to gauge what problems, if any, general practitioners (GPs) were experiencing in the common mental health consultation, how prevalent these problems were in practice, and what GPs' felt were common mental health problems (CMHPs).

The aims and objectives of the study were to ascertain the landscape, in practice, of the management of common mental health. In order to gain an understanding of what GPs are experiencing in practice a series of semi-structured focus groups were conducted at general practices across Wales. Areas of discussion were guided and informed by the areas for consideration revealed by the literature review (see Chapter 2). Discussions were recorded and underwent qualitative Thematic Content Analysis, where commonly cited themes were identified. Findings showed GPs to be experiencing a multiplicity of problems with regard to managing the common mental health consultation. These findings were commensurate with problematic areas as presented within the literature review. For instance, results from this study supported the literature, in that, GPs' cited the high prevalence of mental health in consultations on a weekly basis. Interestingly though, the scoping study also evidenced that GPs lack confidence in managing the common mental health and mental health consultations. Furthermore, there is to some extent a sense of apathy present within GPs' attitude, as there was expectancy by GPs that

such consultations were 'difficult', that they 'drag', and that they don't make a difference. Results showed that there were gaps in the area of education, training and GPs' learning. GPs knowledge of common mental health and mental health was confused, vague and out-dated. GPs were unsure how to manage conditions, both in terms of treatment and the complexities around the individual and their social environment. For instance, uncertainty existed in terms of their position as an advocate for the patient and being able to deal with impacting issues relating to stigma, the sick role, work (whether in or out of work) and the impact upon benefits and financial security. Importantly, limitations of this study can be understood to be the limited number of practices sampled and their representativeness. That said, this study fulfilled its aims and objectives, as the findings generated provided a view of GPs management of common mental health. These results informed the nature and content of the GP Survey presented in Chapter 4.

8.3.1 Summary of results from the scoping study

GPs' understanding of common mental health problems
- Common mental health problems refer to generally reactive states.   - Many of those suffering common mental health problems do not have serious mental health problems.   - Interventions are better at the beginning.   - Interventions with 'inherited' patients, who have common mental health problems, are unsuccessful and these patients are less

motivated to respond, want to get better or want to get back to work.

Consultation difficulties
- GPs' say the length of time it takes to have a consultation around common mental health problems is problematic.   - GPs' felt that being able to give certain advice or to speak plainly is difficult in the common mental health consultation.   - GPs' find it difficult to assess common mental health problems.   - GPs' said that, if the subplot is that people do not want to go to work, it is very difficult or impossible to deal with.

The issue of work with regard to the consultation around common mental health problems
- Mental health and work is difficult.   - Time off of work is difficult to manage (i.e. individuals wanting long periods).   - It is harder for patients to go back to work after time off.   - After time off of work, it is difficult for individuals to find subsequent employment.   - GPs' believe bullying at work creates mental health problems.   - GPs' said people with chronic anxiety would be better off in work.   - GPs have a concern about people's ability to work. However, GPs' lack confidence in knowing what people are able to/or can do at work.

The General Practice
- The location of the general practice surgery makes a difference to the type of lifestyle situation of its patients and availability of resources.   - Attitude and ability to manage patients with CMHPs is different if the practice is equipped with own counsellor, compared to those general practices who do not have such provisions.
Training and Knowledge
- GPs say they want more training in mental health and common mental health.   - Knowledge of mental health issues is vague and out-dated.   - Difficulties experienced in the management of patients with common mental health issues are, in part, due to the conflicting role of the patient advocate and social environmental/lifestyle dependencies of patients (e.g. benefits, financial security and stigma).

The findings from this study supported issues raised from the Literature Review, and led to the development of the GP Survey (as presented in Chapter 4) by providing areas for further investigation.

8.4 Chapter 4: A study of GPs' perceptions and knowledge of common mental health and their management – The GP Survey

The study in this chapter describes the GP Survey. This study was informed by the scoping study described above, and was conducted from March to July 2009 with general practitioners. The aim of this study was to explore the issues raised within the scoping study (described in Chapter 3) around general practitioner management of mental health in primary care. Areas investigated and informed by the previous scoping study were: GPs' understanding of common mental health problems, its prevalence, conditions GPs' thought the term common mental health problems refer to, the common mental health consultation and management therein.

This study was conducted in 2009 and consisted of a questionnaire distributed to GPs across, the then, five Local Health Boards (Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen). Findings from the study supported themes raised in the scoping study around difficulties GPs indicated they are experiencing in the management of common mental health problems. Results show GPs' understanding of the term 'common mental health problems' to encapsulate a broader range of conditions, aside from the anxiety and depression the term is more popularly cited as referring to. Results from the study highlighted the dissonance related to the use of the term 'common mental health problems'. The way in which terms are used and understood is important, and can have significant implications with regard to the targeting of appropriate knowledge and education that GPs feel they require and the availability of resources, along with the framing of patients' complaints.

In addition, results showed the high prevalence of CMHPs within clinical practice along with the complexities surrounding the management of these in general practice. Examples of these management complexities shown to be present are the significant numbers of patients presenting to GPs with co-morbidities, the importance of patient familiarity and GP confidence in relation to the consultation (treatment choice and management). The impact of treatment preference in regards to GPs' prescribing behaviour was shown to produce conflict between practice and clinical guidelines. Knowledge around common mental health problems was also shown to be key in various areas of condition management. For instance, GPs understand common mental health in a very different way through their everyday practice, to that which is posited through the literature and within policy. Further, GPs' convey a need for more appropriate, education and training, along with a need for resources, so that they are better prepared to deal with and manage such consultations. Results showed that GP respondents possessed a range of different education and training experiences not specific to mental health, with only a third of the sample experiencing any form of mental health training. Furthermore, those who indicated having had psychiatric or psychology related job reported as working as an SHO during their initial medical training for periods usually no longer than six months. Respondents also indicated that they felt they had not received appropriate education or training covering common mental health issues and their management. These results need to be considered in light of the majority of respondents practicing in excess of 15 years, therefore the reliability and stability of this training can be understood as questionable.

It may be that the area of confidence in treatment management and within the consultation as a whole, could be in part, be inextricably linked to the level of GPs' knowledge and understanding of conditions. This idea can be seen to be supported by findings that show personal experience impacts upon GPs' confidence in terms of managing treatment. GPs who indicated having personal experience of mental health issues (themselves, an immediate family member or close friend) and experienced positive outcomes with treatment, were shown to have higher confidence managing simple antidepressant therapy, psychological and psychological/pharmacological interventions. Similarly, respondents who indicated experiencing more negative outcomes were associated with having lower confidence levels.

This study, conducted in 2009, fulfilled its aims and objectives by generating data in relation to areas informed by the scoping study (see Chapter 3). The extent to which this has been fulfilled can be understood by the quality of the data generated, as the vast majority of the sample were shown not to be specialists in this area, as may usually be the case in respondent populations to a given subject area. Furthermore, taking into account the findings and considering the role of knowledge and the impact of prior experience upon practice, these results have implications for further research and investigation. Moreover, they provide support for targeted education and support to plug the gap in skills and knowledge.

Limitations associated with this study were the delay in getting started, in part, due to the difficulty of achieving timely responses from Local Health Boards in

relation to Research Governance. The sample size of this study is also a potential weakness in terms of representativeness, the survey would have benefitted by greater numbers. This was, in part, hampered by the financial constraints of distribution. In addition, respondent numbers may have been influenced by survey itself being quite lengthy. Also, the quantitative nature of the survey does not provide in depth rich data into any of the areas under question. However, valuable signposts for further research have been achieved.

Findings from this study have potentially beneficial implications for areas such as public policy, GP training, medical communication with members of the public and advertising. Significant questions were raised around GPs' treatment management as a result of findings from this survey, particularly that of prescribing and referral behaviour where individual differences were unable to be accounted for. As such, this survey informed and led to further more specific investigation into GP prescribing and referral behaviour, which is presented in the following chapter.

8.4.1 Summary of results from the GP survey

What GPs understand to be a definition of common mental health problems
• The definition of 'common mental health problems' (CMHPs) was indicated by the GP sample to encompass a wider range of mental

health conditions/symptoms other than anxiety and depression, of which it is more popularly spoken of:

- Top 4 CMHPs as cited by GPs include: obsessions and compulsions, poor coping, psychosis and stress.

- GPs classed CMHPs as short-term, reactive states or perhaps long-term but not severe.

- CMHPs were said to contribute to a large proportion of all other ills seen by GPs.

Prevalence of common mental health problems in practice

- CMHPs had high impact in consultations:

  - 65% of GPs spend over 10 consultations per week, and 33% of GPs over 15 consultations per week dealing with CMHPs.

Presentation of common mental health problems

- 73% of consultations over a 7 day period were indicated to have a mental health component presented as a secondary condition.

- 61.2% of consultations had a CMHP condition presented as primary condition.

The common mental health consultation

- Over half the GP sample indicated that they did not find the consultation around common mental health straightforward.

- GPs did indicate that they found consultations with those they were familiar with more straightforward than with those patients they were not familiar with.

- GPs indicated being unfamiliar to the patient did offer an opportunity to speak plainly.

- With those patients GPs were familiar with, problems around expectation and openness were cited.

Course of management/treatment – first visit

- When seeing a patient presenting with a CMHP for the first time the majority of GPs requested to see the patient again.

- Of those, 66.3% of GPs would use a screening tool.

- Over half the GP sample indicated prescribing medication (e.g. anti-depressants) on a first visit, 97.5% indicated that they would request to see the patient again. Of those who prescribed medication on a first visit, 60% of those indicated that they do not administer a screening tool prior to the prescription of medication.

Confidence – managing treatment

- GPs indicated high confidence in managing simple therapy (single medication only), and average confidence in the management of complex therapy (two or more medications).

- If GPs were confident in the management of complex therapy they were also confident in managing psychological therapy and the combination of psychological and pharmacological therapy.
- There was no association shown between confidence of simple therapy and managing psychological and pharmacological therapy.

Access to treatment

- Referral for psychological therapies was shown to be problematic. Around half of GPs reported that referral could take over 4 weeks. Some GPs also noted that referral was strongly dependent upon the severity of symptoms, and in some cases GPs indicated they would give up due to prolonged waiting time.

GPs personal experience and management

- A negative relationship between personal experiences of the results of treatment and confidence in managing simple (single medication) antidepressant therapy was shown. That is to say, high confidence managing antidepressant therapy is associated with lower scores of personal experience with the results of treatment.
- A negative relationship was also found between personal experiences of the results of treatment and confidence in managing psychological-based treatment, and confidence managing psychological and pharmacological interventions. That is to say, that higher confidence managing

psychological interventions was significantly associated with higher positive scores of personal experiences of the results of treatment.

- Prior personal experience was shown to impact upon GPs' working practice.

- Prior personal experience is important with regard to scaffolding GPs' experiences and training across the spectrum regarding mental health and its appropriate management.

- Around half of the sample had been in practice for over 15 years.

Education and training

- When asked about refresher courses completed over the last 3 years:

    o 68% of GPs had undertaken a refresher course, though not necessarily to do with mental health.

    o 25.9% had experienced training in mental health or mental illness.

    o 33.6% indicated previously having a psychiatric or psychology-related job.

- Only 18 (15.5%) GPs 'checked' all three of the above options.

- Around half of the GP sample indicated that they felt they did not receive appropriate training or education.

- Of those GPs who had indicated having prior training in mental health, half indicated they felt they did not receive appropriate training or education regarding common mental health management.

- Those who had not undertaken prior training indicated that they had received appropriate training or education.

- It is possible for us to suggest that those who do not undergo further training have a narrower focus, and this therefore is potentially problematic with regard to the appropriate management of mental health related conditions/symptoms.

Findings from the GP survey provided an insight into difficulties and management practices of GPs, of particular interest were those around GPs' treatment management. The methodological approach used within this study does not provide information on the underpinnings of decisions. Therefore, these findings led onto another study, presented in Chapter 5, which used a methodological approach more suited to investigate such factors.

8.5 Chapter 5: Theory of Planned Behaviour: General practitioners' prescribing and referral behaviour

This study was informed by the previous GP Survey and conducted in 2010. Findings in the GP survey showed GPs' prescribing and referral behaviours to be varied and mediated by confidence. In addition, GP prescribing was shown to act outside of clinical guidelines advocated by NICE. Therefore, the aim of this study was to explore more closely prescribing and referral behaviours of general practitioners (GPs). The hypothesis for the study was that GPs behaviour is moderated by many factors. The study explored GPs' intentions with regards to

components of management (diagnosis and treatment (medication v. referral)). In order to do this, the Theory of Planned Behaviour (TPB), an established psychological theory-based framework, was used. According to the Theory of Planned Behaviour model, performance of a given behaviour is said to be a joint function of intentions and perceived behavioural control (Ajzen, 1991). Therefore, the more positive the attitude and subjective norm toward a specific behaviour, and the greater the perceived behavioural control, the stronger should be the individual's intention to perform the particular behaviour of interest (Ajzen, 1991). This theoretical model has been used to predict intention and behaviour in many areas and has been widely used in health research (see Shimp & Kavas, 1984; Jaccard & Davidson, 1972; Davidson & Jaccard, 1975; Sheperd & Towler, 2007).

For the purposes of this study, the TPB model was used to examine the relationship between beliefs, attitudes, perceived behavioural control and behavioural intention of GPs' prescribing and referral behaviours. To do this a questionnaire was developed, in consultation with experts in the field, incorporating the TPB model which uses both direct and indirect measures. This questionnaire underwent cognitive debriefing before being distributed, both electronically and via 'paper and pen' (with the latter approach achieving greater response numbers) to a randomly selected sample of working GPs across Wales.

Results showed that GPs' intention to prescribe antidepressants to patients with common mental health problems is significantly influenced by both their attitude ($p = .044$), summarised by Ajzen (1991) as how hard a person is willing to try,

how much of an effort they are planning to exert in order to perform a particular behaviour; and their subjective norm ($p = .000$) (the social component, described as the extent to which significant individuals (relatives, friends or colleagues) condone this act (Ajzen, 1985, 1991; Ajzen & Fishbien, 2005)). Although, perceived behavioural control was not identified as being significantly influential to GPs' prescribing behaviour, further analysis did show a comparatively even split between those GPs who did not feel in control of prescribing antidepressant medication, and those GPs that did feel in control of prescribing antidepressant medication to patients with CMHPs.

Furthermore, findings also showed that GPs' referral of patients with common mental health problems to psychological-based treatment were influenced by both attitude and perceived behavioural control. The latter, perceived behavioural control, is said to possess two main factors. Firstly, whether the individual perceives they have the relevant knowledge, discipline or skills to perform a particular behaviour and secondly, the extent to which the individual perceives other factors could inhibit or facilitate the behaviour, such as resources, the cooperation of colleagues, or time (Kraft, Rise et al., 2005).

Findings from this study also raised questions around practice culture and expectations. The coupling of attitudes and subjective norm upon GPs' intention to prescribe, present a strong binary. The study conclusion considers the role of the subjective norm within the arena of general practice and primary care, along with differences between general practices. The potential for general practices to

be further separated by their own culture, or way of doing things, is a key factor that should be considered when thinking about how GPs are trained or how processes are evaluated. Therefore, in terms of impact, it is possible for a newly qualified doctor to possess up-to-date and advanced skills and training in relation to common mental health problems to enter into general practice, and for these skills and practices to be eroded or dissuaded over time within the general ethos or host practice philosophy. It is suggested that, such a possibility provides a concern for the improvement of standards across the board as individuals enter the profession year on year. This also raises the question of how to initiate long lasting change in general practices that are potentially resistant. This suggestion is given further support when we consider results from this study also identified the significance of attitude toward GPs' intention to prescribe. This supports one of the conclusions from our previous study (the GP survey), that GPs' prior experiences influence working practice (see Chapter 4: The GP Survey). The presence of these influences is of key importance in regards to scaffolding GPs' personal experiences in relation to training around mental health and its appropriate management. Moreover, although the premise of perceived behavioural control was not found to be a significant factor across both conditions using this model, the median split showed that around half the GPs did not feel in control of prescribing antidepressants to those with common mental health problems. Understanding the relevance of this in relation to the influential presence of attitude and subjective norm, it is possible to see a link between individual GPs in some practices not feeling in control of prescribing and the ethos of the practice itself. Similarly, if we look at the position of control being related

to one's ability to perform (knowledge, skills etc.), this finding can also be seen to support findings from GP Survey, wherein the split between GPs indicating they felt in need of more training and education was also fairly even (see Chapter 4: the GP Survey).

With regards to GPs' intention to refer patients with common mental health problems for psychological-based therapy, findings from this study showed 'intention to refer' to be significantly influenced by attitude. As has been previously discussed within the analysis of GPs' intention to prescribe, attitude is a pervasive and predicable factor within GP behaviour to prescribe medication and the referral of patients with CMHPs. Moreover, findings showed that GPs did not feel in control of referring patients for psychological-based therapy. Perceived behavioural control relates to an individual's perception of their own knowledge and skills to perform a said behaviour and to external control. While considering the continued debate around the availability of psychological-based therapies to match demand and condition/symptom level access requirements to such therapies, this finding is important for beginning to understand factors that influence GPs' referral behaviour.

Overall, findings from this study provide several important signposts for consideration with regards to targeting training, education and the evaluation of management practices. The presence of personal experience, as a feature of attitude and a predictor to prescribing and referral behaviour, is something that

could figure more prominently within the early phases of medical training. Moreover, the presence of the subjective norm as a predictor within the prescribing behaviour of GPs is of similar importance. As in spite of general guidelines which suggest a stepped care approach and watchful waiting, GP respondents indicated that the prescription of medication to patients with common mental health problems is more frequently given compared to guidelines that suggest otherwise (see Chapter 4: The GP survey). Taking into account the predictive factor of the subjective norm toward GP prescribing behaviour, it could be that such preferences toward prescribing are in some way due to the culture of the general practice and general expectations of about how certain conditions are treated. When we consider these results and the likelihood of such outcomes, perhaps policy guidance, and more importantly, the evaluation of behaviour change could be more focused at the general practice level rather than at the individual level.

The present study achieved its aims and confirmed the hypothesis that GPs' prescribing and referral behaviours were moderated by many factors. Findings demonstrated that GPs' prescribing and referral behaviours were significantly influenced by different factors. Furthermore, results also showed factors influential to GPs' prescribing behaviour were different to those associated with referral to psychologically-based treatment. Although this study fulfilled its intentions shortcomings, such as sample size were present. Although the study achieved the number of respondents required for the analytical model to work, it would have been more beneficial to have had an increased sample size in terms of stronger and more representative results. In addition, survey distribution was

crucial to gaining responses. The initial online phase only achieved a very small number of respondents compared to the more traditional approach of the 'paper and pen' survey. Contact details were gained via the HOWIS website (a publicly available website providing general practice information), as a result where contact details were not updated or incomplete, surveys would not have reached those for whom they were intended. Difficulties were also experienced with regards to receiving timely research governance approval, despite achieving swift NHS ethics approval.

8.5.1 Summary of results from the Theory of Planned Behaviour study

Prescribing antidepressants and referral to psychological-based treatment
- GPs' intention to prescribe antidepressants to patients with common mental health problems is significantly influenced by both their attitude and their subjective norm.   - GP' referral to psychological-based treatment was shown to be influenced by both attitude and perceived behavioural control.
Intention to prescribe antidepressants
- Intention to prescribe antidepressants: A median split was executed and series of t-tests were used to identify differences. Results showed both 'attitude' and 'subjective norm' were significant.   - Perceived behavioural control was shown to be non-significant and further analysis showed a fairly even split between those who do not feel

> in control of prescribing antidepressant medication to patients with CMHPs (n=66), and those that did feel in control of prescribing antidepressant medication (n=61).

> **Further analysis: Intention to refer for psychological-based therapy**

> - Attitude was shown to be a significant influence upon GPs' intention to refer ($p = .011$). A crosstab was performed to look more closely at perceived behavioural control, showed n=62, felt they did not feel in control of referring patients with common mental health problems for psychological-based treatment.

Results from this study did show GPs' prescribing and referral behaviour to indeed be moderated by different factors. The research programme had, to this point concentrated on the perspective of the general practitioner, and so it was felt that the position and understanding of lay people was something that needed to be looked at. Therefore, a further study was conducted so as to address this, where findings and topic areas investigated within the studies thus far, led to the development of a survey to be used with the general population, the Mental Health Literacy Survey, as presented in Chapter 6.

8.6 Chapter 6: People's perceptions of GP management of common mental health problems – Mental Health Literacy Study

Informed by the findings generated by the studies within the research programme, the next natural step was to look at the position of the patient in this dynamic. In trying to understand the complexities surrounding the management of common mental health, it was deemed essential to understand how lay people understand common mental health problems and the management of these in primary care. The Mental Health Literacy Survey, conducted in 2011 sought to do this. The aims of the study were to look more generally at people's understanding of common mental health and what they thought about the general management of common mental health problems. In order to achieve this an online questionnaire was developed, this included questions that were the same or similar to some of those presented in the GP Survey (Chapter 4). These were to explore individuals' perception of common mental health, its definition, general practitioner management, the role of the individual and knowledge within management of common mental health. The survey was then posted on the notice board of the staff intranet, accessed by working staff members from various divisions within Cardiff University.

Findings in relation to lay persons' understanding of common mental health problems were similar to findings from GPs in the GP Survey (Chapter 4). Here respondents also disagreed with the more popularly cited expression of common mental health, and indicated that they perceived a broader set of conditions to come under the umbrella of common mental health. Furthermore, findings from this study showed knowledge and experience to be key with regards to all aspects of

common mental health management. Respondents indicated that they felt treatment for those with common mental health problems was dependent upon their own knowledge of their problem. Analysis showed the level of knowledge and experience of CMHPs to be associated. In that, those who indicated having experienced a common mental health problem, also rated themselves as having between good and average knowledge of common mental health problems. The combination of knowledge and experience were associated with being able to identify common mental health in others. However, analyses did show knowledge to be the stronger pervading factor here. Furthermore, a positive relationship was shown to exist between an individual's experience and their belief of being able to help others with a common mental health condition. Similar results were also found, albeit weaker compared to that of experience, between knowledge and ability to help others. Moreover, a relationship was shown between those individuals who indicated having experienced a common mental health problem, and being more likely to be able identify common mental health problems in others. In addition, experience was also associated with an individual's belief of being able to help people with common mental health problems.

Results from the survey displayed further similarity with those from the GP survey. Respondents indicated that they did not think that consultations with the GP around common mental health problems were straightforward. The issue of general practitioners' knowledge was also shown to be key in terms of lay persons' perception of professional management of common mental health problems. It can perhaps be understood that people's view of consultations around common mental

health problems not being straightforward, is linked with their perception that GPs are lacking knowledge and training in this domain. In terms of professional management of conditions, the majority of respondents indicated that they believed psychologists or psychiatrists should be more involved in the treatment of common mental health. The dual management approach was also indicated in terms of treatment preference, as respondents indicated advocating a combination of psychological therapy and medication, above singly administered treatments of medication or psychological therapy.

The aims of the study were fulfilled, in that lay persons' perceptions and understanding in relation to common mental health, were gathered through the study. The nature and design of the survey also led some to results being directly compared to those of the GP Survey. However there were also weaknesses with the study. The first of which can be understood as the sample population, not only in terms of the number of respondents but also the population itself thereby posing issues around representativeness. The sample of university staff are a specific type of population, although respondents indicated working in various divisions and therefore potentially of a diverse social demography. This study would most definitely benefit from a broader distribution to include a variety of societal groups and strata. Furthermore, the survey style approach was predominantly quantitative and as result misses the nuances that can be achieved via more qualitative methodology. Therefore, it is suggested that by using this study as a background to further research, the employment of qualitative approaches would prove

beneficial to fostering improvements in policy and practice, such as general practitioner management and public health communication. Considering the strengths and weaknesses of this study, along with those presented for the other studies, it was considered important to gain further representativeness and validation for these findings. To do this a triangulation study was conducted (see Chapter 7).

8.6.1 Summary of results from the Mental Health Literacy study

Definition of common mental health problems
• Respondents disagreed with the popular view of common mental health, that 'common mental health problems do not refer to conditions other than depression and anxiety and are not short-term', this supports responses from the GP Survey.
Association of experience, knowledge, identification and ability to help others
• Experience and knowledge of CMHPs were found to be significantly associated - those who had experienced CMHPs also rated themselves as having between good and average knowledge of CMHPs. • Individuals who had experienced a CMHP were significantly more likely to be able identify CMHPs in other people.

- Those who indicated experiencing a CMHP felt that they could help people with CMHPs.

- Analysis showed having poor, average or good knowledge of CMHPs, was significantly associated with experience. In addition knowledge was also significantly associated with being able to identify CMHPs in others.

- Knowledge and experience were each cross tabulated with feeling able to help others with CMHPs, analysis showed a significant association for both.

- Respondents didn't feel that their GPs received appropriate training or education covering common mental health and their management.

- Respondents indicated the consultation around common mental health was not straightforward.

- Respondents indicated strongly that treatment for a patient with CMHPs depended on their knowledge of their problem.

- Respondents indicated that they thought treatment should be the combination of psychological therapy and medication (83.1%, n=98), psychological therapy on its own (16.2%, n=19) and medication only 0.8% (n=1).

- Respondents believed that psychologists or psychiatrists should be more involved in the treatment of common mental health problems.

Key driving factors

• A cross tabulation between the combined knowledge/experience variable and being able to identify CMHPs in others, demonstrated some interesting differences:
 	
    o Analyses showed that knowledge was a significant associative factor.
 	
    o Experience did play a role in being able to identify common mental health in others.
 	
    o The combination of having both experience and good knowledge made individuals more able to identify CMHPs in other people.
 	
• The knowledge effect was still present upon analysis of combined knowledge/experience and whether individuals felt they were able to help people with a CMHP.
 	
• Better knowledge was associated with whether an individual felt they were able to help other people.
 	
• Analysis showed if you had poor knowledge of CMHPs, it was the experience of CMHPs which made an individual more likely to feel they could help other people with CMHPs.

The findings from this study provided support for findings gathered via the other studies. Upon completion of this phase of the research programme it was then felt important to further try to validate and contextualise findings with other key health

professionals who have experience of GP management and patients with common mental health problems. Therefore, this study, along with findings from the former studies in the research programme, led to the Triangulation Study (presented in Chapter 7) where all findings were discussed with a group of GPs, primary care counsellors and clinical psychologists.

8.7 Chapter 7: Triangulation of findings – a validation study with GPs, Primary Care Counsellors and Clinical Psychologists

Chapter 7 describes the Triangulation Study. The aim of the Triangulation Study was to contextualise and gauge further the representativeness of the findings gathered through by the research programme. It was felt that the opinions and experience of those working closely with, and/or having experience of the management of common mental health, are vital to the research programme in terms of a robust research evidence approach. Therefore a qualitative approach was used, by way of focus group interviews with allied health professionals (GPs, Primary Care Counsellors and Clinical Psychologists). Ahead of the group discussions each participant was sent a summary of findings, or key messages, from each of the studies conducted within the research programme.

Each finding, from each of the studies, were raised and discussed in terms of agreement. The group discussion approach provided an opportunity for participants to provide further examples and information. Discussion groups were recorded and underwent Thematic Content Analysis.

This study successfully fulfilled its aims, where in addition to validating findings from the study and the literature (see Chapter 2), discussion groups' generated additional information to each of the areas of interest and provided greater insight with regards to the management of common mental health in primary care. Overall, those participating within discussions across the groups (GPs, Primary Care Counsellors and Clinical Psychologists) agreed with the findings presented from across the studies within the research programme. Data generated through the study provided support for the literature around GPs having difficulty with the assessment and recognition of common mental health problems, citing aspects of GP confidence, patient expectation, issues of co-morbidity and the potential influence of what can be understood as a social construction of illness. Furthermore, the importance of labelling, and in some cases the manipulation thereof, was discussed where GPs were said to experience a conflict of position and role. On the one hand as the patient advocate and the other as a professional served with the responsibility to assess people for work and serving the general practice in terms of the QOF. The position of the GP was discussed during the research as a gatekeeper in relation to patients' financial stability where the assignment of a label secured financial provision. While for other patients the assignment of a label was suggested as something to be avoided.

General practitioners' view of management guidelines, reported within previous studies, such as the reluctance to employ screening and watchful waiting, were supported by the GPs taking part in this study. Participants suggested that screening was separate to diagnosis or the prescription of medication, and that the

257

practice of watchful waiting was said to be unsustainable in every day clinical practice. Further information was provided by participants in relation to GPs' difficulties with treating and managing patients, such as those said to be associated with inherited patients. Primary care counsellors cited potential difficulties as being associated with the possible progression of a condition to something more chronic and enduring as a result of it not being picked up. Clinical psychologists raised the suggestion that perhaps it is rather about lacking good management in the eyes of the patient and the lack of motivation to manage appropriately by GPs, because of the complexities of a patient seeing or being seen by different GPs. Findings around GPs' confidence in relation to psychological-based treatment was met with agreement and understanding from participants, who cited patchy knowledge around successful outcomes and treatment availability. The primary care counsellors suggested there were perhaps issues around GPs' lacking confidence, and loss of control, with regard their patients due to being on waiting lists for a period of time and/or the lack of communication on progress. They suggested that for GPs there was perhaps a preference for the administration of antidepressants as a safety net. Clinical psychologists raised concerns around the area of condition prevalence and resource provision. Whereby the impact of GPs not referring those in need for treatment affect statistics around prevalence, and as such do not represent a true reflection of demand and thereby have a direct impact upon resource provision.

Clear agreement was raised around the importance of patient knowledge as a pervasive factor in achieving condition recognition and access to treatment.

Primary care counsellors suggested that perhaps it was that patients were able to provide GPs with clearer messages with regard to their particular complaints. The ability of patients to dictate and obtain treatments or outcomes that they want was evidenced during discussion with GPs, where examples were provided of patients' specifically requesting and receiving antidepressant medication, sick notes and the maintenance of financial security via social benefit system support. However, criticism of such practice was raised within discussion with clinical psychologists, where comparisons were drawn between the management approach by GPs toward antidepressant prescribing, and their management of other more physical conditions. Such as the stronger position held by GPs in relation to not easily issuing antibiotics, suggesting that there seemed practice differences perhaps resulting from a lack of confidence on the part of the GP, toward common mental health management. Furthermore, clinical psychologists, although agreeing with findings presented around GPs prescribing antidepressant medication at a first visit, were also surprised by this finding as it stands in conflict with the suggestion made by GPs that CMHPs are short-term or reactive states.

The above discussion illustrates the possibility of GPs' not fully recognising the nature of a condition by prescribing too quickly. Appropriate knowledge, training and awareness of available treatments were cited by all to be a key requirement going forward, in order to improve appropriate condition recognition. While the finding that GPs want more education and training was cited to be encouraging, the enhanced and targeted provision of education and training was deemed a need in order to remedy, what clinical psychologists saw as a poor understanding of mental health and to increase GP confidence in condition management practices.

However, there was also reluctance from GP participants to engage in more training. In so far as, the proposition of further training was met with a certain cynicism. Examples of further training not meeting expectations or a poor fit for real-world settings were presented. Along with issues around, knowledge decay after having experienced training and educating GPs with regard to published research, particularly in terms of the pervasiveness of statistical presentations.

All groups agreed and suggested that they felt the various challenges and difficulties, as demonstrated through this research programmes' findings and discussion, have led to a 'gap' in the appropriate treatment and management of patients with CMHPs. From their experience, the 'gap' suggested by the groups taking part in this study (GPs, primary care counsellors and clinical psychologists) is distinct from the 'gap' in mental health care, as has already been discussed within the literature and recommendations made in the World Health Report (see Kohn et al., 2004; WHO, 2001). The participants in this study made reference to there being a treatment 'gap' in respect of their belief that there exists a population of individuals left untreated, or inappropriately treated and unsupported, due to their falling between services. In that, their condition(s) are too complex to be dealt with in primary care, but were not severe enough to qualify for secondary care treatment. While the awareness of this problem was clearly acknowledged by all those taking part in the groups, the documented evidence of this along with the size of the problem appears to be lacking.

Although, this study fulfilled its aims and objectives and provided much rich data, it also had its shortcomings. Initially, the protocol for this study included having a group of expert patients, however due to ethical difficulties it was not possible and so had to be redacted. Further, the role of ethnicity was not fully explored or raised by the participants voluntarily. This would prove valuable for further research. In addition to expert patients, this validation study would have benefited from the participation of other key individuals, such as those from community mental health teams, in-house counsellors, telephone helpline operators and other supporting agencies.

8.7.1 Summary of findings from the Triangulation Study

Level of agreement
• Findings were met with agreement from all groups in this study.
Confidence
• GPs' treatment preference is suggested to be due to lack of confidence and sense of control.   • Lack of understanding or confidence lead to not asking questions or the 'right' questions so as not to be in a position to manage the answers.   • GPs' lack knowledge and understanding of the nature of CMHPs.   • Difficulty of managing inherited patients is potentially due to the patients' lack of confidence in GP management, and GPs' lack of

confidence in managing complexities of patients' being seen by other GPs.

Knowledge

- GPs referral behaviour due to lack of knowledge and understanding and confidence of available services.

- GPs' believe that 'screening' and 'prescription' should be viewed separately

- Patient knowledge is seen as indicative of personal insight and aiding the direction of GP management and providing GPs with the confidence make decisions on management.

- The role of psychiatrists and psychologists is not fully understood by patients.

- GPs' training, via the 'medical model', lead GPs' to be trained in a particular way that can make dealing with CMHPs difficult. In addition to the constriction of general practice management systems (e.g. consultation times).

Role of GP

- Position of patient advocate can lead to the manipulation of diagnostic labelling.

Provision of management and treatment for those with common mental health
• GPs' lack knowledge and understanding of how the lack of referral potentially impedes statistical representation of those with mental health conditions and as a result may impact upon service provision and resources.   • A 'Gap' exists where individuals are not in receipt of appropriate treatment or management due to falling between services where their condition is too severe to be treated in primary care and not severe enough to be treated in secondary care settings.
Financial influences
• Monetary remuneration due to QOF   • Financial persuasion by drug companies

8.8 Overall conclusions, implications of the research and future research

The objective of the work described throughout this thesis (begun in 2007), was to conduct a programme of research to look more closely at common mental health and its management in primary care. More specifically, this research considered the position of general practice, with the aim of constructing a view of common mental health and its management from a general practice management perspective, and to establish what GPs' considered common mental health to be

(at the point at which this research commenced there was no concrete definition for these). Also, the research programme investigated the prevalence of common mental health, factors associated with its management and treatment, and influences of these. The research programme consisted of a series of studies conducted to allow GPs to indicate what they considered and understood CMHPs to be, as well to tease apart the varying aspects of condition management therein. Many of the findings presented throughout the thesis have empirical support, coupled with the amount and various types of data collected from what can be understood as difficult sample populations to infiltrate, have combined to produce implications for future research.

The data presented throughout this thesis may prove beneficial to future research, as to date there does not appear to be such a piece of work following through the varying aspects of understanding, management practice and behaviours of GPs, along with the ability to predict outcomes in relation common mental health problems this could help to provide a useful background and aid in the development of new research.

Our findings are consistent with the literature around the prevalence of mental health problems in primary care (Murray & Lopez, 1997; Ormel et al., 1994; Kroenke et al., 1997; Roca et al., 2009; Ansseau et al., 2004; Spitzer et al., 1999; Norton et al., 2007; Jackson et al., 2001). More specifically, findings reported in this thesis provide new insight to the extent of common mental health in primary

care. GPs indicated routinely experiencing a significantly high prevalence of common mental health in general practice on a weekly basis, both by way of their being presented as a primary condition and by their presentation as a secondary condition to a, more primary chronic condition. The latter proves consistent with other research (Kessler et al., 2005a; McManus et al., 2009; Roca et al., 2009; Ansseau et al., 2004; MaGPIe Research Group, 2003). Furthermore, findings from this programme also show that despite awareness from the literature around problems with regards to effective recognition and management of mental health and common mental health problems (National Institute for Health and Clinical Excellence, 2009), these problems still persist. However, results through discussion with other key health professionals in the field (see Chapter 7) do acknowledge that they believe there to be an improvement, though this improvement is not recognised as adequate. Findings from the research programme commenced in 2007, provide insight to GPs' understanding of common mental health through their everyday practice, and show that these are dissonant to that widely posited within the literature and policy. Within the GP Survey (conducted 2009) GPs indicated that they felt common mental health conditions included a broader range of conditions or disorders. The findings and the survey can to some extent be supported, as in 2011, the National Institute of Clinical Excellence updated their guidelines to include conditions that our GP sample had indicated as being CMHPs (generalised anxiety disorder, panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder and social anxiety disorder). The inclusion of these to updated clinical guidance, go some way to providing construct validity for findings we had previously acquired.

Findings from the Mental Health Literacy survey also showed lay persons considered common mental health to encapsulate a broader range of conditions. Our findings can provide support for future research into widening and revisiting these guidelines, this is particularly important when we consider how conditions are recognised and categorised impact upon the provision of resources to treat these.

Both general practitioners and lay people are reported to experience the common mental health consultation as not being straightforward, although findings from this research show this can be moderated and improved by factors such as the familiarity with patients aiding GPs, this is supported by other research (Huibers, Beurskens, Bleijenberg & Schayck, 2008). In addition, a patient's knowledge or insight of their problem(s) was shown to be a positive moderator for the common mental health consultation. This again, was a two-way finding for both patients and GPs' alike and is both supportive of, and by, existing research. Our findings around the common mental health consultation and complexities involved in the doctor-patient dynamic provide a good background for new and further research with a greater sample population and those in varying localities (city, rural locations). This research also has implications for the development of more real-world related training packages for GPs in relation to such consultations.

The position of education as shown within this thesis, is not solely about focusing knowledge to the individual GP, but is also discussed to be beneficial in a more

wraparound sense. Such that, 'whole practice' behaviour can be influenced to limit the impact of predictor factors (attitude and subjective norm) shown to influence treatment management behaviours. Furthermore, the lack of confidence and knowledge that GPs have in relation to the available pathways for treatment is something that is crucial to fostering better management for patients. This research programme provides a good basis for looking at ways in which this can be remedied, and included within practice management systems more generally.

The status of education and training for GPs around common mental health is key, and findings within this thesis indicate that this is inconsistent. As a result this can have potential implications on the GP's ability for the effective recognition and treatment management of mental health problems in presenting patients. More recently education and training has undergone changes, led in part by the General Medical Council's (GMC) Tomorrow's Doctors report (GMC, 2009), which set out more prescriptive and specific standards to be achieved and demonstrated upon graduation. For instance, the Welsh Assembly Government's (WAG) 'Setting the Direction' (2010) policy sets out a change of direction for clinical services in Wales, and puts greater emphasis on primary care and community-based services. However, a focus upon providing GPs with appropriate knowledge to help manage common mental health problems, and the complexities associated with these, is still lacking. For instance, this year (2013) sees the tenth anniversary of BMJ Learning, whose remit is reported to be the sharing of knowledge and expertise to improve experiences, outcomes and value (BMJ, 2013). Currently this online facility is said to offer over 1,000 modules written by experts, accredited and peer

reviewed. However, provision of e-learning with particular reference to common mental health is scarce. Using this facility and searching under the term 'common mental health problems' (conducted 18.11.2013), 865 results were provided. None of the results made specific reference to CMHPs. However, of those results provided, only nine were of relevance. Three dealt with the Mental Health Act, two with depression (depression in adults with chronic health problems and postnatal depression), three related to treatment (access to psychological therapies in primary care, cognitive behavioural techniques in general practice and tricyclic antidepressants), two related to anxiety (generalised anxiety and anxiety disorders in adults), two were in relation to bipolar disorder (in primary care and secondary care), one in relation to the management of personality disorder, one in reference to eating disorders (bulimia nervosa), obsessive-compulsive disorder and insomnia. It can be understood therefore, that findings from this research programme have implications for public policy and the targeting of GP education and training. Furthermore, when we consider the understanding that GPs' and patients alike have of common mental health, potential implications exist too for communication with the public and advertising.

In addition, findings achieved through the research programme in relation to the predictor variables shown to be influential to GP behaviour (attitude, perceived behavioural control and subjective norm), while adding to the literature these findings also provide a basis for further investigation more widely across the GP population in the UK to assess the general position of these factors. As well as the potential impact of factors that moderate GP management behaviours.

A shortcoming of this programme of research is the role of ethnicity. This was

not fully explored within these studies, and so could provide further aspects for

consideration across all factors that appear to moderate GPs' management of

common mental health. However, the research within this thesis does provide a

good framework upon which to conduct further more explorative work regarding

ethnicity more specifically.

In addition, another shortcoming was the omission of the bio-psychosocial model

of care and its relevance to GPs' management practices. As previously discussed

(ref point in thesis) this programme of research focussed on the medical

management and treatment of common mental health in primary care, the

exploration of factors associated with the bio-psychosocial model were not

included within this programme of research, therefore this is an area that

warrants particular attention and further investigation.

Another aspect, not voluntarily raised at any point by any of the participants

throughout the research programme or explicitly investigated with GPs, or lay

people, was the role of other avenues of treatment for common mental health (i.e.

help lines, charitable counselling) where primary care has not been seen as a

route suitable for help-seeking. This is an area that would prove useful both for

gaining more perspective on the prevalence and impact of these conditions, and

why individuals' choose other options. In addition, the role of social demography is an area worthy of further attention.

Furthermore, the focus of future research could be the inclusion of more powerful research approaches, such as longitudinal or interventional studies that could enhance predictive validity. Though this research already utilises a mixed methods approach, this could be furnished further with a narrative approach. A useful next step could be the analysis of GP notes and documentation with regards to consultation and referral documentation. As has already been described, future work would benefit from wider sampling across all groups (GPs, lay people, key health professionals) within Wales and across the UK. A key focus for future research could be looking at trainee medical students, through their practice placements and the early years of their working as a GP to gauge more specifically where, and how, behaviours and approaches change. Furthermore, this research would provide a basis from which to conduct new research to investigate the 'gap' or the group of patients that appear to not be effectively treated within primary or secondary care settings.

In conclusion, the work described throughout this thesis is suggested to contribute to the literature in terms of providing implications for future research, policy, practice and interventions in relation to the management and practice of GPs in relation to common mental health problems and more widely. The aims and objectives of the work were largely fulfilled. The various studies did reveal GPs do indeed encounter difficulties in the management of common mental health.

8.9 Results of the research programme in relation to recent changes

During the lifetime of this research programme there have been several changes to clinical guidelines, and reports have been published to instigate change in regard to education and training. When this research programme began in October 2007, the clinical guidelines in place were the National Institute of Clinical Excellence's (NICE) 2007 guidelines. As has been previously discussed, no concrete definition of common mental health was in place at this time, as has been previously discussed. Within the NICE post-consultation draft 'common mental health disorders: identification and pathways to care', published in 2010 (NICE, 2010), while still focussing upon depression and anxiety, it outlined the inclusion of general anxiety disorder, obsessive-compulsive disorder and post-traumatic disorder. The guideline cites evidence from research conducted by McManus et al (2007) to support the inclusion of these conditions:

- depression (including subthreshold disorders)
- anxiety (including generalised anxiety disorder, panic disorder, phobias, social anxiety disorder, OCD and PTSD)

Following on from the criterion outlined above, the post-consultation draft guideline (NICE, 2010) states that:

> *'The guideline will also cover, where relevant, issues relating to comorbidity, however, as no separate NICE guideline addresses comorbid*

presentations of common mental health disorders, this will not form a key

topic of the guideline'

The guideline then goes on to state that:

'Groups not covered include adults with sub-threshold mixed anxiety and

depression, adults with psychotic and related disorders (including

schizophrenia and bipolar disorder), those for whom drug and alcohol

misuse are the primary problem, those with eating disorder and children

and people younger than 18 years.'

Included within the Common Mental Health Disorders: Evidence Update 31 (NICE, 2013), is a summary of selected new evidence relevant to NICE clinical guidelines 123 'Common mental health disorders: identification and pathways to care' (2011). The evidence update includes eight evidence updates. Two of these were ethnicity or culturally related and sit under the category, 'Improving access to services'. Five evidence updates pertain to the category 'Identification and assessment', one in relation to instruments for identifying anxiety and depression in people with learning difficulties and one in relation to an assessment for diagnosis of depression in older people. It was also stated that none of these would impact upon the current standing of the NICE 2011 clinical guideline. A review by Mann and Gilbody (2011) was included that raised doubt over the use of asking two general case-finding questions in people with suspected depression and suggested further research was needed to assess for diagnostic test accuracy,

however it was also mentioned that this evidence will not change current guidance. Evidence by way of a meta-analysis was included, by Manea et al (2012) that supported the PHQ-9 as a useful instrument to be used in primary care, suggesting that a cut-off score of 10 might be useful. The evidence update document states that these findings are consistent with the use of the PHQ-9 as a validated instrument to use in the assessment of common mental health disorders as recommended in CG123 (NICE, 2011). Evidence was also included around GP recognition of distress and depression, which suggested that GPs may correctly rule out distress and depression in about 80% of people who do not have distress or depression, but that GPs may only diagnose distress correctly in about half of people with distress, and may only diagnose depression correctly in about a third of people who have depression (Mitchell et al., 2011).

In terms of antidepressant prescription, the guidelines continue to dissuade the use of antidepressants in the early stages of a CMHP, and even through to persistent sub-threshold disorders. More specifically the current guideline of CG123 (NICE, 2011) states:

Do not offer antidepressants routinely for people with persistent sub-threshold depressive symptoms or mild depression, but consider them for, or refer for an assessment, people with:

- *initial presentation of sub-threshold depressive symptoms that have been present for a long period (typically at least 2 years) or,*

- *sub-threshold depressive symptoms or mild depression that persist(s) after other interventions or,*

- *a past history of moderate or severe depression or,*

- *mild depression that complicates the care of a physical health problems.*

(NICE, 2011)

Therefore, despite adaptations to guidelines for the clinical care and assessment of common mental health in primary care, it can be appreciated from the findings presented within this programme of research, that such guidelines remain out of touch with how general practitioners routinely manage patients with these conditions in the real-world settings. Thereby, raising the question of whether the guidelines for the management of common mental health, as proposed by NICE, are fit for purpose. This is of particular note given the results herein that GPs' nor their patients understood the model and more specifically, that while GPs' indicated being aware of the clinical guidance, they actively chose not to follow it.

Another strategy introduced more recently by the Welsh Assembly Government (WAG) has been the Mental Health (Wales) Measure. The Mental Health (Wales) Measure was passed by the National Assembly for Wales in 2010, however the primary care component of the 'measure' did not commence until October 2012. The aim of the 'measure' is to ensure appropriate care across Wales that focuses on people's mental health needs (WAG, 2013). To do this, the 'measure' places new legal duties on Local Health Boards and Local Authorities about the

assessment and treatment of mental health problems and consists of four main components, three of which relate specifically to secondary care services and only one specifically in relation to primary care services:

Part 1 of the 'measure' will ensure more mental health services are

available within primary care

(WAG, 2013)

The primary care element is envisaged to be delivered alongside, and within, general practice settings, and provide: assessment, short-term interventions, information and advice, and where appropriate onward referral to other services (WAG, 2013). This kind of regulatory enforcement is something that appears to go some way to beginning to bring about guideline adherence. However, in practice there appears to be gaps within the measure and its ability for effective implementation and adherence. This 'measure' does not seem to take account of grass roots real-world practice in general practice settings, such as those issues discussed within this thesis and demonstrated through its findings. For instance the status of GPs' knowledge in regards to components within this measure, and the status and availability of onward referral and interventions for patients.

Delivery of the primary care component of the 'measure' will be via the 'Together for Mental Health' strategy. This is a ten year strategy that aims to deliver upon the main themes by promoting mental well-being, preventing mental health problems, developing and establishing new partnerships with the public, that are

275

centred upon improving information on mental health, and increasing service user and carer involvement in decisions around their care. Findings reported within this thesis show the pervasiveness of patient knowledge about their condition to improve their ability to achieve treatment strategies they feel appropriate. Therefore, strategies which attempt to enhance patient knowledge of mental health problems is crucial to facilitating improvement to condition management. So too, effectively communicating information on mental health, and that of common mental health, as has been discussed within Chapters 3, 4 and 6 of this thesis, is of key importance.

However, there are shortcomings with this strategy. This strategy is unlikely to be able to fully address the 'gap' of those falling between services, as referenced by participants within the Triangulation Study (Chapter 7). Another area that needs to be acknowledged, and given credence, is the role of the general practitioner. As we have discussed, and acknowledged within the literature, the position of the general practitioner is key with regard to managing individuals with common mental health as in general they are the first point of contact. While accepting this, of equal importance and a source of conflict to GPs', is the role of the general practitioner as the patient's advocate and the challenges bound up with this role will continue to remain (i.e. financial security for patients, labelling, social demography).

The changes and introductions to policy and guidance above serve not to detract from the findings shown within this thesis, but provide support for them. The

findings that are presented within this thesis are consistent with current thinking. However, what I feel is important about the findings reported from this research programme is that they go further. They provide a greater insight and consideration on how to bring about realistic and lasting change with regard to mental health management and engagement, both within healthcare provision systems and more widely.

8.10 limitations of the research

There were a number of limitations associated with the programme of research. Firstly, the initial hypothesis that 'GPs behaviour is moderated by many factors', in retrospect is too broad in nature. Although this programme of research was an exploratory investigation of the management of common mental health problems in primary care, it would have been more helpful to have had a more specified hypothesis. Secondly, sample response numbers and the sample population itself need to be considered. Although, there were similar numbers of male and female participants; it may be that the various recruitment approaches may mean that the sample is not fully representative because of the element of self-selection. Recruitment of participants for each of the studies were essentially conducted via advertising of the research using both online and through letters where those that were interested or motivated to take part selected to participate. Further, the Mental Health Literacy Study only sampled those working for a University institution. While those who participated indicating working across various sectors within the university (security, administration and staff from various sectors within the

university health and medical site), this can still be considered to be narrow as it was still from within one city-based specific business, rather than sampling individuals from across different localities, and spheres of socio-economic strata.

Data collection approaches, such as questionnaires are by nature limiting, due to balancing the need for appropriate information generation and maintaining participant interest and achieving healthy response rates and receiving completed submissions. Limitations are also considered in the shaping of questions, for instance where participants were presented a statement and asked whether they agreed or disagreed with what was presented as the more popularly cited view of common mental health ('common mental health problems/disorders' do not refer to conditions other than depression and anxiety and are not short term (see Chapter 4 and Chapter 6). This question would have benefited by being separated, as it can be understood to ask two questions; the first, asks whether the term common mental health problems referred to conditions other than depression and anxiety, and the second, whether they are short- or long-term. By separating out this question a more focused view of what GPs' consider the term 'common mental health problems/disorders' refer to could have been achieved. Interviews and focus groups are well established in research and are noted for achieving rich data through discussion and providing participants with a place to voice their experiences and opinions around subjects. However, there is the possibility that different elements may be active that potentially inhibit free discussion of participants, such as social desirability. Social desirability is where individuals may report facts that are viewed favourably by others (i.e. the over-reporting of

"good behaviour" or the under-reporting of "bad" or undesirable behaviour)) or the presence of an imbalance of power, such as individuals operating at different job levels within the same environment. Another consideration is the role of the researcher, which may be active both prior to and within the focus group setting. In line with proper ethical protocols it is a requirement that participants are briefed and clearly aware of the research project in question prior to the event, so as to be able to make an informed decision about whether to participate or not. However, it is a possibility that this communication prior to the focus group discussion in itself in influenced how topics were discussed or the issues that were raised. Similarly, preconceptions of the researcher about topics under investigation could influence direction and content of the discussion. However this said, at the point of data collection involving focus groups the researcher had no preconception of how GPs in Wales were managing common mental health, the primary objective being to generate talk and explore various issues raised.

In terms of analysis, data from the GP Survey (Chapter 4) would have benefitted from the employment of more complex analysis such as multiple regression analysis. Using regression analysis would have helped further understand general practitioners' management of common mental health, by showing the contribution of the various predictor variables. Furthermore, adjusting for potential confounding factors such as demography during analysis (gender, practice, location or full/part-time working) would have also proved advantageous showing the extent to which potential confounders account for associations. This accepted, associations or relationships may be spurious as a result of confounder omission.

Limitations were also experienced during application of, and gaining, NHS ethical and Research Governance approval. This process is a lengthy one, and over the course of conducting the research programme various changes occurred that altered and changed the way in which one could apply for either of these. For instance, when the research programme first commenced, Wales comprised several different local health boards and applications for NHS ethical approval were submitted in hard copy. Research Governance was achieved by applying to each Local Health Board independently. This proved difficult, in that some Local Health Boards did not have a specific member of staff to deal with such applications. During the life of the research programme Wales' local health boards were re-drawn so that there are, as is now the case, seven local health boards. Applications for NHS ethical approval were changed so that applications are submitted through one central online portal, at which point Research Governance should also be dealt with. However my experience has been that although initial NHS ethical applications are lengthy and thorough pieces of work and a process which accounts for around three months, it was in fact the applications for Research Governance which were worse. For example, the Theory of Planned Behaviour survey NHS ethics application (including Research Governance) was submitted via the single online portal, and while NHS ethical approval was gained within two and half months, Research Governance for each of the seven local health boards were not received, in some cases, for a further six months. Therefore delaying the study by a considerable margin, and resulted in the recruitment and distribution of the survey occurring at various times across health boards. In addition, due to the delays in ethical approval confirmation and the length of time

outlined for data collection, this resulted in having to submit a further application to amend and extend approval from the NHS ethics committee. Reasons for these delays were in most cases due to a lack of appropriate staff to deal the application, and also questions from some of the Local Health Boards wanting to either add areas of interest from their perspective to surveys, or asking if it were possible for me to provide them with data around failing clinical practice from individual GP participants. Both of the latter were neither included nor provided through the research, and reasons for non-inclusion were upheld and governance approval was eventually received.

The length of time it has taken to conduct the programme of research has also meant that the landscape of guidance for common mental health, primarily that of the National Institute for Health and Clinical Excellence have changed, along with the introduction of Welsh Government strategies such as the Wales Mental Health Measure and Together for Mental Health. In this sense it is worth considering that these changes may have possibly impacted upon results, in that opinion or practice were not tested under the same clinical working practice.

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Appendices

Appendix 3-1: Consent form – Scoping Study

CONSENT FORM

Title of Project: Management of common mental health problems – Scoping Study

Name of Researcher: Katie Webb   Please initial box

1. I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time. I am also able to withdraw the information I provide, without giving any reason, up until the point it is anonymised.

3. I agree to take part in the research as outlined in the information sheet.

4. I understand that the information provided by me will be held totally anonymously, so that it is   impossible to trace this information back to me individually. I understand that, in accordance with the Data Protection Act, this information may be retained indefinitely. I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.

5. I understand that any contact information provided by me for the purposes of taking part in further research will be stored confidentially. This information will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act.

6.
_____

    Name of participant   Date   Signature

7. _____

    Researcher   Date   Signature

Appendix 4-1: Consent form – GP Survey

CONSENT FORM

Title of Project: Management of common mental health problems – GP survey

Name of Researcher: Katie Webb   Please initial box

1. I confirm that I have read and understand the information sheet dated 13/02/2009 (version 1) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from the study at any time. I am also able to withdraw the information I provide, without giving any reason, up until the point it is anonymised.

3. I agree to take part in the research as outlined in the information sheet.

4. I understand that the information provided by me will be held totally anonymously, so that it is   impossible to trace this information back to me individually. I understand that, in accordance with the Data Protection Act, this information may be retained indefinitely. I also understand that at the end of the study I will be provided with additional information and feedback about the purpose of the study.

5. I understand that any contact information provided by me for the purposes of taking part in further research will be stored confidentially. This information will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act.

6.
_____
   Name of participant   Date   Signature

7. _____
    Researcher   Date   Signature

Appendix 4-2: Participant information sheet

Participant Information Sheet

Project title: Management of common mental health problems – GP survey

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully. Talk to others about the study if you wish.

- Part 1 tells you the purpose of this study and what will happen to you if you take part.
- Part 2 gives you more detailed information about the conduct of the study.

Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

Part 1

1. What is the purpose of the study?

The effective management of common health problems in general practice is of high importance. While it is suggested that GPs are key and best placed to recognise and manage individuals presenting with common health and common mental health problems it has been suggested that they find the management of these consultation challenging. However, while interventions and programmes are being introduced to address the suggestion of GPs experiencing 'difficulties' there seems to be a lack of literature and clear evidence pointing to exactly what it is that GPs are experiencing with regard to the consultation around common mental health.

This project forms part of a program of research for a PhD looking into the management of common mental health in primary care.

2. Why have I been chosen?

All GPs working within the Gwent Local Health Board (LHB) have been invited to take part in the research. If you would like to take part you can complete and return the enclosed questionnaire. If you would like further information about the study please contact a member of the research team (contact details below) who will be happy to answer any questions you may have.

3. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep. By completing and returning this questionnaire you will be consenting for the information provided to be included in this study. We would obviously like everyone to answer all the questions, however if there are any you do not want to answer please just skip them and move on.

4. What will happen to me if I take part?

GPs will be asked to complete and return a 'paper and pen' questionnaire around the issues and management of common mental health.

5. What if there is a problem?

Any problems or complaints you have about the way you have been dealt with during the study will be handled by the research sponsor, that is Cardiff University. Further information on this is given in part 2 of this information sheet.

6. Will my taking part in the study be kept confidential?

Information collected via the *'GP survey'* will be stored confidentially, up until the point it is anonymised, so that it will be impossible to trace this information back to you as an individual. This information will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act, and may be retained indefinitely.

The details concerning anonymity are included in part 2.

7. Contact details

If you have any queries, please do not hesitate to contact the chief researcher, Katie Webb, or Professor Andrew Smith:

Katie Webb – PhD Student
PhD student, Centre for Occupational & Health Psychology and Centre for Psychosocial and Disability Research,
webbk50@cardiff.ac.uk
Cardiff University
51A Park Place
Cardiff, CF10 3AT
Tel: 029 2087 0198

Professor Andrew Smith (Academic Supervisor and Chief Investigator)
Centre for Occupational & Health Psychology
smithap@cardiff.ac.uk
Cardiff University
63 Park Place
Cardiff CF10 3AS
Tel: 029 2087 6599 / 6455

This completes Part 1 of the Information Sheet.

If the information in Part 1 has interested you and you are considering participation, please continue to read the additional information in Part 2 before making any decision.

Part 2

8. What if there is a problem?

Complaints:
>   If you have any problems or concerns about any aspect of this study, please
>   contact:
>   Louise Hartrey
>   Psychology Ethics Committee
>   Cardiff University
>   Tower Building
>   Park Place
>   CF10 3AT
>   Tel: 029 2087 0360
>   Fax: 029 2087 4858

Distress:
>   If you are upset or distressed by any aspect of this research please contact the
>   Primary Care Support Service for Wales. The Primary Care Support Service is a
>   direct access, **confidential** counselling, support and educational service for GPs,
>   general dental practitioners and community pharmacists working in Wales. It is
>   funded by the Welsh Assembly Government but is run as an independent
>   service led from Bangor University with co-ordinators in each of three Welsh
>   regions.
>
>   The counselling service is totally **confidential** (in line with the GMC, BACP,
>   UKCP etc, code of ethical responsibilities) however, if you give the counsellor
>   information which suggests that you, or another person, are at risk of actual
>   harm the counsellor will encourage you to consult your GP or obtain your
>   permission to contact someone else. The service provides a list of counsellors
>   for your region together with the counsellors' direct contact details. Since you
>   have direct access to the people listed in the network only the person you
>   choose to contact will know who you are.
>
>   Contact details:
>   Primary Care Support Service for Wales:
>   www.primarycaresupport.wales.nhs.uk
>   *Direct link to Southeast Wales Counsellors and their contact details:*
>   http://www.wales.nhs.uk/sites3/page.cfm?orgId=558&pid=13951
>
>   *Head Office:*
>   Primary Care Support Service
>   Ardudwy, Normal Site,
>   Bangor University, Gwynedd, LL57 2PX Tel No: 01248 383050

9. Will my taking part in this study be kept anonymously?
All information that is collected from you during the course of the research will be stored anonymously, so that it is impossible to trace this information back to you as an individual. Information collected will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act, and may be retained indefinitely.

10. How will the information that I give be recorded?
Information collected via the *'GP survey'* will be converted into numeric scores and subjected to statistical analysis. Qualitative information will be collated and thematically analysed. All information will be stored confidentially, up until the point it is anonymised, so that it will be impossible to trace this information back to you as an individual. This information will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act.

11. What will happen to the results of the research study?

The information that you provide in the *'GP survey'* will be used to frame continuing research looking at GPs management of common mental health. A research report describing the study will be written and everyone who has participated in the study will be offered a summary of this report.

12. Who is organising and funding the research?
This study is organised and funded by the Centre for Psychosocial and Disability Research and the Centre for Occupational and Health Psychology, Cardiff University.

13. Who has reviewed the study?
This study was given has been reviewed by the Multi-Centre Research Ethics committee for Wales on the 12/03/2009.

Your participation in this study is entirely voluntary. If you decide to take part you will be given this information sheet to keep, by completing and returning this questionnaire you are consenting for the information provided to be included in this study.

Thank you for considering taking part in this study and for taking time to read this sheet.

PAPER
VERSION

STRICTLY CONFIDENTIAL

GP Survey

2009

**The Centre for Occupational & Health Psychology, Cardiff
University.
63 Park Place, Cardiff. CF10 3AS.**

GENERAL INSTRUCTIONS

Thank you for taking the time to complete this survey.

This survey should take no more than <u>5 minutes</u> to complete.

You will first be asked to answer some questions about you and where you work before moving on to questions around the management of common mental health and your personal experience.

The questions in part 2 will ask you about your experience of common mental and your opinions with regard medical education.

Please read each question carefully and mark the response that BEST reflects your knowledge or feelings. Do not spend a lot of time on each one; your FIRST answer is usually the best. Please make sure you mark all answers in the space provided.

All your answers will be kept anonymous, so that it will be impossible to trace back to you as an individual, and will only be used for this research project. Questionnaires will be returned directly to the research team. By completing and returning this questionnaire you are consenting for the information provided to be included in this study.

Please do not hesitate to contact the research team if you would like more information about the study.

Katie Webb   WebbK50@Cardiff.ac.uk
Professor Andrew Smith   SmithAP@Cardiff.ac.uk

When you have completed the questionnaire please return it to us using FREEPOST - no stamps are required.

Freepost Address: *GP Survey, The Centre for Occupational and Health Psychology, FREEPOST SWC3313, Cardiff, CF10 3AS*

YOU AND WHERE YOU WORK

We would like to ask you some questions about you and where you work.

1.1 Age (D.O.B):

1.2 Gender: Please tick ONE box.

Male   0
Female   1

1.3   Length of time in general practice (years):   Please tick ONE box.

0-4   0
5-9   1
10-14   2
15+   3

1.4   Number of clinical sessions per week: Please tick ONE box.

0-3   0
4-6   1
7-9   2
10+   3

1.5   Status: Please tick ONE box

Partner   0
Salaried   1
Registrar   2
Locum   3
Retainer/assistant   4
Other   5

1.6   Practice Type: Please tick ONE box

Rural   0
Semi-Rural   1
Urban   2

1.7   Practice Size: Please tick ONE box

1, 000 – 3, 000   0
3, 001 – 5, 000   1
5, 001 – 7, 000   2
7, 001 – 10, 000   3
10, 001+   4

1.8   Practice area levels of deprivation:
Do you receive remuneration for practicing in an area of deprivation? Please tick ONE box

Yes   0 (please go to **1.9**)
No   1 (please go to **1.10**)

1.9   What is the level of payment you receive?

£…………….

1.10   Number of partners: Please tick ONE box

1-4   0
5-8   1
9+   2

1.11Higher Qualifications: Please tick ALL THAT APPLY

MRCGP   0
FRCGP   1
None   2

1.12Specialist Training: Have you undertaken any of the following? Please tick ALL THAT APPLY and provide any examples in the space provided

		If so, what?
Refresher courses in the last 3 years	0	………………………………………………….
		………………………………………………….
Training in mental health		If so, when and what?
		…………...
	1	…………………………………………........
A specific psychiatry and/or psychology related job		If so, what?..
	2	…………………………………………………..

1.13 Training Practice: Please tick ONE box

Yes   0

No   1

DEFINING COMMON MENTAL HEALTH

2.1 The following question focuses on what you think the term 'common mental health problems/disorders' refers to. Please read the statement below and indicate whether you agree or disagree with this statement: Please tick ONE box

'Common mental health problems/disorders' do not refer to conditions other than depression and anxiety and are not short term.

Do you agree with this statement? Please tick ONE box

Agree   0

Disagree   1   (please provide an example of what you think below)

_____

_____

2.2 Of those you consider to be common mental health problems, which would you, say were the four most common complaints? Number ONE being the most common

1 _____

2 _____

3 _____

4 _____

2.3 Thinking back over the last <u>seven</u> days, how many consultations would you say were focused around a common mental health problem? Please tick ONE box

0-4   0
5-9   1
10-14   2
15+   3

2.4 On the whole how straightforward do you find consultations around common mental health problems? On a scale of 1-4, where 1 is very straightforward and 4 is not at all straightforward. Please tick ONE box

Very straightforward			Not at all straightforward
1	**2**	**3**	**4**

2.5 Do you find the management of common mental health problems with patients you are <u>familiar</u> with….(Please tick ONE box)

More straightforward	Less straightforward
0	1

Please tell us why _____

_____

2.6 Do you find the management of common mental health problems with patients you are <u>unfamiliar</u> with…(Please tick ONE box)

More straightforward	Less straightforward
0	1

Please tell us why _____

_____

2.7 What course do you generally take when a patient presents with a common mental health problem on their <u>first</u> visit?

Ask to see them again	0	If so, when ……………………………………
Prescribe medication	1	If so, what ……………………………………
Refer to a specialist	2	If so, whom ………………………………...
Use a screening tool	3	If so, which…………………………………
Other	4	Please explain …………………………………………………… ……………………………………………………

2.8 On average, how many consultations would you say it can take for you to feel comfortable with taking diagnosis through to treatment? Please tick ONE box

1   0
2   1
3   2
4+   3

2.9 consultations would you say had a common mental health problem as a <u>secondary</u> component to a primary condition (e.g. the patient's presentation of a common mental health problem <u>can be</u> associated with a prior condition)? Please tick ONE box

0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
0	1	2	3	4	5	6	7	8	9

2.10 Thinking back over the last <u>seven</u> days, what percentage of your consultations would you say had a common mental health problem as a <u>primary</u> condition (e.g. the patient's presentation of a common mental health problem <u>is not</u> associated with a prior condition)? Please tick ONE box

0-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	71-80%	81-90%	91-100%
0	1	2	3	4	5	6	7	8	9

2.11 How confident do you feel in managing anti-depressant therapy? On a scale of 1-4, where 1 is not at all confident and 4 is very confident, please tick ONE box

	Not at all confident 1	2	3	Very confident 4
Simple (1 medication) therapy				
Complex therapy (2 or more medications)				

2.12 How confident do you feel in using/managing psychological based interventions? On a scale of 1-4, where 1 is not at all confident and 4 is very confident, please tick ONE box

	Not at all confident 1	2	3	Very confident 4
Psychological intervention (no medication)				
Psychological + pharmacological				

EDUCATION AND TRAINING

This next question asks you about education and training.

3.1 Do you feel GPs receive appropriate training/education covering common mental health issues and their management? Please tick ONE box

Yes   0

No   1   (If no, what kind of information/training would you like to see?)

PERSONAL EXPERIENCE

The following questions will ask you about your personal experience.

4.1 Have you, an immediate family member or close friend ever been treated for symptoms of depression; if so, were they treated with: 'medication, psychotherapy, both or neither.' Please read the statements below and tick the ONE box that best applies

No experience   0

Go to question **4.3**

Some experiences with depression in personal life, treated with medication only   1   Go to question **4.2**

Some experiences with depression in personal life, treated with Psychotherapy, without medication   2   Go to question **4.2**

Some experiences with depression in personal life, treated with both Psychotherapy and medication   3   Go to question **4.2**

4.2 How would you describe the results of treatment? Please tick ONE box

Excellent   0

Good   1

Fair   2

Poor   3

4.3 When you refer a patient for evaluation of moderately severe depression how soon is that patient typically able to see a mental health professional? Please tick ONE box

Within 24 hours   0

Within a few days   1

More than a few days, but less than 2 weeks   2

2 to 4 weeks   3

At least 4 weeks   4

Usually unable to obtain access   5

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

If you would be happy to be contacted to take part in a short telephone interview focussing around the management of common mental health, at a time convenient to you, please tick this box

If you would be happy to be contacted to complete a more in depth questionnaire focussing on the management of common mental health, CPD and training, please tick this box

If you would like to receive a copy of the results from this survey once they have been processed and written up, please tick this box

FOR YOUR EASE OF MIND

If you have marked any of the boxes above and provide contact details, your contact details will be kept in a totally different location to that of the survey results, therefore it will not be possible to trace between the two thereby protecting your anonymity.

Please complete below if you have checked any of the boxes above:

Name:…………………………………………………….
Address:……………………………………………………
……………………………………………………………..

Email:……………………………………………………..

PLEASE REMOVE AND KEEP THIS PAGE

Thank you for taking the time to complete this questionnaire focussing on common mental health and its management. Your opinions and experiences are important to the success of this project.

All information that that you have provided in this questionnaire will be held anonymously, therefore it will be impossible to trace back to you. Information collected will be stored securely and maintained at Cardiff University in accordance with their data retention and protection policy. Data will be stored on University computers that are password protected so only members of the research team will have access and may be retained indefinitely.

If you are interested in finding out more about this study please contact:

Katie Webb (PhD student) or Andy Smith (Professor)

Centre for Occupational & Health Psychology

Cardiff University

63 Park Place

Cardiff CF10 3AS

Tel: 029 2087 6599 / 6455

Email: webbk50@cardiff.ac.uk / smithap@cardiff.ac.uk

Appendix 4-4: Cognitive debriefing schedule

Date:

Participant:

Oral instructions to participants:

Briefly talk them through the Information Sheet

- We are testing how the questionnaire works and NOT you and your abilities
- We are interested in how you arrived at your answers and problems you had with the questions
- We WANT you to criticise the questionnaire – my job is to find out what doesn't work
- We would like you to tell us how to make it better; we need your help to do this!
- We would like to test how the questionnaire works in the 'real' world, as we will be sending this questionnaire out to over 350 general practitioners in Southeast Wales. Because of this we would like you to complete the questionnaire on your own, the best you can and any problems you may have we can chat about at the end. To help you remember later, please mark, as you go through the questionnaire, any questions or words you don't understand, or anything else you have difficulty with.

For when questionnaire is completed:

1. What did you think about the questionnaire overall?

- Too long?
- Too difficult?
- Find it interesting?
- Felt comfortable answering the questions (too intrusive?)

2. What do *you* think the survey is all about?

(*if they ask, request that if they don't mind, we will talk in detail about what we are trying to do at the end*)

3. Did you have problems with any of the questions?

    (*Make a note here of which one e.g. 10a, BUT then write notes in the 'notes section'*)

4. How did you find the layout?

    -   Was it easy to read/follow
    -   Were the filter/skipping procedures easy to follow?

5. How could we make it better?

6. Would you fill in this questionnaire by post? Why/ if not, why not?

7. What might encourage you to fill it in?

8. Please tell me what you thought about the information letter?

    -   Easy or hard to understand?
    -   How could we make it better?

9. Further comments/explanations:

Appendix 5-1: Invitation email the Theory of Planned Behaviour study

School of Psychology

Dear Sir or Madam,

Common Mental Health Management

We are writing to invite you to take part in a research project about the management of common mental health problems.

Cardiff University are undertaking a research project to look at how General Practitioners (GPs) manage common mental health and what they think about this.

The effective management of common mental health problems is of high importance. It is suggested that GPs are key and best placed to recognise and manage individuals presenting with common health and common mental health problems. It has been suggested that they find the management of these consultations challenging. However, while interventions and programmes are being introduced to address the suggestion of GPs experiencing 'difficulties' there seems to be a lack of literature and clear evidence pointing to exactly what it is that GPs are experiencing with regard to the consultation around common mental health.

This project forms part of a program of research for a PhD which looks into the management of common mental health in primary care. This study follows on from a 'GP Survey' conducted between May and June 2009 across the Gwent Health Authority region, where the response rate reached 32%. The aim is to take this forward look more closely at how GPs manage common mental health issues, to see what work and what doesn't work so that more targeted and appropriate information, training and interventions can be considered.

All GPs working in Wales are invited to take part. The opinions and experiences of GPs are important to the success of this project.

The study involves filling in a questionnaire around the management of common mental health and what you think about it.

The questionnaire should take no more than **20 minutes to complete.**

314

Taking part is completely voluntary, and anything you tell us will be kept anonymously so that it will be IMPOSSIBLE to trace anything back to you as an individual. More information regarding consent, data protection, complaints etc. can be found on the first page of the questionnaire.

If you are interested in taking part, simply read the information below, and then click on: **hyperlink will go here.**

If you have any questions please feel free to contact a member of the research team:

Katie Marsh (PhD researcher) on (029) 2087 6495 (e-mail: MarshKL1@cardiff.ac.uk)
Professor Andrew Smith (Supervisor) on (029) 2087 6598 (e-mail: SmithAP@Cardiff.ac.uk).

You can also fill in a paper version of the questionnaire (please contact us for details).

Thank you very much.

Best wishes,

Katie Marsh (PhD researcher) & Professor Andrew Smith.

PAPER
VERSION OF ONLINE
QUESTIONNAIRE

STRICTLY CONFIDENTIAL

Common Mental Health Management

2009/2010

The Centre for Occupational & Health Psychology,
Cardiff University.
63 Park Place, Cardiff. CF10 3AS.

GENERAL INSTRUCTIONS

Thank you for taking the time to complete this survey.

This survey will take no more than **20 minutes** to complete.

You will first be asked to answer some questions about 'you and where you work' before moving on to questions around the management of common mental health and your personal experience.

The questions in part 2 will ask about your management of common mental health problems and your perceptions of these.

Please read each question carefully and mark the response that **BEST** reflects your knowledge or feelings. Do not spend a lot of time on each one; your **FIRST** answer is usually the best. Please make sure you mark all answers in the space provided.

All your answers will be kept anonymous, so that it will be impossible to trace back to you as an individual, and will only be used for this research project. Questionnaires will be returned directly to the research team.

By completing and returning this questionnaire you are consenting for the information provided to be included in this study.

*** Alternative ***
PAPER VERSION
Whilst we prefer questionnaires to be completed online we realise this won't suit everyone, especially those using a dial-up connection. If you would prefer to complete a paper version of the questionnaire please contact Katie Marsh on 029 2087 6495 or MarshKL1@cardiff.ac.uk and then send it back to us at the freepost address below:

Freepost Address: *CMH Management, The Centre for Occupational and Health Psychology, FREEPOST SWC3313, Cardiff, CF10 3GZ*

Data Protection

For the purposes of this survey Cardiff University is the data controller. All data collected in this survey will be held securely by the survey software provider (Bristol University) under contract and then retained by the research team (Katie Marsh and Professor Andrew Smith) at Cardiff University in accordance with the Data Protection Act (1998). Data from the survey, including answers to questions where personal details are requested, will only be used by the research team (Katie Marsh and Professor Andrew Smith).

Cookies, personal data stored by your Web browser, are not used in this survey. Please do not hesitate to contact the research team if you would like more information about the study.

Katie Marsh MarshKL1@Cardiff.ac.uk
Professor Andrew Smith SmithAP@Cardiff.ac.uk

What if there is a problem?
Complaints:
If you have any problems or concerns about any aspect of this study, please contact:

> Louise Hartrey
> Psychology Ethics Committee
> Cardiff University
> Tower Building
> Park Place
> CF10 3AT
> Tel: 029 2087 0360
> Fax: 029 2087 4858

Distress:
If you are upset or distressed by any aspect of this research please contact the Primary Care Support Service for Wales. The Primary Care Support Service is a direct access, **confidential** counselling, support and educational service for GPs, general dental practitioners and community pharmacists working in Wales. It is funded by the Welsh Assembly Government but is run as an independent service led from Bangor University with co-ordinators in each of three Welsh regions.

The counselling service is totally **confidential** (in line with the GMC, BACP, UKCP etc, code of ethical responsibilities) however, if you give the counsellor information which suggests that you, or another person, are at risk of actual harm the counsellor will encourage you to consult your GP or obtain your permission to contact someone else. The service provides a list of counsellors for your region together with the counsellors' direct contact details. Since you have direct access to people listed in the network only the person you to contact will know who you are.

Contact details:
Primary Care Support Service for Wales: www.primarycaresupport.wales.nhs.uk
Link to their Southeast Wales Counsellors and their contact details:
http://www.wales.nhs.uk/sites3/page.cfm?orgId=558&pid=13951

Head Office:
Primary Care Support Service
Ardudwy, Normal Site,
Bangor University, Gwynedd, LL57 2PX Tel No: 01248 383050

<div align="center">

To start the questionnaire please click on 'NEXT' below.

</div>

This questionnaire can either be completed and submitted in one session, or you can fill it in partially, bookmark it and then return later to add additional information. You can then submit it when it is completed.

If you want to bookmark and finish the survey later, please use the 'FINSIH LATER' button at the bottom of the page. You will then receive instructions on how to bookmark the page.

Once you have completed all the questions below and are ready to submit the fully completed survey click on the 'CONTINUE' button at the bottom of the page. Your answers will be submitted or you will be prompted to fill in an answer you may have over-looked. Once your answers are accepted as submitted you <u>cannot</u> return to review or amend this page.

YOU AND WHERE YOU WORK

We would like to ask you some questions about you and where you work.

1.1 Age (D.O.B): _____

1.3 Gender: Please tick ONE box.

      Male   0
      Female   1

1.3   Length of time in general practice (years): Please tick ONE box.

      0-4   0
      5-9   1
      10-14   2
      15+   3

1.4   Number of clinical sessions per week: Please tick ONE box.

      0-3   0
      4-6   1
      7-9   2
      10-12   3
      13-15   4
      16+   5

1.5   Status: Please tick ONE box

      Partner   0
      Salaried   1
      Registrar   2
      Locum   3
      Retainer/assistant   4
      Other   5

1.6   Practice Type: Please tick ONE box
Rural   0
Semi-Rural   1
Urban   2

1.7   Practice Size: Please tick ONE box
1, 000 – 3, 000   0
3, 001 – 5, 000   1
5, 001 – 7, 000   2
7, 001 – 10, 000   3
10, 001+   4

1.8   Number of partners: Please tick ONE box

1-4   0
5-8   1
9+   2

1.9   Higher Qualifications: Please tick ALL THAT APPLY

FRCGP   0
MD   1
Other   2 (please specify):…………………….

1.10 Specialist Training: Have you undertaken any of the following? Please tick ALL THAT APPLY and provide any examples in the space provided

		If so, what?
Refresher courses in the last 3 years (e.g. CPD sessions, BMJ master classes)	0	……………………………………………………. …………………………………………………….
Training in mental health/mental illness (e.g. special interest courses)	1	If so, when and what? ………………………………………………………… ……………………………………………………......
A psychiatry and/or psychology related job	2	If so, what?.. …………………………………………………….

1.14   Training Practice: Please tick ONE box

Yes   0
No   1

Management of Common Mental Health

2.1 Please read the scenarios below and indicate your answer by circling ONE of the numbers.

Given 10 patients presenting a common mental health problem for the first time, how many patients would you expect to prescribe psychotropic medication (e.g. antidepressants)?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Given 10 patients presenting a common mental health problem for the first time, how many patients would you expect to refer for psychological based treatment?

| 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

2.2 Below are 10 scenarios of patients presenting with a variety of problems. For each scenario you will be asked to indicate what you would choose to do prescribe *psychotropic medication (e.g. antidepressants)* **OR** *refer for psychological based treatment*. **Alongside the decision route you chose you will also be asked to indicate how DIFFICULT it was for you to make this decision by CIRCLING a number on a scale of 1 to 7, where 1 is** *not at all difficult* **and 7 is** *extremely difficult.*

Scenario 1

The first patient is a 40 year old woman, who comes into your surgery. She tells you that she is feeling very down and cries all the time and doesn't feel up to doing her job at the hospital – she is a nurse. She describes her familial circumstances; that her husband left a month ago and she has been finding it increasingly hard to cope with taking and picking up her child from school and managing her shift patterns at work. She has had no previous episodes. Her previous attendances have been for more general common cold type ailments.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 2

The patient is a 27 year old man, who comes into your surgery. He tells you that he is feeling very frustrated and agitated. He describes how he finds it difficult to concentrate and loses 'his rag' over really small things. He tells you that he's been drinking more and finding it difficult to cope day to day. He is very worried that his anger is getting worse. He has had no previous episodes. His last attendance was over 9 months ago.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 3

The patient is an 18 year old woman, who comes into your surgery. She tells you that she feeling very fatigued and has lost her appetite. She describes how she finds it difficult to concentrate and get out of the house. She tells you that she's been drinking more and finding it difficult to cope day to day. She is very worried as she is due to begin exams in the next two months and is already feeling as if she is getting behind. She has had no previous episodes.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 4

The patient is a 50 year old man, who comes into your surgery. He tells you that he is feeling very tired and is suffering with headaches. He has already taken a week off from work using self-certification. He describes how he is a postman, but is finding it increasingly more difficult to get out of the house. He tells you that he's not ready to go back and when he thinks about doing so he gets very hot and agitated. He says that he is finding it difficult to manage things. Six months ago his father died. He has had no previous episodes.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 5

The patient is a 33 year old woman, who comes into your surgery. She tells you that she is finding it very difficult to leave the house. She describes how she has to go through a series of 'checks' before she can walk through the door. She tells you that this has now extended to when she goes to bed and that she feels unable to stop this routine and has to complete it before she can rest. She no longer works as she was made redundant. Her last attendance was over two months ago when she was having difficulty sleeping due to job insecurity.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 6

The patient is a 34 year old man, who comes into your surgery. He tells you that he is feeling run down. He describes how he works long hours and finds it difficult to concentrate. He tells you that he's worried about losing his job and things at home 'aren't good'. He says that he feels inadequate and finds himself crying sometimes. He is very worried that things might be getting worse and harder to hide. He has had no previous episodes. His last attendance was for a routine check up, results were normal.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?
Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 7

The patient is a 27 year old woman, who comes into your surgery. She tells you that she is feeling very frustrated and agitated. She describes how she finds it difficult to concentrate and loses her 'temper' over really small things. She tells you that she's been drinking more and finding it difficult to cope day to day. She is very worried that her anger is getting worse. She has had no previous episodes. Her last attendance was over 9 months ago.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all 1   2   3   4   5   6   7 Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all 1   2   3   4   5   6   7 Extremely
difficult   difficult

---

Scenario 8

The patient is a 19 year old man, who comes into your surgery. He tells you that he is finding things difficult to cope with. He describes how he finds it difficult to concentrate and feels that he's lost interest. He tells you that he feels very uptight. He tells you that he can't cope and that his exams will be soon and he feels he is sure to fail. He has had no previous episodes. He has not previously attended this surgery.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all 1   2   3   4   5   6   7 Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all 1   2   3   4   5   6   7 Extremely
difficult   difficult

Scenario 9

The patient is a 53 year old woman, who comes into your surgery. She tells you that she is feeling very sad and agitated. She describes how she is not enjoying work and comes home crying most days. She says that she feels she doesn't seem to be doing anything right. She says that she feels her line manager is being very difficult and that she is now at the stage where she dreads going in on a Monday morning. She is very worried. She has had no previous episodes. Her last attendance was over 9 months ago.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Scenario 10

The patient is a 60 year old man, who comes into your surgery. He tells you that he has difficulty sleeping. He describes how he finds it difficult to get up in the morning and doesn't want to do anything. He tells you that he feels very disinterested and finds himself watching daytime TV for hours. He says he feels disconnected and that his wife is getting very frustrated with him. He is finding it difficult to cope day to day. He has had no previous episodes.

More likely to: Prescribe medication (e.g. antidepressants)   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

More likely to: Refer for psychological based treatment   Yes   No

On the scale of 1 to 7, how difficult was it for you to make a decision for this scenario?

Not at all   1   2   3   4   5   6   7   Extremely
difficult   difficult

Managing common mental health and medication (e.g. antidepressants)

3.1 You will now be asked your thoughts about prescribing medication (e.g. antidepressants). Please read the question and indicate by circling your answer on a scale of 1 to 7, where 1 is *unlikely* and 7 is *likely.*

a	If I prescribe the patient medication (e.g. antidepressants), I will feel that I am doing something positive for the patient	Unlikely 1 2 3 4 5 6 7 Likely
b	It causes a lot of worry and concern for the patient if they are found to have a psychological problem	Unlikely 1 2 3 4 5 6 7 Likely
c	If I prescribe medication (e.g. antidepressants) I will identify the patient's underlying problems at an early stage	Unlikely 1 2 3 4 5 6 7 Likely
d	If I provide medication (e.g. antidepressants) I've got to see some patients more often	Unlikely 1 2 3 4 5 6 7 Likely

3.2 Below, you will be presented with statements which refer to those above. You will then be asked to indicate your views to the below statements on a DESIRABILITY scale by CIRCLING a number, where -3 is *extremely undesirable* and +3 is *extremely desirable.*

e	Doing something positive for the patient is:	Extremely undesirable -3 -2 -1 0 +1 +2 +3 Extremely desirable
f	Causing a lot of worry and concern for the patient is:	Extremely undesirable -3 -2 -1 0 +1 +2 +3 Extremely desirable
g	Detecting problems for these patients at an early stage:	Extremely undesirable -3 -2 -1 0 +1 +2 +3 Extremely desirable
h	Having to see some patients more often is:	Extremely undesirable -3 -2 -1 0 +1 +2 +3 Extremely desirable

3.3 The questions below now relate to the IMPORTANCE you attach to different aspects of your management.

1. GPs whose views I respect think that…

   I should   1   2   3   4   5   6   7   I should not
   prescribe medication (e.g. antidepressants) for patients
   who have common mental health problems

2. It is expected of me that I prescribe medication (e.g. antidepressants) to patients who have common mental health problems.

   Strongly disagree   1   2   3   4   5   6   7   Strongly agree

3. I feel under social pressure to prescribe medication (e.g. antidepressants) to patients who have common mental health problems.

   Strongly disagree   1   2   3   4   5   6   7   Strongly agree

4. GPs whose views I respect want me to prescribe medication (e.g. antidepressants) to patients who have common mental health problems.

   Strongly disagree   1   2   3   4   5   6   7   Strongly agree

---

1. Patients with common mental health problems think I…

   should not   -3   -2   -1   0   +1   +2   +3   should

   prescribe medication (e.g. antidepressants)

2 Counsellors/psychologists would…

   disapprove   -3   -2   -1   0   +1   +2   +3   approve

3. Other GPs…

   do not   -3   -2   -1   0   +1   +2   +3   do

   prescribe medication (e.g. antidepressants)

1. Patients' approval of my practice is important to me…

Not at all   1   2   3   4   5   6   7   Very much

2. What counsellors/psychologists think I should do matter to me…

Not at all   1   2   3   4   5   6   7 Very much

3. Doing what other GPs do is important to me…

Not at all   1   2   3   4   5   6   7 Very much

3.4 You will now be asked how CONFIDENT you feel about different aspects of managing common mental health using medication (e.g. antidepressants)

<u>Self-efficacy</u>

1. I am confident that I could prescribe my patients with common mental health problems medication (e.g. antidepressants) if I wanted to.

Strongly disagree   1   2   3   4   5   6   7   Strongly agree

2. For me to prescribe my patients with common mental health problems medication (e.g. antidepressants) is…

Easy   1   2   3   4   5   6   7   Difficult

<u>Controllability</u>

3. The decision to prescribe medication (e.g. antidepressants) for common mental health problems is beyond my control.

Strongly disagree   1   2   3   4   5   6   7   Strongly agree

4. Whether I prescribe patients with common mental health problems medication (e.g. antidepressants) or not is entirely up to me.

Strongly disagree   1   2   3   4   5   6   7   Strongly agree

1. When patients with common mental health problems come to the consultation expecting medication (e.g. antidepressants). I am…

    less likely   -3   -2   -1   0   +1   +2   +3   more likely

                    to prescribe medication (e.g. antidepressants).

2   Feeling rushed in a consultation makes it…

    much more difficult   -3   -2   -1   0   +1   +2   +3   much easier

                    to prescribe medication (e.g. antidepressants).

3. When discussion of medication (e.g. antidepressants) is uncomfortable for patients, I am…

    less likely   -3   -2   -1   0   +1   +2   +3   more likely

                    to prescribe medication (e.g. antidepressants).

1. Patients' with common mental health problems come to the consultation expecting medication (e.g. antidepressants).

    Unlikely   1   2   3   4   5   6   7   Likely

2. When I am in consultation with a patient presenting with a common mental health problem I feel rushed.

    Unlikely   1   2   3   4   5   6   7   Likely

3. Discussion of medication (e.g. antidepressants) within the consultation is uncomfortable for patients

    Unlikely   1   2   3   4   5   6   7   Likely

Managing common mental health and psychological based treatments

The questions below now focus on psychological based treatment.

4.1 You will now be asked your thoughts about referring patients with common mental health problems for psychological based treatments. Please read the question and indicate your answer by CIRCLING a number on a scale of 1 to 7, where 1 is *unlikely* and 7 is *likely.*

A	If I refer the patient for psychological based treatment, I will feel that I am doing something positive for the patient	Unlikely	1 2 3 4 5 6 7 Likely
B	It causes a lot of worry and concern for the patient if they are found to have a psychological problem	Unlikely	1 2 3 4 5 6 7 Likely
C	If I refer the patient for psychological based treatment I will identify the patient's underlying problems at an early stage	Unlikely	1 2 3 4 5 6 7 Likely
D	If I refer the patient for psychological based treatment I've got to see some patients more often	Unlikely	1 2 3 4 5 6 7 Likely

4.2 Below, you will be presented with statements which refer to those above. You will then be asked to indicate your views to the below statements on a DESIRABILITY scale by CIRCLING a number, where -3 is *extremely undesirable* and +3 is *extremely desirable.*

e	Doing something positive for the patient is:	Extremely undesirable	-3 -2 -1 0 +1 +2 +3 Extremely desirable
f	Causing a lot of worry and concern for the patient is:	Extremely undesirable	-3 -2 -1 0 +1 +2 +3 Extremely desirable
g	Detecting problems for these patients at an early stage is:	Extremely undesirable	-3 -2 -1 0 +1 +2 +3 Extremely desirable
h	Having to see some patients more often is:	Extremely undesirable	-3 -2 -1 0 +1 +2 +3 Extremely desirable

4.3 The questions below now relate to IMPORTANCE you attach to different aspects of your management.

1. GPs whose views I respect think that…

   I should   1   2   3   4   5   6   7   I should not

   refer patients who have common mental health problems

2. It is expected of me that I refer patients with common mental health problems for psychological based treatment.

   Strongly disagree   1   2   3   4   5   6   7   Strongly agree

3. I feel under social pressure to refer patients with common mental health problems for psychological based treatment.

   Strongly disagree   1   2   3   4   5   6   7   Strongly agree

4. GPs whose views I respect want me to patients with common mental health problems for psychological based treatment.

   Strongly disagree   1   2   3   4   5   6   7   Strongly agree

---

1. Patients with common mental health problems think I…

   should not   -3   -2   -1   0   +1   +2   +3   should

   refer them for psychological based treatment

2. Counsellors/psychologists would…

   disapprove   -3   -2   -1   0   +1   +2   +3   approve

3. Other GPs….

   do   -3   -2   -1   0   +1   +2   +3   do not

   refer patients with common mental health problems
   for psychological based treatment.

1. Patients' approval of my practice is important to me.

Not at all   1   2   3   4   5   6   7   Very much

2. What counsellors/psychologists think I should do matter to me.

Not at all   1   2   3   4   5   6   7   Very much

3. Doing what other GPs do is important to me.

Not at all   1   2   3   4   5   6   7   Very much

4.4 You will now be asked how CONFIDENT you feel about different aspects of managing common mental health using psychological based treatment.

Self-efficacy

1. I am confident that I could refer my patients for psychological based treatment for common mental health problems if I wanted to.

Strongly disagree   1   2   3   4   5   6   7   Strongly agree

2. For me to refer my patients for psychological based treatment for common mental health problems is…

Easy   1   2   3   4   5   6   7   Difficult

Controllability

3. The decision to refer for psychological based treatment for common mental health problems is beyond my control.

Strongly disagree   1   2   3   4   5   6   7   Strongly agree

4. Whether I refer patients with common mental health problems for psychological based treatment or not is entirely up to me.

Strongly disagree   1   2   3   4   5   6   7   Strongly agree

1. When patients with common mental health problems come to the consultation expecting referral to psychological based treatment. I am…

    less likely   -3   -2   -1   0   +1   +2   +3   more likely

    to refer for psychological based treatment.

2   Feeling rushed in a consultation makes it…

    much more difficult   -3   -2   -1   0   +1   +2   +3   much easier

    to refer for psychological based treatment.

3. When discussion of psychological based treatment is uncomfortable for patients, I am…

    less likely   -3   -2   -1   0   +1   +2   +3   more likely

    to refer for psychological based treatment.

1. Patients' with common mental health problems come to the consultation expecting to be referred for psychological based treatment.

    Unlikely   1   2   3   4   5   6   7   Likely

2   When I am in consultation with a patient presenting with a common mental health problem I feel rushed.

    Unlikely   1   2   3   4   5   6   7   Likely

3. Discussion of antidepressants within the consultation is uncomfortable for patients

    Unlikely   1   2   3   4   5   6   7   Likely

PLEASE PRINT AND KEEP THIS PAGE

Thank you for taking the time to complete this questionnaire focussing on common mental health and its management. Your opinions and experiences are important to the success of this project.

All information that that you have provided in this questionnaire will be held anonymously, therefore it will be **impossible** to trace back to you as an individual.

Information collected will be stored securely and maintained at Cardiff University in accordance with their data retention and protection policy. Data will be stored on University computers that are password protected so only members of the research team will have access and may be retained indefinitely.

If you are interested in finding out more about this study please contact:

Katie Marsh (PhD student) or Andy Smith (Professor)
Centre for Occupational & Health Psychology
Cardiff University
63 Park Place
Cardiff CF10 3AS
Tel: 029 2087 6495 / 76598
Email: MarshKL1@cardiff.ac.uk / smithap@cardiff.ac.uk

Please click on 'SUBMIT' below to finish this survey

THANK YOU FOR TAKING THE TIME TO COMPLETE THIS QUESTIONNAIRE.

If you would like to receive a copy of the results from this survey once they have been processed and written up, please email or telephone:

Katie Marsh

Email: MarshKL1@cardiff.ac.uk

Telephone: 029 2087 6495

Appendix 6-1: Intranet invitation for the 'Staff Well-being Survey'

Hello,

Thank you for your interest in completing the survey. Please follow the link below:

http://discovery.cf.ac.uk/SurveyTracker/wellbeingsurvey1final/wellbeingsurvey1final.htm

and follow the instructions within. When you have submitted your responses you will be given a link to a new page where you can provide your email address separate from your responses, for payment and entry to the prize draw. Your responses to the survey will not be linked with this address. A further email will be sent to this address to provide details on payment.

Regards,

Gary.

REQUEST FOR MORE INFORMATION

Hello,

Thank you for your interest in the staff well-being survey, please see below for more information:
The survey would require you to follow an internet link to a questionnaire that would take you approximately 1 hour to complete and would involve giving responses to questions relating to your well-being (e.g. job characteristics, health behaviours, stress) and attitudes and beliefs that may be related. The survey involves a number of short and long questionnaires related to these topics, in order to determine whether well-being can be measured in a shorter and more practical way than a full questionnaire on each individual aspect. The answers you provide will be held completely anonymously, and your email address will be provided separately and unlinked to your survey for further information on collecting payment and for entry to the prize draw.

If you are interested, please use the link below and follow the instructions within. If there is a specific element you would like more information on then please let me know.

Regards,

Gary.

Link:
http://discovery.cf.ac.uk/SurveyTracker/wellbeingsurvey1final/wellbeingsurvey1final.htm

Appendix 6-2: General population mental health literacy questions

<u>DEFINING COMMON MENTAL HEALTH PROBLEMS</u>

1.Write down what you consider to be the <u>four</u> most common mental health problems? Number ONE being the most common

1 _____
2 _____
3 _____
4 _____

2.The following question focuses on what you think the term 'common mental health problems/disorders' refers to. Please read the statement below and indicate whether you agree or disagree with this statement: Please tick ONE box

'Common mental health problems/disorders' do not refer to conditions other than depression and anxiety and are not short term.

Do you agree with this statement? Please tick ONE box

Agree   0
Disagree   1

3. Have you had personal experience of a common mental health problem?

Yes   0
No   1

4. How good is your knowledge of common mental health problems?

Good   0
Average   1
Poor   2

5. Do you feel that you could identify common mental health problems of other people?

Yes   0
No   1

6. Do you feel that you could help people with common mental health problems?

Yes   0
No   1

7. Do you feel GPs receive appropriate training/education covering common mental health issues and their management? Please tick ONE box

Yes   0
No   1

8. On the whole how straightforward do you think consultations with the GP around common mental health problems are? On a scale of 1-4, where 1 is very straightforward and 4 is not at all straightforward. Please tick ONE box

Very straightforward 1	2	3	Not at all straightforward 4

9. Will the treatment of a patient with a common mental health problem depend on their knowledge of their problem?

Yes   0
No   1

10. Do you feel that common mental health problems should be treated with medication or psychological therapy? Please tick ONE box

Medication   0
Psychological therapy   1
Both   2

11. Should psychologists or psychiatrists be more involved in the treatment of common mental health problems?

Yes   0
No   1

Appendix 7-1: Invitation email – Triangulation Study

School of Psychology

CARDIFF UNIVERSITY
PRIFYSGOL CAERDYDD

Dear Sir or Madam,
Common Mental Health Management

We are writing to invite you to take part in a research project about the management of common mental health problems.

Cardiff University are undertaking a research project to look at how General Practitioners (GPs) manage common mental health and what they think about this.

The effective management of common mental health problems is of high importance. It is suggested that GPs are key and best placed to recognise and manage individuals presenting with common health and common mental health problems. It has been suggested that they find the management of these consultations challenging. However, while interventions and programmes are being introduced to address the suggestion of GPs experiencing 'difficulties' there seems to be a lack of literature and clear evidence pointing to exactly what it is that GPs are experiencing with regard to the consultation around common mental health.

This project forms part of a program of research for a PhD which looks into the management of common mental health in primary care. This study follows on from a 'GP Survey' conducted between May and June 2009 across the Gwent Health Authority region, where the response rate reached 32%. The aim is to take this forward look more closely at how GPs manage common mental health issues, to see what work and what doesn't work so that more targeted and appropriate information, training and interventions can be considered.

GPs, Primary Care Counsellors and Clinical Psychologists are invited to take part in a focus group to discuss issues around the management of common mental health problems in primary care. The opinions and experiences of those working closely with or having experience of the management of common mental health (GPs, Primary Care Counsellors, Clinical Psychologists and Expert Patients) are important to the success of this project.

The study involves taking part in a focus group discussion to talk about issues surrounding the management of common mental health, more specifically prescribing and referral of those with a common mental health problem

The focus group will last **no longer than 1 hour and will consist of between 4-6 people.** You do not have to take part and you are free to withdraw from the discussion at any point.

Taking part is completely voluntary. It is up to you to decide whether or not to take part. If you do, you will be given this information sheet to keep. The discussion groups will be recorded. Information that is collected via the focus groups will be stored confidentially, up until the point it is anonymised, so that it will be IMPOSSIBLE to trace this information back to you as an individual. This information will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act (1998), and may be retained indefinitely.

If there are any problems or complaints you have about the way you have been dealt with during the discussions these will be handled by the research sponsor, Cardiff University.

Complaints:
> If you have any problems or concerns about any aspect of this study, please contact:
> Louise Hartrey
> Psychology Ethics Committee
> Cardiff University
> Tower Building
> Park Place
> CF10 3AT
> Tel: 029 2087 0360
> Fax: 029 2087 4858

Distress:

If you are a health professional and are distressed or upset by any aspect of this research please contact:

> The Primary Care Support Service for Wales. The Primary Care Support Service is a direct access, **confidential** counselling, support and educational service for GPs, general dental practitioners and community pharmacists working in Wales. It is funded by the Welsh Assembly Government but is run as an independent service led from Bangor University with co-ordinators in each of three Welsh regions.

> The counselling service is totally **confidential** (in line with the GMC, BACP, UKCP etc, code of ethical responsibilities) however, if you give the counsellor information which suggests that you, or another person, are at risk of actual harm the counsellor will encourage you to consult your GP or obtain your permission to contact someone else. The service provides a list of counsellors for your region together with the counsellors' direct contact details. Since you

have direct access to the people listed in the network only the person you choose to contact will know who you are.

Contact details:
Primary Care Support Service for Wales:
www.primarycaresupport.wales.nhs.uk
Link to their Southeast Wales Counsellors and their contact details:
http://www.wales.nhs.uk/sites3/page.cfm?orgId=558&pid=13951

Head Office:
Primary Care Support Service
Ardudwy, Normal Site,
Bangor University, Gwynedd, LL57 2PX Tel No: 01248 383050

The information provided during the group discussions will be used to frame continuing research looking at GPs management of common mental health. A research report describing the study will be written and everyone who has participated in the study will be offered a summary of this report.

This study is organised and funded by the Centre for Psychosocial and Disability Research and the Centre for Occupational and Health Psychology, Cardiff University.

This study was given approval has been reviewed by the Research Ethics committee for Wales on the 15/12/2009.

If you have any questions please feel free to contact a member of the research team:

Katie Marsh (PhD researcher) on (029) 2087 0106 (e-mail: MarshKL1@cardiff.ac.uk)
Professor Andrew Smith (Supervisor) on (029) 2087 6598 (e-mail: SmithAP@Cardiff.ac.uk).

Thank you very much.

Best wishes,

Katie Marsh (PhD researcher) & Professor Andrew Smith.

Appendix 7-2: Pre-focus group document – Triangulation Study

Focus Group Themes – Information for participants in advance of discussion group

This project forms part of a program of research for a PhD which looks into the management of common mental health in primary care. The effective management of common mental health problems is of high importance. It is suggested that GPs are key and best placed to recognise and manage individuals presenting with common health and common mental health problems. It has been suggested that they find the management of these consultations challenging. However, while interventions and programmes are being introduced to address the suggestion of GPs experiencing 'difficulties' there seems to be a lack of literature and clear evidence pointing to exactly what it is that GPs are experiencing with regard to the consultation around common mental health.

For this research data has been gathered via several modes of investigation: focus groups with GPs, GP survey, theory of planned behaviour survey: prescribing/referral behaviours and a general population mental health literacy survey.
Data collected during this programme of research has indentified many aspects and influential factors associated with CMH management.

The focus group you are attending today is one of three groups being conducted with GPs, primary care counsellors and clinical psychologists. The objective of the focus groups is to try and triangulate the findings and hear what you think about some of the findings that have come out of this programme of research.
For your information, below is a guide to some of our findings and themes around which our discussion will be based. I would really like to know what you think about the findings and whether you agree with them or not.

Consultations around common mental health
1. Consultations not straightforward: over half GP survey population and 70.5% general pop Mental health literacy survey
2. Difficult to assess CMHPs – medically/subplot work
3. Consultation length
4. CMHP = generally reactive states
5. Anxiety, depression, obsessions and compulsions, poor coping, psychosis, stress

Management of common mental health
1. Difficult to manage inherited patients, re: interventions
2. Interventions better at the beginning
3. Work issue very difficult to manage, especially when work is an influence
   a. Consequences are significant – harder to get back to work, find another job etc
4. High prevalence of CMHP as a secondary condition (73% GP survey) and as a primary condition (61.2% GP survey)
5. Over half indicated prescribing medication (e.g. anti-depressants) on a first visit. 97.5% indicated that they would request to see the patient again. Of

those who prescribed medication on a first visit, 60% of those indicated that they do not administer a screening tool prior to the prescription of medication.

6. Treating CMHP:
   a. GP confidence mixed in the management of antidepressants
   b. Less confident in the management of psychological therapy unless able to manage complex therapy

7. Personal experience of CMHP: significant influence in the working practice management of CMHPs
   a. A significant negative relationship was also found between personal experiences of the results of treatment and confidence managing psychological based interventions (-.458, $P<.002$), and confidence managing psychological and pharmacological interventions (-.463, $P<.001$), that is to say that higher confidence managing psychological interventions was significantly associated with higher positive scores of personal experiences of the results of treatment.

8. Influences of prescribing and referral behaviour:
   a. Whether GPs prescribe antidepressants to patients with common mental health problems is significantly influenced by both their attitude and their subjective norm.
   b. Referral to psychological-based treatment was shown to be influenced by both attitude and perceived behavioural control
   c. Attitude and subjective norm had significant influence on GPs intention to prescribe antidepressants
   d. Considering referral to psychological-based treatment, attitude was found to be a significant influence upon GPs intention to refer for psychological treatment
   e. Analysis also showed GPs did not feel in control of referring patients with CMHPs for psychological-based treatment.

9. Mental health literacy survey: Respondents indicated strongly that they thought treatment for a patient with common mental health problems depended on their knowledge of their problem, 81.2% (n=95).

10. Gen pop thoughts on treatment: When asked about treatment for common mental health problems (medication, psychological therapy or both), respondents indicated that they thought treatment should be the combination of psychological therapy and medication, 83.1% (n=98). Psychological therapy on its own, 16.2% (n=19) and only 0.8% (n=1) indicating the use of only medication.

11. Respondents believed that psychologists or psychiatrists should be more involved in the treatment of common mental health problems, 95.7% (n=111).

Training
1. Wanting more training in mental health
2. Gaps in the amount of refresher courses and training in mental health undertaken by GPs:
   a. Sample for GP survey: 68% had undertaken a refresher course, though not necessarily to do with mental health.
   b. 25.9% had experienced training in mental health or mental illness.

     c. 33.6% indicated previously having a psychiatry or psychology- related job.

     d. Only 18 GPs 'checked' all three of these options.

     e. 47.4% of GPs indicated that they felt they did not receive appropriate training/education.

3. Mental health literacy study: 67.5% of respondents (general population) didn't feel GPs receive appropriate training/education covering CMH and its management.

[To be printed on Cardiff University headed paper]

<u>Debriefing Sheet</u>

Thank you for taking part in this focus group on common mental health and its management. Your opinions and experiences are important to the success of this project.

All information that has been provided during this discussion group will be stored confidentially, up until the point at which it is transcribed and anonymised, so that it will be IMPOSSIBLE to trace this information back to you as an individual. This information will be stored securely on university computers which are protected by passwords so only the researchers can access them. All data will be held by Cardiff University in accordance with the Data Protection Act (1998), and may be retained indefinitely.

If you are interested in finding out more about this study please contact:

Katie Marsh (PhD student) or Andy Smith (Professor)
Centre for Occupational & Health Psychology
Cardiff University
63 Park Place
Cardiff CF10 3AS
Tel: 029 2087 6599 / 6455
Email: marshkl1@cardiff.ac.uk / smithap@cardiff.ac.uk

Appendix 7-4: Consent form – Triangulation Study

School of Psychology

CONSENT FORM

Title of Project: Management of Common Mental Health Problems

Name of Researcher: Katie Marsh

Please initial box

1. I confirm that I have read and understand the information sheet
    dated 14/07/2011(version 2) for the above study. I have had the opportunity to
    consider the information, ask questions and have had these answered satisfactorily.

2. I understand that my participation is voluntary and that I am free to withdraw from the
    study at any time.

3. I agree for the information I give to be used in the research.

4.   I agree to be audio-recorded during my participation in the above study.

5.   I agree for anonymised direct quotes from the discussion group to be used in the
         report.

6. I understand that the information provided by me will be held totally anonymously, so
    that it is   impossible to trace this information back to me individually. I understand
    that, in accordance with the Data Protection Act, this information may be retained
    indefinitely. I also understand that at the end of the study I will be provided with
    additional information and feedback about the purpose of the study.

7.
_____

Name of participant   Date   Signature

8. _____

Researcher   Date   Signature

347