

"Co-Producing a Community of Practice Model for Primary Care Mental Health: A Participatory Grounded Study Conducted During the Pandemic"

Lisa Jane Hill

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Abstract

"Co-Producing a Community of Practice Model for Primary Care Mental Health: A Participatory Grounded Study During the Pandemic"

This research addresses the discovered disconnect within mental health primary care education policy and practice.

Purpose

The primary objective of this study is to align personal and community goals through a collaborative approach. It seeks to integrate community perspectives into future mental health policy (Faltermaier 1997), education and practice to enhance outcomes and promote active community participation.

Method and Methodology

The literature strategy combined historical and contemporary literature reviews to inform the context, the method and methodology. The qualitative methodology applied Grounded Participatory Theory and Cognitive Flexibility Theory.

Pre-pandemic, the method engaged six community participants in a focus group using two data collection methods Disney Modelling and Appreciative Inquiry (Chapter Three p.52). Fourteen telephone interviews were conducted during the pandemic, using Grounded Participatory Theory (Brown, Danaher 2019, Chapter Three p.61). Post-pandemic member checking and reflexivity were applied to refine the co-produced community of practice model for primary care mental health (Chapter Four p.197).

Key Outcomes

1. Collaborative Learning Theory was developed to integrate community perspectives into mental health education.
2. Government policy can promote community involvement in educational initiatives using a community of practice approach.
3. The gap between policy and practice needs redressing through co-production to improve mental health outcomes.

4. The physical and mental health of the primary care workforce interviewed showed that self-stigma meant help was often sought too late or not at all.

Results

Community participants emphasised the importance of relational care and highlighted educational gaps in mental health primary care. Health and social care professionals often neglect self-care due to self-stigma. The COVID-19 pandemic exposed severe health inequalities and confirmed the Inverse Care Law (Hart, 1971). These findings revealed a significant disconnect between community needs and current practice. The shared values and experiences of the community informed the development of a community of practice model for primary care mental health aimed at addressing these challenges.

Conclusion

This study contributes to mental health education by co-producing a community of practice model for primary care mental health. The model is based on community values and can enhance mental health outcomes by fostering stronger connections between policy, practice, education and community needs.

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Co-Produced Glossary of Mental Health Terms Used in the Thesis.

The research concerns primary care mental health and uses medical terminology, abbreviations, and jargon not used daily in English.

Participants co-produced the following glossary, which is in alphabetical order and aims to debunk the jargon used in the thesis.

Glossary

Advocate - An advocate is trained to listen and speak to people in times of need when it is difficult to express views, have people listen, and have them taken into account.

Alternative Therapies/Complementary therapies - A way to treat illnesses using techniques outside of traditional medicine.

Antidepressants - Medicine used to treat depression and chronic pain, also used in other mental health conditions such as anxiety or obsessive-compulsive disorder.

Antipsychotics - Medicine used in schizophrenia and bipolar disorder, sometimes with severe anxiety or depression.

Anxiety - Mental and physical state that arises from a fear of the future or a situation. Anxiety is typical, with mild worry. However, in excess, it can stop people from functioning entirely, and it is also associated with several conditions ranging from diabetes to depression.

Article - The Human Rights Act 1998 lays out each human right, known as an article. This is from the European Convention on Human Rights.

Behaviour Therapy - Behaviour therapy is a way to change undesired behaviour through targets, positive reinforcement, and desensitisation.

Bipolar Disorder - Episodes of depression and despair against a mood swing to mania and excitability with periods of even behaviour between.

Capacity - The ability to understand information and make and communicate personal decisions.

Care Act 2014 - Local authorities must assess the needs and eligibility of adults and carers for care and support.

Chronic Disease - A long-term condition that has to be lived with as there is no cure.

Clinical commissioning groups (CCGs) - Responsible for commissioning healthcare in a local area and replaced by integrated care boards in 2022.

Clinical Psychologist - A professional with a qualification in psychology specialising in therapy.

Cognitive Therapy - Aims to identify and replace thinking patterns leading to destructive feelings and behaviours.

Cognitive Behaviour Therapy - Talking therapy to change negative thinking, feeling, and behaving patterns.

Community Mental Health Team (CMHT) - A multi-disciplinary team of mental health workers working in a community setting. This includes psychiatrists, community psychiatric nurses, occupational therapists, social workers, care workers, and psychologists.

Community Psychiatric Nurses (CPNs) - Care for people with mental health issues in the community and may operate from a general practitioner's surgery, providing support, medication, and support to families and carers. Role to help recover back into the community from the hospital and prevent mental health deterioration.

Community treatment order (CTO)—Following hospitalisation under a section, discharge, and removal from the section, a community treatment order means people may have to live somewhere designated or receive medication. If conditions are not followed, they can be returned to the hospital.

Consultant - A consultant is a specially trained doctor who works in one area of medicine, is usually hospital-based, leads medical teams, and is consulted for medical opinions.

Counselling - Talking therapy is where a counsellor listens and helps people see feelings and problems differently. Counselling can be conducted informally by GPs, psychiatrists, nurses, or more formally by counsellors. Community Psychiatric Nurses can carry out counselling in primary care. **Consent** - Consent is agreeing with another person about an action they've proposed. Legally, consent is valid if the person can decide, has enough information to make that decision, and freely consents.

Crisis resolution and home treatment services - 24-hour, short-term care in the community during a crisis to prevent hospital admission.

Data Protection Act 2018 - Sets out how organisations must handle and process information (MIND 2023). It gives rights to access and the holding of correct personal information.

Data subject - The person to whom the personal information relates and who wants to access the information held.

Dementia - A loss of memory capacity that interferes with social and occupational functioning causes someone to find it hard to self-care and eventually affects all areas of a person's life.

Depression - A mood disorder demonstrated by extreme sadness lasting for longer than two weeks with physical and emotional symptoms.

Diagnosis - A doctor identifies the symptoms and condition based on signs and tests.

Delusions - Delusions are described medically as irrational thoughts with no aspects of reality.

Disability - The legal meaning comes under the Equality Act, which identifies impairments that are either physical or mental and substantial, adverse, and have a long-term effect on daily activities.

Disability discrimination - If a person is mistreated due to a physical or mental health condition.

Discrimination - The law covers the following types of discrimination: direct discrimination, discrimination arising from disability, indirect discrimination, harassment, victimisation, and noncompliance, with the responsibility to make reasonable adjustments.

Doctors Consultation - A doctor meets a patient and asks questions about problems, may examine them, and organises investigations to understand the presenting issues, their cause, how the patient feels and thinks, and a clear action plan.

Early intervention - Recognition of early warning signs for mental health problems to prevent deterioration.

Electroconvulsive therapy (ECT) - An electrical current passes through the brain, causing a seizure/fit.

Empowerment - The skills, knowledge, attitudes, and power that enable individuals to be responsible for their decisions, lives, health, and care.

Episode - Defined as a time when poor mental health is experienced.

The Equality Act - The law explains disability and discrimination.

Evidenced-Based (Medicine) - Evidence can be from scientific trials or senior professionals. The evidence is published, and guidelines are developed to inform care delivery.

Generalised anxiety disorder - Long-term condition where everyday things make people stressed and worried.

General Data Protection Regulation (UK GDPR) - How organisations can use personal information explaining access rights and the correct personal information.

General Practitioners (GPs) - A local doctor trained to work in the community to treat common medical conditions and refer patients to hospitals and other agencies for urgent and specialist treatment.

Generalist - A clinician sees, assesses, and manages problems differently from a specialist or consultant. Generalists in primary care include practice nurses and district nurses.

Hallucinations - Hallucinations are sensations without a known source. They can include voices, pain, or a burning sensation.

Healthcare - Healthcare does not have a legal definition. The National Framework for National Health Service (NHS) Continuing Healthcare says healthcare is related to treating, controlling, or preventing disease, illness, injury, or disability and offering care or aftercare for a person.

Human Rights Act 1998 - Human rights are protected by the Human Rights Act 1998.

Improving Access to Psychological Therapies (IAPT) - NHS-run talking therapies programme across England. Referral may be by the GP or by self-referral.

Insomnia - People struggle to get off to sleep and wake up, so they do not feel refreshed the next day. (NHS inform 2023)

Isolation or social isolation - A low level of social contact in daily life increases the risk of poor mental health.

Local Government - Local councils run social services, public health, schools, and housing and leisure departments.

Mania - A bipolar disorder symptom with tendencies for excitement and over-activity both physically and mentally, plus impulsive behaviour.

Managing Disease - After a diagnosis, a treatment plan includes medication, therapy, education, and regular reviews with information given to patients and carers.

Medical treatment - The term comes from the Mental Health Act. It is medical treatment that relieves the signs and symptoms of mental ill health, such as nursing, medication, talking therapies, and psychological intervention.

Meditation - A 'mind-body' state that increases calmness and a sense of wellbeing.

Mental Health - Emotional wellbeing that affects thinking, feeling, relationships and everyday living.

Mental disorder - The Mental Health Act discusses that people can be sectioned if mentally disordered or "any disorder or disability of mind" (Her Majesty's Government 1983). It includes psychiatric diagnosis and some learning disabilities.

Mental Health Act 1983 (MHA): This law covers sectioning (detention, treatment) of mental health disorders.

Mental Illness / Ill health - If mental health is disrupted, thoughts, emotions, or behaviour are affecting their daily lives. It is not always psychiatric and is the most common of conditions seen in primary care.

Mental Wellbeing - Positive feelings of happiness affect all areas of a person's life.

Mindfulness - Mind and body exercise to manage thoughts and feelings in the present moment.

Mortality - Death

Morbidity - Causing illness or disease usually long-term, but not death.

Obesity - Significantly overweight with a body mass index of over thirty.

Obsessive-compulsive disorder - A chronic, relapsing condition with recurrent and unwanted thoughts or rituals that become uncontrolled.

Occupational health - Occupational health assesses for physical or mental health problems that affect employment or employment practices and environments that cause sickness.

Occupational Therapists (OTs) - Enable people to adapt to their environment and cope with daily living in a hospital or the community.

Panic Disorders and panic attacks - People with panic disorder experience fear that happens without warning. Panic attacks describe an episode of severe fear, often with overwhelming physical feelings.

Post-traumatic stress disorder - Affects people following the experience or witnessing of a highly traumatic or catastrophic event.

Paranoia and Paranoid Disorders - Feelings of persecution and a sense of self-importance. People with the disorder can function but are often self-isolated.

Patient - In mental health, The Mental Health Act of 1983 identifies a patient as someone suffering or appearing to be suffering from a mental disorder. In primary care, it applies to all using primary care.

Person-Centred Care - Based on the patient's needs, feelings, and beliefs, ensure they have the proper support and skills to meet those needs.

Practitioner - A person registered to provide healthcare services. Nurses, doctors, and social workers are examples.

Primary Care - Community services provide open access to patients locally and include GPs, Pharmacists, Dentists, and District Nurses, amongst others. This is often the first point of contact for people needing healthcare. "It's provided by professionals such as GPs, dentists and pharmacists." (MIND 2023)

Psychiatrist - A doctor who specialises in diagnosis, treatment, and prevention of mental health conditions, either community or hospital-based and is employed mainly by secondary care.

Psychological therapist - A practitioner of psychological therapy. "They deliver interventions to help people understand and make changes to their thinking, behaviour and relationships, to improve mental wellbeing." (Bupa UK 2023)

Psychosis - Severe mental illness that may cause hallucinations and delusions. It is often a symptom of delirium and schizophrenia.

Quality and Outcomes Framework (QOF) - Part of the GP contract is to encourage Primary Care to deliver standards of care in long-term conditions, including mental health. By hope, recovery is a journey that enables people to live a life with a purpose.

Resilience - The level of pressure that can be managed before it turns into stress. It can be built through developing positive thoughts and healthy living.

Schizophrenia - Schizophrenia is a mental disorder with "positive" or psychotic symptoms and "negative" symptoms, including social withdrawal and low motivation.

Secondary Care - Healthcare services usually require a GP's prior referral. These include hospitals, community mental health teams (CMHTs), early intervention with psychosis teams, and assertive outreach teams.

Section - Being kept in hospital under the Mental Health Act 1983.

Services - Local councils, government departments, charities, private companies, hospitality, places of worship, GPs, hospitals, and clinics.

Service Provider - A person or organisation that provides a service to a member of the public, either free or paid. This can be an NHS body, a small local group, or a national voluntary sector organisation.

Severe and Enduring Mental Illness - Severe mental health problems, including schizophrenia and bipolar disorder.

Social anxiety disorder - Frightened by being watched or judged in any social situation, including work.

Social care – Healthcare and social care have no legal definition. However, the National Framework for NHS Continuing Healthcare says activities of daily living, maintaining independence, social interactions, and accessing housing come under social care.

Social Inclusion - To ensure those stigmatised or impoverished can be involved in any decisions about them to improve their lives and wellbeing.

Social workers - Social workers can be mental health workers based in multidisciplinary community mental health teams who deal with social problems, such as housing, money, and work.

Stigma - Societies fear and lack of knowledge on mental health and other illnesses, leading to social isolation and health inequalities.

Stress - Feeling the pressure of life is not a mental health disorder but increases the risk of developing it.

Symptoms - Evidence or signs of a health condition that the person notices.

Talking therapies - Talking to a trained professional about feelings to help throughout a difficult time.

Trauma - An extremely upsetting, stressful or threatening situation.

Treatment - An intervention to reduce or remove the symptoms of mental ill health.

Voluntary Sector - Voluntary sector organisations can be small community groups or large national organisations. They are independent of the government, value-based, and not set up for financial motives.

Chapter One

1.0 Introduction

This chapter outlines the study, establishing connections between its key chapters and summarising the research's aim, questions, and objectives. This study includes a literature strategy and review, a detailed explanation of research methods, the findings, recommendations, and conclusions.

1.1 The Origins of the Research and Title

The research originated from a comment by a general practitioner (GP) studying mental health on a postgraduate primary care course. The GP questioned the effectiveness of teaching centralised mental health guidelines from the National Institute for Health and Care Excellence (NICE). Further discussions with primary care colleagues, including GPs and nurses, revealed a perceived disconnect between policy and practice.

A literature review contextualised primary care mental health to explore the anecdotal disconnect and confirmed the gaps between policy and practice. The research addressed these gaps by co-producing an educational model using a community lens. Participants included healthcare workers, individuals with lived mental health experiences, and their families.

The title, '**Co-Producing a Community of Practice Model for Primary Care Mental Health: A Participatory Grounded Study Conducted During the Pandemic**' reflects the importance of education having a community input. The research used an inductive analysis approach, drawing inspiration from Max Weber's concept of *verstehen*. Verstehen is to understand someone by "walking in their shoes ". To obtain individual perspectives from people's social world (Chowdhury 2014). A line in the poem by Mary Lathrap '*.... Walk a mile in my moccasins,*' further inspired the researcher (Lathrap 1895) to manage the research compassionately.

1.2 Aim

The research aimed to make an original contribution to primary care mental health education from a community perspective, supporting professional development. Concept mapping (Appendix Twenty) revealed gaps in current policies, particularly community involvement in mental health education. No existing learning theory in primary care mental health was found in the literature that engaged the community as equals (Appendix One).

1.3 Research Questions and Objectives

The research was guided by two key questions framed by Cognitive Flexibility Theory (CFT), which views learning as context-based and adaptable (Patel 2009). It was chosen as a methodological approach to balance the complexity of primary care mental health (Sweeney 2017, Johnsson, Nordgren 2019, Banzhaf, Miller 2004).

1.3.1 Research Question One

Is there potential to create a learning theory for primary care mental health education that considers community perspectives?

The question arose as the literature review revealed a lack of learning theories incorporating community input (Appendix One). The study sought to explore how education methods can align with the needs of individuals, organisations, and communities.

1.3.2 Objective One

Develop a learning theory grounded in community perspectives by mapping participant values against UK policy and existing learning theories.

1.3.3 Research Question Two

Will government policies on community participation in mental health education be enacted in primary care?

Literature showed that community perspectives were missing from significant national health policies. The question explored how community participation might influence policy enactment.

1.3.4 Objectives Two and Three

Objective Two: *Identify shared community values to develop an epistemology for primary care mental health education.*

Objective Three: *Co-produce a pedagogical framework with the community and evaluate it against existing literature.*

1.4 A Qualitative Approach to Research

The research used a qualitative methodology, incorporating one focus group of six participants and fourteen telephone interviews to capture community values and experiences. Grounded Theory, blended with Participatory Research, provided the Participatory Grounded methodology, allowing a diverse understanding of primary care mental health.

1.5 Community Participants

Participants were from Northwest England and included individuals with lived experiences of mental health, healthcare professionals, and volunteers. Their contributions informed the co-production of educational recommendations.

1.5.1 Co-Production

Co-production enabled participants to contribute to the development of a community of practice model for primary care mental health (Brandsen, Honingh 2013, Brandsen Honingh 2016). Member checking ensured themes accurately reflected participants' views (Charmaz 2006, Creswell 2009, Thomas 2017, Motulsky 2021).

1.5.2 Community Participation

Community participation in mental health is part of global healthcare policies, but little is known about its role in primary care education. A conceptual framework outlines

areas of participation in primary care nursing, with severe mental health an apparent omission (Heuman et al. 2022, Appendix Two). This research explores the barriers to participation experienced by the community in primary care mental health and highlights future workforce challenges and opportunities.

1.6 Background - Primary Care and the Commitment to Health

Primary care is at the heart of community health, as the Alma-Ata Declaration (World Health Organisation 1978) and Astana Declaration (World Health Organisation 2018) emphasise. These declarations stress the importance of integrating mental health services and community participation to tackle inequity and disparities in health (Walraven 2019). This research argues that engaging the community in mental health education can address growing inequalities and improve care, allowing knowledge to move fluidly between the community and health (Park, Abrams 2019).

1.7 Professional Interests of the Researcher

The researcher has extensive experience in mental health as a clinician, manager, and educator. Personal experiences with mental health issues further motivate the researcher's commitment to exploring community-based mental health education.

1.8 Summary of Chapter Outlines

Chapter One: Introduction of this study, including aims, objectives, research questions, and origin.

Chapter Two: Literature Search Strategy, Historical Context, and Current Policy Affecting Primary Care Mental Health Education. The literature review shows the impact of austerity policies on the healthcare workforce and funding before the pandemic.

Chapter Three: Reflexive writing discusses the method including the data collection methods of Disney Modelling and Appreciative Inquiry used in a focus group of six participants before the pandemic. The process was changed to telephone interviews with fourteen participants during the pandemic. The methodology of Participatory Grounded Theory and thematic analysis are detailed.

Chapter Four: Discussion of the findings from the focus group and telephone interviews, capturing final themes and sub-themes. Based on the community's insight and supported by the literature, recommendations are made to develop a community of practice model for primary care mental health.

Concluding Chapter: Reflects on the study, answers the research questions, shares the objectives and outlines the strengths and limitations of the research.

Chapter Two – Literature Review

2.0 Introduction

The literature review contextualised and informed this study's method and methodology by examining primary care mental health policy through historical and current literature. The literature reviewed whether the anecdotal gap, expressed by a general practitioner, between mental health policy and practice was a documented phenomenon in primary care.

2.1 Literature Search Strategy

The literature search followed an iterative process, systematically searching and evaluating relevant sources to identify key themes, gaps, and differences in perspectives. Initially, a broad literature review using the search term "primary care gap" in **CINAHLPLUS** identified only one relevant paper published since 2012. A more expansive Boolean search used the terms *Primary OR Care OR Mental OR Mental Health OR Gap* yielded over 7,000 responses. To refine the results, the search was limited to full-text, peer-reviewed academic journals from the UK and Ireland in English and published between January 1st, 2013, and January 1st, 2018.

In addition, **CINAHLPLUS** was searched for evidence of patient and caregiver involvement in continuing medical education for primary care mental health. The search was narrowed using terms such as *Primary AND Care AND Mental Health AND Education*, which resulted in six relevant studies. A further search for 'primary care competencies' produced three irrelevant results, indicating gaps in this area. A search in **CINAHLPLUS** and **PubMed** focused on 'patient expectations' in primary care. A systematic review by Miglietta et al. (2018) revealed no gold standard measuring patient satisfaction with primary care mental health.

2.1.1 Key Findings

The term 'continuing medical education in mental health' yielded two outdated results from 2004. A further refinement, focusing on 'continuing medical education in primary care mental health' and 'competency-based education,' uncovered trends toward patient-centred, outcomes-based approaches (Tekian et al. 2018). However,

significant gaps were identified in understanding patient and caregiver perspectives (McCall et al. 2004a, Moja, Kwag, 2014, Reid et al. 2017).

Additional searches in **PubMed** for 'competency-based primary care mental health medical education' yielded 1,525 results. After filtering peer-reviewed articles and removing duplicates, 38 relevant studies remained. However, none involved service users, prompting further searches with the terms 'patient participation in developing competencies for mental health' and 'service user involvement in mental health education.' The searches returned no results, a notable gap in the literature.

2.1.2 Exclusion Criteria

Several studies were excluded based on relevance, quality, and methodological rigour:

- **Relevance:** Studies that did not focus on primary care or mental health were excluded. Hospital-based mental health research was not included as it was not relevant to the scope of this study.
- **Geographical Scope:** Papers not specific to the UK or Ireland were excluded due to contextual relevance.
- **Outdated Research:** Given the rapidly evolving nature of primary care mental health education post-pandemic, older studies were excluded unless they contributed significantly to the historical context.
- **Quality and Rigour:** Studies lacking peer review, empirical evidence, or small sample sizes were excluded. Opinion pieces and studies with unclear methodologies were also omitted.
- **Methodological Fit:** Quantitative studies were included only if they could triangulate with the qualitative data and supported the narrative.

2.1.3 The Grey Literature

The term 'gatekeeping' was identified as a gap in the literature, with no academic studies found in **PubMed**. References to gatekeeping practices appeared in the grey literature. To ensure the policy was current, the grey literature was used in government reports and professional guidelines (Michels et al. 2018, RCGP 2016).

These sources filled gaps where peer-reviewed research was lacking, particularly concerning the education and governance influencing GPs.

2.1.4 Stage Two of the Literature Strategy:

The second phase of the literature strategy coincided with the COVID-19 pandemic. Emerging themes related to how the pandemic reshaped primary care mental health education were explored. New policy directions were reviewed to ensure this study's ongoing relevance. Additional databases, including **PsycINFO** and **Scopus**, were used to broaden perspectives on mental health and education.

Both stages of the literature strategy significantly influenced the development of a semi-structured interview schedule (Appendix Three) and informed the method and methodology outlined in Chapter Three, p. 61. The literature review also incorporated global mental health policy to offer a broader knowledge base while remaining focused on UK-specific findings.

2.1.5 Conclusion of Literature Strategy

The literature review revealed greater community engagement is needed in the co-production of primary care mental health education programs. While this study identified critical qualitative themes related to the research questions, there remain significant gaps in the literature, particularly concerning the perspectives of patients and caregivers. The historical context commences with the closure of mental health institutions, providing valuable insight into the evolution of primary care mental health education.

2.2 Closure of Institutions

The large Victorian mental health institutions closed in the early 1990s and coincided with general practitioner fund holding, a short-term policy overridden by the next government. The lack of capital investment in the NHS resulted in buildings being unfit for purpose. There was short-term political investment and no long-term solutions (Williams et al. 2019, O' Dowd 2019). The large asylum workforce included trusted patients (trustees), occupational therapists, qualified and unqualified nurses, psychologists, psychiatrists, pharmacists, chiropodists, domestics, catering staff,

gardeners, electricians, and farm workers. There were other roles, too, as the asylum was integrated into the local community, including funeral directors, access to local faith communities, and local shops. The environments evolved, long-stay patients and staff worked in 'farm factories,' psychiatrists ruled, and the medical model prevailed, focused on diagnosis and pharmaceutical treatment (Middleton, Moncrief 2019).

The closure of asylums in England was during a period of change, partly influenced by an understanding of equality, rights, and the social determinants of health. Laing (1978, 2010) argued mental illness was a response to capitalism and families. He was a psychiatrist who believed we were all alienated from our inner selves in one way or another. Therefore, those with schizophrenia express their alienation through ways society finds unacceptable (Laing 1978). Paolo Freire (2017, p.21) offered the idea of the prescribed behaviour of those who were oppressed, here shown by those who had a mental illness, following the guidelines of the oppressor. This view corresponds with Laing and social psychiatrists today. The literature showed psychiatrists thought they had a role in the social determinants of health to identify discrimination and issues such as food security. The literature discussed the need to prevent mental ill health alongside more education and research on the mental, physical and cognitive effects (Shim, Compton 2020, Hatzenbuehler et al. 2010, Jones et al. 2017, Jeste, Pender 2022).

In 2024, arguably, people diagnosed with schizophrenia will not always be left with the autonomy to choose their own life and instead have a path laid out to suit society. The sole use of psychotropic medication means illness sat with the person. The closure of institutions was based on economic decisions, as health authorities were cash-strapped and needed equipment and development in acute general hospitals. The private enterprise, National Car Parks, bought land and cottage hospitals, and large institutions were sold to developers, often within prime locations (Talbot-Smith, Pollock, 2006).

The workforce did not always follow patients into the community, creating disconnects (Cylus et al. 2019). The asylums were often based miles from the

catchment area they served, and along with workhouses, they were associated with fear and stigma (Workers 2014). The people leaving the hospital, some who had been there most of their lives, and arguably the local workforce struggled to become part of these new communities created by the hospital closures.

2.3 UK Government Policy

UK government policy directed the shift from institution to community, with centralised policies coming from respective governments. The policy was written on behalf of people with mental health and not by people with mental health, their families, or carers. The literature showed two world views: policymakers and those the policy was aimed at. The two world views hold different assumptions, and policy does not appear nurturing, compassionate, or helpful. The United Kingdom (UK) government produced policies and legislation, including the Mental Health Act 2007 (Bowen 2007), from centralised, majority governments, often unopposed. The concept of mental health, related social context, service structures, resources, and treatment were all affected by the significant amount of United Kingdom government policy (Lester, Glasby 2010). The World Health Organisation Mental Health Atlas 2014 (World Health Organisation 2015) showed that the United Kingdom reported a national mental health strategy (Department of Health 2011) that was built on the original NHS Plan 2000 (Her Majesty's Government 2000). The revised approach resulted in a government mandate for NHS England (Department of Health 2015) to deliver mental health care (Department of Health 2012, Department of Health 2014). The United Kingdom's parliament's sovereign power remained the supreme legal authority. Parliamentary sovereignty was challenged by the introduction of the Human Rights Act (1998), which positively promoted people's mental health rights, redressed power imbalances, preserved dignity, and stopped discrimination. A majority parliament moved the UK away from the European Union (Parliament United Kingdom (UK) 2019), leading to an ongoing re-examination of the Human Rights Act (1998) governing the NHS and Social Care.

2.4 The Mental Health Act (2007) and The Human Rights Act (1998)

Two critical pieces of legislation were designed to promote and protect people with mental health and their place in society. The Mental Health Act (Her Majesty's

Government 2007) and the Human Rights Act (1998). The law applicable to mental health was the Mental Health Act (Her Majesty's Government 2007, Her Majesty's Government 2018b), and recommendations were debated in parliament in 2022. However, it remained in draft form and has not yet been enacted (Her Majesty's Government 2018, Department of Health and Social Care and Ministry of Justice 2022). The Care Quality Commission (2015) monitors the Mental Health Act (2007) to manage and treat people within society. This is sometimes done without their permission and differs from European Union law. Article 26 of the Charter of Fundamental Rights of the European Union (EU) (European Union 2017) declared people with disabilities had a right to independence and community participation. Article 35, Healthcare within the Charter of Fundamental Rights of EU (European Union 2017), supported research that advocated the right of preventative health care and treatment by the Royal College of Psychiatry (Patel, Bhui 2018).

The original National Service Framework for Mental Health (Department of Health 1999) focused on working-age adults, included mental health promotion, and supported people to manage their health care (WHO 1984). The definition promoted positive mental health instead of mental illness. It combines assessment, diagnosis, treatment, rehabilitation, support to carers, specialists, and primary and social care. The government distributed local resources based on a needs-based formula with workforce costs and no infrastructure. The money was given to commissioners to invest in services. The result was the development of an underfunded secondary care service with poor infrastructure and little investment in education for the workforce.

The Policy Implementation Guidance (Department of Health 1999a) set a vision that commissioning primary care mental health improved working between providers across the statutory sectors. These included health, social care and the voluntary sector. The aim was to improve access, treatment, and care for people with common mental health disorders such as anxiety and depression and those with severe mental illness. Existing staff would have improved education, new working methods and roles.

Recovery initiatives included Recovery Colleges that provide safe environments for people with mental ill-health to learn whilst being supported and were well-evaluated (Newman-Taylor et al. 2016, Bourne et al. 2018, Wilson et al. 2019). Support Time and Recovery workers were recruited in the 2000s (Huxley et al. 2009). However, the literature showed the vision was not fully implemented (Annor, Allen 2009, Simmons, Wright 2004, Michie et al. 2007). The workforce was merged into other teams, and improving access to psychological therapies became a priority. It also delivered mental health primary care with varying degrees of success. Primary Care Trusts (PCTs) initially oversaw investment in the National Health Service; they became Clinical Commissioning Groups (CCGs). Commissioning was merged with provider trusts, forming Integrated Care Systems following the new Health and Care Act (Her Majesty's Government 2022).

2.5 The NHS Plan 2000-2019

The National Health Service (NHS) plan (Department of Health (DH) 2000) emphasised preventative services and included service user and carer-led services. These priorities led to a plethora of national guidance from subsequent governments with little continuity and a lack of investment in primary care mental health research, education, and development.

Key historical policy documents included 'Choosing Health: Making Healthier Choices Easier' (DH 2004), which set out a strategy to help people make healthier choices in their lifestyle. This was followed by 'Our Health, Our Care, Our Say', a new direction for community services (DH 2006). 'Strong and Prosperous Communities' was the Local Government White Paper (Department Communities and Local Government 2006), which set out proposals to enhance local leadership on health and wellbeing. National Service Framework (Department of Health (DH) 1999) and the NHS Plan (DH 2000) were replaced by New Horizons (DH 2009). The strategy broadened delivery by looking at all adults using an integrated dual approach. New Horizons had a preventative, inclusive agenda and was welcomed by the voluntary sector and communities,

With a change in government came policy changes that strengthened the need to listen and improve patient experiences, known as the Darzi review, 'Equity and Excellence: Liberating the NHS (DH 2010). The document included six consultations (Department of Health 2010a, Department of Health 2010b, Department of Health 2010c, Department of Health 2010d, Department of Health 2010e, Department of Health 2010f). The strategy (DH 2010) aimed to decentralise the NHS from politics, enable clinicians and give citizens a more significant say. Lord Darzi was a clinician whose view put patients' and clinicians' experiences alongside safety and quality. Lord Darzi aspired to develop the NHS and used a community perspective to enable choice, a partnership approach to care, and access to high-quality information. The process empowered patients by using their knowledge, valuable time, and energy to solve their health problems. However, it was seen as privatisation of the NHS and increased administration and bureaucracy, with 210 Clinical Commissioning Groups purchasing services.

The Health and Care Act (2022) replaced Clinical Commissioning and created 42 Integrated Care Services. Their remit was to improve outcomes and tackle inequalities in experience, including access, build productivity and assess value for money. The approach no longer separated commissioners from providers, the drives were collaboration and improved local population health. However, a previous tension in primary care of balancing individual care against community engagement to tackle inequalities may arise. Inequalities were to be addressed through the wider social determinants of health, an area historically primary care was not always equipped or motivated to undertake (Hutt, Gilmore 2010).

NHS England devolved commissioning to specialist services for mental health and included secure units and eating disorders within Mental Health Foundation Trusts and the private sector. Outcomes hit the headlines with failures in both industries (George 2022, Cooper 2022), including non-compliance with the Mental Health Units. The Use of Force Act (2018) was brought in after the death of forty-six people in mental health care between 2010 and 2014. NHS England was an arm's length body to the government responsible for direction and leadership (Kings Fund 2018a). It moved from overseeing commissioning to moving forward with a policy of integration

and strategy at the government's behest. It aimed to prevent institutional system issues that resulted in deaths and inadequate care. Examples of system failure within the NHS include Mid-Staffordshire NHS Foundation Trust (Francis 2013) and Telford Hospital (Vize 2022).

Within mental health provision was a culture of patients not being listened to (George 2022, Cooper 2022). The National Service User Network (NSUN) wondered who was believed (NSUN 2022). The literature showed commissioning arrangements along the mental health spectrum, voluntary, faith-based work, expensive specialist, and forensic mental health interventions remain developed in silo and separated from physical health care. A localised, participatory approach was an opportunity for new ways of working with the community instead of more of the same.

2.6 Historical Policy Findings and Relevance to this study

The historical policy context outlined the aim, not the means to achieve policy changes. The disconnect between policies supported the anecdotal disconnect expressed by the GP. Money came down from the central Government into mental health with investment in workforce targets, but not infrastructure and without a system of producing a wider primary care workforce (Skills for Health 2014, Skills for Care 2014). A deficit in policy on medical education in primary care and mental health compounded the disconnect of the workforce. Neither peer research on skills needed (Dezetter et al. 2013, MacVicar et al. 2015, de Kock et al. 2014, Lempp et al. 2015) nor peer recommendations for continuing medical education (Vannieuwenborg et al. 2016) were reflected in workforce policy documents. The legislation from the central government, enacted by NHS England, does not reflect patients' wishes or clinicians' responses to their environment, causing a further disconnect.

2.7 Current Policy

2.7.1 The NHS Long-Term Plan (2019)

The UK had been in an austerity period, with reduced government spending balanced against increased costs across community health and social care, with demand escalating. There were workforce shortages, and the government and NHS

responded by expanding appointment numbers to improve access to primary care post-pandemic. However, an increased GP workforce had not materialised. The providers (acute trusts) had an overspend of £960 million (Kings Fund 2019a), with new funding allocated to the NHS over five years of 20.5 billion pounds. To access the funding, NHS England issued a revised government mandate to develop the NHS Long Term Plan (NHS England 2019a) and release previous investments (Department of Health (DH) 2014, DH 2015). The purpose of the NHS Long Term Plan (2019a) was to access funds for the National Health Service (NHS) (Health Service Journal (HSJ) 2019). An increase of 2.3 billion pounds in funding for mental health went into the Clinical Commissioning Groups (CCG) baseline in 2023/24 (Health Foundation 2019). Earlier allocations had not been ring-fenced to mental health, so they did not reach the front line as other priorities of overspending received the money (Kings Fund 2019b).

The Health and Social Care Act (Her Majesty's Government 2022) was an opportunity to invest in primary care mental health by developing Primary Care Networks (PCNs) at a neighbourhood level. However, the restructure added more bureaucracy for Trusts. The PCNs had been given more flexibility, though expected services to meet the community's needs. There was a call for an exact direction to make mental health a strategic priority (Health Service Journal (HSJ) 2019). In areas of health inequality, funding enabled local programmes to reduce disparities and ensure that allocation met unmet needs (Kings Fund 2018b). The plan showed specific goals with health checks and better access for people with severe and enduring mental illness and rough sleepers. It showed the role of primary care in targeting smoking, obesity, alcohol, drugs, and hypertension. These were all commonly linked to mental health issues or were co-morbidities due to lifestyle choices, negative symptoms of psychosis, and psychotropic medication's side effects.

Primary care collaborative networks are aimed at General Practitioners to manage population health. Collaborative systems require an investment of capacity, time, and trust to be factored in alongside creating multi-disciplinary teams across primary and secondary care. The NHS Long Term Plan (NHS England 2019a) specified

that missed targets meant potential fines for providers and commissioners (Kings Fund 2019b). Targeted areas were more likely to be prioritised as NHS Clinical Commissioning Groups previously needed £700 million in savings to fund initiatives (Kings Fund, 2019a). The NHS Long Term Plan (NHS England 2019a) made no assumptions about primary and community care savings and referred to an increase in the acute sector's demand. Post-Covid, the vaccination programme showed the development of Primary Care Networks as a basis of local partnership working. The workload post-Covid and the development of Primary Care Networks mean most activities and funding of 225 million pounds were targeted in 2023. The key to this was recruiting an extra workforce to enable better outcomes for the community, with investment in addressing unmet needs in areas of higher deprivation. One new role was that of a mental health practitioner funded jointly between trusts and primary care, designed to integrate pathways and bring primary and secondary care closer together. However, the money was not ringfenced and different areas used the money in other places (O'Dowd 2019).

The other concerns included recruitment and capacity, with some trusts reluctant to go above their contract of one mental health practitioner in each Primary Care Network and two in the bigger trusts (NHS Confederation 2022). The NHS committed post-pandemic to delivering twelve billion pounds of savings annually by 2024/2025. This did not include pay rises, recruitment costs, inflation, or the need to catch up on elective surgery waiting lists (NHS England 2022).

2.7.2 Strengths of the NHS Long-Term Plan (2019)

Community Mental Health teams had no access time, so they moved to set a target of four weeks as a standard for the desired outcome. Rethink (2019) believed this might achieve parity of esteem with physical health, as set out in the Five-Year Forward View Mental Health (NHS England 2016a), with money put aside for mental health. The funds were retained if targets were breached, so punitive measures were placed on commissioners and providers (Kings Fund 2019). The literature showed Community Mental Health Teams (CMHTs) had been underinvested since the onset of the Mental Health NHS Plan (Department of Health 1999, Malone et al. 2007), and there was no detail on the investment levels or workforce needed. Furthermore,

Community Mental Health Teams funding had cuts of 20% from 2012 to 2015 (Kings Fund 2019a).

The redesign of the core specialist community and mental health services enabled trust and strengthened access to biopsychosocial interventions to improve support (Vannieuwenborg et al. 2015). NHS England targeted recruiting two thousand social prescribing link workers to tailor health plans, attract talent and capitalise on lived experiences (Mental Health Foundation 2019). The action required public health input, now housed within local authorities, alongside broader support outside the NHS. The support included housing, employment, and social care. Research showed the impact of social prescribing link workers was not evidenced, and there was limited evaluation of the impact of current programmes (Kiely et al. 2022, Foster et al. 2021).

The Health and Care Act (2022) was introduced to drive integrated care at scale. It aimed to have the active voices of service users and carers. The aim was to improve health and well-being and work across organisational barriers with the best use of local resources.

2.7.3 Weaknesses of the NHS Plan

Children and perinatal services lacked clarity within the mental health model despite a commitment to new care models with a comprehensive offer from birth to twenty-five. The mental health investment in schools lacked the detail needed for comprehensive services, though the investment was planned to rise faster than all other NHS budgets (Health Foundation 2019, NHS England 2019b). The programme's weakness was austerity cuts, which stripped social care services and public health.

Mental health issues increased in children and young people during the pandemic. The impact remained unknown and ongoing (His Majesty's Government 2023). Wilkinson and Pickett (2019) report data showing 83% of 18-24-year-olds had stress levels pre-pandemic and could not cope. Young people with mental health needs require structure during the pandemic. The removal of access to school, difficulty in

accessing Children and Young People's Mental Health (CYPMH) services and the disruption, which included keeping a social distance, had long-term mental health effects. Socioeconomic factors affected whole families, and unmanaged grief was an issue (Piera Pi-Sunyer, 2023, Pickett, Wilkinson, 2015).

Mental health was impacted by increased use of social media and exposure to inter-family and personal physical and sexual violence (Weigle, Shafi 2024). High and low educational attainment impact employment and social inclusion to affect mental health (Broer et al. 2019) positively or negatively. The data showed after the first lockdown, death and significant injury rose by a quarter, followed by abuse or neglect, all compounded by poverty and a lack of access to support. Highlighted were the risks to refugees, asylum seekers, children and those from the Black and Asian Minority Ethnic groups (Women Aid 2022).

The NHS plan discussed integrated models, and despite the onset of Integrated Care Systems, there remained a lack of clarity on whether resource allocation meets demand (Health Service Journal (HSJ) 2019, Her Majesty's Government 2022). There were ramifications as the NHS plan was not an entire system plan (Kings' Fund 2019). One example of disconnect was delayed transfers and charges that required social care input without clarified links (Kings Fund 2019). The end of out-of-area placements was a crucial area in funding the plan. However, there was no detail, and out-of-area placements remained, which resulted in long-term institutional care.

People with mental health, learning disabilities, and autism tend to have three or more conditions, known as co-morbidities. Previous policies did not detail how they were to be supported (HSJ 2019). Post-pandemic, the onset of Integrated Care Systems aimed to address high demand and responded to two-thirds of the over sixty-fives forecasted to have co-morbidities by 2035. Seventeen per cent of those were estimated to have at least four or more conditions, and a third will have a mental illness. Mental illness includes depression, dementia, or cognitive impairment, and multi-morbidity increases with several diseases or impairments (Damarell et al.2020). The pre-pandemic research identified in 2015 that 34.1% of people over the

age of sixty-five, with four or more long-term conditions, had mental health problems (National Institute of Health Research 2018).

The risks were that priorities would be on restructuring and focusing on priorities at a larger scale. The new duty to cooperate across sectors was not a legal requirement, and there was a risk of disconnection from communities. NHS Improvement, Health Education England, NHSX, and NHS Digital were all to be part of NHS England, whose role included workforce planning and development. Mandatory education outlined in the NHS Plan (2019) was a priority for people with learning disabilities and autism.

2.8 Workforce and Development.

The NHS Plan was now the responsibility of NHS England and excluded education, capital, local authority, and public health expenditure alongside social care. It showed a commitment to increased investment in Continuous Professional Development. The increase of Black, Asian, and Ethnic Minorities in leadership is relevant to developing the primary care workforce and mental health education programmes. The political climate of uncertainty due to Brexit and change in Government leadership impacted the NHS Plan (NHS England 2020) as it relied on government decisions on distributing education budgets. The United Kingdom immigration policy impacted recruitment (Her Majesty's Government 2018a, Kings Fund 2019b). The primary care workforce had no strategy for recruitment, succession or retention plans (Kings Fund 2019b, Health Foundation et al. 2018). NHS England published its workforce strategy (NHS England 2020) to build on the Interim People Plan (NHS England 2019c). The document outlined the need for an inclusive environment and encouraged NHS staff to look after one another. It summarised that education and an increased workforce were essential. Post-pandemic, the need for health and wellbeing support escalated, alongside issues such as discrimination. It emphasised retention of those who returned to support the NHS during the pandemic. The Peoples Plan 2020/21 (NHS England) was published against a backdrop of concern about reliance in the United Kingdom on international recruitment of nurses. It highlighted a 97% reduction in recruit registrations from nurses trained internationally throughout the pandemic. The

data showed that pre-COVID-19, there were 40,000 equivalent vacancies in the workforce (Buchan, Shembaknevar 2020).

The Royal College of Nursing member survey (Building Better Future for Nursing 2020) discovered that 36% thought about leaving. Forty-two thousand members responded, giving low pay (44%), inadequate staffing levels (43%), and a lack of management support (42%) as reasons to leave. The report showed that 74% of respondents felt valued by the public, yet only 18% felt valued by the government.

The People Plan 20/21 (NHS England 2020) assumed more UK citizens wanted to become part of the NHS workforce. The document did not include recruitment to social care or government allocation to the NHS recruitment and education needs. There were no detailed plans to transform the rhetoric into the needed workforce. The British Medical Association (2020) welcomed the workforce plan. However, they did not believe it was enough. 45% of doctors suffered from mental health conditions related to or worsened by the pandemic. The British Medical Association welcomed the focus on equality and diversity. They found the shortcoming that long-term medical workforce supply was not addressed and recognised a need to focus on inequalities. One recommendation included doctors become generalists. However, the policy could affect the progression of specialists, and the medical consultants' future pool could be affected. The data showed that the government pledge of 50,000 nurses by 2025 had a shortfall of 26,247 posts. The target of 6,000 extra GPs has seen the recruitment of only 738 since 2019, and the policy was stopped (Allegretti 2022) with 474 practice closures since 2013. The practices in areas of high deprivation were those with the highest numbers of GPs who had left the workforce (Thomas, 2022).

2.8.1 Relevance of The NHS Plan and the Workforce Plan to Study.

Neither the NHS Plan (2019) nor the NHS Peoples Plan (2020) showed how policy thinking with practitioners was reconciled nor reflected the community's expectations. The literature supported the perceived anecdotal disconnect between the espousal of policy and practice. The Royal College of General Practitioners (RCGP) called the NHS Plan (2019) aspirational but needed an increase in General practitioners and

funding for primary care (RCGP 2019). Mental health issues were reported by leaders of 59% of NHS mental health trusts (NHS Providers 2019). These included how benefits changes led to increased demand for mental health services with a reported increase in loneliness and isolation. Homelessness was an issue of mental ill-health, alongside cuts to local services, concerns about demand that outstripped supply, long waiting lists for children and crisis services (NHS Providers 2019, Ranmal et al. 2021).

An Interim Peoples Plan (NHS England 2019c) and a more detailed NHS Implementation Framework (NHS England 2019b) set out indicative funding and workforce and included the reduction of funds for out-of-area placements and the savings to fund critical initiatives and tackle health inequalities (Charlesworth, Johnson 2018). Health inequalities mirrored how the social determinants of health, the policy of austerity, COVID-19 and politics affected the population, whilst there remained a need to reconcile care, a good birth, life, and a good death. The Inverse Care Law (Hart 1971) demonstrated that those who need medical care the most are least likely to receive it, whilst those with the least need for health care tend to use health services more frequently and effectively (Kings Fund 2001). It applied to those born and who grow up in non-nurturing environments, with poor employment prospects, inequities with money and health, a lack of resources and a loss of power and autonomy, all areas heightened during the pandemic.

2.9 The Marmot Review and the Social Determinants of Health

The Marmot Review (Marmot 2010) explained how public expenditure on policies, through the life course, acted on the social determinants of health to reduce health inequalities. The Labour, Liberal, and Conservative parties welcomed The Marmot Review (Marmot 2010), though no parties implemented the recommendations. The six policies gave every person the best start in life and enabled children, young people, and adults to maximise their capabilities and control their lives. The policies created fair employment and decent work to ensure a healthy living standard and develop healthy, sustainable places and communities. The final policy strengthened the prevention of ill health and recommended a joined-up approach (Marmot 2010).

The UK period of austerity saw public expenditure cut from forty-two per cent in 2010 to 35%. In the follow-up report, *Health Equity in England: The Marmot Review Ten Years On* (Marmot 2020), the impact of austerity on policy areas was outlined. The policy areas included increased child poverty, a decline in education, a rise in food banks, and communities that had lost hope and resilience. The result was that communities were left behind, and health inequalities increased.

The Health and Social Care Act (2022) recognised the need to integrate community care. However, there was no funding to make this happen, nor was there any mention of how to engage with the community, as local Integrated Care Systems determined the details. The NHS Implementation Framework (2019) was centralised with targets attached, set by NHS England and the NHS Improvement Agency. It did not mention the essential skills needed for mental health in primary care or engagement with local communities. The social determinants that affected mental health were outside the NHS's control. They required a coordinated approach, including housing, employment, debt, and social relationships. Social determinants have risen and affected mental health and created a demand for low-level mental health needs from primary care and an increased need for specialist care.

With inequalities, unmet needs increased (NHS Confederation 2020). The Conservative government had a White Paper on 'Levelling up' (Her Majesty's Government 2022), planned to unlock the potential of people and places. The paper was top-down, with neither detail nor budget and no discussion on how communities would engage, participate, or lead. The social determinants can be changed, an argument Beresford, Rose and Carr (2018) supported following their evaluation of the omissions of the United Kingdom Research and Innovation mental health agenda. They found survivors of mental health research needed to be recognised and boundaries pushed.

2.10 The Financial Cost of Mental Health

Trautmann et al. (2016) queried whether society reacted appropriately to the burden of mental health disorders. They evaluated the economic costs of mental illness and sources and included the World Bank (Shidhaye et al. 2016, Patel et al. 2016)

and the Global Burden of Disease Study (Murray 2022). The World Economic Forum (WEF) formula data showed the cost of mental health will rise to \$6 trillion globally by 2030 from \$2.5 trillion in 2010. They used three financial approaches outlined below and quantified the economic disease burden (WEF 2022).

2.10.1 Human Capital Approach

The Human Capital approach refers to direct or visible costs associated with diagnosis and treatment, compared to indirect and invisible expenses, including income loss or early retirement. The Human Capital Approach showed how mental illness affected individuals and their families, workplaces, society, and the broader economy (Doran, Kinchin 2019). Trautman et al. (2016) estimated direct costs and calculated epidemiological data based on prevalence against economic data per patient. In mental health, the price of a secure bed per night was multiplied by epidemiological data, an example being an out-of-area placement. Trautmann et al. (2016) estimated the global direct mental health costs to be 2.5 trillion dollars, whilst indirect costs were estimated at 0.8 trillion dollars, expected to double globally by 2030 (Trautmann et al. 2016). The WEF estimated thirty trillion dollars in direct costs by 2030 (WEF 2022). The formula was based on lost economic growth, estimated by the projected impact of mental disorders on the gross domestic product. However, the formula relied on economic growth being dependent on both labour and capital, which was affected by the depletion of labour and capital from mental health. Indirect costs were estimated to be 16.3 trillion dollars by 2030, as much as cardiovascular disease and higher than any other condition.

2.10.2 Prevalence-Based Approach

McCrone et al. (2008) estimated the cost of mental health expenditure in England by 2026. Using a prevalence-based approach, they estimated the costs of depression, anxiety, schizophrenia, bipolar disorder, related conditions, eating disorders, personality disorders, child and adolescent disorders, and dementia. The authors estimated an increase of 14.2%, with health service costs to increase by 45% to £32.6 billion in 2026 based on 2007 prices.

2.10.3 Statistical Life

The value of statistical life was an investment in a subjective, estimated insurance value against risk. The approach covered costs associated with disability, estimated at 8.5 trillion dollars, expected to double by 2030. In summary, direct health costs were low; indirect costs were high and expected to increase.

The literature findings did not explain why there was not more of a political and economic response to mental health, knowing preventative strategies such as community interventions in school and health have an impact (Chisholm et al. 2016, Nordentuft et al. 2013, Wykes et al. 2015). The NHS Long-term Plan (NHS England 2019a) aimed to save money by investing in primary care and digital technology to catch illnesses earlier, including school issues and when people presented with physical health issues. There was no clarity or idea of investment; Trautmann et al. (2016) hypothesised three reasons. The first was diagnostic, with treatment methods still in the first stages of development. The second was mental health stigma, and misconceptions were endemic throughout society, including healthcare. Finally, people rarely die from mental ill health, and NHS funding decisions were based on mortality and life expectancy, to which mental health only indirectly contributed (Bennett et al. 2018). Post-pandemic, the economic argument was highlighted as inequalities gaps have widened, with investment in the community, services, mental health and education all needed.

2.10.4 Objectification

A financially driven model was a potential reason for disconnecting due to objectification (Fredrickson, Roberts 1997), linked to the impact of consultation in primary care mental health (Timmermans, Almeling 2009). Objectification theory reduces the individual into a series of parts, and the mental health literature showed the impact on services, policies, and guidelines instead of the whole person. The evidence in the literature showed conditions affected wellbeing and included obesity (Ueland et al. 2019, Hill 2018), body image and eating disorders (Cook-Cottone 2015, Schaefer, Thompson 2018), and women being sexualised (Fredrickson, Roberts 1997, Fasoli et al. 2018).

The risk of objectification was people became commodities, and, in the NHS, services were commissioned to prove the value of money first, then quality second. This evidenced that time-poor environments were likelier to use stereotypes and be objective instead of subjective (Kruglanski, Freud 1983, Neuberg, Newsom 1993, Van Knippenberg et al. 1999, Landau et al. 2019). The result leads to uncertainty on how to relate to others positively, and compensation for this is downplaying subjective attributes (Landau et al. 2019).

2.10.5 Commodification

The link to commodification was due to every health contact having a financial price, as the UK adopted a neoliberal approach in the 1980s. The outcomes have resulted in economic inequalities in society, compounded by the association of happiness and positive health with material wealth and consumerism. Therefore, behaviour countering what market forces identify as desirable arguably becomes pathological. It was too simple to say that mental health was a symptom of neoliberal policies, as other factors contribute to mental ill-health. Capitalism can increase mental ill-health, and human nature's medicalisation reduces social issues (Ferguson 2017). However, the danger of one viewpoint was the person suffering does not have all aspects of their life considered.

2.11 The Push of Policy Against the Pull of Practice.

General practitioners became fundholders in 1993 (Ham 2018). They held the budget for their population but were far removed from psychiatric developments and their communities. One reason was medical students tended to have a degree of privilege. According to Moberly (2016), there were fundamental reasons. Pupils from disadvantaged backgrounds were less likely to apply and less likely to be accepted. 29% of the most affluent social groups were represented compared to 1% from underprivileged backgrounds. Pupils from private schools made up a quarter of medical students. Moberly (2016) found students from private and grammar schools performed worse at medical schools than those educated at non-selective schools. Junior doctors who attended private schools were less likely to enter general practice than state schools (Moberly 2016, Rimmer 2015). Studies showed medical students

left medical school in 2019 with over £80,000 in student loans and struggled to pay (Westhof 2015, Ercolani et al. 2015).

Medical students pay for essentials such as rent, heat, travel, parking, scrubs, exam fees, and food during a cost-of-living crisis, which is dearer for those who studied in London. The British Medical Association discovered that 60% of medical students cut down on basics, and 53% took second jobs (Murray 2022). Debt puts off those from state schools and areas of high inequality and reverses the recruitment trend.

Medical students are often not local to where they practice and may not understand the local demographics, including poverty, social inequality, and the impact on mental health (Taylor-Robinson et al. 2019, Stansfield, Bell 2019). The literature did not show whether sociology was on the curriculum of all medical schools to enable GPs to understand the relevance of local demographics. The presented problems in the consultation required skills to prevent disconnect. McCallum et al. (2019) discovered general practices in deprived areas are less likely to become training practices. There was a lack of literature on the views of GP trainers who work in deprived areas with increased medical and social complexity (Alberti et al. 2017). The literature showed a further disconnect between the community and practice, indicated by a lack of uptake, attendance, and adherence to primary care initiatives such as exercise referral schemes (Shore et al. 2019). Medication treatment plans in the community showed a lack of awareness and adherence (Kayyali et al. 2019).

There was evidence of a lack of commitment to guidelines by primary care practitioners in long-term conditions found through the evaluation of electronic records with heart disease (Hayhoe et al. 2019), chronic obstructive airway disease (Dedman et al. 2019), diabetes (Salinas et al. 2019) and across the cancers (McDonnell et al. 2019, Paranjpe et al. 2019, White et al. 2019). The picture was reflected across all mental health conditions, often accompanied by a lack of attendance by patients. The literature believed it was due to a lack of knowledge by practitioners, patients, and barriers, such as stigma (Xanidis, Gumley 2019, Sumner et al. 2020, French et al. 2019, Smith et al. 2019). The lack of participation resulted in the lack of adherence and added credence to the view of a perceived

disconnect between policy and practice (Sampson et al. 2019, Newlove-Delgado et al. 2019, Karasz et al. 2019).

2.12 Mental health education in primary care

The literature found little guidance on the management of mental health in primary care. One study asked people with serious mental illness how they saw primary care. Their view was it was the cornerstone of recovery. However, primary care clinicians felt ill-equipped to manage their needs (Lester 2005). Post-COVID, there are options for psychiatric and talking therapy services based in primary care and the post-code development of the mental health practitioner in Primary Care Networks (Kings Fund 2020). Primary care mental health was not a standard part of undergraduate medical nor practice nurse education, with few placements being community-based and the majority in the hospital setting (MIND 2016, de Cates et al. 2019, Feeney et al. 2013). The impact of placements influenced an understanding of the authenticity of being a GP, their choice of individual career, and arguably continuous professional development choices (Amin et al. 2018, Williams 1998). The short-term hospital-based psychiatric placement offered limited education on the complexity of primary care mental health problems.

The research focused on the chemical and physical impact of mental health and recognised the social determinants that affected mental ill-health, such as inequality, racism, and austerity. No research involved a discourse with those who suffered from mental health issues and their loved ones. COVID-19 impacted communities, primary care, and the National Health Service (NHS). It was a physical health issue with a significant mental health impact; post-pandemic research showed the majority of the population naturally recovered and moved on (Rauch et al. 2020). However, for those from more deprived areas, with inequalities, there is a long-term impact on recovery. There was a possible increase in psychiatric disorders and suicide among those who experienced social disadvantage and the effect of lockdown on young people's mental health (Mishara, Chagnon 2016, Carey et al. 2024).

2.13 Long-Covid

Data shows the prevalence and impact of Long-Covid affected those with and without mental health issues. 2.1% of the UK population self-reported Long-Covid, defined as symptoms that last longer than four weeks after Coronavirus; fatigue is the main symptom (Yong, Liu 2022, Van Kessel et al. 2022, Ayoubkhani et al. 2022). Those affected tend to be of working age, between 35 and 69 years old, female, residents in deprived areas or employed in health and social care, teaching, and education. Finally, those with a pre-existing condition or disability were at risk (Ayoubkhani, Pawelek 2022).

2.14 Policy Push against Practice Pull

Thomas et al. (2018) examined distress and healthcare support in austerity and welfare reform contexts. They referred to a study by Karasz et al. (2012), who found a lack of research on patients' narratives. This has led to a lack of knowledge about patients' defined experiences against broader clinical frameworks within which GPs in the UK currently work. Primary care is the first point of contact with emerging and enduring mental health problems, and increased mental ill-health was linked to a shorter life span (Department of Health 2011). The increased pressure on primary care practitioners was combined with a lack of evidence in the literature on people's views of the services and the impact on mental health practice. These lead to implications for primary care mental health education in an increasingly complex environment (Pedersen et al. 2012, Whitley et al. 2015, Herzog et al. 2015).

Traditionally, the government drove centralised policy alongside NHS England, which resulted in the push of policy against the pull of practice. The medical model's traditional risk averseness versus patient autonomy and choice resulted in a further disconnect. The literature showed little information about the impact of primary care on improving the positive well-being experiences of those who delivered and those who received primary care. Positive well-being is crucial to primary care outcomes and reflects the World Health Organisation's vision of primary care in the 21st Century (2018). The vision puts individuals and communities at the centre of primary care with the right to the best achievable health and well-being. The world's renewed

commitment to social justice is expressed through adequate social protection and concerted efforts to address the needs of those most disadvantaged.

2.15 Call for a Paradigm Shift.

United Nations Special Rapporteur Dainius Pūras (2019) echoed UK-centric findings and discussed how social determinants such as poverty, discrimination, and violence were the root causes of mental distress. The global view studied proves the perceived disconnect between policy and practice was a broader issue than in the UK. Pūras advocated that policy and practice challenge social inequality and disconnection and advance the cause of human rights (United Nations 2006), dignity, and mental health (Pūras 2019). Pūras showed the disconnect is not unique and belongs to a broader set of issues related to human rights that tackled stigma and discrimination through experiential knowledge (Borkman 1976, Castro et al. 2019). The views argued that a social model of mental health is at the other end of the spectrum from the evidence-based medical model where psychiatrists diagnose and treat, and to which the policies referred. A call for a paradigm shift or a considerable rethink (Kuhn 1970) of mental health delivery (Pūras 2019) required a transformational move away from the medical approach and clinical diagnosis based on classification (American Psychiatric Association 2013) or the International Classification of Diseases (11th Edition) (2022).

Mental health appeared complex as each person had different experiences, views, and responses. General practitioners (GPs) and their workforce have personal lives and experiences and developed theories and concepts based on emotions alongside facts (Stolper et al. 2009). Facts do not change people's minds even when large volumes of misinformation concerning mental health are debunked (Larson, Broniatowski 2021). The Classification by Diagnostical Statistical Manual V (American Psychiatric Association 2013) classified mental illness in psychiatry; it is not used as a standard in the UK in mental health diagnosis in primary care. Diagnosis and prescribing follow National Institute of Health and Clinical Excellence (NICE) guidelines in secondary care (NICE 2014). Some communities were labelled ill, whereas others were not, and arguably, the behaviour of those diagnosed can be

the same as all of us. Behaviour's impact on the self and the broad community's mental health does not fit into neat diagnostic boxes.

2.16 Current UK Model of Primary Care Mental Health

The National Institute of Health and Social Care Clinical Excellence (NICE) recommended the stepped-care model of mental health in primary care to show value for money despite limited economic evidence (Reeves et al. 2019). NHS England recognised the services were not always easily accessible due to location, length of sessions and more complex conditions, such as obsessive-compulsive disorder, required input. The issues resulted in the NHS England manual Improving Access to Psychological Therapy (IAPT) (NHS England 2019d). The centralised, target-based service had low-intensity workers on the front line who managed referrals from primary care. Improving Access to Psychological Therapy services, now known as NHS Talking Services, were not independently evaluated and had high rates of non-attendance with unaccountable services (Scott 2018). Arguably, if an intervention worked before, there is no guarantee it would again, as what worked with one person did not always work with another. Humans tend not to follow manuals, and there is no linear method to manage mental health (Frost et al. 2017). It required an evolving, changing system that reacted to an individual at a community level. Post-pandemic, mental health and society have changed. This reinforced the argument that paradigms of understanding mental health need to shift.

2.17 Potted History of Service User Engagement

The NHS had experienced criticism of its process-driven culture, which distressed patients, their families, and healthcare professionals. Kennedy (2001), Berwick (2013), Francis (2013), Keogh (2017), and Willis Commission (2012) recommended moving away from process to value-driven approaches with an emphasis on patient-centred care and compassion. Traditionally, secondary care mental health has engaged service users and their carers (Scammell et al. 2016) with recognised engagement benefits (Bluston 2019).

The original English service user movement originated as a union for people with mental health conditions in 1973 in a day unit in Paddington. Based on a Scottish

Trade Union, the original movement started a wave of political service user organisations. The movement stood for personal views and demanded rights from an oppressive system. The movement pioneered practical ideas such as crisis cards, advocacy, and befriending. There was a dynamic of inadequate consultation with service users, who fought to get solutions such as crisis cards on the health agenda. They became viewed as anti-psychiatry instead of empowered groups (Jackson 2008). Rose and Kalathil (2019) reflected on how the Government still supported the dynamic as service users were at meetings. However, decisions were made elsewhere. Over two hundred independent service user-led groups, self-advocacy groups, and survivor groups have closed in the last few years (NSUN 2019). Those who survived risked being finance-driven instead of service user-led, steered by commissioners or providers, placed within secondary care, and potentially tokenistic. They ticked a box at a time when independent voices were required.

The National Service User Network (NSUN) reported they were increasingly sidelined. Professor Beresford leads the national network of disabled people and service user network, 'Shaping Our Lives'. He shared that one-sixth of its user-led members have gone, and closure rates were accelerating (Beresford 2019). Of concern is the loss of independence of user-led organisations. The literature showed barriers to service user engagement remained at policy, education, research, recruitment, and development levels. It remained too soon to assess whether the policy of Integrated Care Boards will address these.

2.18 Engaging the Community and Policy

Tony Bovaird (2007) reviewed case studies of service users and the co-production of community services and concluded that there was immense potential to make public policy effective by engaging communities. The NHS Plan (2019) aimed to turn integration into reality. Bovaird's review showed how a co-production approach integrated throughout the service provision planning cycle enabled the social construction of services and culture rewriting throughout the planning process. Barriers found by Bovaird (2007) included those politicians had not trusted their communities to make decisions, professionals were uncontested, and community engagement was not put into practice. He proposed that workers skilled in co-

production should challenge professionals, share power and broker new roles internally within organisations. However, barriers to participation are arguably the current workforce situation, as primary care struggles to deliver care post-pandemic. Traditional ways of consultation are costly due to time, repetition, and depletion of resources. General Practice employs 130,000 people (Digital NHS UK 2020), and Allied Health Care staff have overtaken general practitioners (GPs), outnumbering them by 8% (Lacobucci 2019). The British Medical Association (2021) has been monitoring workforce trends, discovering limited growth in GP numbers since 2015, with two administrators to each GP. The GP Patient Survey (NHS England 2022c) assesses patients' experiences with healthcare providers since the pandemic and shows a ten-point drop in satisfaction. Loss of GPs to retirement alongside a shortage of nurses and paramedics has led to primary care struggling, prompting the Royal College of General Practitioners (RCGP) to set out a report showing 91% of the primary care workforce have concerns over delivering the right level of care to meet the need (Lafferty 2022, Royal College of General Practitioners (RCGP) 2023). NHS England has responded by recruiting an extra 2,000 link workers, who are non-medically trained (Lafferty 2022).

A systematic review examined critical areas contributing to service users' engagement and choice in self-directed disability services in Australia (Lakhani et al. 2016). The transferable learning was that a policy change based on self-direction was required. The NHS Plan (2019) discussed choice and control without being explicit about self-care. Self-budget initiatives enabled service users to make personal choices and produce better outcomes. However, if budgets were insufficient to meet needs, lower-paid, lower-skilled staff were hired. The results were flawed decisions made with provider incompetence.

People with mental health experienced poor health and worsened morbidity outcomes. Barriers to accessing complex healthcare pathways for people with disabilities were common. Issues in decision-making included the accuracy of the information, level of support, location, and socioeconomic status. The Committee on the Rights of Persons with Disabilities (2017) saw all those issues in their initial United Nations report of the United Kingdom. The United Nations paper (2018)

highlighted areas of concern across the lifespan and advocated the need for community participation and policy change. The Equality and Human Rights Commission (2018) evaluated the report and found inequality in people with disabilities across education, employment, living standards, health and care, justice, and participation.

Only a quarter of people who experienced mental ill-health received treatment (Centre for Economic Performance's Health Policy Group 2012) and lost out on the NHS with reduced life chances due to death from preventable causes. Mental health affected those who were poor, unemployed, and faced discrimination. However, the Five-Year Forward View for Mental Health (NHS England 2016a) focused on access to treatment and therapy, a small amount of employment support, and little about improved life chances. Discovering the absent community view on primary care mental health will show if it fills community service deficits. The United Nations paper (2018) outlined an inclusive approach and ensured consultation with participants across all policy and legislative frameworks.

Gardner et al. (2019) found a need for more clarity on what was meant by consumer engagement about commissioning, hindered by a lack of empirical evidence on how to engage. More evidence is needed on the skills and competencies required by consumers and professionals and a need for methods to engage diverse groups and sectors. The National Collaborating Centre of Mental Health (2019) produced a toolkit to enable co-production in mental health commissioning. However, there needed to be more evidence of its application. The reasons may be due to challenges associated with meaningful and practical participation highlighted throughout the literature. Gardner et al. (2019) discovered solutions and proposed clarity on whom commissioners seek to engage with and why. They suggested that stakeholders were critical to awareness of inequalities and control over the design and delivery of services. Consumer engagement was required as a whole system approach to the organisational change plan (Bovaird 2007). Doing this required relationship building and shared priorities, with the recognition that it took time and resources.

2.19 Developing Technological Solutions.

Torous et al. (2018) undertook a clinical review of user engagement with mental health smartphone applications to understand low uptake. They presented theories that disengagement, including a lack of privacy, poor usability, unhelpful in an emergency, and lack of trust in their efficacy by users and clinicians. The conclusion was that the lack of user-centric design was responsible for low engagement. The apps were designed to provide clinical information but did not meet people's needs. They were impractical and omitted early warning signs of ill health and sleep hygiene. This study's authors concluded that opportunities were absent throughout the design and testing process of clinical and peer participation. Poor health literacy and the need for added health education were missed.

Goodwin et al. (2016) described a different approach to collaborating closely with community education to meet needs. An example of a successful collaborated study of an app and therapy was designed in a community in Australia by Tighe et al. (2018) with results of an exceptional 97% adherence. The research of Tighe et al. (2018) showed that community insight enhanced design alongside a commitment to help the community and build on peer support. Qualitative research showed rich data supplied insight into young people's experience with services. Transferable learning was when people without favourable outcomes needed to be included (Pycroft et al. 2013). Technology offers opportunities to engage and educate young people. The literature supported the latest technology and the latest technological thinking driven by the preferences of students (Gibson 2001).

2.20 Summary of UK Findings in the Literature

The literature's findings challenged the researchers' objectivity and motivated research on the disconnect articulated to deliver education based on policy-driven evidence in primary care. The literature review found little guidance to manage mental health in primary care post-COVID other than psychiatric and talking therapy services. Despite all patients being in primary care, nothing was found in the literature about patient involvement in primary care mental health education or research. The term used for patients in psychiatry is service user, and universities were ready to use service user involvement in undergraduate teaching (McKeown et

al. 2014). There was a broader call for patient participation (Branfield et al. 2006) and power to improve healthcare when implemented (Matthews et al. 2019a, Matthews et al. 2019b), despite a lack of information on the current impact or action on any findings (Curwen et al. 2019).

The literature showed that education and evidence-based medicine use the best-known evidence to find the best possible solution (Masic et al. 2008). In the UK, these recommendations were top-down from the National Institute of Clinical and Social Care Excellence (NICE) in the form of guidelines alongside the centralised policy, 'Five Year Forward View Mental Health (2016), the 'NHS Long Term Plan' (2019) and the NHS and Care Act (2022). The mental health strategy, 'No Health without mental health' (DH 2011, DH 2012), found that people with mental health problems die between 10 and 25 years earlier than the rest of the population. This data was still quoted in current policy (NHS England 2016a, NHS England 2019a), and factors included health inequalities.

The literature suggested that poorer people with mental health, addiction, or learning disabilities were less likely to get what they wanted or have their needs met (Kings Fund 2015). The Inverse Care Law (Hart 1971), where those with the most need receive the least, was applied. The disadvantage and discrimination faced by parts of Black, Asian, and Minority Ethnic communities have increased the stigma towards COVID-19 and mental health. The findings showed that those most at risk needed to be supported by looking at deep-rooted issues. The issues included institutional racism (Lacobucci 2020), long-term health issues, overcrowded housing, impact on public-facing workers, and links to life expectancy due to cancellations of routine care.

2.21 Conclusion

In conclusion, the literature findings informed the inclusion of people with mental health issues, their caregivers and members of the workforce within the research. The aim was to co-produce education in primary care, previously produced by statutory bodies such as Public Health England (2015). Public Health England was replaced, with apparent haste, during COVID-19 by two bodies: the UK Health

Security Agency [UKHSA]) and the Office of Health Improvement and Disparities [OHID]). With a vision developed by external management consultants without consultation (Hunter et al.2022).

Patients who attended primary care reflected on their needs and expectations (Olde Hartman et al. 2011). The resulting discourse resulted in a challenge to the UK government and the National Health Service. The literature has shown that government and NHS advisory committees tend to consult management consultants or large charities, which do not always represent people with disabilities (Branfield et al. 2006, Beresford 2019b). The literature showed a lack of collaboration between professionals and the community, with no clarity on terminology, the function of services or prescribing in primary care.

Communities were organic, changing constantly, and fluidity struggled to be captured in restrictive models of care as practised in the UK and evidenced by the IAPT model. Foucault (2012) wrote how doctors modified patients' stories to fit the biomedical model. Anything social, complex, or emotional was filtered out by selecting symptoms to manageable conditions. The biomedical model made the consultation doctor not patient-oriented. The current literature showed that policy and practice remained medically dominant. Mental health can be triggered through social issues and remains a social construct (Busfield 1988, Hyatt et al. 2014). However, social needs do not have the same status, and the lack of investment in social care caused further inequalities.

2.21.1 Macro, Meso, Micro and Nano Perspectives

From a macro perspective, the government initiatives were to support incomes and supply social protection during the lockdown. The NHS Long Term Plan (2019) priorities are related to ongoing matters of deep concern to all communities. Within local and national governments, mental health had a high community profile, politically and economically. The current health service model moved from its original free entry point to an increasingly neoliberal approach, with primary care as the access point. The Meso-level response had increased reliance on social control, with businesses putting their interests first. Local charities and food banks stepped up during the pandemic amid the rising cost of living and a background of high rents and

insecure tenancies. At a micro-level, self-care was vital for the individual and their family. Self-care was particularly relevant to those at risk and those with mental health issues. My research goes on to examine the participants' experiences of mental health at a nano level within primary care.

2.22 The Literature Findings' Effect on this study

The literature findings explained the nature of the two research questions. The first question explored the potential to produce a learning theory in primary care mental health education that considered community perspectives. The literature review found three supportive theoretical assumptions underpinned future curriculum: Primary care mental health remained complicated and participation essential. My study's analysis methodology needed to be inductive in a rapidly changing environment influenced by the pandemic and politics. Neither the NHS Long Term Plan (2019) nor the Health and Care Act (2022) detailed how the NHS engaged with communities to shape services and improve the mental health response. However, it supported the move towards place-based integrated care systems to bring services closer to improve population health. The risk is that large systems may move further away from the local community, whose voices remain unheard.

The literature influenced the second research question of whether the government policy of community participation in mental health enabled policy enactment concerning primary care mental health education. The literature showed little evidence of community participation. The methodology and method chosen in this study ensured that all participants were community members. This included but was not exclusively, people and their caregivers with experiential knowledge (Borkman 1976, Castro et al. 2019) to inform future primary care mental health education.

3.0 Chapter Three Methodology and Research Design

3.1 Design and Re-design of the Methodology and Method

This chapter offers a reflexive account of the research initiated before the COVID-19 pandemic, focusing on community experiences of mental health within primary care during the pandemic. The primary objectives are to develop a learning theory and future educational model. The research methodology was initially mapped against the Seedhouse Ethical Grid (1998) (Appendix Four) and then the British Educational Research Association guidelines (2018) using domains and questions influenced by Stutchbury, Fox (2009), and Flinders (1992) (Appendix Five). The following were identified as the three main potential areas of risk. Working reflexively enabled me to monitor, minimise and address these risks through a series of questions below that acted as prompts and reminders throughout the physical research and analysis.

1. Avoiding imposition, I queried whether I was making unreasonable or insensitive demands on participants and ensured I minimised any bureaucratic burden on those I invited to be involved.

2. Telling the truth, if there was any need for covert research, I wondered how I would deal with this and what I would do if I found out something the participants did not like. I considered how I would report unpopular findings and deal with others' misrepresentations of my study.

3. Cultural sensitivity: Were my values, norms, and roles in my work environment likely to be challenged by this research? How could I adapt to accommodate these norms and expectations? Finally, there was the risk of people's potential concerns around COVID-19.

In light of lockdown restrictions, the methodology was redesigned to minimise these risks as outlined in the Ethical Grid (Appendix Five) and approved by the Staffordshire University Ethics Committee (Appendix Six). I positioned myself as a critical humanist researcher and acknowledged reflexivity's significant role throughout this study's four phases: Wanting, Doing, Digesting, and Feedback. To analyse the data effectively, I employed two thematic analysis models discussed in this chapter (Braun and Clarke 2006, Jennings et al. 2018) to assess the strengths of primary care mental health services.

3.1.1 Phase One – Wanting In the Wanting phase, I outline the piloted data collection tools, the member-checking process, the influence of relevant literature, and insights from a pre-pandemic focus group.

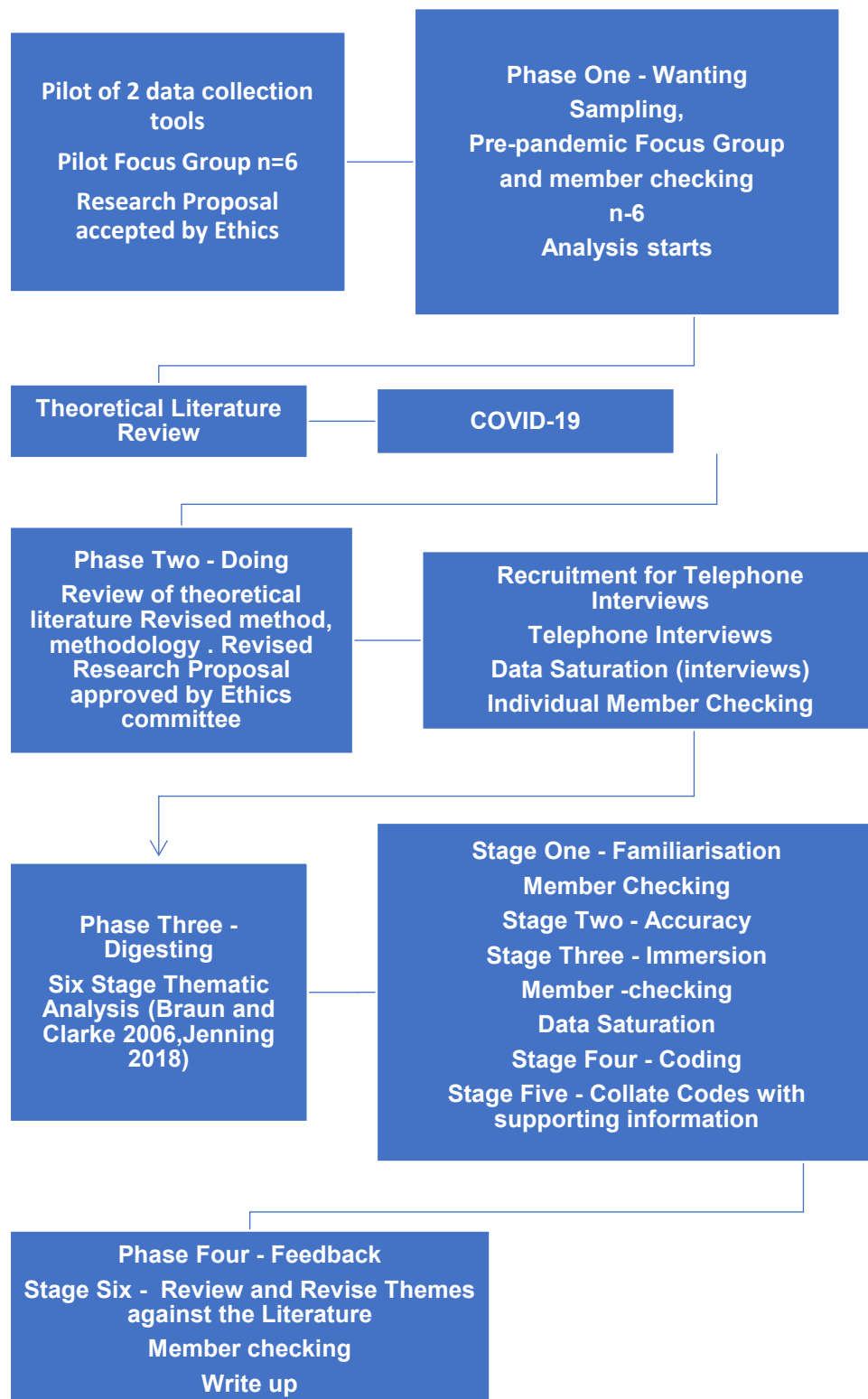
3.1.2 Phase Two – Doing The Doing phase highlights how the methodology evolved due to COVID-19, transitioning from focus groups to telephone interviews. I reflect on this implementation and provide the rationale for the methodological changes.

3.1.3 Phase Three - Digesting In the Digesting phase, I discuss the first five stages of an integrated Six-Stage Thematic Analysis (Braun and Clarke 2019, Jennings et al. 2018). I detail how I familiarised myself with the data to ensure accuracy. This immersion enabled me to analyse, reflect, and effectively map my initial thoughts. I also introduced a step so members could check and ensure the data was reviewed before final coding and achieving data saturation.

3.1.4 Phase Four—Feedback The final phase, Feedback, employed a member-checking process (Creswell 2009, Gray et al. 2015). I searched the literature to contextualise what was known about the primary care mental health themes. The qualitative methodology enabled me to interpret the data accurately, identify effective practices in primary care, and assess the potential future impact on mental health services.

Table One shows the four stages combined with the thematic analysis.

Table One Flow Chart Showing Four Phases of this study, integrated with Thematic Analysis



3.1.5 Influences on the Justification for the Research

My journey into mental health began at 16, first as a live-in community service volunteer and later as a psychiatric nurse. As an educator of young people entering health careers and a programme developer to those needing mental health support, I am increasingly curious about why general practitioners (GPs) often struggle to adhere to national guidelines. I wondered whether individuals with mental health issues in primary care experience poor outcomes and whether educational interventions could effect change. Motivated by these questions, I sought to understand mental health experiences from a community perspective within General Practice. With my background, I recognised the importance of addressing power imbalances and fostering inclusion and empathy. I was committed to ensuring the integrity of this study, and participants consistently reported feeling believed and supported throughout the research process.

3.1.6 The Challenge of Qualitative Research

Pursuing a Doctorate in Education through qualitative research presented a significant personal challenge, given my clinical background and familiarity with quantitative methods. I immersed myself in extensive reading and the research process, which illuminated how my experiences shaped my understanding of the world. Initially, I was uncomfortable, as I had previously viewed myself as reflective and attuned to social injustices. However, through the lens of reflexivity, I explored my professional and personal strengths and weaknesses, gaining deeper insight into my motivations. I learned reflexivity is essential in qualitative research, guiding my transition from numbers to narratives (Punch 2013).

3.1.6 Writing the Literature Review

I wrote my literature review during a personal, transformative learning period whilst on the Trans-Siberian Railway, surrounded by the beauty of silver birch trees. This experience inspired a profound reflection on the harmful impacts of human actions on the world. It reinforced my understanding that my worldview is shaped by interactions with others, whether orderly or chaotic. The literature illuminated that mental health is not solely a medical issue but also a social construct. I recognised that centralised

policy-making often lacks consultation with those possessing the most relevant knowledge: the community. Qualitative research, rooted in social constructivism, acknowledges the dynamic relationship between me and the rapidly evolving environment. I aimed to amplify the voices of those often unheard in existing literature, exploring their feelings, community roles, hardships, and positive experiences of mental health in primary care. Through participatory research, I sought to challenge traditional inequalities and adopt a more inclusive approach. As I delved deeper into the literature, I became aware of my assumptions about the significance of education in primary care mental health. My initial search terms reflected these biases, potentially limiting the scope of my inquiry. Recognising this, I expanded my literature search to encompass perspectives challenging the medical model. I understood that an exclusive focus on professional education might obscure critical factors such as patient empowerment and systemic barriers. This reflection prompted me to refine my methodology, aiming for a more holistic understanding of the patient experience in primary care mental health.

3.1.8 Stance as an Early-stage Researcher

Identifying as a critical humanist (Magill, Rodriguez 2014, Veugelers 2011), I adopted a holistic approach, employing a kaleidoscopic lens to gain insights into the diverse worldviews of my participants. I prioritised the emotional well-being of all involved, respecting their perspectives and balancing facts with lived experiences. In my view, a critical humanist collaborates with participants to co-produce knowledge. This understanding, inspired by Paulo Freire's work (2017, p.48), emphasises the ontological vocation of humanism and the critical thinking necessary for mutual humanisation. Reflexivity became essential in managing power dynamics and navigating the complexities of qualitative data, fostering participant autonomy and mitigating confirmation bias. By valuing participant independence, I was able to challenge my preconceived notions and remain open to evolving understandings.

3.1.9 Reflexivity and Kant

3.1.9.1 Reflexivity

Throughout the research process, I maintained a reflexive journal that significantly influenced my methodology and methods. I learned reflexivity is a powerful tool, enabling me to recognise my limitations as an early-stage researcher. By actively

listening during telephone interviews, I could build rapport and gather rich data to deepen my understanding. I acknowledged my role as an information conduit and embraced the subjective nature of qualitative research, particularly from a community perspective. Engaging the community in research offers a potential bridge between the often-disconnected realms of theory and practice (Williamson et al. 2020).

As I analysed my findings, I frequently encountered themes of inequality and injustice. To address these issues, I sought guidance from a distinguished social researcher who emphasised the importance of grounding my work in facts. This experience reinforced my belief that engaging with the community enables a collaborative approach to tackling health inequalities by critically examining policies and challenging existing behaviours (Williamson et al. 2020). I integrated data from external organisations such as the United Nations and World Health Organisation and national research through reflexivity, revealing how power dynamics influence mental health discussions and highlighting the disconnect between policy and clinical practice.

3.1.9.2 Kant

During my study, I found it beneficial to apply four questions attributed to Kant to guide my reflexivity: “What can I know?” “What ought I do?” “For what may I hope?” and “What is the human?” (Drasgow et al. 2020). The third question, often translated from German as “What am I allowed to hope?” (Pleger 2017, Pleger 2020), resonated deeply, as hope is a cornerstone of recovery and trust. I was particularly struck by the notion of “allowing” hope, suggesting it requires permission.

This framework focused on participants' lived experiences, helping me identify what could be known. I reflected on my knowledge and capacities, utilising supervision to enhance my understanding. The question of hope became especially relevant, as resilience and aspiration were crucial in navigating the uncertainties of the pandemic. Ultimately, the human aspect of my research remained central, emphasising the importance of respecting participants and acknowledging their contributions to the research process. I recognised that my position significantly influenced the construction of the research, analysis, and the generation of findings and recommendations in collaboration with the community.

The strength of my supervision sessions played a pivotal role in my development, fostering a positive and enabling environment. Inviting participants to collaborate with me and engaging in member checking at various research stages facilitated a constructivist approach, allowing active participation and a deeper understanding of the discussions while recognising the potential of multiple interpretations. Reflexivity allowed me to appreciate the value of maintaining a learning log and the insights gained from participant feedback, which helped sustain my momentum throughout the research.

3.1.10 Peer Feedback

The member checking process and supervision sessions were motivational tools, prompting me to seek peer feedback to assess its meaningfulness. This included participating in research conferences, creating a poster that showcased my original methodology, delivering three presentations on my progress, and finally sharing my initial findings (Appendix Seven). I also informed the Directors of the centre I had recruited from throughout the process. I consistently asked participants for their reflections on progress, which led to the Discovery Tree (Illustration One, p.191) development. This tool provided a “total vision of the context” (Freire, 2017, p. 77), allowing deconstruction to illustrate how components interrelated and synergised.

3.1.11 Member Checking

Member checking is often called the gold standard in qualitative research (Madill, Sullivan, 2018, Motulsky, 2021). While Goldblatt et al. (2011) noted that member checking can sometimes harm relationships, my experience was markedly different. The methodology mitigated risks to participants, aligning with Freire’s (2017, p. 79) view of them as co-investigators. The more engaged participants became, the more they embraced the term “experts by experience,” co-producing the method that fostered mutual understanding and enabled interpretation and action (Erdmann, Potthoff, 2023). The insights, opinions, and ideas shared by participants culminated in a complex yet simplified response to the multifaceted issues at hand. I recognised that by organising patterns, solutions could emerge from the chaos. Therefore, member checking became critical to ensure participants were accurately represented and their voices were amplified (Choi, Roulston 2015).

Their interest in the research allowed them to contribute more than mere verification; they guided the analysis and enhanced my understanding of thematic categorisation. The emphasis on relational care drove the member checking process, directing my research toward examining primary care consultation and developing a community of practice model for primary care mental health. The member checking process included an “expert advisory group” comprising four self-selected participants who provided ongoing support throughout the research. I consistently referred back to them, ensuring their input was woven into the fabric of this study. Birt et al. (2016) discussed synthesised member checking. My approach extended this concept further by providing participants with their data, anonymised collective data, and opportunities to review codes and themes at various stages. This process, informed by Creswell (2009), is essential to establish the credibility of the findings (Lincoln, Guba, 1985) and their interpretations.

The initial member checking session occurred directly after the pre-pandemic focus group during the feedback session (Appendix Eight), during which I shared the paper sheets (Appendix Nine, Appendix Ten). The member-checking informed the NVivo analysis (Edlund, McDougall, 2019) (Appendix Eleven) and facilitated agreement on emerging themes (Appendix Twelve), contributing to the evolution of the Discovery Recovery Tree (Illustration One, p.191).

3.2. Influence of the Literature

The literature review found supporting themes and the anecdotal disconnect identified by general practitioners between policy and practice. The articles showed that individuals with significant needs had high morbidity rates and were subject to the Inverse Care Law (Warren 2018), where those who received the least economically received little investment. There was a lack of political will to bring about change. Technical issues with systems prevented integrated care, and inequalities resulted in health and social disparity.

The literature revealed that there were disconnects between centralised policy and practice, and the views of the wider community were not considered in the policy of participation described in the Five Year Forward View Mental Health (Independent Mental Health Taskforce 2014), Five Year Forward View Mental Health

Implementation Plan (NHS England 2016a, NHS England 2016b), NHS Long Term Plan (NHS England 2019a) and Health and Care Act (Her Majesty's Government 2022). The landscape from the literature highlighted complex services in a changing, politically influenced health environment, which was silo-based with objective pharmaceutical and physical research.

The literature showed a shift from relational consultations to a transactional primary care model, including objectification and commodification. Although the literature found areas of disconnect, it was not specific on exactly what these areas were and whether the community perceives the disconnect as their expectations, which were not reflected in the literature. Theories both explain and challenge knowledge within a series of critical assumptions. Background reading in philosophy provided insight into primary care mental health being a complex science (Aita et al. 2003, Sweeney 2017, Greenhalgh, Papoutsis 2018).

The literature contextualised the disconnect between education and practice and shed light on the influence of policy on primary care and mental health. It underscored three key theoretical assumptions informing future curricula: the complexity of primary care mental health, the need for community participation, and the necessity of an inductive analysis adaptable to dynamic environmental factors. These included COVID-19, educational paradigms (Guba, Lincoln 1994), political climates, economic shifts, and health inequalities. A disconnect between undergraduate education and practice confirms the perceived disconnect between policy and practice.

3.2.1 Ongoing literature search strategy

The literature search strategy described in Chapter Two (p.6) refined the questions and objectives and informed the method and methodology. Having two straightforward research questions steered the rest of the research and enabled ongoing literature searches, ensuring relevant literature was searched and selected to allow for and inform the ongoing analysis. The literature searches were not as comprehensive as the primary literature review in Chapter Two, as time was a factor. I used reading around the subject to inform the analysis and challenge my thinking. The conclusions were based on

qualitative data, and the literature is there to be the knowledge base. Top-tier journals and national databases were examined, and articles were screened to see if they were relevant based on where else they had been cited and whether they applied to the two research questions. The strategy worked well as I developed a daily habit of reading research papers and became smarter at screening. I had reviewed literature before in partnership with other reviewers, so it was initially overwhelming to do searches individually. I learned how to find independent papers that were not pharmacologically sponsored and learned to spot others' biases. Summarising the data was a disciplined process as I would take the papers with similarities and differences to compare. I found it easier to do this in a traditional way of printing out, using Post-it notes and highlighting relevant and interesting areas. Traditionally, a literature review is not always recommended using Grounded Theory before the research (Ramalho et al. 2015). I used the first literature search to contextualise the research, seek learning theory and inform the method and methodology.

All the emerging information came from the participants, and the literature informed the discussions and reduced my subjectivity. Therefore, I could construct my recommendations and ensure they were relevant and fresh through engagement and critiquing the literature. Reflexivity enabled me to recognise how complex participants' lives were and how complexity influenced their worldviews. On a personal level, the literature findings challenged my assumptions and, I believe, enabled the methodology and analysis to move forward.

3.3 Sampling

The community purposively chosen in this study was urban, in a high area of deprivation, and vulnerable to mental ill-health. The participants in this study were experts through lived experience or working in primary care mental health either in the community or formally employed within the statutory sector. The research questions and objectives directing this study required a knowledge of primary care in either a professional or patient capacity (Punch 1998). In choosing the sample of

participants, I decided on working-age adults, though I recognised some participants had retired but returned to work. The one criterion is that they used primary care. I discovered that not all participants used primary care and did not understand the purpose. I found I could compare what was said by the participants and had a coherent, motivated group sharing insights and perceptions.

3.3.1 Participants Characteristics

The community's involvement in the research provided insights and perspectives on implementing the NHS Plan (Her Majesty's Government 2019). The Community Participation Ladder (Chogguil 1996) (Appendix Thirteen) depicts community participation levels, aiming at empowerment. The findings revealed that current services inform patients rather than co-producing with them, showing a knowledge gap. The findings show active engagement between primary care and the community can bridge this gap and address mental health comprehensively. The member checking ensured community involvement, highlighting areas of improvement such as cultural competence, intra-psyche beliefs, and communication. Demographic details were captured in Table Two (p.49), which outlines each participant's identifiers and characteristics. The identifiers attribute quotes to each participant, ensuring confidential and ample data to show the analysis and to sustain the findings. Educational backgrounds ranged from no qualifications to a PhD. Eleven participants had personal insights into mental health through lived experience or caring for someone with mental ill-health. The mental health spectrum ranged from none to various diagnoses such as anxiety, depression, addiction, and psychosis. The views of all the participants were considered. The following table places each participant in the order in which they were interviewed throughout the pandemic.

'.... I have had a lot of brushoffs, a lot of it. So, I'm glad that you're asking my opinion.'

Participant One

Table Two Participant Identifiers and Demographic of Participants

Participant Number and month interviewed	Sex	Age Range (years)	Focus Group Member	Telephone Interview	Experience with mental health	Current Role
Participant One April 2020	F	25 - 30	No	Yes	Yes	Volunteer with Addiction Service
Participant Two April 2020	F	35 - 40	No	Yes	Yes	Hospitality Industry
Participant Three May 2020	F	45 - 50	No	Yes	Yes	Artists offering sessions to people with mental health
Participant Four May 2020	M	40 - 45	No	Yes	Yes	Unemployed
Participant Five May 2020	M	20 - 25	No	Yes	Yes	Information Technology (self-employed)
Participant Six June 2020	M	50 –55	Yes	Yes	Yes	Finance Manager Third Sector
Participant Seven June 2020	M	45 –50	NO	Yes	Yes	Full-time carer for a partner with mental ill health.
Participant Eight June 2020	M	65 –70	No	Yes	No	Retired GP
Participant Nine June 2020	F	45 - 50	Yes	Yes	No	Social Prescriber Social worker and advocacy background
Participant Ten July 2020	F	50 -55	Yes	Yes	Yes	Social Prescriber Background Nurse worked in primary care.
Participant Eleven July 2020	F	55 -60	Yes	Yes	Yes	Social Prescriber Primary Care background leading Addiction services.
Participant Twelve July 2020	F	55 - 60	No	Yes	No	Senior Nurse Manager Community Nursing team. Background Practice Nurse in Primary Care.
Participant Thirteen August 2020	M	40 - 45	Yes	Yes	Yes	Social Prescriber Background third sector management
Participant Fourteen August 2020	M	60 - 65	No	Yes	No	Senior Administrator managing primary care services.

3.3.2 Local Demographic Data

38.3% of people in this study area need academic qualifications. The population grew due to slum clearances in the nearby city, and 95.6% of the people were white. Unemployment rates and benefit claims were 25% higher than the national average. The area is highly deprived, with shorter life expectancy. Nationally, during the first lockdown, 12.4 people per 100,000 died and 57.7 deaths per 100,000 from all causes. Fatalities cost UK productivity £6.86 billion (Bambra et al. 2020).

3.4 Stage One Pre-pandemic Focus Group

3.4.1 Design of the focus group

I am a trained facilitator who uses facilitation techniques to promote practical discourse among participants with different backgrounds and experiences. The focus group used the criteria laid out by Breen (2006) to share and compare participant experiences, develop and generate ideas, and explore issues of shared importance. I chose the focus group to be with the participants to pick up body language and nuances. I wanted to observe reactions, ensure participation and, most importantly, allow people to discuss ideas with one another to develop priorities (Plummer-D'Amato, 2008). I knew how dynamics impacted groups and had experienced managing different dynamics (Berne 1968, Farnsworth, Boon 2010, Van Inglegom 2020). I knew that both my and the participant's time was a factor, and focus groups are a quick way to gather good data that participants understand as they produce it. Bias is an issue that was mitigated by the session's design using data-gathering tools. My bias was mitigated by completing the reflective diary and being debriefed within a supervision session (Hamilton 2020). The member checking process allowed for transparency when interpreting the results. I also knew that as I was discussing mental health, sensitive issues may arise, and a focus group is an excellent environment to manage these.

The focus group had six participants, with studies recommending three to twenty group numbers (Söderström 2011). The size was seen to be enough as it meant there were two groups of three, and I had conducted a pilot that showed positive feedback on group numbers. I initially expected to complete four to six focus groups until I had begun to reach saturation (Morgan 1996). There was little in the theoretical

literature on focus groups and saturation.

Creswell (2009) describes Grounded Theory as a qualitative method of inquiry where the researcher develops a theory grounded on participants' views based on their experiences and behaviours (Gjersoe 2014). Grounded Theory was helpful as it offered an iterative process of sampling the data, collecting and using member checking, and then analysis (Hennink, Kaiser 2022). COVID-19 meant only one focus group happened pre-pandemic before changing the method to telephone interviewing. It took sixty minutes to review the process, and we spent ten minutes checking the content. The thematic analysis approach enabled a reflexive approach to saturation. The themes became influential in their own right, and what appeared from the one pre-pandemic focus group on primary care mental health was a kaleidoscope of information from different lenses. Using rich information as a base layer of the findings made sense.

3.4.2 Recruitment

The participants were recruited to the pre-pandemic focus group through a poster in the local community wellbeing centre (Appendix Fourteen). I found literacy issues in the area and wanted inclusivity and diverse experiences. The research was explained to a volunteer with a background in psychology at the community wellbeing centre. Their role was to describe the research to anyone interested and give them an information sheet (Appendix Fifteen). Six participants were interested, signed informed consent forms (Appendix Sixteen) and were invited to a first focus group (Appendix Seventeen).

3.4.3 Pilot of Data Collection Methods

Six members of a wellbeing centre with personal experience in mental health were recruited to pilot two data collection methods before this research. The goal was to decide if Appreciative Inquiry (Cooperrider, Whitney 1999) and Disney Modelling (Dilts 1994) would effectively gather data. They proved effective and were replicated in the pre-pandemic focus group (Gillard et al. 2012, Bloor et al. 2001, Bole et al. 2017, Chiu 2003). The pre-pandemic focus group also had six participants (Tierney 2018, Söderström 2011), as more were

observed to restrict input.

3.4.4 Appreciative Inquiry

Appreciative Inquiry (Cooperrider, Whitney 1999, Cooperrider, Srivasta 2017) focused on the participant's positive experiences of primary care and mental health instead of deficit-oriented information (Whitney 1998). The methods used in data collection in the pilot and pre-pandemic focus groups complement a participatory approach, and the analysis produced inductive themes. The outcomes were captured on sheets of paper, and the focus group produced themes contributing to the findings. The aim was to generate and evaluate ideas quickly, construct and critique, create themes, assess obstacles and flaws, dream up ways to implement them and run a critical eye to fix problems. The process is cyclical, considering empathically and critically, the participant accounts in a safe environment. The two data collection tools, Appreciative Inquiry (Cooperrider, Whitney 1999, Hung et al. 2018) and Disney Modelling (Dilts 1994) focus on positives instead of deficits, as these potentially block knowledge transfer in primary care and cause a disconnect. Appreciative Inquiry incorporates a broad range of communication, allowing participation and analysis through the integrated approach of Participatory Grounded Theory. Active participation improved the quality of dialogue and mutual learning. The method proved replicable, enabling clarity on participants' insights to understand primary care mental health education from community experiences.

3.4.5 Disney Modelling

Disney Modelling (Dilts 1994) enabled participation at all levels using four specific thinking styles, allowing parallel thinking. The four thinking styles are outsider, dreamer, realist, and critical friend. The pilot outcome showed that combined with Appreciative Inquiry, an external view of the discussion was produced, which included pictures, offering solutions and conceiving creative ideas. The group adopted a realistic view, reviewing the dreams, selecting the best one, and building plans to move the rhetoric to reality. The plans are reviewed during the next stage of Disney Modelling, where the critical friend is introduced to find the strengths and risks, and then the

process is restarted. Disney modelling does allow the capture of negatives; however, the joint approach with Appreciative Inquiry resulted in a creative method that worked well, focusing on strengths and building on creativity.

3.4.6 Reflexivity and the Focus Group

After reading my reflexive piece, I realised that my beliefs and life experiences needed to be kept separate from the research as I agreed with some of the views about power imbalances. I was determined to learn to practice reflexively to prevent my own experience and bias from creeping in (Denzil, Lincoln 2003). As I transcribed the feedback, one comment stood out from Participant Two, who attended the pre-pandemic focus group and the telephone interview.

‘.... There should be more research like this, and we have something to say.’

Participant Two

I revisited the comment and captured it in a note on my desk. I had been dutifully thinking about how to make suggestions on how to improve GP education. However, the comment enabled me to realise that this is counterproductive. I needed to change my stance and listen to understand why it required improvement and to whom. I undertook the literature search, wanting solutions on how to shape the research. I realised that to ensure a robust community participation approach, I needed to listen to and understand the community's perspectives on primary care mental health.

The first findings were captured as themes to be built on during the telephone interviews. The participants were enthusiastic, and reflexivity helped me remain unbiased. I recorded the feedback and kept a log, notes, and worksheets from the session. Generational trauma affected some group members, and I found it essential to be open, honest, and empathic with everyone taking part.

3.4.7 Member Checking Pre-pandemic Focus Group

The participants outlined their positive experiences of primary care, enabling me to start constructing emerging themes of primary care mental health. Member checking

helped me to share the emerging themes with the participants. They thought I had interpreted them correctly and agreed with the priorities. Following the focus group, one member expressed the need for a conversation to explain the impact of their lived experience, which they could not do due to time constraints. They felt uncomfortable sharing their experiences with the group but said they would happily talk frankly one-on-one. Other group members shared this sentiment, which helped shape the future redesign of the research. Their feedback was co-produced with the precise aim of ensuring I heard the community's voice.

3.4.8 Initial Themes

The themes from the pre-pandemic focus group were created using NVivo (Edlund, McDougall 2019), a software program that organises focus group text (Appendix Nine, Appendix Ten) and image data (Appendix Eleven).

3.4.9 Implications of the Findings from Focus Group

Participants shared how mental health touched them as a communal experience, but management and understanding differed. I established different relationships with each focus group member and recognised reflexivity's importance. By looking at their outcomes through a kaleidoscopic lens, I could view them holistically to understand values and meaning and develop the final recommendations (Whelan 2018). The created patterns informed the themes, analysis, and recommendations.

3.5 Doing – Phase Two:

The COVID-19 pandemic changed the patterns of our world, causing me to want to include the mental health experiences of the community and the impact. I restructured the ethics proposal, realising the need for a more participatory approach and a move to telephone interviews (Appendix Six). The literature search confirmed the need to engage, listen, and recognise shifting patterns. Centralised policymaking had created disconnected patterns, making them disjointed yet interrelated. Despite the limitations of direct observation, I changed my method and methodology to contextualise and inform themes produced by the focus group and supported by literature.

3.5.1 Change of the Method to Telephone Interviews

The implications of moving to telephone interviews and a supportive discussion were held with supervisors. The Staffordshire University ethical committee approved the research (Appendix Six). The participants' data were protected by law under the General Data Protection Regulation (GDPR). The Data Protection Act (2018) application ensured that all personal data was used transparently and fairly in line with UK data protection principles. Each participant received an information sheet about this study's purpose, their rights to data protection, and how to access support if needed. All participants were informed that they could leave this study at any time. A discussion was held with the pre-pandemic focus group participants, and all agreed to be recruited, interviewed by telephone, and recorded using Artificial Intelligence Technology.

3.5.2 Recruitment for Telephone Interviews

I contacted the original focus group members, except one who had changed their job. Five participated in the ongoing study through recorded telephone interviews using semi-structured questions. A further nine participants had expressed an interest in the focus group. They were contacted by telephone with their permission to explain the change in the research method due to COVID-19. They were sent a letter in the post via the wellbeing centre for further information (Appendix Eighteen).

Fourteen applicants, in total, agreed to take part in a telephone interview based on the semi-structured questions. Ten participants requested pre-interview telephone discussions. I explained the research's process and nature through the introductory telephone call, which helped to establish rapport. The aim was to ensure that each participant understood their input was valued and the expectations and to minimise risk (Faija et al. 2020). Informed consent and confidentiality were offered, alongside the help available if anything discussed caused any distress. I maintained reflexivity to build trust, prevent bias, and gather data for analysis. The pandemic caused mixed emotions in participants, and keeping a reflexive diary enabled me to ensure that the data produced was credible. The data reflected the unique times we were going through. Each interview happened at a time suitable to the participant following

informed consent. Participants were treated as experts and equal partners collaborating with me, the data gatherer, through discussion and freethinking to share their insights and experiences.

3.5.3 Telephone Interviews

Fourteen interviews were conducted, and the findings were collated, so further participants' valuable time was unnecessary. All were offered the opportunity to comment on their interviews and be involved in the ongoing member checking process. Gathering emotional experiences and ideas was a privilege during a lockdown period. I had read extensively and was well prepared for each interview, genuinely interested in the breadth of the discussions, showing positive reinforcement and a healthy curiosity. The participants spoke without interruption and were encouraged to evaluate themes and ideas within an equal relationship. The information shared was sometimes very personal at times due to the pressure of being locked down on individuals' mental health. Ongoing support was available, and there was a local, supportive online group that everyone could access if needed.

3.5.4 Listening

The change to telephone interviews meant an extra focus on listening and interpretation skills. I studied the literature on telephone interviews and learned that nuances may be lost despite all the best intentions. I recognised that I was unlikely to interview participants twice due to time constraints. Each telephone interview focused on the participants' issues, clearly focusing on their primary care experiences. Reflexivity enabled me to recognise outcomes that can become entangled with data collection. I was mindful that data is gathered through a participatory approach. Time was built to engage with participants and build rapport. Some interviews were expected to take longer than the estimated 30 minutes as participants had much insight to offer. I understood the need to understand and listen to personal experiences and be human. Nuances such as laughs and silences were listened to. The interviews were semi-structured, so I let people speak freely, gently guiding them back if necessary. Additionally, Rudyard Kipling's poem, "I Have Six Serving Men" (Kipling 2009), guided the development by posing essential questions: 'What,' 'When,' 'Where,' 'How,' 'Who,' and 'Why' (Appendix Thirty-Six). The whole

process took time, and the unique environment of the lockdown allowed that. There were moments when intuition took over, and I realised that listening was the most important thing I could do. I showed I was listening by repeating what had been said and paraphrasing.

3.5.5 Individual Member Checking

Following their telephone interviews, participants asked for further involvement in the research. Member checking allowed participants to support the final interpretation and analysis. The themes produced were shared back, and participants agreed to check their discourse to ensure I had understood and valued them. The National Institute of Health and Social Care (2009) recommends telephone interviews in psychological interventions. There is also transferable learning from the robust evidence following an assessment of risk by telephone. With the right communication skills, I could create a safe space to build rapport, using feedback, empathy, and silence to generate participation and outcomes. Member checking built my confidence in telephone interviewing as a method. I felt supported by the participant's input, and they said they liked the member checking process, too. One participant reflected on how they felt, writing a poem during lockdown (Appendix Nineteen).

3.5.6 Limitations and Strengths of Telephone Interviewing

The main limitation of telephone interviewing was being unable to assess body language, which may mean my intuition was unused, and critical nuances were lost in translation. Not seeing people's visual responses meant energy was placed into engaging participants and enabling them to relax. The telephone calls averaged between 40 minutes and up to one hour and twenty minutes. However, the benefits included listening to audiotapes, using open questions, and offering interviews in people's homes at a time to suit them. Telephone interviewing had its strengths, as three participants were particularly hard to engage due to their mental ill-health. Telephone interviewing worked well as they may have disengaged from a face-to-face interview. The level of cooperation was high, and there was a willingness to discuss personal issues that were not there in the focus groups. Validity was ensured by recording, transcribing, and sharing the main findings with those interviewed.

I took a participant-observer role during the telephone interviews, counter to the more active role undertaken with the focus group. (Johnson et al. 2006). The subjective experience in my reflexive log supported whether any biases or assumptions were made and, if so, how to manage them. An example is that I missed asking, in an early interview with a professional working within primary care, about the impact of the pandemic on their mental health. I could return to the participant and discuss that due to the reflexive process when I discovered it was an issue with other professional participants.

My time in the field was extensive as I regularly attended the wellbeing centre pre-COVID to recruit, run, and set up research. When the centre reopened, I developed the Discovery Recovery Tree (Illustration One, p.191) as a visual aid to show progress, themes and sub-themes to date. Grey literature using local authority documents enabled further understanding of the community's issues, including deprivation and inequality.

3.6 The Onset of COVID-19 and Change in Methodology

The outbreak of COVID-19 required me to reconsider my methodology alongside the described method. I revisited the theoretical literature and changed the original methodology of Interpretative Phenomenological Analysis (IPA) (Smith, Shineborne 2012). I initially chose the IPA methodology to gain an insider's view and adjusted it to suit this study's requirements. Interpretative Phenomenological Analysis (IPA) uses double hermeneutics (Pietkiewicz and Smith 2014). The methodology allows the participant to make sense of their world, followed by the researcher. The original objective was to conduct a comprehensive analysis that captures the participant's description with insight and interpretation of what is meaningful to them. In mental health, particularly within psychology, IPA applies hermeneutics to interpret the participant's detailed world.

The literature review revealed that the community's voice was missing from primary care policy, mental health education, management, and mental health treatment. I needed a shift in my approach that was not only focused on the individual voice but

also on the broader community. With IPA, a comparison is made from case to case, and the recruitment process is a homogenous sample related to the research topic. Evidence showed that IPA works well with people diagnosed with mental health problems (Wagstaff et al. 2014). However, I wanted to find out what the community was experiencing and develop an educational framework to meet their needs post-pandemic. After revisiting the literature review, the focus group outcomes, and the driver of the pandemic, I took a step back to decide how to respond to the two research questions and meet the objectives using concept mapping (Appendix Twenty).

3.6.1 Concept Mapping Exercise

I undertook a concept mapping exercise (Appendix Twenty), reflecting the focus group and theoretical literature findings. The focus group found that mental health does not easily fit into any one model, be it biological, social, psychological, cultural, or spiritual. Every experience is personal, and the discourses show how each manifestation differs. However, the impact of mental and physical ill health is still devastating. My decision to research with the community ensured I listened and empathised with the broader community.

The concept mapping showed a need for a participatory approach to research rather than the more individual, interpretive approach of IPA I had initially intended. I mapped three theoretical approaches, Cognitive Flexibility Theory (Patel 2009), Grounded Theory (Glaser, Strauss 2017, Noble, Mitchell 2016) and Participatory Research, against the original anecdotal disconnect between policy and practice, supported through literature. This study focuses on primary care mental health education from a community perspective post-COVID. Cognitive Flexibility Theory (CFT) and the literature review refined the two research questions.

I found that merging Participatory Theory and Grounded Theory allowed flexibility in the data-gathering method with any individual or group activity producing data (Dick 2005). Concept mapping (Appendix Twenty) was helpful as it visualised the relevance of participation, including the need for the community's values and insights. It showed the need for a transparent, visual understanding of the theoretical framework's key concepts, relationships, and transferability (Johnsen et al. 2000,

Vacek 2009, Chabeli 2010, Lozano et al. 2017). The literature supported the anecdotal disconnect between theory and practice, whilst the theoretical framework connected me and the community to what is already known, showing exact investigation methods (Appendix Thirty-Five). The theoretical framework produced the methodology to meet the research questions, and the objectives were finalised through the concept mapping exercise (Appendix Twenty).

Table Three - Research Questions and Objectives

	Research Questions	Objectives
Question One	Is there the potential to produce a learning theory for primary care mental health education that considers community perspectives?	Objective One: To generate a learning theory that considers community perspectives.
Question Two	Will the government policy of community participation in mental health enable policy enactment concerning primary care mental health education?	Objective Two: To identify the meanings of shared values from the community to develop an epistemology for primary care mental health education.
	.	Objective Three: Co-produce an education framework informed by the community and evaluated through current literature.

3.6.2 Cognitive Flexibility Theory

Cognitive Flexibility Theory (Spiro 1988, Spiro et al. 1992, Odaci, Cikrikci 2019) enables understanding of mental health by listening to personal views to find what works and developing problem-solving skills (Ozuah, 2016). Primary care is a complex area (Sweeney 2017) with different variables relating to consultation styles, particularly behaviours and attitudes (Upshur 2001, Miller et al. 2019, Cherry 2021). The learning theories initially examined in the literature review appear complicated and related to teaching instead of knowledge gained from a community perspective and the relationship with primary care.

Cognitive Flexibility Theory counters the danger of simplified concepts and compartmentalisation of knowledge to prevent advanced knowledge acquisition (Spiro 1988, Patel et al. 2009). Cognitive Flexibility Theory (CFT) is used in medicine (Coulson et al. 1997). It is case-based, relying on being interconnected rather than silo thinking. It offers an underpinning approach to research. The two research questions and three objectives in Table Three (p.60) supported the literature on health policy findings whilst highlighting neglected areas.

3.6.3 The Move to Participatory Grounded Theory Strengths and Limitations

Two theoretical approaches were applied: Grounded Theory (Glaser, Strauss 2017) blended with Participatory Research. The mixed approach incorporates the community's views on the research and analysis. The theoretical framework outlines the main variables that affect this study and how they differ and influence the work. Community participants identified a significant gap between community and clinical practice. Despite the relevant solutions in the literature, the community voice remained absent, and the solutions were not implemented in policy. Community participation is critical to the thesis, as it explores participants' needs, preferences, and values. Co-production began to generate a learning theory by uncovering underlying patterns that enable facts and values to produce greater significance. The process developed an epistemology of primary care mental health education through collaboration with the community. The theoretical framework is participatory, ensuring the anthology of diverse knowledge, and the inclusive, inductive approach avoids a

disconnect between theory and practice. Participatory Theory and Grounded Theory (Glaser, Strauss 2017) were used alongside Cognitive Flexibility Theory to set and answer the research questions with rigour from a community perspective. This approach offers new understandings and insights and contributes to knowledge development and learning.

To ensure community representation, involvement needed to take place at all levels. The research had to go beyond assumptions and get a community response to gain further insights. As an early-stage researcher, I discussed with my supervisor the mixed-method approach to offer a reflexive framework and build on the original findings from the focus group. Participatory Grounded Theory is inductive, interpreting what the experts, Husserl (1970), called people with lived experience, mean instead of what they say.

The positivist approach to collecting data includes treatment outcomes, deprivation data, clinical governance, and mortality rates (Ribeiro et al.2019). The National Institute of Health and Social Care (NICE) produces quantitative evidence and informs the United Kingdom's clinical practice. Reason and Rowan (1981) explained that people were uninvolved in research and that recipients were not empowered.

The strengths of Participatory Grounded Theory are the opportunity to research with people to capture the community experience. It allows the community a voice, often unheard in research, and literature shows it is missing in current policy and practice of mental health in primary care. It enables discourse on the role of tractable social determinants such as poverty, inequality, structural racism, and austerity (Williams et al.2020). The mixed method aimed to address the complexity of primary care and find a way to engage with the community by incorporating anthropological and philosophical approaches. The kaleidoscopic, holistic view showed how to understand values and gave the freedom to look at many parts of information. The limitations were that the initial collated data appeared chaotic, and combining Grounded Theory and Participatory Theory enabled clear patterns that informed the themes, the analysis, and the recommendations.

3.6.4 Traditional Grounded Theory

Creswell and Poth (2016) discuss two features of research design: constant data comparison with emerging categories and theoretical sampling of diverse groups. The strengths of Grounded Theory are the emergent theory quality that grows from detailed, systematic data collection and thematic analysis approach. As an early-stage researcher, I can keep an open mind and look at data through different lenses over time. Qualitative methods can approach and analyse the personal meaning of stress factors, mental ill-health, disease, and illness.

Recognising procedures such as comparison and theoretical sensitivity challenges preconceptions and ambiguity, and knowing the process is emergent. Using Grounded Theory alone risked preconceptions due to my earlier knowledge of mental health while acknowledging insights through reflexivity reduces risks.

Bauer and Gaskell (2000) describe qualitative research as a didactic nightmare with little procedural guidance or clarity. This is a position addressed over the last twenty years with a multitude of conflicting guides, which, as an early-stage researcher, appears tribal and confusing. The Grounded Theory approach offers a lens to address somatisation, resilience, compassion and instinct alongside measurable science, which can inform future health promotion and disease management strategies, education content and design (Davis et al. 2019). The data gathered from qualitative research is not linear and moves from side to side (Noyes et al. 2019). The blended approach was of value as it offered a different methodological approach to understanding the causes and impact of health disparities (Jeffries et al. 2019) instead of more traditional, centralised, data-informed epidemiological studies.

3.6.6 Participatory Research

Participatory Research is a methodology that argues the involvement of research partners in the knowledge-production process, enabling their world to be studied. Combining science and practice can inspire a cognitive shift, allowing a fresh perspective on established ideas and situations (Bergold and Seckinger 2007, Bergold and Thomas 2012). Participation is essential in this theoretical framework and is as important as the findings. The theoretical framework has been revised to be participatory, pragmatic, yet fluid, strengthening this study. It allows critical evaluation

of assumptions and a shift from description to analysis. Participatory research is beneficial as it includes systematic inquiry. The telephone interviews were undertaken with a community affected by the pandemic to develop a primary care mental health community of practice model.

I recognised that participatory research simulated power and my relationship with the participants. I worked hard to build a positive, inclusive relationship. Member checking and recruitment were two outcomes that showed participants had responded positively.

The key focus was the critical relationship between the participants and their GP surgery. I could engage those most impacted by directly working with the community and co-producing a primary care mental health model. By valuing their knowledge, I could understand the complexity and inequality within the literature causing the disconnect between policy, education, and primary care, alongside the focus group's finding of a perceived disconnect between community and practice.

3.6.7 Merging Participatory Research and Grounded Theory

To address the disconnect between policy and practice, the risk of my potential bias and the need to participate in this study, I merged Participatory Research and Grounded Theory (Glaser, Strauss 2017). The aim was to find evidence of the community's expectations regarding primary care mental health and their main concerns and determine if they could develop education and learning theory through community participation. This study used a participatory and grounded methodology to explore the community's knowledge, experiences, and insight.

3.6.8 Participatory Grounded Theory

The Participatory Grounded Theory approach has been used to improve organisational context. While there is limited evidence of the effectiveness of quality improvement collaboratives, the underlying evidence of the strategy is positive. Breckenridge et al. (2019) used the classic Grounded Theory to generate relevant theory directly from practical experiences within health. The research used a co-produced participatory approach, and the process and the findings were co-owned for knowledge mobilisation. Schouten et al. (2008) found that multi-institutional quality improvement is acceptable as a healthcare strategy despite little evidence of effectiveness. They believed this was due to the complexity and variety of each

quality improvement collaborative. Teram et al. (2005) support the integration of Participatory Research and Grounded Theory, as it empowers the community to inform professional practice. The approach helps address power imbalances between the community and professionals and supports collaboration.

The disconnect between policy and practice is a recurrent issue in literature, and there is a need to challenge professionals and academics to deliver practical outcomes. A grounded, participatory approach can be used to develop and conduct research into education, primary care and mental health. Reeb et al. (2017) used a similar approach in investigating service-user-led education utilisation concerning homeless shelters. A qualitative approach was used, including written reflections using the Grounded Theory methodology (Glaser, Strauss 2017). This replicable approach enabled them to achieve their aim, showing that service users led students to develop self-efficacy, address stigmatising attitudes, and become aware of their privilege. Reflection encouraged me to understand how the studies influenced this research. I examined how society's elements fit to understand the relationship between the community and primary care, alongside how and why people behave as they do.

3.6.9 Similarities Between Participatory and Grounded Research

Merging theory that uses inductive approaches is similar to Participatory Research and Grounded research. Further similarities include data analysis, interpretation, and theory development alongside data collection (Dick 2003, Dick 2005). The key to the research study is participation, sharing insights and growing a shared understanding to become a theory aligned with primary care mental health education. This is the same as in Grounded Theory (Glaser, Strauss 2017), which ensures that data collection methods can be flexible in supporting learning.

The learning from integrated work outlined by Breckenridge et al. (2019) shows what works in primary care from participants' perspectives, recognising that individuals have their views and values. The Breckenridge et al. (2019) study compared and collected what worked, producing their theory in creating a large-scale change. There are risks as well as benefits of bringing together an integrated approach. Grounded Theory (Glaser, Strauss 2017) makes discoveries from empirically collected data.

Unlike Participatory Research, it does not rely on independently constructed research, nor does it have the same desire to change at a ground level. Merging the two approaches ensures that the community's voice is heard to enable policies at an empowerment level. This study aims to listen to the community voices to develop an original learning theory from the findings. However, its objectives do not include changing the system. Participants collaborated with me on a discovery journey to co-produce theory and ideas, not organisational or social change. Participatory Grounded Theory is an inductive approach that interprets what people with lived experience mean instead of what they say. The positive approach to collecting data includes treatment outcomes, deprivation data, clinical governance, and mortality rates. Quantitative evidence produced by the National Institute of Health and Social Care (NICE) informs clinical practice in the United Kingdom. Reason and Rowan (1981) argued that people were uninvolved in research, and recipients were not empowered.

The methodology allowed the community a voice, often unheard in research, and the literature showed that it is missing in the current policy and practice of mental health in primary care. It enabled discourse on the role of tractable social determinants such as poverty, inequality, structural racism, and austerity. The blended approach of Participatory Theory and Grounded Theory recognised that individuals and their social environment work together to cope with illness and economic hardship, independent of health professionals. Therefore, the community is no longer uninformed and expected to adapt to a health system. The literature had signified a need for community-engaged research approaches to inform future economic and health policy (Faltermaier 1997). The onset of COVID-19 meant through necessity that the method changed from a focus group to using semi-structured questions in telephone interviews, completed individually, enabling active participation. The methodology supported the change and ensured trustworthiness. The traditional criticism of qualitative research as being subjective and biased is prevented (Cope, 2014) through the application of a rigorous framework as defined by Lincoln and Guba (1985) that audits the trustworthiness of the findings (Table Four p.67). Haq et al. (2023) discussed measuring qualitative research to ascertain the level of trust and remove the issues surrounding subjectivity. However, the importance of subjectivity is

indisputable in this work as it cannot be denied. Paulo Freire (2017, p. 24) is empathic that without subjectivity, it is a 'world without people'.

I appreciated that the research needed credibility; quantitative research is found through validity and reliability. Applying the Four Dimension Criteria (Lincoln and Guba 1985) in qualitative research ensures the research is credible, transferable, dependable and confirmable. All field notes and images were collected and stored safely in a locked filing cabinet. Re-examining the focus group data and immersion with the transcribed audio files from the telephone interviews observed patterns and derived meaning. Mind mapping (Buzan 2018) collated the data from the datasets and developed ideas. The member checking process allowed discussion with participants on whether the themes were suitable.

Table Four How Trustworthiness, as described by Lincoln and Guba (1985), is adapted for this research.

Credibility	The findings were trustworthy	Long-term engagement with the participants moving from outsider to insider role. Continuous observation within the focus group Transcribing of data, immersion in data Debriefing with supervisor and peers Supported by literature review. Member checking process Development of Discovery, Recovery Tree
Dependability	The research is solid and replicable	Analysis Process and Review Method, Flow Chart - Table One (p.40). Triangulating the qualitative data with the literature Member checking with participants throughout the process (Jennings et al. 2018) to determine whether the findings were accurate and consistent with their beliefs.
Confirmability	The findings were linked to the data	Triangulation with the literature Audit trail as shown in the appendices. Reflexive Account merged into the method section.
Transferability	The findings can be transferred to other settings	Saturation Sampling method Duplicating the analysis - discussed at conferences with peers.

3.7 Phase Three Digesting

3.7.1 Research Analysis

Throughout the analysis, I wanted to ensure fidelity to the methodology and ensure participation happened at all stages of the analysis. I looked in the literature for tools for involvement and found the Jennings et al. (2018) analysis framework. The tool has four steps. The first step ensured co-production through consultation and verification. The second provides a realistic analysis process within the available time and resources managed through member checking and ongoing discussion with participants. The third ensured all demands were reasonable. The fourth managed expectations and dynamics by clearly defining the roles of the community participants as experts and myself collating information for analysis. I used the Jennings et al. (2018) Framework throughout the analysis to ensure genuine co-production and participation. I found it helpful to ensure each stage of the Braun and Clarke (2019) analysis was participatory (Table Five p.69).

The findings were part of the reflexive thematic analysis shown by Braun and Clark (2006) and described in Rowan (2016). The data interacts and flows, showing the coding and the inductively produced themes and categories directed by the data. The reasoning is to find the patterns of meaning following the completion of the research phase using the Braun and Clarke six-stage approach (2019). The sequential and flexible approach enabled me to interrogate data from the start of this study to find the latest ideas and concepts and evidence of existing views across the interviews. Overlooking individual data is mitigated by each transcription being evaluated on its merit and pooled to keep the particular phenomena. Table Five shows the research's robustness through applying the revised framework.

**Table Five Braun and Clarke's Thematic Analysis (2006) incorporating
Jenning (2018)**

Stages	Thematic Analysis Process
Stage One Familiarisation with the Data and ensuring co-production through consultation and verification (Jennings et al. 2018)	• Re-examination of the focus group data, Immersion with the transcribed audio files from the telephone interviews • Observed patterns and derived meaning. • Mind mapping (Buzan 2018) collated the data from the datasets and developed ideas (Appendix Twenty-Four). • Discussed with participants the NVivo outcomes. Are these suitable themes? Anything else to add?
Stage Two Accuracy of the Data Roles of participants and willingness to be part of the member checking process (Jennings et al. 2018)	• The transcriptions produced by the transcribing tool did not consider the local dialect. • There were inaccuracies and missing nuances from the transcripts of the telephone interviews, • Each transcript was reviewed using the co-produced semi-structured interview schedule (Appendix Three) as a framework to ensure accuracy as part of the inductive process. • Notes and remarks on each transcript and initial coding of keywords (Appendix Twenty-One).
Stage Three Immersion	• Relistening and correcting each transcript, capturing silences etc. and timings. (Appendix Twenty-Two). • Initial coding and decoding of the text to find the first impression (Saldana 2021) (Appendix Twenty-Three). • Revisiting each telephone interview transcription, • Notes produced during the interview were captured in the reflexive learning log, and personal observations were removed. • Thoroughly checking the transcriptions confirmed the data and interpreted the data correctly. • The researcher (I) recognised they were interpreting data at the first part of the analysis to produce codes from the captured patterns. • The collated and weighted coding made emerging themes and subthemes.
Stage Four Coding Focus Group Coding telephone interviews	Coding Focus Group Focus group output data analysis by NVivo (Edhlund, McDougall 2019) produced twenty potential principal codes Appendix Eleven) Disney modelling prioritised those areas as being more critical.

	Sub-coding was collated by hand from output sheets made by the focus group Patterns appeared The semi-structured interview schedule was co-produced using focus group data. • Edited transcripts merged into an Excel spreadsheet (Appendix Twenty-Five, Appendix Twenty-Six) • Commonalities and differences found • Eight hundred identified areas, coded and mind-mapped, enabling data interpretation. • Focus Group outputs mapped against telephone findings. • Patterns showed potential primary and sub-themes appearing, supporting, and expanding on findings from the focus group (Appendix Twenty-Four). • Excel spreadsheet for further analysis to find key themes.
Stage Five Merge Data Participants experts The researcher (my) role as data collector (Jennings et al. 2018)	• Using Excel to merge focus groups and telephone data • Find patterns relevant to the emerging themes to establish viability. • Coding on the Excel spreadsheet using colour to find commonalities (Appendix Twenty-Seven) • The research questions provided a clear focus for coding • Developing The Discovery and Recovery Tree to look at the merged data using the best time and resources (Jennings 2018) (Illustration One, p191).
Stage Six Review and Revise Themes Participants were experts by experience (Jennings et al. 2018) Saturation	• The reviewed themes were merged or removed if irrelevant to the two research questions. • The codes were rearranged to make each theme distinct • Inclusion supported by listening to and rereading each corrected transcription and mapping times to re-listen again (Appendix Twenty-Eight). • The established patterns of meaning were achieved through knowing data, coding data, developing initial themes, and writing and re-writing to narrow down final themes. • The eleven most discussed areas saturated the information, becoming a central phenomenon with the most conceptual information (Creswell, 2016). • Members checked the final themes eight, two, three, and seven, experts by experience (Jennings et al. 2018). • Thematic analysis captured in the findings expands on the Subordinate themes and sub-themes.

3.7.2 Application of the Thematic Analysis Six-Stage Process (Braun and Clarke 2019, Jennings 2018)

3.7.2.1 Stage One – Familiarisation of the Data

The thematic analysis involved me re-examining the pre-pandemic focus group data conducted in the autumn before the onset of COVID-19, gathered through the combined approach used in the pilot study of Appreciative Inquiry (Cooperrider, Whitney 1999) and Disney Modelling (Dilts 1994). The transcribed and audio files from the telephone interviews were read and listened to again to see patterns and derive meaning. Mind mapping (Buzan 2018) collated the data from the datasets and started to show connections, finding meaningful patterns from the data (Appendix Twenty-Four). The approach worked to engage the research participants throughout the analysis process. The stages of familiarisation were achieved through immersion, re-transcribing, and scrutinising the data.

The key themes were re-examined to produce a detailed analysis. The telephone transcripts were printed and then listened to again, as the transcribing software had only produced keywords without context. The transcribing process was redone verbatim to capture the dialect, pauses, laughter, and silences, replicating the recordings. The software allowed me to revisit and listen to the recordings again, hearing intonation, pauses, and laughs. I marked these into transcriptions and checked changes in voice pitch to decide if participants felt stressed or if there was a danger of over or under-exaggeration.

Reviewing the transcripts and listening to the interviews verbatim, I gained knowledge of the data, found similarities and differences, and coded them in distinct colours as themes and ideas emerged (Appendix Twenty-Seven). Each transcript was reread, and the coding was completed individually. My primary role was to gather data to manage the complexity of each response depending on the participant's worldview and to develop a context.

3.7.3 Member Checking the Data

Stage one of the Braun and Clarke model (2019) was invaluable as it ensured the data was all collated and shared with participants to verify. I used the NVivo analysis

(Edhlund, McDougall 2019) and mind-mapped the pre-pandemic focus group data to create initial themes. These were then mapped against the themes appearing from the telephone interviews by hand with participants. The Discovery and Recovery Tree (Illustration One, p.191) was developed to help participants visually interpret the data and engage them in discussing emerging findings. I incorporated their thoughts effectively, preparing the final coding and analysis to reflect, think, and capture ideas and decide the final values and themes. The member checking enabled me to rely on the participants' interpretations.

3.7.4 Stage Two Accuracy of the Data

The transcriptions produced by the transcribing tool did not consider the local dialect. There were inaccuracies and missing nuances from the transcripts of the telephone interviews, which I believe is due to misinterpreting regional accents. Each transcription had time spent reading and rereading to become familiar with it until I understood the content. The transcripts were supported by notes in the learning log and reviewed. The semi-structured interview schedule (Appendix Three) was the framework that ensured accuracy as part of the inductive process. The findings reflected the data and were therefore transferable. The correct transcription of the recordings ensured reliability, and times were noted for when to relisten (Appendix Twenty-Six). The annotating of pauses, laughter, and silences helped us move to the next stage of the immersion process.

3.7.5 Stage Three Immersion

Revising and correcting each transcription enabled immersion in readiness for the coding and decoding of the text to find the first impression (Saldana 2021). The opportunity to immerse myself in the research by revisiting each telephone interview, relistening, pausing, and correcting the transcripts was a real positive to this study's outcomes (Appendix Twenty-Six). It allowed complete immersion in the data, enabling key findings and observations to be logged. Quotations relevant to the research were also found and ensured all participants' views were represented. Notes produced during the interview were captured in the reflective log and annotated to show pauses. The discussions were double-checked, ensuring transcription was correct to understand mental health phenomena in primary care.

Thoroughly checking the transcriptions confirmed the data chosen, removed any personal observations about others and interpreted the data correctly. I recognised I was interpreting data and ready to produce codes from the captured patterns.

3.7.6 Member Checking

I invited participants to check their final transcripts individually to ensure I had interpreted them correctly and used their quotes appropriately. I referred to Creswell and Poth (2016). I used three types of quotations: discrete quotations that were shorter and showed diverse views, embedded quotations offering a change of direction in the text and longer quotations, which were more limited due to word count, to discuss issues such as complexity. The quotations used were chosen to show the findings and support the analysis while ensuring confidentiality (Eldh et al. 2020).

3.7.7 Stage Four - Coding

Following immersion, I transcribed the telephone interviews, coding and mapping them against the focus group outputs and ensuring they were supported or challenged by current literature (Appendix Twenty-Three). Through the community participants' insights, experiences, and transferable knowledge, they could decide what they believed worked best in primary care to support mind mapping (Appendix Twenty-Four). A further paper exercise was conducted to code and colour these first impressions and then explore the patterns on an Excel spreadsheet, seeking commonalities, even if there were opposing views (Appendix Twenty-Seven). Codes were developed initially based on how often items were discussed and emphasised. The transcriptions were then relistened to thematically against the times discussed to ensure thematic data was coded.

3.7.8 Coding following the pre-pandemic Focus Group.

The focus group output data analysed by NVivo (Edhlund, McDougall 2019) produced twenty potential principal codes that I believed were pertinent to the research questions from studying the literature (Appendix Eleven). The member checking process also highlighted the areas. The pre-pandemic focus group data produced codes showing distinct regions, and Disney modelling prioritised those

areas weighted as more important. Sub-coding was collated by hand from output sheets to semi-structured interview schedules was co-produced, and initial outputs coded included general practitioners' soft skills alongside their ability, experience, competence with mental health prescribing, and the need to educate, including cultural competence and attitude. The surgery environment was discussed, suggesting a one-stop approach where all services were accessible in one place. The future climate needs to be conducive to care. A large part of the discussion centred on the receptionist's skills, education, and role and how vital surgery is in providing primary care for mental health. Confidentiality, accessibility, and appointments arose alongside advocacy and engaging with the third sector. The evolving practice of social prescribing, relational issues, transactional issues, and the need to develop patients to understand primary care and the pressures involved were discussed and coded.

3.7.9 Coding Following the Telephone Interviews.

The telephone interviews used a semi-structured interview schedule approved by the Ethics committee, formulated following the focus group and honed by examining the historical context in the literature (Appendix Three). These provided a template to shape each interview and allow participants to share their knowledge and expertise freely, allowing themes to develop and be rich in perception and insight (Appendix Thirty-Two). The initial literature review showed apparent gaps in the definition of primary care mental health. The focus groups could not define what primary care meant, so the first question in the telephone interviews explored the term and examined the best personal experiences of primary care.

I immersed myself in the recordings and transcriptions, sorting and open coding (Khandkar 2009). It soon became apparent that what was in the medical literature and guidelines did not reflect the participant's primary care experiences. A paper exercise coded the fourteen transcripts onto an Excel spreadsheet, identified commonalities and included opposing views. The telephone interviews, once reviewed, were mapped against the transcripts, finding eight hundred identified areas, coded and mind-mapped, enabling the data interpretation. The coded groups were examined, with potential primary and sub-themes emerging, supporting, and

expanding on the findings from the focus group. Areas relevant to the themes arising from the focus group and subsequent emerging patterns were highlighted. Identifying the final themes' commonalities allowed me to collate these into an Excel spreadsheet. Rereading data enabled an opportunity to work out the data's key focus and find informative theme names.

3.7.10 Use of the transcribing tool in telephone interviews

The transcribing tool allowed each interview to be printed out, and initial coding was used to decode the text to identify a first impression (Saldana, 2021), including timings (Appendix Twenty-Nine). The transcribing tool produced critical themes from each telephone interview using the most repeated words and phrases. However, the transcriptions and recordings needed to be more accurate due to the interviewees' local accents, which the software struggled to pick up. Each transcribed recording was listened to individually and edited to ensure the transcriptions were accurate. This was a positive outcome, as reviewing the transcripts enabled me to immerse myself in the data. Once accuracy had been established, the initial focus group outputs and the transcription data were revisited. The coding and capturing of outcomes were completed visually using mind mapping (Buzan, 2018) (Appendix Twenty-Four) to examine the findings and determine if the themes gathered reflected discussions. The opportunity to re-listen to each transcript allowed me to become immersed in the data and create a shape to the research and the data flow by capturing recurrent themes and colour coding onto Excel (Appendix Twenty-Seven) and comparing focus group and telephone interview data to find similarities and disparities (Appendix Twenty-Eight). Pauses, laughs, and intonations were logged, creating an accurate, auditable transcript from the original script (Appendix Six).

3.7.11 Data Saturation

The telephone interviews were collected and analysed simultaneously during the research until my supervisor, and I thought data saturation was reached. To achieve an inductive and participatory methodology, I followed the Six-stage thematic analysis approach developed by Braun and Clarke (2019). The thematic analysis involved reading the qualitative data produced by the focus group and telephone interviews to find meaningful patterns from the data and engage the research

participants throughout the analysis process. As it was a blended theory, I used an approach in which the participants' accounts would guide the saturation process. As the interviews progressed, it became clear I was collecting rich data on other themes, particularly the impact of lockdown, which I did not use in this study as the research questions and objectives guided it.

Different saturation points were suggested in the literature, such as when coding is completed or when themes are produced and no new information appears (Fusch and Ness 2015). However, I needed help to give a fixed point. I found the more fluid saturation definition of Grounded Theory (Mwita 2022, Guest et al. 2020) helpful when combined with a reflexive approach. Although I recognise the subjectivity of the approach, there was sufficient information on the analysed data to produce a learning theory, answer the research questions and develop a fresh paradigm for education (Guba, Lincoln 1994) in primary care on mental health. I found the different concepts of saturation complex. I used reflexivity to see whether I had enough data to respond to the research questions and objectives, as the themes produced a breadth of knowledge.

The depth of knowledge was produced using the continuous comparison method from Grounded Theory (Corbin, Strauss 1990, Kolb 2012), making a constant improvement process. Coding was completed until no more themes or sub-themes were produced. The ongoing interviews strengthened the theories, allowing concepts to appear (Holton 2007). I began the data analysis from the beginning, which helped the interview process, allowing themes to be expanded on and new topics explored. This study reached data saturation after completing the final interview (Participant Fourteen). No new codes nor themes were produced; instead, richness and quality of knowledge were used to inform the themes.

Responding to the participant's account, rather than sticking to the semi-structured questions, helped to explore themes from different perspectives and at varying levels of complexity. It also meant that themes, such as stigma, could be added. The ongoing discussions showed the impact of stigma in the broader community, including health professionals not seeking help and support for their own mental and

physical wellbeing due to professional and self-stigma. Knowledge would have been lost if data saturation had stopped when the theme was repeated. The information powerfully sorted the codes into themes and clarified which codes were conceptual (insight) while others were more tangible (the receptionist). The member checking process was invaluable here as iterative and theoretical sampling were discussed alongside the progress of coding and prioritising key concepts. Saturation was agreed upon when the research questions were answered and the objectives were met. The saturation was helped by having two straightforward research questions and objectives to respond to, using my transferable interpretation and communication skills to support the research process.

3.7.12 Stage Five Collated Codes with the Supporting Information

Using Excel, the excerpts were all mapped and collated. The merged focus group and telephone data showed patterns relevant to the emerging themes, enabling me to review viability. A further paper exercise found the patterns of meaning from the merged, completed dataset by coding on the Excel spreadsheet using colour to identify commonalities (Appendix Twenty-Seven). I included views that were opposing. However, I found few of these as the participants held similar views on what they wanted based on their experiences. When I reached the stigma theme, I found the experiences of upper management within the NHS were markedly different from those with lived experience and also NHS and social care employees. The coded groups were all examined, with the themes appearing, supporting and expanding primary and sub-themes into emerging patterns. The telephone interview data further explored potential themes to decide if they represented the community voice within primary care, answering the research questions in Table Three (p.60).

The research questions provided a clear focus for coding, enabling the choice of what was relevant to subjective feedback. There was interest in the research from participants, and it was essential to ensure themes were applied to the questions. Immersion enabled the choice of the final themes using the inductive process to identify and prioritise themes and sub-themes accurately representing the data and capturing findings. Collating all data ensured that direct quotes from participants enabled a deeper understanding of what was discussed and provided evidence of

emerging themes and their interpretation. The analytical process offered further proof, inductively mapping each theme alongside the current literature, strengthening the findings. The process supported enabling research participants' voices to create a grounded, participatory paradigm. I ensured that all quotes were anonymous and that each respondent was represented.

3.8 Phase Four - Feedback

3.8.1 Stage Six Review and Revise themes.

The reviewed themes were merged or removed if irrelevant to the two research questions. The codes were rearranged to make each theme distinct and have enough data to support its inclusion by listening to and rereading each corrected transcription, enabling initial coding, and decoding text to find the first impression (Saldana 2021). The established patterns of meaning were achieved through knowing the data, coding the data, developing initial themes, and writing and re-writing to narrow down the final themes. The eleven areas in Table Six (p.79) are the most frequently discussed by the focus group and the community participants in the telephone interviews. They saturated the information, becoming a central phenomenon with the most conceptual information (Creswell, Poth 2016).

Table Six Final Themes Following Saturation

Checked Themes	A Theme from the focus group B Themes from telephone interviews C Theme from Literature Review	The main Themes decided following analysis and member checking process	Sub Themes chose to follow the analysis and member checking process. X=Yes
Access	A B	-	X
Advocacy	A B	-	X
Appointments	B	-	X
Atmosphere within surgeries	A B		X
Attitude	A	-	-
Compassion	A B		X
Community	A B		X
Complexity	A B C	-	X
Confidentiality	A	-	X
Continuity	B	-	X
COVID-19	A B C	X	
Cultural Competence	A B	-	X
Disconnect	B	-	X
Doctor Shopping	B	-	X
Education/pedagogy	A B C	X	-
Empathy	A B	-	X
GP Experience	A C	-	X
GP Skills/Expertise	A B	-	X
Inequalities	A B C	X	
Insight	B	-	X
Medication	A	-	X
Mind and Body	A	-	-
Model of Care	A B C	X	-
Practice Nurse	A B	-	X

Objectification	B C	-	X
One-Stop Service	A B	-	X
Outcomes	B	-	X
Patient as Experts	B	-	X
Personality	B	-	X
Pharmacy and prescribing	B	-	X
Psychiatry	C	-	X
Psychological Therapy	B	-	X
Reception	A B	-	X
Recovery	B	-	X
Referral	B	-	
Reflection	B	-	X
Relational	B	X	-
Religion	B	-	X
Recruitment	B	-	X
Revolving Door	B	-	X
Risk	A	-	
Social Prescribing	A B	-	X
Special Needs			
Spirituality	B	-	X
Stigma	B	x	
Support for Recovery	B	-	X
Telephone conversations	B	-	X
Term Primary Care	C	X	-
Third Sector			
Time Pressure	B	-	X
Transactional Care	B	X	-
Trust	B	-	X
Trust			
Waiting List	A B	-	X
Workforce	A B	X	-
Treatment	C	-	X
Train Patients	A	-	X

3.8.2 Member Checking Post-pandemic

Member checking was used. However, before its use, safeguards were put in place to prevent distress, to be individually identified, and to address complexity (Goldblatt et al. 2011). Participants checked the themes to ensure they were clearly, accurately represented and reflected in the discussions. Following each interview, a summary and copies of themes were shared with participants to comment. The recommendations were captured pictorially in the Discovery and Recovery Tree to reduce complexity and support participation and understanding. The tree grew to show the final themes and values from the analysis (Illustration One, p.191). The final themes and values were discussed individually by telephone with four participants with lived experience, seeking their opinions. They echoed that the themes were significant, and all four stressed that they felt the relational aspect with its sub-theme of continuity was one they would select as the priority outcome. Therefore, the thematic analysis expands on these themes and associated sub-themes, sharing the focus groups and community participants' voices, knowledge, and insights. Post-pandemic, following the centre where I had advertised, reopening, I spent time discussing the research outcomes with participants using the Discovery Recovery Tree and finding their thoughts on whether what was captured represented their interpretations.

3.8.3 Limitations of this study

The pre-pandemic focus group had limitations as it was not a naturally occurring discussion but was controlled through the two data collection tools. It produced relevant data to inform the more comprehensive study, a known function of focus groups (Vaughn et al. 1996). I facilitated the focus group, looked at dissenting voices and actively encouraged them to inform the research. The telephone interviews offered an opportunity to hear all voices, including the dominant ones in the focus group. I could see their views and understand why. The change in the method to telephone interviews had limitations; I was aware through the literature on telephone interviews that nuances may be lost despite all best intentions (Glogowska et al. 2011). I met five of the fourteen participants face-to-face during the focus group, enabling rapport. I knew it was essential to form a rapport with the remaining participants. The telephone was chosen as not all participants had access to or could

use the internet, as initially, I had thought of doing 'Microsoft Team Meetings.' The telephone showed similar results to the pre-pandemic focus group, which was at least as effective. My concern was the loss of nuances (Glogowska et al. 2011). However, I was impressed with how much information people shared. I wonder if the limitation concerns me rather than the participants, who all said they liked the telephone interview. Mainly, they could do it in their own home at a time that suited them.

Limitations of the changed methodology Participatory Grounded Theory included constant checks to ensure a participatory approach was applied. I used member checking constantly to determine if what was being produced made sense and if it reflected participants' views rather than my own. Combining Jennings (2018) with the Braun and Clarke Thematic Analysis (2019) mitigated this at the analysis stage. Participatory Grounded Theory is a powerful research method that helped turn qualitative data into conceptual theory. However, as an early-stage researcher, I recognised it was only as effective as my skills. Understanding how it is linked to theoretical concepts was limited at the start of the research, and much reading was needed to increase my understanding.

3.9 Conclusion

I found the onset of the pandemic an opportunity to re-read the theoretical literature and change my method and methodology. Telephone interviewing was supported through transferable skills that made it compelling, and positive feedback showed that the participants liked it. Telephone interviewing enabled different themes to appear after memo sorting data into mind maps (Buzan 2018) (Appendix Twenty-Four). The semi-structured interview schedules used in the telephone interview were also used in the pre-pandemic focus group, and a combination of questioning, clarification, and initial analysis was used. I also changed the methodology by combining Grounded Theory and Participatory Theory. The two approaches complimented each other, and as an early-stage researcher, I found applying them straightforward. The constant comparative method was used to analyse the data as soon as data collection began in the pre-pandemic focus group. The first analysis informed telephone interviews and original themes appeared, complemented by the

fluid approach of the data analysis model. Emerging patterns formed the first theory and practice ideas that showed professional relevance. I analysed the data and then shared it with the participants to ensure that it reflected the truth, identified in the ethics proposal, and respected their views.

My growth using qualitative research developed throughout the Doctor of Education and built on my previous recording and analysis skills. I have learned to triangulate data collection methods (Denzil, Lincoln 2003) by incorporating my previous quantitative research skills. I found understanding the underpinning philosophy of the three research methods helpful in creating the theoretical framework. My stance as a critical humanist was combined with Kant's questions, which enabled the reflexive approach. Finally, the actual interviews and member checking led me to understand the different aspects of the interaction (Aldiabat, Le Navenec 2018). Despite the unprecedented times, the participants demonstrated insight, knowledge, dignity, and humour in dealing with complicated lives and services. All quotes used in the thematic analysis were anonymous, and each respondent was represented. The themes were carefully thought through and collated, demonstrating the validity of the thematic analysis.

4.0 Chapter 4: Thematic Analysis Findings

4.1 Introduction

This section presents the findings from dialogues addressing the disconnects identified in the literature review. These findings were based on individual telephone interviews and one pre-pandemic group discussion, as outlined in Chapter Three. The findings support the co-production of a values-based primary care mental health education framework. A qualitative approach was adopted to delve into the social world of the participants, collating and merging superordinate themes and sub-themes. Further literature searches were performed to support responses to the research questions and to achieve the research objectives.

4.1.1 Knowledge Gap

The telephone interviews showed a disconnect forming between primary care and the community, exacerbated by silo services, contributing to inequalities (Sharma et al. 2024, Marmot 2020, Bambra et al. 2020). Interviews conducted during the pandemic highlighted the significant impact of health inequalities on individuals over their lifetime and their immediate adverse effects on poverty, housing, education, employment, and mental health. Generational trauma emerged as a significant issue affecting some of the participant's mental health, heightened during the pandemic and still unresolved.

4.1.2 Impact of Literature on Findings

The literature provided insights into two key questions (Table Three p.60). The first question explored the development of a learning theory for primary care mental health education that incorporates community perspectives. Reviewing the literature on learning theory and mental health education revealed that while there were existing learning theories of continuing medical education (Appendix One), none explicitly considered community perspectives for primary care mental health. The current medical theory used in primary care is based on a psychiatric-driven biological model, pharmaceutically driven (Wren-Lewis, Alexandrova 2021).

The primary objective of this study was to generate a learning theory that integrates community perspectives.

The second question examined whether government policies promoting community participation in mental health translate into effective policy enactment concerning

primary care mental health education. The literature review uncovered no evidence of policy enactment. No explicit models have been identified to engage communities or incorporate their voices in policy formulation (Appendix Thirty). Current mental health legislation is under review, with recommendations emphasising choice, dignity, and race equality in services. An example is Community Treatment Orders, which, despite their intention to enforce medication compliance in the community, have been criticised as intrusive and coercive, particularly toward Black, Asian, or Minority Ethnic individuals (MIND, 2022).

4.1.3 Superordinate Themes and Sub-themes

A qualitative approach was adopted to explore the social world of the participants, collating and merging superordinate themes and sub-themes. Additional literature searches supported the response to the research questions and achieving the research objectives. Each superordinate theme is outlined with related sub-themes, providing an analytic narrative that enhances cohesiveness and context. The findings were presented logically alongside relevant literature, incorporating quotations to contextualise the data interpretation. This approach facilitated a deeper understanding of what participants in the community knew and understood about mental health services provided by primary care, ultimately leading to the development of a co-produced pedagogical framework.

Initial outputs coded from focus groups highlighted several key areas: General Practitioner soft skills, expertise, and education, including cultural competence. The discussions in telephone interviews further elucidated issues such as confidentiality, accessibility, appointment scheduling, advocacy, and engagement with the third sector. The richness of qualitative data was ensured by evaluating each transcription's merit and pooling them to retain the specificity of the phenomena observed. Table Seven (p.86) shows the superordinate themes and sub-themes produced from the pre-pandemic focus group and the telephone interviews. They combine to form a comprehensive narrative integrating participant perspectives with theoretical insights, offering a robust proposed pedagogical framework.

Table Seven - Superordinate themes and sub-themes produced from Focus Group and Telephone interviews.

Superordinate Theme	Sub-themes
Impact of Health Inequalities and COVID-19	-Inverse Care Law
	- Listening to the Community
	- Transferable Learning
	- Inequalities among people from Black, Asian, and Minority backgrounds
	- Inequalities impacting mental health during the pandemic
	- Inequality, COVID-19, and education in primary care mental health
Stigma	- Self-care and stigma of professional participants
	- Stigma and Diagnosis
	- Stigma and long-term mental health
	- Stigma and Inequalities
Relational Aspects	- Telephone consultation
	- Relational Outcomes
	- Atmosphere within surgeries
	- Caring and compassion
	- Empathy and understanding
	- Insight
	- Insight as a coping mechanism
	- Continuity Repeating stories
	- Trust
Transactional Approach	- Targets and transactional care
	- Objectification
Model of Care	- Doctor shopping
	- Access and appointments

Superordinate Theme	Sub-themes
	- Improving
	- Access to Psychological Therapies
	- Time Pressure
	- Waiting lists in secondary care
	- The revolving door in primary care
	- One-stop service
	- Complexity
	- Disconnect
	- Cultural Competency
Intrapsychic	- Religion Spirituality
	- Adaptive coping
Primary Care Workforce	- The GP workforce
	- Recruiting the wider Primary care Workforce
	- Receptionist
	- Social Prescribing
	- Advocacy
	- Practice Nurse
	- Pharmacy and the prescribing of psychiatric medication
GP Education	- GP expertise
	- Gaps in GP education and mental health
	- GP education and recovery in mental health
	- Soft skills
	- Communication skills
	- Educating the wider primary care workforce
	- GP ability – hard skills
	- Participation Research
	- Reflection

4.2 Exploring the Terms 'Primary Care,' 'Primary Care Mental Health,' and 'Accident and Emergency'

4.2.1 The Term 'Primary Care' as Understood by Health and Social Care Staff

The literature review reveals that primary care mental health lacks a universal definition. In the United Kingdom, primary care primarily refers patients requiring psychiatric support to specialist mental health care services. Access to these services is typically assessed based on criteria to determine if individuals are at risk to themselves or others. General practitioners (GPs) rarely collaborate with secondary care due to a lack of integrated systems (Murtagh et al. 2021).

The role of primary care is often described as transactional, managing over 90% of mental health cases (England, 2017), yet it is allocated only 8% of the overall NHS budget (NHS England, 2023). The literature also indicates a higher threshold to enter secondary care services and a reported reduction in primary and secondary care demand during the pandemic. This demand reduction is partly attributed to a shortage of practitioners in the secondary care workforce (Mansfield et al. 2021). However, the decrease in demand suggests that many patients may have undiagnosed or delayed diagnoses of mental health conditions (Williams et al. 2020).

The narrative that people are not demanding health services can unfairly blame the community rather than recognise a lack of understanding and awareness of available services. Individuals with long-term mental health issues, stress, common mental health disorders such as depression or anxiety, older adults, and those with comorbidities or bodily conditions are increasingly managed solely by primary care. The findings indicate a significant lack of discourse with the broader community, particularly those not recognised as service users or survivors. Consequently, their voices remain unheard in policy, practice, and education.

Focus group discussions revealed that participants had varying levels of understanding regarding primary care and mental health. To further explore this, the first part of the telephone interviews asked the participants about their knowledge of primary care (Appendix Three) to gauge the community's understanding of primary

care and primary care mental health. Interestingly, the Accident and Emergency (A&E) Department was frequently mentioned during the interviews, with some participants mistakenly believing it to be a part of primary care. This prompted further inquiry into participants' understanding of the term 'primary care.'

Differences in understanding the language of health care reflected the focus group findings, highlighting a significant knowledge gap between the community and participants working in Health and Social Care. Health and Social Care staff demonstrated a more comprehensive understanding of the role of the GP, particularly in referring patients to other services. This contrasted sharply with the community participants' views, which often needed clarification about the functions and boundaries of primary care, especially regarding emergency services like A&E. The findings underscore the importance of clear communication and education about the roles and functions of different healthcare services. Bridging this knowledge gap is essential to ensure that community members can effectively navigate the healthcare system and access the appropriate level of care when needed.

"... primary care is like the first point of contact when you go to your dentist. Maybe a pharmacist or some advice, somebody going to, if need be, make a further referral for you to secondary care."

Participant Eleven

Those who had worked in Health and Social care described primary Care as health services outside or before secondary care, including Family Practitioner services, Family Health Services, and Community Health services, including the midwife. The health and social care participants understood that free services, including opticians, dentists, and pharmacies, depend on eligibility.

4.2.2 The Term 'Primary Care' as Understood by Non-Clinical Community Participants

Non-clinical community participants did not all understand the terms "primary care" or "secondary care." However, they understood the role and function of Primary Care. Two participants described it as,

'....the first port of call'

Participant Three, Participant Seven

Participant One identifies a clear understanding of why they would attend,

".... I would go there for anything that was a continuous illness or continuous rash or sinus problems or mental health - Daily things that you can't get rid of."

Participant One

It became clear that the language was the barrier and that the term primary care was unfamiliar to the community,

".... most people talk about it as your surgery or doctors. You don't hear the term primary care that often."

Participant Three

One reason for the difference in knowledge and understanding between those employed within Health and Social Care and the wider community may lie in the historical origin shared here by Participant Eight.

"....it (primary care) hadn't used to exclude services provided by the town hall. Social Services and such things were different; some primary care was initially involved. The District Nursing, which was run centrally, and the General Practitioners, which were much more independent, came closer together, so they needed a term, and primary care was what came out."

Participant Eight

4.2.3 The term 'Primary Care' as Understood by those Working within the Voluntary (third) Sector.

The voluntary sector support staff working as Social Prescribers perceived primary care as part of the community if social and psychological support is needed.

".... Primary care is the first point of contact. It's the first place people get seen when they have a problem. So, for example, like a GP community nurse or us, the third (voluntary) sector is often the first point of contact....like a doorway into the NHS. It's the first place."

Participant Ten

Participant Nine was employed in the same role as Participant Ten and echoed the description of primary care being part of the community.

".... We are often the first points of contact. You know, like people wandering off the street because they have really big issues sometimes. We are the first people that they see, and we're the referrers out."

Participant Nine

4.2.4 The Term 'Primary Care Mental Health as Understood by Those who are Expert by Experience

The community participants with lived experience of mental health views differed from those who worked within the healthcare sector. They struggled to describe primary care and mental health. The view was that it was part of the same service as secondary care, including a psychiatrist, Community Psychiatric Nurses (CPNs) and prescribers. The findings show that the organisational language of the NHS leads to a lack of clarity about where to go when suffering from mental ill-health.

Primary care mental health differs from psychiatry; it applies to all ages on a continuum ranging from mild stress, manifesting through bodily symptoms, to severe mental illness. Severe mental illness is recommended to be initially diagnosed and treated in secondary care (NICE 2014). However, once someone is discharged, ongoing management is within primary care alongside those who do not meet the threshold for secondary care unless they self-help, access the third sector or attend the Accident and Emergency department.

4.2.5 The Term 'Accident and Emergency,' as Understood by Health and Social Care Staff.

Those with insider health knowledge defined the Accident and Emergency Department (A and E) as secondary care, hospital-based care that overlaps with hospital outreach services. The overlap included secondary care and mental health services. There was one view from Participant Fourteen that outreach hospital services are part of primary care; therefore, secondary care, including Accident and Emergency, is hospital-based, providing services to the community.

4.2.6 The Term ‘Accident and Emergency,’ as Understood by Participants with Lived Experience

Community participants with lived experience could not clarify the differences between primary care and hospital-based Accident and Emergency services. Those with lived experience of mental health strongly believed that the GP was part of the community and that the Accident and Emergency Department (A and E) was a default place to attend if the GP was not available.

".... Primary care is first contact if you are ill like Accident and Emergency Department (A and E) or the doctors."

Participant Two

Attitudes from health professionals impacted individuals' general beliefs about seeking help in primary care. The participant below demonstrates why they were so worried about talking to their GP about how they felt following attendance at the Accident and Emergency Department (A and E).

"....it was, it was awful (Accident and Emergency) moreover because it (primary care consultation) was completely not. Why was that? Not everyone's that person - Nice to be surprised."

Participant Five

Accident and Emergency Departments are debatable safe havens being overcrowded and struggling to run efficiently. Waiting times have been at their worst since 2004 (British Medical Association (BMA) 2021). The Office of National Statistics (2023) monitors four-hour waits and shows that targets are substantially higher than the 8.1% in January 2013, rising to 42.4% in September 2023. To reduce pressure, provide alternative safe spaces and improve the community's understanding of where to go with mental health problems would reduce the use of A and E. However, the alternatives are unclear; if someone is in a public place whilst having a mental health crisis, they can be taken to a place of safety by the police under Section 136 of the Mental Health Act 1983. However, there is no broad provision for 136 suites, resulting in the default of Accident and Emergency Departments or even police cells being used. Participant Two learned that by contacting emergency services during the pandemic, they were more likely to get a timely mental health assessment.

".... I've felt so bad I will ring 999 feeling suicidal; they will put you through to a specific contact rather than sending out an ambulance straightaway...."

Participant Two

Yoon et al. (2015) found that neither continuity in primary care nor same-day access alone alleviates pressure on mental health in A and E. A model is required to offer direct referral to access, assessment, treatment, and support at all levels of mental health that are not solely risk-based. Community participants did not all understand the relationship between primary care, primary care mental health or Accident and Emergency (A and E).

"I might have given you a better explanation years ago when I was more involved in the services, but at the moment, it is just what goes on around me."

Participant Three

Individual clinicians understood it differently, leading to further misunderstandings on the following processes, including accessing Accident and Emergency. Participant Eight described the knowledge difference between those working within Health and Social Care and participants from the community.

".... I don't think that most laypeople locally have a concept of primary care. They know about the individual services, but they don't know about it all being more closely tied together now.... I don't blame them for that."

Participant Eight

4.2.7 Summary of the Findings of the Terms 'Primary Care,' 'Primary Care Mental Health,' and 'Accident and Emergency.'

The findings show that professionals, not community participants, understand the term primary care, and there needs to be more clarity regarding the function of primary care. Participants in the voluntary sector perceived their services as the first mental health access point. Clinicians saw the health service as the first entry point, and those with lived experience needed clarification about different service roles and needed to understand how they linked to themselves. The terms 'the first point of contact' and 'front door'. 'General Practice', 'pharmacy', 'dental' and 'eye health

services are all used by the NHS to describe primary care services (NHS England, 2021a).

The findings from those interviewed by the voluntary sector and those with lived experience saw the community, voluntary sector, and primary care as part of a whole approach. A counter view was from the clinicians who saw it as separate and a gatekeeping service to secondary care rather than being a part of community services. The development of Primary Care Networks nationally reflects the thinking of the voluntary sector. They are formed on general practitioner registered patient lists to provide care and collaboration between primary care and the more comprehensive health and social care workforce.

One learning outcome is that the Accident and Emergency Department becomes a default to the GP if the GP is inaccessible or if people are not registered with a GP practice.

The term primary care mental health has a lack of clarity of definition in the literature and by the community. The models of care vary, ranging from specialist provision located in the community (Pettersen et al. 2014) to integrated models of care in the literature (Thielke et al. 2007). Primary care mental health is viewed as primary care, the first port of call, where the local doctor is based, offering advice and access to specialist care and support. Integrating primary care with community and voluntary sector services could improve mental health support access and understanding.

4.3 Impact of COVID-19 and Inequalities

The initial discussion on the term primary care highlighted inequalities experienced during lockdown between those with lived experience of mental health and those with professional backgrounds. Participants with lived experiences felt they could not always share their mental health with others during the pandemic. The result was avoidant behaviours, leading to not getting help until it was too late.

“.... I sleep all day,”

Participant Four

“.... you isolate yourself, and you keep away.”

Participant Four

Inequality included access to healthcare, and the findings show poverty impacted all areas of people's lives, including healthy eating, fuel poverty and purchasing essential medications. The literature revealed that societal inequalities have caused the community to become increasingly divided. Pre-pandemic mental health problems were 74% higher in the region where this study was undertaken than in the rest of England and expected to worsen (Pierce et al. 2020, Marmot 2020). Poverty removes autonomy and hope, both factors needed to improve positive mental health (Mental Health First Aid USA 2022). The area has a high use of food banks, and there is evidence in the literature linking food poverty to suicidal ideation in adults (Davison et al. 2015). The data in the literature was stark, and the message was that life expectancy has stopped improving nationally while health inequalities have grown wider (Marmot 2020). Women's life expectancy has fallen, a pattern in deprived communities (Marmot 2020). Marmot believes society and health are joined; when society is flourishing, so is health. England has social and economic inequalities alongside health inequalities, and those in more deprived areas show a fall in life expectancy and twenty years longer in poor physical health. People with mental health problems die 15 and 25 years earlier than the rest of the population, attributed to lifestyle issues (Romain et al. 2020, Fiorillo et al. 2019). The literature shows that people with mental health problems have low physical activity, poor diet, and high tobacco usage whilst facing obstacles to engaging in health behaviours (Romain et al. 2019, England 2017). The higher use of primary care and mental health services in areas of deprivation is counter to those living in more affluent regions, showing a rise in life expectancy (Office National Statistics 2020). Participant Three remained in employment and responded more positively to the lockdown.

".... I've been on the whole lockdown by myself, which I thought was gonna be a lot more detrimental to my mental health than it has been, but I think that's because I've made myself busy."

Participant Five

COVID-19 affected people differently. When asked how participants were coping with it, there were different views. Those in employment had a purpose.

“....To me, it’s about the fact you’re sort of out and about. Lifts your mood. But if I slept in and stayed in all day, it would affect me mentally. You know I’d feel a bit. I’ve not done anything today; I’m a bit fed up. You know, social interactions are important, and just getting out about doing something,”

Participant Thirteen

Mental health issues increased throughout the pandemic. The following comment is from a participant interviewed later in the pandemic.

“.... It’s so scary cos you don’t understand why you are feeling so crap or why you are feeling so edgy for someone new to that feeling? It really terrifies me.”

Participant One

In the United Kingdom, lockdowns restricted people’s movements, and the National Health Service changed, with non-essential treatments cancelled delays to treatment, and a focus on specialist services (NHS England 2020a). Participant Twelve believed that mental health services were not the main focus.

‘... Mental health obviously got lost in a sludge of COVID.’

Participant Twelve

4.3.1 Listening to the Community

The community needed to be more engaged in decision-making at a government level during COVID-19. There needed to be a clear primary care strategy despite COVID-19 exposing system-wide weaknesses. There was a centralised step-change to multi-disciplinary teams, workforce reform, and financing review (Institute of Government 2020, Patel et al. 2016, NHS Confederation 2022). The mental health problems shared by the community and impacting on education ranged from work-related stress to enduring psychosis across the whole life course. COVID-19 added a further layer of mental ill health, including Long Covid.

4.3.2 Transferable Learning

There is transferable learning from the limited literature on reductions in premature birth during COVID-19 (Philip et al. 2020, Homer et al. 2020, Green et al. 2020). The reduction is due to modifiable risk factors addressed during the lockdown period when the advice was that pregnant women must stay home. The differences are attributed to increased hygiene, home nutrition, exercise, and potentially less weight gain, leading to fewer infections. The data is relevant to mental wellbeing, as having less access to substances, alcohol, and unprotected sex are all contributory factors which contribute to mental ill health, alongside work stress and pollution. Two other factors, isolation and loneliness, caused mental health in those who had not experienced it before, and it worsened in those already diagnosed.

4.3.3 Impact of Inequalities on People from Black, Asian and Minority Ethnic Backgrounds

COVID-19 affected people from Black, Asian and Ethnic Minorities (UK Obstetric Surveillance System 2020). Women who suffered from socioeconomic inequality had less access to health and poor outcomes (Morris 2020). There is increasing evidence that mothers with long-term stress increase the risk of their babies developing mental or physical illness later in life (Sarkar et al. 2008, O'Connor et al. 2013, Matas-Blanco, Caparros-Gonzalez 2020). Health inequalities are factual, and one area under-explored is whether bias and discrimination play a part. Cultural competence is more than understanding people's race and background (Carillo et al. 1999), and a recent report shows people from ethnic backgrounds fear racist treatment from NHS professionals, leading to further inequality and longer wait times (NHS Race and Health Observatory 2022, Wise 2022). However, data is not routinely collected, so it is difficult to understand why health inequalities are happening. One volunteer at a wellbeing centre thought that barriers had worsened during the pandemic. The literature shows there is evidence of a failure to maintain statutory requirements, resulting in a lack of will to collaborate with migrant women, racist and discriminatory practices, and a hostile environment to data share (Womens Aid 2021). The theme of health inequalities demonstrates a macro perspective requiring community views to inform policy. However, policy rhetoric does not discuss how to engage communities. Recent research echoes the findings in this study of social inequalities and social

anxiety as barriers to participation (Baxter et al. 2022).

4.3.4 Links to Learning Theory

Transformative and reflective learning theories explore beliefs and experiences to influence and shape ideas and concepts. Transformation Theory is a challenging theory aiming to change how people view their world. It could be instrumental in addressing bias and discrimination, challenging pre-conceived ideas and, arguably, examining how those impact inequalities on others and behaviours. The transformative learning process and co-production in primary care mental health are attractive. However, there is a risk that few represent many, and so becomes too narrow a view (Beck, Forsyth 2020, Robert et al. 2021, Turnhout et al. 2020).

4.3.5 Inequalities Affecting Mental Health Arising During the Pandemic.

Inequalities exposed during the pandemic which affect mental health include the rise in the UK of physical, sexual, and emotional abuse. Being at home was not always the safe place needed during the lockdown, and domestic violence increased by seven hundred per cent (Bibby et al. 2020, Hill et al. 2020). Pre-existing inequalities discussed by participants included trouble with moving from income support to Universal Credit, and two community participants had housing issues. Both were from a lesbian, gay, bisexual or trans background and had moved accommodations as they had felt unsafe in their previous environment. Though welcomed, government initiatives to support incomes and provide social protection throughout the pandemic did not help those community participants with lived experiences. The findings echoed the literature that the participants felt disadvantaged and stigmatised within society due to negative attitudes toward diagnosis and recovery (Corrigan et al. 2018). The Meso-level response of social control is evident in rising fuel, food and rent prices and the government's return to austerity (Walsh et al. 2022).

4.3.6 Summary

The profound impact of the COVID-19 pandemic on pre-existing societal inequalities mainly concerns mental health disparities and access to healthcare services. Delving into individual experiences discovered systemic barriers and poor healthcare

outcomes, illuminating the challenges faced by the community during the pandemic. The challenges include limited access to mental healthcare and economic hardship resulting in heightened vulnerability to mental health issues. Comprehensively understanding and addressing these inequalities can foster an environment of equitable mental healthcare provision. Advocating systemic changes, including emphasising the importance of community-informed mental health policies, contributes to more inclusive and resilient healthcare systems in the post-pandemic era. Paulo Freire (2017, p.28) discusses how only political power can change systematic education. However, a key finding is that adopting a different approach to people can enable transformation. Linking funding and the content of primary care education to centralised NHS policy to gold-standard evidence has historical roots in behaviourism (Boyd et al.2018). We do not know whether education and policy are fit to practice post-pandemic, nor do we understand the breadth and depth of the future needs of those with mental ill-health. The broader population may have developed mental health issues ranging from long COVID, grief and trauma to deeper, chronic problems that are unseen. The professionals' short and long-term mental health at an individual level is also unknown. Raising awareness of mental ill health's depth and breadth of need is an opportunity to make community-informed mental health an integrated health and social care priority. The onset of COVID-19 may function as a catalyst, with meaningful change and innovation in the future of primary care mental health services and individual wellbeing. The rising cost of living and stress on current health and social care services make this increasingly necessary. However, it is pushed down the priorities of an ever-changing political landscape.

4.4 Stigma

Systematic reviews alongside historical literature (Rakhimova 2024) and social media underscore stigma's pervasive impact on mental health discussions, affecting diagnosis and treatment adherence. Misconceptions about mental health persist, hindering help-seeking behaviours and perpetuating societal stigma. Understanding and addressing stigma is crucial to fostering supportive healthcare environments and promoting recovery. The multifaceted nature of stigma in healthcare settings underscores the importance of destigmatising mental health to ensure equitable access to care and support. Responding to inquiries about visiting GP surgeries,

participants with nursing backgrounds, like Participant Ten, expressed reluctance, highlighting underlying stigma.

“.... I don’t go, I suppose.”

Participant Ten

Participants in health and social care shared their inability to spot and manage personal stress, leading to delays in seeking prompt help.

“... I was diagnosed with hypertension 12 years ago - I had it for four years and kept denying it - it took me a while to go and get treatment. And they were actually really understanding - I expected to be told off for not having gone sooner.”

Participant Twelve

Alongside absenteeism, those staff working without support or recognition of their mental health may suffer from presenteeism. Presenteeism is working whilst ill and performing poorly due to the stigma attached to discussing their psychological and physical health. The stigma led to participants with professional backgrounds delaying treatment and being hesitant to discuss how they felt due to fear of losing their role.

“.... you didn’t say you were mentally ill because it affected your career. Yeah, back in the day, there was a time you would have been potentially removed from the register, so I think people have forgotten this.”

Participant Ten

Participant Two discussed how rapidly they had sought help with a cancer scare whilst delaying their mental health needs and not seeking support. The GP asked how they were, and the participant recognised their anxiety and depression.

“.... she put me on some antidepressants for a while. It did work, and I wish I’d gone earlier, but I did put it off, predominant being that you’re a nurse working

in mental health, so you can't really go and say you've got a problem and you know I should be able to deal with it."

Participant Ten

Mental health support is accessed through the general practitioner, and the findings show this was a negative experience for some. Professionals seeking help with mental health problems are reflected in the MIND Workplace Wellbeing Survey (2016), which found that pre-COVID-19, 9 out of 10 primary care workers found their job stressful, with 1 in 5 developing mental health problems. Post-COVID-19, NHS staff continue to work daily with the pandemic with rising cases. The NHS staff survey (2021) shows that 44.0% of staff reported work-related stress, an increase of 3.7% from 2020. Frontline staff were most affected, reporting stress levels of 46.6%, up from 41.7% in 2019. 49.6% of staff working in COVID-19 environments reported stress. However, the survey does not include primary care.

The NHS recognises the psychological harm caused by COVID-19 and has invested in occupational health and wellbeing hubs to support their staff to access rapid support. These include confidential helplines and local support networks. However, there are gaps in the range of provision to primary care as wellbeing guardians are not extended to primary care, although staff can access support through the hubs. The hubs vary; some NHS Foundation Trusts offer help simultaneously, and some offer a call back within two days.

The findings show that due to self-stigma, primary care staff are not always aware they are suffering from mental ill-health and need awareness raising, support and supervision. Currently, mental health is seen as separate instead of inclusive in primary care. Staff had concerns about career repercussions, including fitness to practice and the impact of coming forward with mental health issues (MIND 2016). Participants were worried about what peers thought of them, showing both peer and personal lack of insight into their physical and mental health.

4.4.1 Stigma and Diagnosis

All community participants with a lived experience of mental health or addiction referred to stigma and how the community and services saw them. Two extracts from Participant One discuss the impact of not having a precise diagnosis. The doctor in the text is the GP.

‘.... I think continuity and listening to those two simple things are absolutely huge. I get that at the moment; I’m really lucky- other people don’t get that - It’s only the past two years I’ve got it - for 15 years – I’ve seen two psychiatrists who said I had cyclothymia, but it was never ever in my notes - put as a possibility but no follow up - there was no follow up around personality disorder. So, in a total depressive anxiety disorder, I don’t even know if depression or anxiety or something - so many names going around my head with what the doctor said - it was never continuous. As I say that, I went to a psychiatrist - could it be bipolar? And then she said it might be - it’s always well just going back to your doctors to see how you feel in a couple of weeks or months or whatever.’

Participant One

Participant One discussed the impact of not having a precise diagnosis on employment.

“.... Lost jobs were some really, really bad experiences until recently. Moving forward, it’s got better, and this is just because I have cyclothymia. It is interesting - if I was able to put on a Job application, I have this, or if I was able to, say to my boss, I mean, I don’t work cos of this condition, but I never tell them anything, because I don’t know what they’re going to think. And then when I do act out, they sack me because I didn’t tell them I was ill or be able to tell the Job Centre. And I’m confused; I’ve got all these different diagnoses. I’ve had to send in my medical records, so because it’s wishy-washy, it’s well. Do you have it or not? Because suppose drinking was the symptom?”

Participant One

The impact of stigma can lead to a vicious circle of discrimination, intensifying the impact on mental health. A lack of correct diagnosis creates further stigma, with barriers to accessing support and services alongside day-to-day social implications affecting participants' wellbeing. Primary care is where everyone in the community is equal, and it is not easy to label someone mentally ill if they present with issues such as physical health or housing. Receiving a correct diagnosis is essential in the prevention of relapse and recovery rather than being labelled with a diagnosis and offered negative phraseology that stigmatises and does not offer hope and recovery. Psychosis diagnosis happens in secondary care following GP referral (Her Majesty's Government 2019).

Behaviours impact both self and the broader community, and the primary care workforce can learn to understand the needs and social determinants of health from the community. Redressing health inequalities instils hope and the need to redress the described complex services. This involves being able to integrate and collaborate, build on current health policy, and redesign services to meet needs at a community level. Primary care cannot do this alone due to investment, skill, and time issues, nor is it the sole responsibility of primary care.

A more comprehensive model covers all aspects of the community, including housing (Timson, Clair 2020), employment, education, and health. Petterson et al. (2014) found that only thirteen per cent of the population received integrated care between primary care and secondary mental health services. This remains an issue despite changes to the NHS contract in 2019 (RCGP 2017a) to improve working practices. Secondary care providers are not responsible for prescribing and delayed discharge.

4.4.2 Stigma and Long-term Mental Health

The isolating impact of managing stigma in those participants with long-term lived experiences were shared.

".... The main thing that's kept me well is being able to laugh about it. Yeah. Generally, people call people names nutcases or barmy....Those things don't

bother me what bothers me is that people don't want to talk to you. Yeah, on purpose, try and stay away from you. That's worse."

Participant Three

Participant Three experienced stigma, which can be sensationalised by the media and can creep into health. There is far more awareness of using language such as '.... *barmy*' or saying someone is a victim with the implications that people with mental illness have a poor quality of life. Participant Three shared an example of stigma after being advised against pregnancy, leading to discrimination as they were not offered a choice in their care. Participant Three was on a drug associated with a significant risk of defects and development issues in babies whose mothers are on the medication.

. *".... I was on valproate and scared about pregnancy, and I was interested in showing the images (of babies). They never told me this when I first went on tablets years ago."*

Participant Three

Participant Two describes how a mental health diagnosis removed all aspirations to study and have a career.

"....one was a counsellor who said. Basically, you're a small-town girl - shouldn't have these grand dreams - that had a massive negative effect and years later self-destructive...."

Participant Two

The counsellor's comment significantly impacted Participant Two, who believed the opposing view. Paolo Freire (2017,p.37) believes that self-depreciation derives from internalising opinions held on them by what he calls the 'oppressors.'

Participant Three showed how they dealt with stigma through resilience,

".... I'm not embarrassed about mental health if I don't tell people. It's because I have my own reasons - A. This person doesn't need to know."

Participant Three

Participants discussed negative experiences of attending the Accident and Emergency Department (A and E) with staff not believing the person presenting had a physical or mental health condition. COVID-19 was seen as raising mental health awareness, changing attitudes across the community, and resulting in less stigma in those with lived experiences.

“.... There’s a shift in the way we talk about mental health, for sure. And more so now, maybe that COVID background might have detrimental effects on care. But I still just think people would talk about it more - there’s more of an openness to talk about it than it was - maybe only slightly, and it’s definitely not where you should be. And definitely, it has been a shift. And it’s helpful.”

Participant Five

Participant Eleven suggested that certain primary care staff attitudes contributed to societal inequalities.

“.... one of the staff at the addiction services - he was absolutely disgusted at the fact that this guy was a paedophile and really called him out, you know, dirty, so n so and all the rest of it, and I’m not working with him anymore.”

Participant Eleven

There is limited literature on staff attitudes to paedophilia and a lack of awareness regarding how attitudes can lead to prejudice, impairing the patients' functioning at all levels. Sexual obsessions and intrusive thoughts are different to paedophilic acts and feature across some mental health conditions and require an accurate diagnosis and treatment rather than prejudice and hate. Though some things are difficult to understand and go against moral codes, everyone accessing health can expect professionalism and compassion. The limited literature discusses staff awareness education, case management and supervision so an accurate diagnosis is made on whether a mental health condition is distinct from whether someone is liable to commit an act (Glazier et al. 2013, Ferreira et al. 2021). As shown here by Participant One, relationships between professionals and patients can deteriorate if stigma and prejudice are evidenced.

“.... The doctor just thinks you’re a pisshead, to put it bluntly.... You start thinking, what’s the point - You don’t understand - no point me telling you again because you don’t even care. After all, if you cared, it would have been sorted now.

Participant One

Participant Seven shared the reaction of their GP when they wanted to discuss the impact caring had on their mental health. The advice was to find someone else to ring who would listen, resulting in a negative relational experience between the patient and GP.

“....The doctor is probably one of the worst ones. I’ve ever experienced.”

Participant Seven

Participant One expressed their experience of being treated as an inconvenience due to their mental health issues.

“... The doctor may come across you as an inconvenience - I felt like I’ve not trusted what a GP said. As in because I think they haven’t really listened to it. And usually, I have been proved right in the end.”

Participant One

The term ‘*being treated*’ is one that suggests having a mental health condition is the fault of the person, causing more stigma. Participants recovering from mental health and addiction repeatedly used terms of wanting to feel listened to, being heard, being understood, and having a choice. A recurrent theme was the need not to keep repeating their story, which can become frustrating and distressing.

“.... I want the GP to be understanding and not to have to go through all the same information again.”

Participant Three

Participant Fourteen describes the relational link between patient and GP, explaining how patients, in this case, their parents, saw themselves as unequal in the relationship. Participant Fourteen believed their parents’ experience directly contrasted with their equal relationship with their GP due to the equality of

socioeconomic status, which redressed traditional power imbalances and impacted health (Galobardes et al. 2007).

“....The GP is God. My parents would never question the GP. They wouldn’t ask for clarification, they’d nod sagely to the GP when he said something, and they wouldn’t understand half of what he was talking about. And would be ashamed or embarrassed to ask.”

Participant Fourteen

4.4.3 Stigma and Participants with Professional Backgrounds

Participants holding senior positions in health reported distinct experiences during telephone interviews. Participant Fourteen describes an example of the equal relationship they experienced with their GP.

“.... I was actually the referee for the medical school of my current GP because I knew his parents, who are both GPs.”

Participant Fourteen

Participant Fourteen explained the benefits of developing a shared, agreed treatment plan between themselves and the GP,

“.... I would immediately point to the shared partnership in care - it was fairly obvious that I was going to need surgery. However, we went through various potential options and debated alternatives. And at the end, we sort of shook hands and said, yep, surgery it is. And then he said, right, I’ll get on to the consultant, saying what you’ve told me, he will check it out, and so on. So, you felt that you were participating, understanding, making an informed decision, and so on and sharing in the care that I was going to undergo.”

Participant Fourteen

Asking participants with a professional background how they coped with their mental wellbeing, they discussed preventative factors such as family, money, and purposefulness,

“..... I’m fortunate. I don’t have to worry about basic human needs. I’ve got food in the fridge. And I go out to work. Those things are really, really important. I’ve got family around me that I can always call. And it’s just the basic stuff, really - And I acknowledge that I am privileged. I think part of what

we need to do are making a recovery point of view is trying to support people to get to this position where they feel they've got that."

Participant Twelve

Participant Twelve shared a family member's recent positive practice in Primary Care.

".....they knew that X was an FY1 (trainee GP), so they didn't treat X as a usual patient. They said, what do you want? X said I want this. And so....X found it positive."

Participant Twelve

Participant Fourteen found that their equal relationship with the GP resulted in a two-way trust.

"....I was struggling to breathe one night, and I rang up the emergency service. And they contacted him (GP). And the first thing he said (GP), this guy will not ask for emergency services unless he needs it, get it, get somebody out there straight away."

Participant Fourteen

A recurrent finding is that recovery requires autonomy with the health provider, whether a GP, nurse, receptionist, or pharmacist. As Participant Fourteen experienced, a power imbalance affected relationship satisfaction and equality.

".... That you're seen as a partner, in fact, then they talk about the fact that the patient is a partner in the treatment."

Participant Fourteen

Derksen et al. (2020) found that greater equality in communication enables patients to discuss their needs and aspirations, allowing GPs to look at problems through their patients' eyes. Participant Fourteen shares an example of the equality they had experienced.

".... I mean, X (GP) has known me for years, we have a level of honesty, we can speak. He speaks to me in a way that he probably would not speak to other patients, but he speaks to me in trust and respect and I same to him."

Participant Fourteen

Participant Nine describes their positive experiences of relational care.

" I've never had any problem, and if I've needed to go and see the doctor for anything, they've listened to me, they've understood, they've helped me. So, I've got nothing but good experiences, really."

Participant Nine

Participant Fourteen shared an example of best practice they had experienced.

".... I was discharged. The following day, he (GP) was ringing up to ask me how it had gone, how I felt, etc."

Participant Fourteen

Surprise, expressed by Participant Five, at the positive response given by their GP when attending with a mental health issue,

".... I was expecting a stoic, really bland script response when going to a doctor with a mental health problem, but he sat me down, told me some books to read, discussed a prescription, and went through it nicely and calmly. He was also a trainee doctor, so maybe because we are both the same age, he kind of understood a little bit more."

Participant Five

4.4.4 Stigma and Inequalities

Stigma, reflected in negative language and passive attitudes, affects mental health discussions. Stigma and mental health were apparent through the discourse through negative and passive language. Examples from those with lived experience, coded during the transcribing process of the findings' terms used were *should, could, and always*. Participants who held senior NHS positions, it seems, can redress stigma, develop positive, equal relationships, focus on strengths, and build self-esteem. The telephone participants shared their best experiences in primary care. The two examples below highlight examples of the equal relationship and the benefits experienced by Participant Fourteen from his GP.

".... I was diagnosed Saturday, talking through with him Sunday and was at X neurosurgery explore on Monday discussing treatment options which were quite obvious was gonna be soon."

Participant Fourteen

".... gave me a number, which he gives to patients where you can phone him on this number, get through to him and discuss any particular matter or stress issue that I was having. When I would sit and then we'd arrange to meet,

usually in a way from the surgery but in a convivial atmosphere confidentially and chat through the issues.”

Participant Fourteen

4.4.5 Summary of Stigma

Health and social care professionals admitted difficulty in recognising and addressing their stress, resulting in delays in seeking mental and physical health help, as articulated by Participant Twelve's experience with hypertension. In addition to absenteeism, professionals often face presenteeism due to the stigma surrounding mental health discussions in the workplace. Fear of repercussions, as expressed by Participant Ten, leads to delayed treatment seeking and reluctance to disclose mental health struggles. Community participants with lived experiences of mental health or addiction consistently mentioned stigma in their interactions with the community and healthcare services. Participant One's account underscores the impact of not receiving a precise diagnosis, affecting employment and social perception. Stigma exacerbates barriers to accessing support, as discussed by multiple participants, ultimately impeding recovery. Participant Three described the isolating impact of stigma, emphasising the importance of understanding and compassion. Instances of discrimination, such as Participant One's experience regarding pregnancy advice, underscore how accurate diagnosis and supportive care combat stigma.

Participant Twelve shared that preventive factors, like family support, contribute to resilience. Stigma, reflected in negative language and passive attitudes, affects mental health discussions, with senior NHS staff often redressing stigma through positive relationships and strengths-focused care. Participant Fourteen's experiences exemplify the benefits of equality in healthcare relationships.

A systematic review (Vistorte et al. 2018). showed stigma in primary care is an issue, with schizophrenia receiving the most. Older, experienced doctors, rather than young, inexperienced ones, held beliefs about whether the patient would adhere to treatment. The systematic review discussed the current classification system and the need for a more user-friendly approach to primary care.

Self-stigma affects attitudes, beliefs, and health-seeking behaviour, while those who are angry tend to turn their anger inward (Saeed et al. 2020). The impact on diagnosis is now seen with mental health and other stigmatising conditions such as HIV and now COVID-19 (Saeed et al. 2020). Evidence shows that learning about psychiatry early in undergraduate education improved attitudes toward mental health (Farooq et al. 2014). Staff working within health alongside the wider community still appear not to understand mental health. An example from Participant Two, whose counsellor believed that mental health is a negative experience in life, ‘

.... *you're a small-town girl - shouldn't have these grand dreams* ‘.

These misconstrued beliefs increase stigma and make life difficult. Mental health episodes tend to happen once, and many go on to fully recover, particularly if they get early help.

Within primary care, many people present with physical health issues such as not sleeping, chest pain, or weight changes, as mental health is not just psychological. The interviews showed that all of those interviews with a lived experience described forms of self-harm, addressing a further stigma that those who are ill are dangerous when, instead, they are more likely to be vulnerable. The data on culture and stigma shows how they impact communities within a culture and individuals, and research shows how both reduce help-seeking from general practitioners when needing formal support (Bracke et al. 2019). This research is particularly relevant to those most vulnerable in our society who are refugees and asylum seekers and have experienced war, torture, loss and grief and need compassion and access to mental health support.

4.5 Relational Aspects of Primary Care Mental Health

The relational component of primary care mental health was referred to throughout the discussions. The member checking process selected the sub-themes of the atmosphere within surgeries, including the reception and waiting area, telephone consultations, attitudes, compassion, and caring combined with continuity, empathy, understanding, trust, and how personality contributes to the overall relational experience.

4.5.1 Telephone consultations

During the pandemic, the move to telephone and video consultations was perceived as favourable by those participants interviewed with lived experience. However, a finding was that access to the Internet and existing primary care relationships built on access and continuity were needed, as evidenced here by a participant with lived experience of mental health.

".... I see him, and he is also very accessible, in the sense that he makes telephone conversations, he does a video call if necessary and so on. So I can talk. He is the only GP I've seen for the last five years."

Participant Four

Participants needed to share physical health issues with doctors and nurses; they wanted those who knew their history well, so telephone and virtual communication were valued. Participant Fourteen explained how their positive experiences worked in practice.

".... I'd had a blood test on Monday....I started with the cough on Wednesday. So, by the time he (GP) got the blood test back, I was coughing very badly and spoke to NHS 111, who referred me on to him - we had a video conversation. We went through the blood test, and he decided I would have had to lock down and go into shielding. And he was aware that that would probably affect me adversely mentally."

Participant Fourteen

COVID-19 changed the face of UK primary care, emphasising telemedicine and triage systems (Marshall et al. 2020, Khan et al. 2020, Snoswell et al. 2020, Thornton 2020). One of the largest groups of the population identified to suffer from a lack of face-to-face contact are people with long-term chronic conditions, including mental health, and those without access or knowledge of technology or internet access, leading to the exclusion of patients (Thornton 2020). One finding from the interviews was that establishing a good relationship with a GP and holding complete knowledge of facts about a person's mental health leads to participants enjoying the virtual experience, particularly if they dislike the atmosphere in surgeries.

4.5.2 Link to Learning Theory

Connectivism Learning Theory (CLT) and the impact of digital technology on consultations, meetings and education shaped the landscape during COVID-19. Connectivism offers opportunities to connect with people learning technology to engage with health. The capacity to adapt due to continuous learning is evidenced as knowledge and systems change. Connectivism offered a learning platform to engage the community remotely, offering bottom-up engagement and discussion opportunities. It is an opportunity to allow a democratic process as it is flexible, allowing medical and social learning through collaboration. Connectivism Learning Theory ensures a method of updating information quickly, allowing discourse to provide understanding, a quality highly valued during the pandemic by those with lived experience who had existing rapport with their primary care team. The learning was that initial rapport needed to be established face-to-face alongside continuity, and the approach was valued. Recognising that factors such as poverty, access, and ability cause inequalities in digital access is essential. It influenced the study design to undertake telephone rather than web-based interviews.

4.5.3 Relational Outcomes

Community participants wanted relational, face-to-face consultations as they enabled a positive experience,

“.... face to face with GP, she was lovely.”

Participant Three

Participant Fourteen reflects on the need for outcomes in primary care.

“....suppose what I'm looking for is his (GP) support to allow me to live a reasonable life and to know that if there were problems like when I had the heart attack.... if you could set outcomes in primary care, what would they be?”

Participant Fourteen

The Participants did not want to waste the GPs' time. They wanted to be listened to and satisfied with the outcomes of the consultation when the GP had all the knowledge on hand. The focus group discussed consequences, expressing the need to,

“....Talk with the patients, ' what do they want?”

Focus Group

Participant Two wanted to be listened to, accurately diagnosed, and receive follow-up and support.

".... I want to get back to work and be supported - Yeah, it's about them supporting you on that journey."

Participant Two

Participant Two expanded on the outcome they wanted from their GP.

".... you don't judge, and you do listen and, and you're straight with me."

Participant Two

Desirable outcomes included listening and understanding, leading to an environment conducive to building trust and empathy. Relational care has evolved alongside primary care, with a breadth of literature dating back to the 1950s on relational-based General Practice's strengths (Rudebeck 2019). People with lived experiences, in contrast to those interviewed with clinical and professional backgrounds, described experiencing negative, relational experiences.

".... I have been to GPs where they've just picked the pen up straightaway or started typing straight away, and at that point, you lose the will to talk about what's going on because you know you're not being heard anyway."

Participant Nine

".... I felt like I've not trusted what a GP said - because I think they haven't really listened to it. And usually, I have been proved right in the end."

Participant One

The relational aspect became broader than the consultation. Outcomes included satisfaction with the physical surgery atmosphere and the individual experiences from the Annual Mental Health Review (NHS UK 2022).

4.5.4 Atmosphere within Surgeries

Participants discussed how, when physically attending a GP surgery, the environment and reception staff made a difference by being either welcoming or intimidating.

".... What experience of going to a doctor's surgery is most important? Feeling welcome."

Participant Three

Recommendations focused on improving the waiting room experience to change the atmosphere within surgeries, including the environment's aesthetic. The waiting rooms Participants discussed how the environment of the practice could be seen as clinical, cold and unwelcome. The practice team needed to be welcoming at all contact points, including a GP, receptionist, nurses, and pharmacist. Ideas to improve the environment included water coolers, wall art, and plants that could make the waiting room more attractive and pleasant, helping with stress management. A literature review and study by Clapton and Reid (2017) echoed the importance of waiting areas and how cluttered spaces with leaflets and negative images adversely affect the atmosphere. Despite being light and airy, new purpose-built primary care facilities were described as unpleasant. The joint public and private ventures are investments between health and private providers. To recoup the investment, rooms can be costed, and charges can be put in place, creating barriers between the community and social care and moving further towards a neoliberal NHS (Aldred 2008). There are too many computer monitors, screens, out-of-order machines, and seeing into offices with paper files on view, which are some of the findings of Clapton and Reid (2017). The surroundings impacted participants negatively, and the learning outcome is that the waiting room experience affects mood and understanding of the consultation process.

".... The surgery I go to is not the most modern or the cleanest or anything like that. But there's a genuine feeling of welcome.... not just to me but all patients comment on it."

Participant Fourteen

The atmosphere in surgeries is a neglected area of research and a missed opportunity to engage, inform and reassure patients before they access the GP, nurse, or Allied Health professional within the consulting room. Participants believed the waiting room was crucial to their primary care experience. Clapton and Reid (2017) conclude that the waiting room environment influences patients' beliefs about autonomy. The participant interviews concluded the waiting room was an overlooked issue in those with mental health issues. It could benefit from community participants working alongside healthcare providers to inform and improve the experience.

4.5.5 Links to Constructivist Learning Theory

Constructivist Learning Theory reflects how participants build their understanding and share their experiences and knowledge. It is a valuable theory contextualised within the community and historically built over time with generational experiences. Constructivist Learning Theory involves reflecting on what has been learned, allowing people to learn by creating a social experience. It is not passive with an exchange of meaningful information. The positives lie in applicability, as Constructivist Learning Theory builds on what each participant knows, combining the approach to engage the community in a broader, more inclusive type of learning. An example is to address issues in the waiting room before consultation.

4.5.6 Caring and Compassion.

Participants with long-term mental ill-health discussed their caring relationship with their GP at the Annual Review of Mental Health. The national strategy, 'Five Year Forward View for Mental Health' (NHS England, 2021), sets targets to ensure people with severe mental illness (SMI) have their physical health needs met. Participant Three explained what they wanted from a consultation, as the consensus was that little understanding or empathy resulted in a non-trusting relationship between the general practitioner, their workforce, and the community.

“.... I want GP to understand and not have to go through all the same information again.”

Participant Three

The following statements show how important continuity was when enacting the policy of annual health checks. They address the data that people with mental health issues in deprived areas can expect to spend twenty years in poor physical health (Office National Statistics 2020). Participant Six wanted to see the same GP annually and form good relationships.

“.... this particular doctor.... I made a pretty good relationship with him the first time I met him because I have mental health issues; he took a lot of time to go through everything, ask me questions, ask me how I felt, ask me about my medication, ask me about my general wellbeing, made me feel welcome. I've been with him ever since. Every time I go, he asks me how I am. He won't ask

all the questions again, and he'll wish me all the best when I leave. He will go through medication once every twelve months; you can tell he cares - know what I mean?"

Participant Six

By building trust and rapport, the GP demonstrates the ability to be compassionate through listening, understanding, and not having to repeat traumatic personal stories. When asked what was essential when meeting the doctor, Participant Seven described a caring, positive attitude that offered reassurance and compared the NHS to private care at their new practice.

".... There were two doctors there in the surgery, and they were the nicest doctors, you thought.... you were going to see a private doctor. So lovely people."

Participant Seven

The participant insights explain how caring and compassion at Annual Mental Health Reviews influenced engagement and subsequent long-term recovery.

4.5.7 Empathy and Understanding

The interviews showed how caring and compassion lead to empathy and understanding. A lack of empathy is demonstrated through not listening and showing little understanding. Listening indicated kindness; a carer looking after their partner with mental illness, whilst offering unpaid care, explains how a positive experience and empathy make a difference, so they feel valued.

"....not patronised and again that sort of feel that you know, a bit more to it, you're not just a statistic going in and out of the door."

Participant Ten

Participant Thirteen describes a more clinical approach from their new GP following the retirement of their regular GP following a period of painful irritable bowel syndrome. Participant Thirteen describes being prescribed multiple ineffectual treatments and requesting a medication sourced independently. The drug worked well. However, the experience was harmful as prescribing multiple, ineffectual drugs by the GP made the person believe they were not initially listened to, leading to a lack of empathy and perceived superior attitudes as experienced by Participant Thirteen. The literature found humility and patient outcomes link trust and satisfaction

with self-reported health (Huynh et al. 2020, Colombo et al. 2022, Swendiman et al. 2019). Paulo Freire (2017, p.63) says that no dialogue is without humility. With the quality of understanding, the participants thought the consultation could have been clearer, with information missed or misunderstood.

“.... Doctors seem to have a superiority complex, like they know better your body at the end of the day.... Ask the patient what they want.”

Participant Thirteen

Having a shared experience of mental ill-health was thought to be positive by the community participants. During the lockdown, there was an awareness that primary care staff were experiencing more stress and distress.

“.... it's easy to empathise - if you've been there yourself, you can empathise - the same as the GP or the same person that listens.”

Participant Nine

During the pandemic, community participants expressed empathy toward their GPs, recognising that stress may lead to a perception of unapproachability. Post-pandemic life remains fraught, and empathy can be a way of showing kindness and compassion to those who are suffering through health inequalities and money worries, who are angry and frightened. Recognising how people feel can give insight into preventing matching negative energy and being more positive and compassionate.

4.5.8 Insight

The findings from participants show that insight enables new perspectives and an opportunity to rely on and act upon instinct, supporting those with lived experiences in their recovery. A discussion on inexperienced doctors supporting recovery led to personal understanding from a community participant with mental health and previous alcohol issues.

“.... when you're new to it, and you've got doctors who you feel like you just want to talk about the world, and they drop you in it because they can't do anything. It's awful. It's only until you have long-term treatment that you start to understand sometimes. I think I might have become complacent. Well, I know I can take it - gonna take it, just kind of okay with it now. But really, I should be saying, I'm not okay push me now, let me see a psychiatrist to get rid of that

medication - really, I shouldn't be okay with that – I'm glad I said that because, as I was talking, then I actually just changed my mindset thinking - I do actually think that maybe I've just become complacent maybe I didn't understand that."

Participant One

A lack of insight is thought to be a sign of psychosis (Tordesillas-Gutierrez et al. 2018). Two community participants with lived experiences shared their experiences of insight and the psychotic crisis.

".... I know I'm going unwell, but I don't know what to do about it. I become very unwell, very quick, and before you know it, I'm in a right psychotic state."

Participant Six

".... We always have days we are not great, but if it carries on, I know the triggers and understand the stress that I can be overwhelmed by.... I'm aware of not stopping the medication and being aware of my own thoughts."

Participant Three

The impact of becoming unwell with long-term mental health issues was referred to in the interviews by Participant Three.

".... It destroys your life - as severe as the last time I had it - my life just falls apart. I know what happens to my relationship, know what happens to where I live, I know what danger I face just by being ill - lifestyle and how you live your life makes a big difference."

Participant Three

4.5.9 Insight as a Coping Mechanism

Insight as a coping mechanism is a finding viewed by participants as a feature of psychotic and addiction recovery, requiring the valuing of expertise from those peers in the community with lived experience of mental health.

".... I find it easier to distract myself from those thoughts and saying it will pass; it will go away. But then when it happens....as you're older, you develop more insight and can recognise the symptoms.... quite early on - I can recognise the things I need to do and hold on to any positivity. I was very brave. I don't fall into the same trap."

Participant Two

Understanding how insight affects self-care became a recurrent theme. One participant with a history of depression shared their thoughts when they felt low or anxious and how they would seek help from the GP.

“.... I looked at my habits and behaviour first. So, I looked at drinking, socialising, and I tend to cut that out first to see if it has a bit of an impact.”

Participant Five

4.5.10 Links to Learning Theory

Behaviour Learning Theory observes how people respond when given information on health promotion techniques and self-care alongside Talking Therapy Services and health trainers (smoking cessation, managing obesity, etc.). The results of Behaviour Learning Theory are measurable and used by the NHS as a framework to observe how people respond and by participants to assess the impact on mental wellbeing.

4.5.11 Continuity

The need to have access to ongoing support and continuity when managing mental health is key across all community participants, particularly those with lived experience (Freeman, Hughes 2010).

“.... the two GPs I do speak to are very in tune with me. They are very open to me.”

Participant One

Gray et al. (2018) found that continuity reduces morbidity, which builds on Sturmberg's (2002) research findings that morbidity, age, and frequency of attendance are poor indicators and can potentially double a GP workload. Research showed that non-COVID-19 patients did not access needed care, resulting in delayed diagnosis and care (Kumpunen (2021). Transformational care includes technical leadership and managerial support, legislation, and regulation. Terms used included benchmarking through measurement and a need to integrate community health services with digital technology (Kumpunen et al. 2021. These solutions offer innovative approaches; however, there is a risk the GP sees the most unwell, breaking down the patient and GP relationship (Rudebeck (2019). COVID-19 moved the primary care team toward practising triage and task distribution, potentially

reducing the relational side of primary care. A participant with a clinical background in the focus group believed there was a need for continuity, one reason being due to shared record-keeping.

“.... All medical records are in the same surgery, no need to see the same GP.”

Participant Five

None of the community participants, apart from the three with health management experience, Participants Eight, Twelve, and Fourteen, knew that psychiatric records were held separately in secondary care from primary care. However, the impact was detectable, as the remaining participants did not believe information sharing happened, and one service did not know what the other was doing.

“.... They (the local community) know that they’re not stupid, so they don’t want to come to another person who doesn’t know anything about them.”

Participant Nine

Lack of continuity was linked to concerns around the GP prescribing medication and adjusting the dosage, with continuity being critical to observing changes in the mental state when the person presenting lacked insight into their mental health.

“.... I must have gone to the doctor for a check-up, and he said, you know you don’t seem your bouncy self, so it was nice to know that he recognised because I’ve seen him quite a lot over the months.”

Participant Eleven

Continuity was discussed in more detail to understand why it is essential that participants feel comfortable with one doctor. In this case, seeing the same doctor and team in an extensive group practice was viewed as a positive during a period of mental ill-health.

“.... you don’t have to explain everything around it. You can just say, look, I feel like this again. What - What can I do?”

Participant One

Among the strengths of continuity in those with lived experience of mental health were being listened to and demonstrably heard, which resulted in understanding.

4.5.12 Dodo Bird Verdict

There is a transferable concept in a therapy known as the Dodo Bird Verdict

(Rosenzweig 1936). Supporters argue that all treatment is equal due to common factors, the most important being the therapist—one who is respectful and has high expectations. The Dodo Bird Verdict is transferable to primary care mental health with evidence from GPs or primary care practitioners offering positive responses and high expectations alongside compassionate, respectful, collaborative work with participants on their recovery or discovery journey. Arguably, not all therapies are equal, with better outcomes depending on the disorder.

“.... So, understanding, brilliant Dr X - so understanding.”

Participant Four

Participant Eight's extensive experience in Primary Care was evident. They responded in one word to the question of continuity from their perspective within the system.

‘.... eroded.’

Participant Eight

The literature shows reasons for a decline in continuity, including demand exceeding the trained workforce and staff being under pressure. Primary care has a sizeable workforce of 186,087 (NHS Digital 2022) structured from a top-down perspective, and there is a risk of losing continuity. Participant Eight further explained why they believed continuity had been eroded.

“....He's (ex-CEO NHS England) saying that GPs don't treasure continuity of care.”

Participant Eight

The semi-structured interview inductively led to a query about what advice to give to someone with mental health issues. All participants repeated the recommendation to maintain trust and continuity in developing and maintaining trust.

“....Try to see someone you know, and if they can't get an appointment with someone they know. Wait.”

Participant Eight

During COVID-19, viewing continuity with the same GP was challenging; however, those with access responded positively.

“....They'll ring me at the moment with the COVID thing - so the GP at the moment, I'm very happy.”

Participant Four

Continuity was a key theme valued by participants with lived experiences, and all interviewed did not like to see different doctors. There was recognition that a trusted GP could pick up how people were, and people could be open about how they felt, knowing they would be responded to and believed.

4.5.13 Repeating Stories

Relational care and continuity stop the repeating of individual stories. Participant One described the impact repeating their life story had on them.

‘....traumatic,’

Participant One

Mental Health and trauma are linked, and repeating life stories, which are often traumatic to staff who are not trauma-trained, can increase trauma (Sara and Lappin 2017, Copeland et al. 2018). The participants keenly felt the frustration that through the repetition of traumatic experiences, further help was needed, with harrowing stories potentially repeated. The view from the community participants was that this led to frustration and distress, and Participant One describes a disconnect between those asking the questions and those who responded.

“.... I’ve told it once that was bad enough. Why do I have to do it again? - And then if particularly, if nothing happens, then if you get referred to someone else, and then you must be assessed again, and you start thinking, what’s the point? I don’t understand - no point me telling you again because you don’t even care.”

Participant One

Participant Two discussed undertaking a questionnaire in the reception before being able to see a doctor.

“.... I was in a bad place, and it (the questionnaire administered in reception) was asking the question about suicidal thoughts and self-harm. I don’t want to sit in a room full of strangers - having to answer difficult, stressful questions. They were those graded 1 to 7, and if you scored under or over, a specific score would depend on the outcome of seeing a doctor.”

Participant Two

The repeating of personal stories is discussed here with a third-sector worker who empathised with those having to reshare their traumatic experiences.

“.... they’ve already repeated that story so many times they’re exhausted.”

Participant Nine

Repeating stories is a finding linked to a perceived lack of empathy and identified as a barrier to developing insight and continuity. There is a view trauma is relational, sharing inner thinking with an external body (bodies) and medicalising the inner thoughts. Therefore, a diagnosis results in a transactional aspect of people’s experiences (Fassin, Rechtman 2009, Sherman et al. 2021)). Repeating stories to health professionals hindered relational consultations as it was seen as challenging to build trust, which was a value identified repeatedly throughout the findings. Reliving experience is a personal narrative, seen as healing when managed as the basis in therapy. However, the findings raise the issue that participants were reliving traumatic events in their lives and there was also concern with telling people of the nature of that traumatic event. Participant Four shared how the experience of reliving and telling their life story felt.

“.... distressing.”

Participant Four

The life events had feelings attached and repeating this to a non-trusted person without a therapeutic alliance and continuity resulted in some participants disengaging, mainly if the event was testimonial, such as abuse.

4.5.14 Trust

Listening led to building trust and replacing previous negative experiences with positive ones. Without trust, participants sought a practice or doctor they could trust as shared here by Participants Fourteen and Four.

“.... I feel trust between a doctor and patient is so important.”

Participant Fourteen

“.... I can tell him anything.”

Do you trust him? Interviewer

‘....Yes, I do a lot.’

Participant Four

Participant Five shared how their positive experience with their GP enabled trust with other professionals and how they would advise others who became mentally unwell to do the same.

“.... always trust professionals, and I know these services are there for a reason. So, these people are thinking, I’m not going to go because I believe the old rubbish, go, get going. Don’t worry about it.”

Participant Five

Reviewing the literature, Goold and Lipkin (1999) found that consultations have three functions: gathering information, developing and maintaining a therapeutic relationship, and imparting knowledge. An anxious patient who is not made to feel at ease will potentially not fully understand shared information. Goold and Lipkin’s conclusions are that relationships influence the quality and content of information, potentially preventing practitioner burnout. Patients are more treatment compliant with shared care, taking part more fully, and doing better biologically, with higher satisfaction levels. Parker et al. (2020a) found that 40% of general practitioner (GP) consultations have an emotional component with limited time and resources. The literature looks at the relationship from a GP perspective (RCGP 2020). Not listening to emotional needs is recognised as an undesirable outcome.

“.... Some primary care workers assume superiority re. patients.”

Participant Thirteen

The community participants accepted that GPs might have personal stress due to COVID-19, aggravated by the time constraints of the consultation, which may lead to the perceived unapproachability of GPs. Considering mental health as part of the consultation is a compassionate step, alongside not rushing patients. The consultation's negative aspects, including being rushed due to time distribution, access and waiting times, resulting in a lack of trust, were directly attributed by participants to transactional care. The literature shows historical gaps in knowledge regarding the impact of the current financially driven model (Dowrick et al. 2009, Olde Hartman et al. 2011).

4.5.15 Relational Care and Links to Learning Theory

Cognitive Learning Theory was mapped against Relational Care, Model of Care, Workforce and GP education (Appendix Thirty-One) by analysing objectively how

practitioners feel (metacognition) and think. Information is gathered to support the consultation process. Medical education is an excellent example of applying Bloom's Taxonomy (Armstrong 2016), which uses Cognitive Learning Theory. Medical students and postgraduates can improve recall of traditional exam structures and consultation by using metacognition to define areas of strengths and weakness and set goals. Evidence of Cognitive Learning Theory includes awareness of how past experiences impact, listening to receive information and developing meaningful consultations. The theory holds the attention and the ability to retain what was learned. Cognitive Learning Theory supports comprehension of the factors experienced by the community causing mental health. It supports wellbeing allowing an understanding of a transferable model to participate and embed what is learned (reification). The cognitive process fits into a community participation approach as it builds on self-efficacy, building resilience in the practitioner and the community environment.

4.5.16 Summary

The findings showed empathy builds insight whilst offering both the experienced practitioner and community participants an opportunity to gain new perspectives. Participants shared how life experiences developed insight into their conditions and how detrimental the impact of mental ill-health was. The findings showed a knowledge gap between the community's expectations of primary care responses and their understanding of their life experiences. Community participants see insight as key to recovery and enable self-management with continuity required to facilitate insight. The primary care mental health themes included telephone consultations, the atmosphere within surgeries, caring and compassion, empathy and understanding, insight, continuity, repeating stories, and trust.

Three learning theories—connectivism, constructivism, and Cognitive Learning Theory—identified the connections between these themes.

One prominent theme is the importance of relational aspects in primary care mental health. Participants emphasised the significance of feeling listened to, understood, and valued by their healthcare providers. This relational component extends beyond individual consultations to encompass the overall atmosphere within medical practices, including the waiting room experience and interactions with reception staff. Continuity of care emerged as another crucial aspect, with participants expressing a preference for consistently seeing the same healthcare provider. Continuity facilitates

trust-building and a deeper understanding of patients' needs and experiences over time. Insight, empathy, and compassion were essential for healthcare providers to foster positive patient experiences. Participants valued practitioners who demonstrated empathy and understanding and those who took the time to build rapport and engage in meaningful dialogue.

Patients and staff find challenges, such as the need to repeat traumatic personal stories and being emotionally taxing. They may hinder the development of trust and therapeutic relationships. The impact of external factors such as the COVID-19 pandemic on healthcare delivery and patient experiences created a shift towards telemedicine and its implications for access and continuity of care. Overall, the findings underscore the importance of relational care, continuity, empathy, and insight in primary care mental health settings and the potential role of learning theories in informing healthcare practices and improving patient outcomes.

4.6 Transactional Approach to Primary Care Mental Health

Participants discussed transactional care. There were two views. Those who worked professionally within care, particularly in medicine, came from a more privileged position, as shared by Participant Eight.

“.... I prefer, and I think this is your middle class, well affluent, well educated, you can cope with transactional practice.”

Participant Eight

The broader community view acknowledged transactional care affected the patient experience and that government committees did not allocate enough funding. The non-clinical participants did not fully understand the separate roles of the governing bodies as they were far removed from the community and could not discuss whether they were efficient or effective. There was awareness of Primary Care Networks and NHS England with a shared view from those with lived experience and professional backgrounds that a clear focus and direction towards primary care mental health are needed. Participants disagreed with the current practice of limiting their discussions with their GPs, such as one health problem per appointment. They believed that people who go to primary care to see a GP have little interest in the 'business side' and its targets. The Quality Outcomes Framework (QOF) sets targets against which

primary care is paid and includes mental health, depression, and dementia. They accept that mental health is complex and recognise what is needed from patients.

‘ for many patients with mental health problems, the most important aspects of care quality relate to the doctor’s interpersonal skills, the time given in consultations and the opportunity to discuss a range of management options’
(NHS England 2022d:56).

The telephone interviews addressed the need for more GPs, allowing more appointments and time. A community participant who discussed their referral to secondary care expressed a negative experience of the transactional impact on personal care.

“.... The secondary care, the mental health, is shocking. History is worse than the GPs because they don’t have history - they don’t see you daily.”

Participant One

One participant believed people should wait instead of accessing services promptly due to the expense. The view occurred during the lockdown when the NHS struggled to meet demand, and help-seeking behaviour changed (Kumpunen 2021).

“....I think too much time is wasted on the NHS, so, I believe. People need to wait until it’s important.”

Participant Five

4.6.1 The Inverse Care Law

Tudor Hart identified the Inverse Care Law to health in 1971 whilst working as a GP and pioneering a population approach to clinical care at Glyncoed Health Centre in South Wales and, in doing so, set a Positive Care Law. Tudor Hart believed the collaborative relationship between the GP and the patient is not transactional. Instead, it is relational, producing social value. Market forces, the neo-liberal approach to health care we have seen develop since the mid-1980s, are currently combined with austerity policies, meaning those with the most need receive the least, as shown within this study. There is no easy solution to a collaborative approach, which was also advocated by Hart (2006) and includes epidemiology (Coggon et al. 2019). This study supports Hart’s findings of the need for clinical care and long-term relationships resulting in trust between general practitioners and communities. All participants valued the nano level of GP practice as essential to

local community wellbeing and social cohesion. The findings show a division between the layperson and those who understood primary care policy. Placing unrealistic expectations of primary care with no community participation leads to the Inverse Care Law. Evidence is the overuse of NHS services, including general practitioners prescribing health care that is unlikely to benefit their patients (Powell et al. 2013). Examples shared were prescribing medications that do not work, placing patients on therapy waiting lists not aimed at their needs and re-referring patients around the services. Overuse causes financial costs to the NHS and demotivates the community. Further evidence is a misuse of A and E due to a lack of integrated transport, wait times, inappropriate referrals, and access issues in primary care. Treatments in A and E are limited in mental health. However, it is an access point to secondary care (Ismail et al. 2013). People attending are more likely to be triaged, seen, if necessary, by the psychiatric team and referred to their GP. The community participants interviewed, including social care and health staff, struggled to understand the healthcare model, wanting to end the revolving door with a one-stop approach to care via their GP. The result is an underuse of services, such as not attending vital physical health checks, resulting in chronic ill health and premature death (NHS England 2021b).

4.6.2 Links to Lifelong Learning Theory

Lifelong learning builds on the gaps in mainstream education and overcomes challenges such as financial barriers by offering an equal chance to learn and share information. Regardless of demography, Lifelong Learning Theory challenges the Inverse Care Law (Hart 1971) and provides learning opportunities across ages and abilities. It cross-references into other theories, particularly connectivism and transformational learning theory.

4.6.3 Positive Care Law

Positive Care Law offers a counter position to the Inverse Care Law (Hart 1971), focusing on the community, family, health, and wellbeing instead of the transactional, neoliberal approach to health (Hart 2004). The Positive Care Law enables belief and support in informal care in the community. The community participants did not believe in the current policy, nor did the

medical model meet their needs, wanting shared leadership alongside clinicians to enable a local model of care.

4.6.4 Targets and Transactional Care

The community participants in the original focus groups discussed the transactional element of primary care and the need to build on mental health going forward.

“.... I know it’s (primary care) got to run as a business and this and that - is a massive demand for mental health, but also at the moment and people’s is going to affect people quite badly actually the longer it (COVID-19) goes on. I think we need a specialist doctor who’s actually trained in mental health that people could actually go and book and see.”

Participant Thirteen

The community participants were all aware of political discussions around the NHS and how these linked to potential increases in National Insurance, with Participant Thirteen suggesting that people pay proportionate to their earnings.

“.... I watched Newsnight, and Andy Burnham was on. He said mental health and social service should be incorporated into primary care, not seen as a second-class society.... if it needs an increase in national insurance or 50p to a pound a week. Yeah. I think people would pay that course. They would - If you’re on a really low income, don’t start charging them extra. Just keep that the level that around for anyone above that another pound a week....they should be organising the finances.”

Participant Fourteen

Participant Ten thought it was related to targets when discussing why there was a transactional element.

“....I think it’s because of targets and the amount of time and targets that GPs have to meet nowadays and when it’s paid whether they can afford to have an extra GP or have a social prescriber.”

Participant Ten

The Quality Outcomes Framework, known as QOF (NHS England 2022d), lays out the requirements of general practitioners to deliver care, including mental health, to achieve QOF points and gain payments across a broad range of conditions. The aim

is to incentivise practices to address target populations and disease registers.

Participant Fourteen reflected on how a partnership between the GP and the patient could create a different transactional relationship.

“.... And I think it also gives you that sort of transactional relationship with the GP, which is more than money.”

Participant Fourteen

Participant Eight discussed why they chose to work in a small practice throughout their GP career due to early experiences of working in larger environments.

“....I was promoted to a 23-doctor practice at headquarters with its own X-ray department, a couple of its own consultants, physio inbuilt, etc. And again, it became transactional rather than relational.”

Participant Eight

Participants viewed relational and transactional care as separate entities unbalanced in a model governed by transactional care. The literature supports this view with primary care making advances in digital medicine, encouraging people to use low-cost, widely available applications instead of costly health services. Examples included people presenting with mental health problems diverted from the GP by the receptionist to the pharmacist. The focus group discussed how people did not understand how nonattendance and missing appointments cost the surgery and believed this should be more expansive knowledge.

Relational medicine takes time. It does not always have immediate results or tick the transactional box of quantity over quality. However, it offers continuity over a life span with a depth and breadth of knowledge plus ongoing support and understanding desired by participants to meet their unique health, social, and emotional needs. As Participant Eight viewed it, working in a transactional manner was getting in the way of relational care.

“.... One of the difficulties is I’m quite certain in my mind; it’s that primary care should be relational. And it’s transactional. And because it’s transactional, you need all the job titles so that when Mr A is off, Ms P can take his place.”

Participant Eight

A move to outcomes-based practice entails driving a values-driven approach instead of an economic model. Forbes forecasted that 15% of global healthcare spending

would be linked to value and outcome-based care concepts (Das 2019). One area of transactional care was the misuse of services, an example being the lack of understanding of the role and function of the Accident and Emergency, which is perceived as a default to primary care if no appointment is available. Participant Twelve discussed how the financial reality of primary care post-COVID-19 concerns the ability of the NHS to deliver going forward.

“.... I suppose one of my fears is as we come out of a lockdown, we have to pay back the billions. Yeah. we’re going to have to go back to be defensive.... take the reins off the Over Performance Management and actually just let people look after people - the right things will happen.”

Participant Twelve

Before the first COVID-19 lockdown, the Conservative Government leader discussed mental health, saying, *'We can improve mental health, save money and boost the economy all in one go'* (Johnson, 2019). The view that mental health is an economic issue offers a narrow perspective of human beings' value being in productivity instead of flourishing, implying work is the answer. Participants understood the impact of government investment in primary care. Post-pandemic, there is a rise in pressure on general practice and secondary care due to missed appointments and diagnoses. However, this is not the only pressure, as the move to telemedicine, vaccinations, and managing the waiting list has resulted in primary care appointments being 34% up from 2019 levels, whilst GP and nurse numbers are down. Full-time GPs have now reduced from 31.9% of the primary care workforce to 24% post-pandemic (Institute of Government 2021). The Health Foundation research (Shembavnekar et al. 2022) predicts one in four posts will be vacant by 2030. It is clear that developing Primary Care at scale requires consideration, and the future GP workforce requires a clear career pathway that includes the skills to manage care in the future.

4.6.5 Objectification

The sub-theme of objectification arose from the literature and the telephone interviews. The findings show that the consultation gathers information in a time-poor (ten-minute) environment, and the person presenting is treated as a sum of their parts. Commodification occurs when communication is impeded, reducing people to

the status of 'things' (Freire 2017, p.101). There is a danger of missing the general practitioner's physical, spiritual, cultural, social, and psychological needs.

".... You go in, I feel like this pain, that pain, whatever - asking questions, real quick exam, right, off you go - it only looks at that one small part - just a statistic going in and out of the door when you have 10 minutes slots."

Participant Ten

".... I would see a particular doctor, for example, for having an orthopaedic problem and then see a different doctor for respiratory problems. The standard of care I got for.... those individual problems were excellent. But it wasn't for the whole person. And it was physiological language."

Participant Twelve

When discussing objectification with a retired professional on whether you see the whole person gather a holistic view, the following observation came:

".... It's not about people. It's about diseases. It's about people's diseases rather than those that have them."

Participant Eight

A reason for objectification in primary care was given as GPs now holding their budgets. The need to support the development of recovery in long-term conditions in the NHS has resulted in reinstating the Quality Outcomes Framework (QOF) following the pandemic in April 2022. The total number of points awarded to GP practices annually is 635 points, each worth £207.56 reinvestment into primary care and to supplement GP salaries; the national average practice population figure is 9,374 (NHS Digital 2022). Participant Ten discussed the impact of budget holding on themselves.

".... an awful lot of surgeries hold their budgets - I think sometimes that's why people feel like a commodity or a statistic because it is not you as a person.... It's about me as a condition, as opposed to me as the person."

Participant Ten

Objectifying participants made them feel de-moralised and lose self-worth, feeling they and their lives were not valued, resulting in an under-use of services. The evidence from the literature and national strategy supports this underuse. People with

mental health both live with and die earlier from chronic conditions related to lifestyle and the side effects of psychotropic medication (De Mooij et al. 2019).

4.6.6 Summary

The transactional approach to primary care mental health encompasses various perspectives and challenges within the healthcare system. Transactional care focuses on quick, business-like interactions, while relational care prioritises building trust and long-term relationships between healthcare providers and patients.

Transactional care creates challenges, and the participants expressed concerns about the transactional nature of primary care, which may limit the depth of care provided. Issues such as limited time per appointment and focus on meeting targets (like the Quality Outcomes Framework) contribute to this challenge.

The Inverse Care Law, proposed by Tudor Hart (1971), suggests that those with the greatest need for healthcare often receive the least. This is exacerbated by market forces and austerity policies, leading to inequalities in access to care. In contrast to the Inverse Care Law, the Positive Care Law emphasises community-focused, relational care that prioritises the wellbeing of individuals over purely transactional approaches. Participants discuss how targets set by frameworks like the QOF can influence care delivery, potentially leading to a focus on meeting quotas rather than addressing individual patient needs. Patients are concerned about being objectified in primary care, where they may feel like their healthcare needs are reduced to statistics or conditions rather than being seen as whole individuals with complex needs.

The importance of community involvement in designing and delivering primary care mental health services. It supports the objective of developing a pedagogical framework incorporating community knowledge and resources to build a more integrated and responsive model of care. To address the challenges identified, a call policy intervention goes beyond the purely medical aspects of care and addresses broader social determinants of health, such as housing, employment, and education. The need to shift towards more relational, community-centred approaches to primary care mental health is required whilst recognising the systemic challenges and inequalities within the current healthcare system.

4.7 Model of Care

The institutional level of primary care identified by participants enabled the theme of a primary care mental health model of care to emerge, offering access to a team operating together in an individual location. The consensus was the team required psychological and physical care specialists of all ages to collaborate with the community. Social care workers in the third sector support the community, linking integrated primary and secondary care services. Complex issues such as addiction, depression, and Post Traumatic Stress Disorder, access to specialist care, enabling links with other professionals and information sharing. Participant Twelve had a view on what needed to happen to bridge gaps,

“.... We’ve done quite a lot of work integrating health and social care; amongst neighbourhoods, we’ve struggled with the primary care and mental health teams, and that was predominantly around leadership capacity within the mental health provider. I wonder whether that perspective is because the community is naturally in primary care as it fills the gap. Absolutely.”

Participant Twelve

One view of a primary model of care from a health professional is that they do not need specialist mental health input. However, this was different from those participants with lived experience who expressed the need to see a mental health expert or psychiatrist quickly to prevent rehospitalisation. A big fear shared is going back into the hospital environment and losing everything, particularly to those with psychotic illnesses. They recognised they needed a psychiatrist to prescribe when experiencing a psychotic crisis. They did not believe the GP always had the knowledge to prevent and manage the emergency side of psychosis. The discussions highlighted a model of care including a specialist linked to primary care to support and expand the GP role in helping this group of people.

“.... It’s to support the GP, almost to advise them.”

Participant Twelve

Participant Eight discussed accessing a model of care so those with depression or anxiety with a professional in primary care concerned people who became lost in the system.

“.... first place the place I would try would be CBT at MIND - if that didn’t work, then there’s probably a single point of access still, where you’re then assessed

in a complicated manner at a distant hospital, and then.... getting lost in the system - it shows what a hazardous minefield of attrition, of organisational attrition, it is for people to be seen.”

Participant Eight

Member checking with participants produced sub-themes that discuss access, appointments and waiting lists. Referral pathways need precise information to explain why people are referred to secondary care, their rights, and preferred outcomes and follow the recommendations by NICE (2014) in collaboration with personal choice. The participants valued confidentiality with their GP, allowing an honest examination of the factors causing their mental health. Participants reiterated that GPs and their staff required a pedagogical framework to learn how to recognise the signs of mental ill health co-produced by the community.

The participants felt there was not always trust in knowledge and expertise when presenting mental health issues in primary care. A one-stop responsive service, it was thought, would counter the complexity leading to the disconnect between community and practice. Arguably, primary and secondary care outcomes are to meet the community's expectations and require a responsive care model.

Literature acknowledges primary care is complex and highly interactive (Upshur 2016). Newton (2017) reviewed UK and USA papers researching primary care models of mental health. The breadth of provision described matches the terms used in the findings, including 'integration' between primary and secondary care, 'unintegrated' services such as psychiatric out-patients, high-functioning ways of working and allowing communication at all levels. The community participants wanted a primary care mental health service model to build on community strengths and respond to needs within the community.

The definition of primary care mental health as the first point of call to all mental health, linking the GP to the community they serve, is pivotal to an integrated care model. The literature on complexity is vast (Sweeney 2017, Johnsson, Nordgren 2019, Banzhaf, Miller 2004). However, analysing

existing models for managing complexity through consultation is more limited. Widening health inequalities post-COVID-19 have highlighted the need to manage people with complex needs seeking help from their GP.

4.7.1 Links to Emotional Intelligence Learning Theory

General practitioners have long struggled with complexity (Johnsson, Nordgren 2019, Banzhaf, Miller 2004). Emotional Intelligence, supported by Cognitive Learning Theory, builds relational components of mental health consultation.

Emotions are often non-logical and make us unique beings. Emotional Intelligence Theory is a debatable theory that is challenging to measure due to the variances of each human being and is not based on intellect or ability. In consultation, emotional intelligence influences compassion and empathy, improving patient and GP outcomes. The evidence in the literature shows it acts in a preventative capacity to reduce burnout and psychosomatic complaints whilst increasing job satisfaction (Cherry et al. 2018).

Emotional intelligence develops as part of attachment throughout childhood and enables understanding, perception, and the ability to manage others and their emotions. (Cherry et al. 2018, Soto-Rubio 2020, Borges 2009) Using emotional intelligence within a primary care mental health consultation enables the GP, Allied Health Practitioner, or receptionist to be aware of their own and others' emotions.

The Balint Society established optional postgraduate groups with GPs in 1969, using psychotherapeutic techniques, where clinicians meet and discuss cases, particularly those that are complex (Balint Society 2022, Balint Journal 2018, Balint 2013, Routledge, Balint, Balint 2013, Van Roy et al. 2015, Vanheule, Inslegers 2015). There are gaps in knowledge regarding the impact of the current financially driven model (Dowrick et al. 2009, Olde Hartman et al. 2011). Participants believed listening with empathy would result in value-based outcomes that challenge inequalities. Peer-to-peer approaches recognise the need for healthcare professionals to manage interactions between professionals and those seeking their support and

guidance (Balint Society, 2022).

4.7.2 Doctor Shopping

The atmosphere within practices, creating negative experiences, impacted participants' leaving for other surgeries, described in these findings as “*doctor shopping*.” Participant Four described wanting to change practices due to an experience with an unsympathetic practice nurse that led to a breakdown in the relationship.

“.... I see the practice nurse as not very good, not very caring - had a go at me being late - a really friendly practice - really caring apart from the one person.”

Participant Four

“*doctor shopping*” in the literature describes people illicitly seeking prescriptions (Soerio et al. 2021, Micallef 2021). “*doctor shopping*,” contextualised within these findings, is choosing to go to a different professional within one practice or to change practices to access a doctor or other health professional of choice. The desired relationship between participants and their doctors referred to continuity, trust, understanding, and caring, all qualities enabling co-production and preferred by those with lived experience.

“.... it's the good thing about primary care is the continuity. You can have it whenever you want. That's the ideal choice, more than access will hopefully stop you from having to go - well, the idea, I suppose, is to stop you having to go to Accident and Emergency Department (A and E) and stop having to self-harm for the day.”

Participant Two

Sansone and Sansone (2012) concluded in their study of the literature on doctor shopping that it was more than getting prescriptions and can be attributable to a range of patient behaviours. The reasons to doctor shop expressed by the community participants with lived experience of mental health and the carers or those recovering from addiction were all due to relational issues, including a lack of continuity leading to a loss of trust. All participants with lived experience had used different practices, and four travelled a distance by public transport to access a doctor of choice. Their reasons for leaving their previous GP were relationally

influenced by the environment and personal characteristics of their GP or other healthcare professionals. The ongoing theme of the ability of the GP to understand and empathise was described as a positive experience when they give time and listen. Participant Seven and Participant One had changed their surgery due to having previous negative experiences.

"....My best experience was with a new surgery, actually - when you start with a new surgery, you get a health check done. Yeah, straight in, and the nurse was brilliant. Did my blood pressure - blood checks, whatever? That was fantastic. Then, I had an appointment to meet the doctor; Dr X sat down. And it was actually a double appointment. I was in there for about 30 minutes, it was a really good discussion, just about all my problems. And it was just a nice atmosphere. Nice and cheerful, and I was happy to change my surgery. And I've had good experience ever since at that surgery."

Participant Seven

".... Definitely same doctor and have on-day appointments for mental health should have just in case appointments or a call. That call will save that life for anyone who rings."

Participant One

Participant Three and Participant Two discussed moving to a different GP practice due to dissatisfaction, including experiences in the practice's reception.

"....I changed GP several years ago, and I found the new GP - the staff was easier to talk to - like the receptionists made such a big difference - they pick up if I am a bit stressed - my GP surgery has got time to phone or see me in person at the surgery."

Participant Three

".... That's why I changed my GP to another because the receptionist was so cold."

Participant Three

"....The last surgery, you're frightened to ring up to make an appointment because - I mean, this is all them frontline staff - I know they are under the

cosh a lot and they are under a lot of pressure, but they need some training in like customer service skills - The manner and the tone of voice by a couple of the staff, not all mind you, it puts you off wanting to ring up because you know that the answer is gonna be you can't get an appointment today blah blah blah, this that and the other, and it's just the attitude."

Participant Two

A reason to change surgery is explained simply here by Participant Seven following attendance with a physical health problem.

".... They didn't listen enough."

Participant Seven

Large practices were found to be off-putting. Participant Eight shared the background of when practices were initially encouraged to merge and take more significant numbers.

".... Kenneth Clark, when he was Secretary of State for Health, he got Sheffield University to run a piece of research about patients coming from small practices to large practices because he knew, sitting as he did in Whitehall, that's what would happen. However, he found the contrary, that: patients are moving from large practices. So, he embargoed this study for 18 months before it could be published, and then it was published very low-key."

Participant Eight

Participant Eight raised the topic of doctor shopping, reflecting on when patients were customers. The findings challenge this view as the practice appears to be happening again.

" before 1948, patients were customers almost. And then so that tradition continued into the health service until about the mid-sixties, and then it's been progressively squeezed out."

Participant Eight

The findings showed participants move between doctors and surgeries if they are unhappy with their care.

".... I think this is one of the things that had less attention paid to it than in previous times when the patients voted with their feet and bottoms. When there were more doctors than there was a need for them - the reputation of the

doctors was well known, and people went to whoever, to whichever they preferred - that's right when they were customers."

Participant Eight

The findings show community participants with mental health move practices to seek a relational approach to their care, including at the reception. NHS patients in England can move practices if they re-locate, have an issue with their current GP or have been removed from the GP list. However, there is no requirement to give details on why they have chosen to leave. Websites show surgeries scored highly on the friends and family test when information about the surgery, access and what is offered (Best Doctors Near Me 2016). Word of mouth played a part in the community participants' being interviewed, freely discussing the strengths and limitations of their GP practice, including broader experiences such as cultural competence. The findings showed that participants found surgeries to respond to their needs, and doctors shopped if they felt unheard of and did not have trust in their local GP practice.

4.7.3 Access and Appointments

The focus group had raised the lack of access as an area of why people with mental health deteriorated if there were delays. Participant Seven and Participant Eleven value access, continuity and availability.

"....But it's the good thing about primary care is the continuity. You can have it whenever you want. That's the idea. Choice more than access. Very available."

Participant Seven

".... you can always get access, or you can get a telephone consultation. I've not really tried during this period of isolation but on a normal working week."

Participant Eleven

The focus group occurred before access and appointments became more difficult during the lockdown. Participant Eleven reflects on an experience during lockdown when wanting to speak to their usual GP.

".... access can be a problem - I had that telephone consultation in April. It was about a month before I made the appointment online. So, I couldn't get to see him for a month."

Participant Eleven

Participant Eight described one explanation for why those receiving services are struggling with access, particularly during the lockdown.

“.... I think that if you have a very complex system, the people that designed it, they know it, the people that it's designed for, they will understand it. The people that didn't design it, or it wasn't designed for, won't understand it.”

Participant Eight

Appointments are traditionally ten minutes in primary care. However, post-pandemic in the area where the research is undertaken, it has been reduced to five minutes and one condition only. Two contrasting views emerged concerning understanding this pressure of time: the need for top-down education to the community from primary care by those participants with a clinical background, including talking to the patients about realistic outcomes. The teaching would include community learning and understanding the time limits and restraints on the GP and their team. Further, top-down instruction included educating patients that GPs have duties other than appointments for those frustrated with waiting. However, the telephone interviews differed as those with lived experience believed primary care needed to listen to and understand the community instead of being told what to do. Listening to community participants was empowering for participants with long-term mental health issues.

“....I think sometimes, with mental health in the past fobbed off, things seem to be getting better now. Sometimes, I believe the GP know what's best for me, but quite recently, I am absolutely in more control. I can finally tell them things about myself and get through to them.”

Participant Three

The same participant discusses being listened to again later in the interview.

“.... I've been dealing with the mental health system since my late teens - not always a nice experience - so know what I am doing by the age of forty-six. Yeah, Expert by experience.”

Participant Three

The telephone interviews with community participants agreed that preparation before a consultation is essential to maximising the experience.

“.... Be open about your problems or anything that you’ve got, don’t leave it behind, so write some notes down beforehand, so you don’t forget something during the consultation because you know your health issues the best.”

Participant Thirteen

The focus group examined appointments expressing the need for patients to exhibit certain behaviours. These included arriving on time or cancelling if they could not attend. They were pleasant and courteous to reception staff and understood their difficulties, including not knowing why patients attended. This one-way communication varied in the telephone interviews, with focus group members sharing the problem that appointments are not always when you want or need them, nor are they easy to make. There is little choice of whom to see, resulting in untimely referrals and waiting lists. It became clear that experiences were more favourable with available appointments, choice of doctor, approachable staff, and timely referrals from those working in health and social care. A picture of inequality emerged as there was no equality in booking appointments (some can book quicker appointments online), and not all participants were technical or had access to the internet) and 10 minutes is not long enough for all patients.

Participant Ten offered more insight into access as a problem.

“.... five or six years ago, so when we started, it was great because you got appointments, no problem. But obviously, like everything else getting an appointment now.- it’s predominantly the accessing it that’s the biggest problem.”

Participant Ten

“.... I think many people get het up about the actual waiting to go and see the doctor who got ten past ten appointments and still there at half-past, or twenty to whatever.”

Participant Ten

However, the experience in getting appointments varied. Here is one occasion from Participant Six during the lockdown.

“.... Well, you have to make it on the day, so if you really want an appointment, you have to get up at, say, seven o’clock and get there for eight o’clock at my local doctor’s.”

Participant Six

Starfield et al. (2005) show access to primary care helps prevent illness and death whilst addressing inequalities through equitable distribution of health instead of specialist care. The literature indicates current policy is focused on prominent issues such as suicide. It is reactive to secondary care mental health, lacking clear plans of positive engagement with primary care mental health. Participant Twelve believed primary care suits the more affluent instead of those with more challenges, causing the disparity.

“... I think that, to a certain extent, the politicians have designed their primary care NHS to suit people like them, but then they probably still go privately anyway. But it doesn't suit people such as the ones that we care for.”

Participant Twelve

National contracts restrain primary care from engaging closely with the community; the two agreements (Directed Enhanced Services (DES) 2020 and Quality Outcomes Framework 2022) were on hold during the pandemic and reintroduced in 2021. The development of primary care networks aims to bring together local practices, engaging and focusing on local care (NHS England 2021). The DES (NHS England and NHS Improvement 2020) includes financial payments of 50% of costs to Primary Care Networks to hire staff, such as social prescribers or wellbeing therapists. It lays out priorities such as health checks for learning disability patients. The QOF (Quality Outcomes Framework) (NHS England 2022a, NHS England 2022d) outlines a voluntary reward system to incentivise primary care to do things such as keep a mental health disease register. Points and financial rewards improve physical health, life expectancy and employment chances for those with mental health diagnoses. Participant Twelve expressed a wish for these to be removed.

“... hopefully, as we come out of lockdown, the QOF (Quality Outcomes Framework) national and local DES (Directed Enhanced Services) performance is off the table now - so I just hope that when we come out, we can walk the talk and we can do some neighbourhood working.”

Participant Twelve

4.7.4 Improving Access to Psychological Therapies

The findings show all those interviewed had experienced mental ill-health ranging from stress to psychosis, manifesting physically, mentally or both and managed within primary care. During the pandemic, all community participants shared they felt vulnerable regardless of background. Access to support was at two levels: those who were aware of the role of primary care had direct access to their GP, whilst those who did not understand the function of primary care accessed A and E or were signposted following ringing 111 as default.

NICE recommends NHS Talking Services within primary care, formerly known as Improving Access to Psychological Therapy (IAPT). These services tend to be in secondary care or the third sector, not primary care. Participant Four was confused about IAPT and the workforce quality after their GP referred them.

“.... It is very frustrating - yes, it was the therapist - I think he had issues too - so he stopped calling me - never know if therapy ended or not - I’m coming for you to help, and you have issues yourself.”

Participant Four

Psychological therapy services developed through the Improving Access to Psychological Therapies (IAPT) programme provide valuable support and treatment to people. Waits can be long, with participants discussing being assessed and having to wait.

“.... So been on a waiting list, been seen, and now back on a waiting list - that’s so frustrating.”

Participant Four

However, Talking Therapy does not present a complete solution to the range of challenges in primary care. Ninety per cent of people with mental health are treated in primary care (England 2017) without the knowledge, understanding, support, and resources allocated within primary care. Waiting lists are recurrent issues, particularly in therapy services. Significant numbers of people assessed are too complex for Talking Therapy Services. Yet, their referral may be rejected to specialist mental health services if they are no immediate risk to themselves. General practitioners (GPs) and practice nurses are left to pick up the pieces by supporting people they are untrained to assess and treat. MIND (2016) undertook research showing 46 per cent of trainee GPs had an educational placement in a mental health setting, which

tended to be psychiatry (hospital-based) instead of primary care, third sector or IAPT (Sabey, Harris 2011). Eighty-two per cent of practice nurses within the MIND (2016) research felt ill-equipped to manage mental health, with 42 per cent having had no mental health education.

4.7.5 Time Pressure

The community participants found time a pressure, as they believed it was difficult for GPs to show compassion within the ten-minute consultation. Discussing mental health is valued when the GP gives time to listen and build rapport. Participant One spoke of the consequences of overrunning, causing a pressured atmosphere and overspilling to other staff.

“.... definitely the problem with GPs - can only do so much you only have a 10-minute appointment, you’re sat there crying your eyes out, and all they want to do - you hate yourself - and they’ll give you antidepressants and then refer you to the counsellor, but he won’t see you for six months - I’m sat listening to - that the tablets won’t work for a couple of weeks - so can’t self-medicate, so don’t take any other drugs, and drink.”

Participant One

Participant Six spoke about their experiences with a GP who could listen and one who did not.

“...I suppose when you go to the doctor and when you see the doctor, he has actually got time to listen to you, and he is actually listening to all of your problems so he can make a proper diagnosis - instead of rushing people - getting people in or out cos I’ve actually been to the doctors- not going to name any doctors - but he’s been actually writing while I’ve been speaking and I pulled him up on it right good, so it’s to get their full attention.”

Participant Six

Time and listening were studied in the literature (Parker et al. 2020b, Cocksedge et al. 2020, Sargeant, Au-Yong (2020), Lundkvist et al. 2020). However, fewer studies reflect the patient’s view (Murphy, Salisbury 2020).

“.... I know him. He’s a personal doctor, and he knows me, and he’s got time to listen to you - all of your problems, actually listening and has got time for me and is giving me a proper diagnosis.”

Participant Six

Those interviewed in the focus group and individually spoke about how important it was to have the time to listen. Participant Eleven thought their positive experiences over the years with their GP were due to more than that.

“....the time to listen and wanting to listen.”

Participant Eleven

Discussing the positive experience of going to their doctor, Participant Eleven shared how having time to listen to them led to a positive, trusting relationship.

“.... I've got confidence in going to the doctor. I would go to the doctor with anything; it wouldn't faze me to discuss anything. However, private, and I will always get help from there. And you just put your mind at rest that there is someone there that's looking out for you know that you can go to if you need to for, they'll help.”

Participant Eleven

The community participants suggested ways people with mental health concerns manage a ten-minute consultation, ensuring the support needed to recover includes using the coping mechanisms, insight, and expertise of those experienced with a lived experience of mental health.

“.... just to be honest with the doctor, because often they come in - and they're self-medicating....because he's heard it all before and nothing will shock them, and they'll help, you know, they'll help you. Hopefully.”

Participant Eleven

The focus groups identified community knowledge as needed and recommended people with lived experiences draw up a list of things to tell their doctor to aid the consultation. The health professionals and carers urged those with lived experience to discuss with the receptionist when they needed extended time and book a double slot to manage their complexity.

4.7.6 Waiting Lists for Secondary Care.

The literature shows waiting lists were both a historical and current issue, particularly young people moving from children to adult services at eighteen, with GPs struggling to manage care (Appleton et al. 2021, Hinrichs et al. 2012). During COVID-19, surveying members of the Royal College of Psychiatrists found 43% reporting an increase in crisis and 22% reporting a decrease. Routine outpatient appointments decreased by 45%. The report emphasises that 49.6% of the UK population had an elevated level of anxiety in 2020 and forecasted elevated levels of unmet needs (Williams et al. 2020). Rethink Mental Illness (2020) surveyed eight hundred people with mental illness, with 80% saying the measures during COVID-19 had worsened their mental health. Reasons included struggling to access mental health services when the country went into lockdown, receiving less support from mental health services, non-attendance at appointments, or not booking as they did not wish to burden the NHS or because appointments were unavailable. The data produced by NHS England shows that across the nine Clinical Commissioning Groups formed in 2021, waiting lists were linked to deprivation. The area where this study was completed has an average wait of 37 weeks and one of the highest deprivation scores in the country, according to NHS Health Analytics (Lane, Clark, Peacock 2022).

4.7.7 Revolving Door in Primary Care

The revolving door is a term used in mental health to describe people admitted into the NHS and being readmitted due to a lack of services in the community. The following describes how the findings from the third sector reflect the patient experiences of the secondary care revolving door. These include a lack of services in secondary care to support people and long waiting lists for secondary care support (Baker 2020, Eisen et al.2002). Little is known of the community's expectations of mental health in primary care apart from a paper outlining the emotional needs of those over the age of sixty-five (Jaworski et al. 2017) and expectations in a secondary care setting (Ortiz, Schacht 2012, Eisen et al. 2002).

“.... I mean, I don’t mind sitting with people and talking to them. I don’t mind making referrals, but the referrals I would be making would be back to the people who have sent them to us.”

Participant Nine

The impact of a revolving door in primary care is shown to lead to using other services, such as Accident and Emergency, for self-harm and suicidality. As social prescribers, voluntary participants shared the need for appropriate secondary or social care referrals to address the revolving door. Healey (2021) found that not all primary and secondary care patients will meet eligibility thresholds for specialist treatment and support. However, if primary care had resources and infrastructure, unnecessary referrals could be reduced significantly.

“.... I think the referral source is significant for service, knowing that you just waste so much time otherwise knowing they’re going to come back in again with the same issues.”

Participant Nine

The revolving door is a vicious circle, particularly those without English as a first language, with no or low educational attainment, or unemployed, who were more likely to have common mental health problems. (Guessoum et al. 2020, Singh et al. 2020a, Racine et al. 2020, Gallie et al. 2003). Participant Two shared their experience of being sent full circle back to their GP after seeking help.

“.... it’s disappointing each time you go because they can’t give you a quick fix, and you want to feel better, so it’s kind of disheartening because usually, you have to have so many weeks and months of depression before they’ll even properly look at you, and if they don’t give you anything that day, then you just don’t have nowhere, and sometimes that ends in Accident and Emergency Department (A and E) either self-harm or overdose - to just go to hospital - be seen quicker which then leads to the hospital - then having people in the mental health Unit - they just think that you just overreacted and then send you home with aftercare and the aftercare says oh you regressed and you’re okay today, so we’ll discharge you, and you can go back to GP, again - so very much disheartened.”

Participant Two

The findings show confusion about the role of social care in primary and secondary care, evidenced by Participant Nine's experience during the pandemic.

".... Whereas initially, what happened was that people started coming because the GP advised them to come, or what have you, but now we're getting people turning up that the mental health services don't want to work with. And that's really worrying."

Participant Nine

Participants discussed accessing a one-stop service within the community as part of a solution.

4.7.8 One-stop Service

Participant Three saw primary care as the key to referral to the right service.

".... I don't really see the GP other than when it's time for blood tests or something than mental health - Or obviously, if I'm feeling particularly poorly or need a review of my meds, I'll go to the GP, and they will send me up to another place a mental health unit. They have people there that talk to me - pretty much what I need a GP for."

Participant Three

Participant One shared their need for assistance in one place.

"....I feel they should be a mental health nurse or doctor in every single GP practice - because you should communicate with that GP weekly depending on how unwell you are, and it should not just be a GP. It should be a session, whatever."

Participant One

The one-stop service must be in primary care so the GP can access a bed directly or via a referral. The community participant who shared this had a long-term experience and a history of previous admissions. Current one-stop services include access to talking therapies, social prescribing, and community activities. Access to secondary services remains through referral, though trusts use single access points, meaning one number and one e-mail as best practice. Participant Six gives an example of when the GP could not access a bed in secondary care.

".... I've been in hospital three times, and in the end, they asked me, parents, to phone the hospital up to err get me a bed - sort of saying I'm very unwell -

the doctor came to my house to do a home visit then say I need to go into hospital and then I'd either get a bed straight away, or I'd have to go to – secondary care - to the psychiatrist there and get a bed then.”

Participant Six

Newton's (2017) literature review found that primary care mental health models offer integration across a spectrum between primary and secondary care. However, the literature needs to show integration with the community, though there were toolkits to support listening and learning (Thorstensen-Woll 2021).

4.7.9 Complexity

Participants define complexity as gaps based on their experiences leading to disconnections in care. Areas discussed included a lack of understanding of age-related conditions and giving support to disabilities. There was an expressed need for GPs to understand the needs of local people from diverse cultures with ethnicity and gender issues. To have access to accurately translated information in different languages and formats. Managing complexity using prescribing does not always work with mental health as it does not always respond to medication, and there was a call for the GP to understand social and holistic therapy. Participant One discussed a lack of understanding of their condition and needs within primary care during the pandemic.

“.... If I feel a bit high or even energetic - I just want to get higher and higher, and the quickest way to do that is to drink - sometimes, when I felt low, I don't even drink because it felt so low. I didn't need to drink. A lot of the highs were just much more. So that was an issue that if I felt like, oh, you know, do with a drink with the boredom, then I would? I'll have a drink just to keep me up - It was a medication for me more than anything, yeah.... It's not a very good medication. It's a bit shit. Other things affect the liver, withdrawals, oh my gosh.”

Participant One

Participant Twelve thought that primary care is complex due to bureaucracy and the workforce.

“... In sort of management lines, job titles, it’s complex, but in outlook, it shouldn’t be complex.”

Participant Twelve

Participant Eight describes managing complexity well in primary care by comparing happy and unhappy colleagues. Complexity is linked to transactional care instead of compassionate care.

“... there were the GPs I used to work with.... those who are interested and know more. How could you do this? And how could you do that? They look so happy. And then you saw others that look just totally burnt out and unhappy. Looking back, they just got bogged down in paperwork and the minutia.... looking back, it’s probably the more transactional practices that weren’t allowed to have continuity. And were just bang for buck. Ten minutes, one condition that was the most unhappy.”

Participant Eight

When querying how Participant Eight managed complexity, they said they enjoyed the challenge.

“... I came across recently a description which was incomplete of a morning’s work and just my delighting in its.... intellectual complexity of what I was facing.”

Participant Eight

The literature on the complexity of primary care is prolific, including how it impacts the uncertainty of diagnosis (Hewson et al. 1996, Peek et al. 2009, Singh et al. 2020b). Views from Participant One during COVID-19 highlighted the need to understand complexity.

“... It was about February or March. I was drinking every single day whereas before it was not so bad - was nobody was out; nobody was visiting anyone - actually got really, really bad whereas before I’d drink mostly every day but not in the morning - anytime was drinking time - it got so bad I couldn’t function without having a drink and then by mid-fall - All of us to lock down - It kills me.”

Participant One

Complexity in a transactional, bureaucratic environment offers a theoretical approach to consultations, allowing the GP to identify and understand both conscious and unconscious behaviour, which sometimes appear irrational and erratic. The

complexity of mental health within the literature shows a need to identify and manage complexity within primary care by listening to the patient and exploring their experiences (Kingstone et al. 2020, Rock, Carrington 2018). Solutions to tackle the added complexity of COVID-19 include using rapid design in medical education using virtual and technological solutions despite the risk of exclusion and a lack of equity. (Thakur et al. 2020). Previous suggestions have included managing the complexity of primary care mental health by developing its classification system (Gask et al. 2008).

4.7.10 Disconnect.

Participant One discusses help-seeking in primary care, evidencing their disconnect experience.

“.... they can refer you and get a letter, but an addict is the one who always has to do the addiction process. I’m the one who got the referrals.”

Participant One

“.... I was going to try this drug prescribed for one to stop cravings - it is not dangerous, more like an anti-acid tablet but apparently stops your cravings for alcohol, so to enable it – Addiction service - told me to ask doctors to prescribe it - but then like the other doctor must have been a locum doctor that prescribed it - but when I spoke to my - the other doctor she was unaware why I was prescribed it she was unaware as to why I wanted to be prescribed it while I was still doing it, so the communication - Between the doctors was kind of there was no communication - at any point, she didn’t say ask the doctor I just put the prescript in so she did it without asking why she’d done it, so my real doctor was unaware I was taking it.”

Participant One

The disconnect identified between services before COVID-19 has widened (Mahase 2021), with patient waiting lists exceeding 5.3 million in May 2021 and 7.2 million in November 2023, as recorded by the Office of Fiscal Studies (Hospital Times 2023). Medical leaders reported these figures to highlight the “disconnect” between the NHS workforce and the government’s decision to lift COVID-19 restrictions (Mahase 2021). Participant Three explained the problem of getting needed medication and the impact the ‘disconnect’ can have.

“.... I was getting a prescription from the hospital. She would only give me a supply each time I would get in contact with my GP. Have you a letter from such and such re. my change in dosage to Olanzapine? Get back in touch with a woman again at the hospital. The doctors haven’t prescribed it to me because they haven’t heard from you. She said that I’d send prescriptions out to you, and then these people, whoever they were, to deliver the prescriptions to my house. The doctor prescribed me the medication I need, and I was doing what I normally do. I was worried. I wasn’t gonna get the prescription. It’s hard enough getting valproate acid now cos every time for the GP surgery, I have to say please, put a note on for the doctors to say I’ve had a discussion re problems pregnancy, I know all side effects, so if I don’t have that note in, I won’t get the tablets.”

Participant Three

Participant Three's discussion of the role of a nurse prescriber in primary care exemplifies the disconnect between disciplines in primary care.

“.... She didn’t know I had blood tests for her. So obviously, she said before we change anything, she knew the prolactin levels were high. So, obviously, hadn’t liaised with my GP; it all gets complicated. It’s people not communicating with each other that’s where you get problems.”

Participant Three

The disconnect between the primary and secondary care workforce expanded during the pandemic, demonstrating how instead of a resolution, a blame game ensued, resulting in the person with mental health issues becoming frustrated yet powerless. Participant Three summarised the stress disconnection caused.

“.... Why don’t these people know? They’re the ones who referred me to secondary care. So why aren’t they communicating with each other? So why am I doing all this? What if I was ill? I wouldn’t be able to do this - it’s a good job. I can take the stress of worrying about getting my meds for the next few months.”

Participant Three

Medical language and jargon feed the disconnect. Participants who have worked with mental health expressed that the people they saw had good health literacy and understood their conditions. However, participants with mental health experiences

expressed that they were not always treated as if they understood, and medical jargon created further misunderstandings. Participant Fourteen shared their elderly parents' knowledge of jargon.

".... My dad had problems, but he had no concept - mother says to him what had happened, and I'd end up, you know, having to sort of inquiring on his behalf because one can - the GP said to my dad, I think you're going to need a cabbage - my dad had no understanding of what that was until he told me, mother, that he was gonna have to eat more greens. (CBAG - Coronary bypass artery graft). He ended up with four cabbages."

Participant Fourteen

Further discussion on this translation of the medical to layperson terms described as problematic for GPs from Participant Fourteen.

".... it worries GPs as well because sometimes they will say to the patient, you know, do you understand that etc. and the patient will say yes, and you know damn well that the patient doesn't."

Participant Fourteen

".... The other thing that's difficult, of course, is the medical language.... the problem of local colloquialisms versus medical matters."

Participant Fourteen

Participant Twelve shared insight into why individuals and whole relationships with the community may be disconnected.

".... Statutory, big organisations have seen carer organisations and voluntary organisations as second-class citizens. They are more than equal - they should be the leaders because it happens in communities. It doesn't matter. It's not what GPs do to people that keep them healthy and happy. It is what communities and carers do."

Participant Twelve

The findings show the division between participants with a health and social care background and participants from the community regarding health services, jargon, and the terms used. Clarity on language and removing jargon would enable direct community engagement to pull social care out of town halls and primary care management out of offices and back into the communities they serve.

Social marketing (National Social Marketing Centre 2022) considers an adaptable approach to underpin the delivery of a primary care mental health curriculum, exploring whether the community lens offers a significant step change. It enables informed discussions on changes to practice. Discussion on what aspects of statutory provision add benefit and value to the local community outweighs barriers to inclusion. Social marketing is creative and looks at diverse ways to engage the local community using approaches and methods led by communities to enable local strategies to respond to local health needs.

4.7.11 Cultural Competence.

Participants discussed the need to respond to complex challenges such as diverse cultural interpretations of mental health, possession by evil spirits (Jinn and Juju) and the impact of a mental health diagnosis, including dementia, on the ability to find dowry marriages. Cultural competence enables an understanding of the diversity of the local community. Only some of the community understands primary care and its role in healthcare provision. One reason, arguably, is that it is not a concept in all countries. Frequent NHS restructuring through centralised policy leads to community disengagement due to jargon and the lack of clarity on the role of primary care. The literature supports the findings that more education uses a cross-cultural curriculum to understand social and cultural differences and remove complexity (Carillo et al. 1999). Bias, racism, and discrimination are inherent in the NHS (Kar 2021, Iacobucci 2020), and there is a need for healthcare staff to examine and understand their own social and cultural differences (Green et al. 2000).

The focus group identified a lack of cultural competence in GPs and the wider primary care workforce, including understanding the needs of different ethnic origins, having access to translators if English is not the first language and recognising the diverse cultural needs of ethnic groups. The findings show that a lack of cultural competence impacted all levels of the pathway in mental health. The example here came from an advocate working alongside people with mental health to support their rights.

“.... there was a Muslim woman on the ward. And her mental health was horrendous. It was really, really poor. And she believed that was a curse on her, and she believed that there was a ghost haunting her house. She believed in the Jinn, as most Muslims do the thing is the tribunal that we’re assessing that she was sectioned - the tribunal that we’re going to decide whether or not a section was removed or not - was a panel of pretty much English people there wasn’t really any Muslims on the panel.”

Participant Nine

Cultural competence can be wide-ranging. Participant Fourteen made a tongue-in-cheek comment regarding their equal relationship with their GP.

“.... He was born and brought up here - we used to have a standing joke we’d go to conferences—the two of us. And we’d say who’s the stranger and the answer it was me because I’m from Yorkshire. He was the local lad.”

Participant Nine

Cultural competency is critical to understanding the diversity of the local community and its participants to enable an understanding of primary care and its role in healthcare provision. The literature supports the participant's views that physicians were not adequately trained to manage socially and culturally diverse populations (Tanhan, Young 2021). One paper outlined a patient-based approach and potentially transferable learning reflecting best practices. The cross-cultural curriculum removed complexity by raising awareness of perceived barriers and cultural and social differences. The transferability of learning involves listening, ensuring the right questions are asked, and, importantly, seeing people where they are – in the community (Betancourt et al. 2003). Discussing cultural competence raised awareness of spirituality and religion’s role in mental health and also self-help as a coping mechanism.

4.8 Intrapsychic

4.8.1 Religion and Spirituality

The term intrapsychic was chosen by the researcher as religion and spirituality do not sit neatly within the biological model. Intrapsychic is a term coined by Freud and further developed by Carl Jung, which refers to the unconscious where there is no

chance and everything has meaning. The theory is that areas of the brain are outside our awareness. Carl Jung's thinking is outside the medical curriculum. However, his theory of 'individuation' is relevant (Fumugalli 2020). The medical curriculum relies on clinical evidence, yet participants with lived experience require more than a biological response. Jung theorised that human beings need spirituality and an appreciation of the unconscious. The participants had different understandings of spirituality and religion, leading to various interpretations. However, all interviewed believed their beliefs positively or negatively impacted their wellbeing.

".... the spiritual perspective meditation helps to keep my mind calm and help me to feel more open to feeling more able to manage the day so. Therefore, I cope better mentally. So, my spiritual beliefs about compassion and altruism. That fits in with keeping my mental health well."

Participant Nine

There were firm opinions when asked whether there is a link between spirituality and mental health and whether people were religious. Participant Seven had experienced the sudden deaths of relatives and firmly linked those with their own and their family's mental health whilst using faith as a coping mechanism.

".... but there's a link with spirituality.... some kind of faith. Some belief, even if it's just in yourself, is a helpful factor."

Participant Seven

".... I mentally write sometimes a letter to God. You know, people might laugh and think God. But I write a letter to God, you know, can you help me out with the situation? Now, when I'm helped out and the situation changes. I could put that down to well God's answered my letter, or by doing the behaviours, to bring about that change myself."

Participant Seven

Participant Ten explored the personal impact of being an Irish Catholic.

".... it did give me a sense of security, ... it just seems that many of my family Auntie's - were pretty highly strung. So, whether or not that's a trait. But I do think there's something in that I do think when you're little particularly; you're

very much got the good and the bad and the evil and the heaven and hell and let's go into purgatory and all our business and be left in the middle - You can't just say no and leave it at that you feel like you have to explain yourself when you say, you know that sorts of things. - that culture shapes your personality."

Participant Ten

Participant Ten strongly connected the link between guilt and mental ill-health.

".... there was that kind of guilt on letting somebody down somewhere - as I said, I think my stress and anxiety and all that at the time was probably as much linked to that."

Participant Ten

The GP's role in supporting recovery and the discourse was explained using spiritual terms, as seen with Participant Nine.

".... I've got faith in the GP. It makes me feel I've got faith in the practice. It also makes me feel more human." ".... it gives me a belief. I'm being like heard, and that I mean something. At that moment, and that my condition or my problem means something at that moment."

Participant Nine

The literature shows that current medical education varies and only sometimes includes spirituality, which is linked to a lack of cultural competence and knowledge of the needs of the local population. The intra-psychic finding is that belief is a potent force within mental health consultations, and impacts thought and behaviour. Participant Six believed there to be a strong link between religion and spirituality plus mental ill-health.

*".... Definitely linked I've got schizophrenia – I and people with schizophrenia see visions and things and get- **Very** high highs and **Very** low lows....sort of seeing visions and things I don't understand why but you do in the past when I've been ill, I've thought I've been Jesus one minute and the devil the next*

you know what I mean when I had psychosis when you are mentally unwell you do see a lot of spiritual things.”

Participant Six

When asked whether Participant Six believed the thoughts, they explained,

“.... At the time, you do, but it’s a load of nonsense, just your brain playing tricks on me. I don’t have audio hallucinations I have visual hallucinations - absolutely very terrifying, particularly if you see Satan and God - two people I don’t want to meet two entities.”

Participant Six

The findings show that belief is perceived as a protective or potentially harmful force within participants’ lives and holistic wellbeing. Religion and spirituality offer solace; however, there was little evidence of whether it reduced the risks to mental health. Participant Six regularly attended church and found comfort and protection from their psychosis, and the environment calmed them, acting as an adaptive coping mechanism.

“.... how do I know I am coping well? I’m a committed Christian; I feel very happy, contented, and peaceful. I know I wasn’t well when I was worried, paranoid, and anxious.”

Participant Six

When asked whether faith had an outcome, Participant Six responded emphatically.

“.... tremendous peace and love, basically tremendous feeling of wellbeing and contentment.”

Participant Six

Others who prayed said they found peace. However, there was little evidence of whether people became religious before or after getting ill; rather, it was alongside their mental health. No one religion stood out from the findings; the participants had backgrounds that included Catholicism, Islam, Baptist, Buddhism, and spiritualism (the belief that one can contact the dead). The finding was that with belief comes a

different daily coping mechanism which helps protect against mental ill-health, supports the management of grief, enabling. Adaptive coping. Participant Seven described the impact on their partner following the tragic loss of a child,

“.... watches a lot of clairvoyant stuff - life after death, which is understandable because she’s hoping that X is in the spirit world - gets the comfort that way.”

Participant Seven

The language used regarding the consultation included words demonstrating the belief spirituality and faith gave peace and a sense of wellbeing. There was a counterview by Participant Ten, who believed their religion potentially caused a long-standing generational neurosis:

“.... I think I’ve always had, you know, a predisposition towards, as the rest of the family does because we’re Irish Catholics - are allowed to have that neurosis around.”

Participant Ten

Participant Nine recognised that mental illness was understood differently within a different faith.

“.... my partner’s Muslim if you’ve got a mental health problem. Often, you think you are possessed. So, you find people. In some cases, they have been beaten because they wanted to get this demon beaten out of them if they have schizophrenia.”

Participant Nine

Discourse from the community repeatedly included the need for empathy, understanding of support from GPs, and the acknowledged need at times that the GP leads in managing mental ill-health, making them important as a ‘higher power.’ As shown here when discussing with Participant Seven whether spirituality is linked to the GP consultation,

“....if there is a God, the doctor is going to be a second God because this person can hopefully heal you that’s what you go for So, I think it’s faith that you’re gonna get something good.

So, do you look at it almost as a spiritual experience going to the doctor? Interviewer

Yes.”

Participant Seven

4.8.2 Summary

Participants believed that the personal sharing of beliefs based on knowledge and life experience enabled an enhanced consultation. Spirituality includes individual thoughts, beliefs, and values, and it is explored inductively by exploring the impact of spirituality and religion. The findings show the difference it made at a personal intrapsychic level daily and within the consultation. The findings show that the community believed their wellbeing was negatively or positively linked to their spirituality, regardless of spiritual faith or belief, a Jungian concept (Noronha 2022). Participants stressed the importance of intrapsychic beliefs at every level of their mental health and personal well-being journey, regardless of whether they were religious, spiritual, or having no belief. The intra-psychoic beliefs appeared to work as adaptive coping mechanisms and intrapsychic understanding was used positively; one example is possessing elevated social skills by developing self-belief. Intrapsychic beliefs can be used negatively if someone is in conflict either socially, within the faith, morally or neutrally to explain why people have loves, likes and dislikes (Schmidt et al.1999). A school of thought believes love is fundamental to who we are as humans and can support healing. The argument supports the idea that without love, the emotions of anxiety, depression, and fear affect individuals (Bonhoeffer 2021). Paulo Freire (2017, p.62) discusses how love is about courage and commitment to a cause of liberation through education and is necessary for dialogue.

4.9 Primary Care Workforce

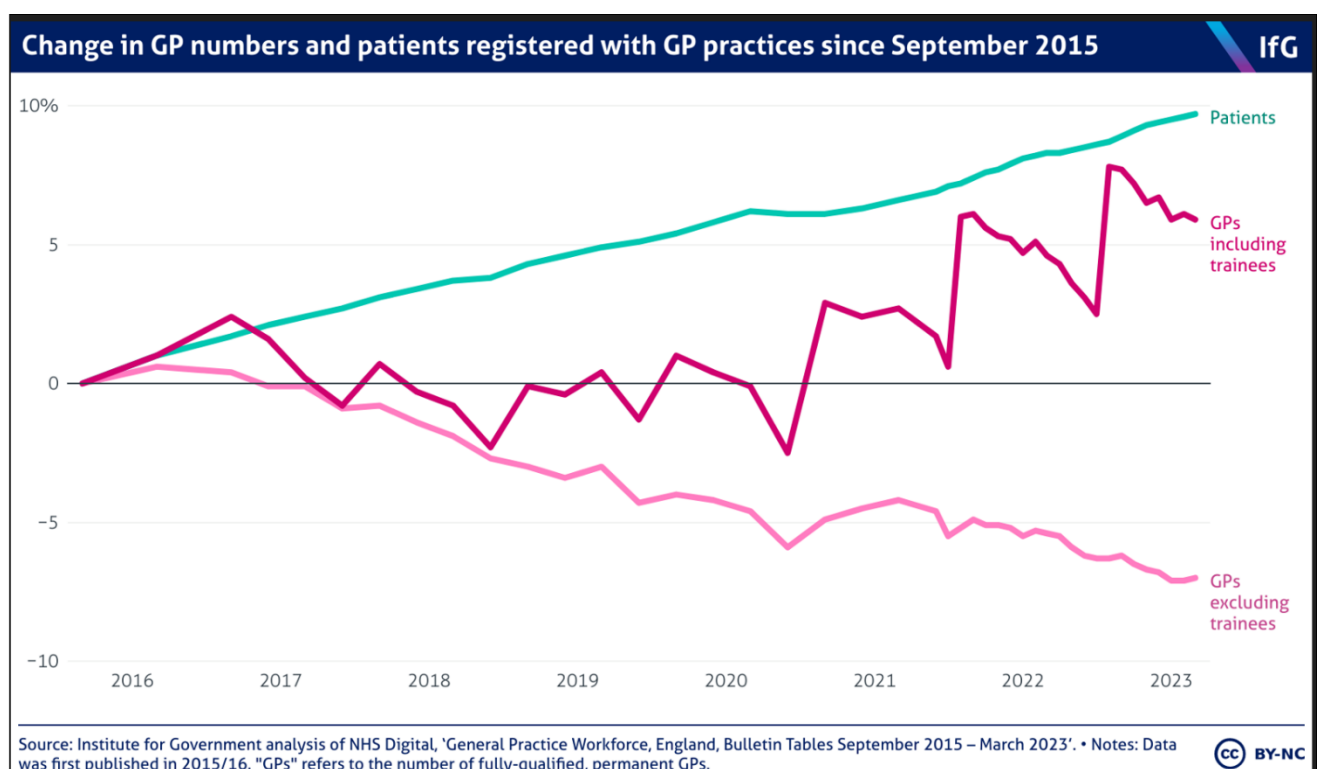
4.9.1 The Primary Care Workforce

There is a slow growth of permanent, qualified General practitioner numbers despite high numbers of doctors entering GP education, with only 27% intending to work full time as General practitioners one year after qualifying, and the long-term picture shows only 5% stay in general practice after ten years (Kings Fund 2019b). The Kings Fund (2019b) surveyed GP trainees and found that 69 per cent of those responding stated that the working day's intensity is an issue, balancing against managing the general practitioners' wellbeing and the risk of burnout alongside delivering excellent quality patient care. The survey (Kings Fund 2019b) discusses the reasons, including a lack of staff, the increasing complexity of patients, partly due

to an ageing population, high, unreasonable expectations from the public to cure all, against policies encouraging self-care and reducing referrals to hospitals. Kings Fund Report (Kings Fund 2019b) concludes that a GP trainee wants to see change and spend longer with patients for quality performance. The British Medical Association conducted a study in 2021 with 2050 GPs and found that 51% were experiencing mental health issues, including burnout, 47% were planning to reduce their hours, and 16% were planning to leave altogether. The British Medical Association (2021) states that 6,000 were to be recruited centrally by 2024, yet there are 1,744 fewer than in 2015, with 1,139 leaving General Practice in 2021 or working reduced hours. Whilst patient numbers were up by 1,918 per practice, despite fewer GP practices, face-to-face appointments now up to two-thirds of all contacts.

The following graph shows how patient demand has increased while GP numbers have decreased. The population has become more complex than in 2015 and has significant inequalities, with many struggling financially. The data from NHS Digital (2024) shows that qualified GPs were leaving practice.

Table Eight Graph showing changes in GP numbers and patients (NHS Digital 2023).



4.9.2 Recruiting the Wider Primary Care Workforce.

Participants discussed recruitment of the broader workforce in primary care mental health, such as the practice nurse, receptionist, and new roles, including advocacy and social prescribers. Heaslip et al. (2018) examined the benefits of Values-Based Recruitment, reflecting the need to recruit people into the NHS and Higher Education programmes. Heaslip et al. (2018) discovered no studies recruiting medical students, one in mental health social work (Anghel, Ramon 2009) and one in adult nursing (Rhodes, Nowata 2011). Heaslip et al. (2018) found that value recruitment benefits candidates, service users, and services, and one potential reason for the lack of research in this area was that some nurses opposed service user involvement. Community participants thought it was important that both the GP and the patient, so the GP had the right attributes to undertake relational care. In partnership with the community, recruitment would identify characteristics such as character and personality to determine resilience and values.

'....Some people in primary care shouldn't be in primary care. Yeah, yeah. Yeah, I'm sorry, but some people are not suitable for that profession '.

Participant Thirteen

A community solution was to ensure local practitioners have the same personal values and behaviour outlined in the NHS Constitution (NHS England 2013) and Values-Based Recruitment Framework (Health Education England 2016).

Recruitment is an issue in the UK, losing one in twelve newly qualified general practitioners. The General Medical Council workplace survey (2024) found that 37% of GPs wanted to leave the NHS due to burnout and workload.

4.9.3 Receptionist

Receptionists who understood the issues locally and were linked to local professionals and resources were desired. Offering a good welcome at reception and being approachable was seen as vital. Time with the GP was short and precious. However, time in the waiting room was often long, and with the right staff, it became manageable.

".... you have to go through somebody to get to the doctor. That's quite difficult."

Participant Five

There was much discussion with participants, both in the focus group and in the interviews, about the atmosphere of the surgery and how important access to the doctor was. The receptionist was seen as a vital primary care team member with power and influence on those with lived experiences and addiction. When asked about the receptionist, a community participant with lived experience shared how they were signposted to another part of primary care,

“....There’s one woman in particular who, if you’re not dying sort of thing, it’s hard to get an appointment. They’ll say.... the person at the pharmacy diagnose you.”

Participant Two

Medication and condition management information was not readily available in the reception area. Participants wanted privacy, as waiting rooms were public spaces. Participant Two shared how they did not like public cross-questioning or sensitive questions in the reception area, which could be upsetting.

“.... What are you here for?”

Participant Two

The focus group believed listening, being friendly, genuinely interested, courteous, and sympathetic skills were essential. All participants thought receptionists should be able to get appointments quickly and recognise those in mental health crises. Receptionists were the first point of call and influenced consultation with the GP or nurse. Participants Nine and Seven shared their experiences.

“.... the receptionist can be quite rude.... I know they have got to gather a certain amount of information to know.... whom to prioritise, and I think also the receptionist should have a certain manner about them. A lot don’t. But that’s the first point of contact you will see when you go to a GP for surgery. So, I think that’s important. You know that they are welcoming because if you don’t feel welcome in reception, you’ve got a few reservations about who you will see next.”

Participant Nine

“.... it’s difficult to get past the receptionists. But when you go to the doctor, they’re almost isolated.”

Participant Seven

Examples from community participants with lived experiences showed frustration when asked why they were ill and struggled to get appointments and also found the telephone system was complicated.

“.... you can ring, but you can never get through.”

Participant Six

Medication and accessing repeat prescriptions were essential functions during the pandemic. Participant Two shared their brother's experience.

“... went to the chemist to get his prescription and was told had not been done and had to go to doctors. The first thing they (doctors) told him to get out was didn't have a face mask, so if you now want a repeat prescription, you have to ring up and should have been told by text or e-mail, but my brother has neither, so he didn't know he had to ring up told to go and ring up my brother didn't know so asked if on this occasion - Can we just do it now? - No, you have to go away and ring up - so can I speak to a Dr - no, you can't - I think it's an emergency - so the receptionist said - I don't think it's an emergency. He had to go and stand outside twenty feet away from the desk to ring them up - to get his prescription. Where is the logic - Now that he knows that he has to ring up for it, he can do it from now on for them to say it's not an emergency. You're not qualified to say if it's an emergency or not. He can't wait several days without his meds.”

Participant Two

The idea of the receptionist being vital in setting the atmosphere within primary care was repeated.

“.... I think when you walk into reception nice to see a smiley face. How can I help you, please - that initial contact? That initial bit before you go anywhere. The reception is not right. It puts you off straight away, and some people should not be on reception.”

Participant Thirteen

Participants discussed the workforce in primary care, with a perceived need for more doctors and practice nurses to enable quicker appointment times. More permanent doctors were preferred instead of locums, as participants valued continuity, leading to trust. Specialist advice or experience was not always available from the GP surgery.

Four participants working at senior levels within primary care were unclear on what primary care workers understood as their role and purpose. Participants with lived experience required support to manage the complex system, and participants suggested social prescribers could navigate the community.

4.9.4 Social Prescribing

The social prescribing role is new to primary care, and experienced participants from the third sector emphasised the need to grow and develop the service engaging primary care. The focus group believed there was a need to promote social prescribing to GPs to raise awareness. Community social prescribers in primary care (social roles) encourage GPs to refer to the third sector. They enable GPs to focus on medical problems instead of social ones, which take time, helping social prescribers encourage and support self-help by drawing on strengths. The findings showed that self-help is vital to individuals with lived experiences and their family's wellbeing at a micro-level. Self-help and access to primary care for health workers are also as important. The literature showed that self-help is particularly relevant to those at risk of mental health, and the interviews reflected on how insight and intra-psychic beliefs work as adaptive coping mechanisms. The evidence base for social prescribing is currently weak, and its impact is unclear partly due to a lack of standardised measurement and evaluation (Kiely et al. 2022, Foster et al. 2021). However, partly due to the role not being understood, social prescribing cannot plug a gap in the GP workforce. It is a supplementary offering of needed support within the surgery, whether social prescribing or an advocacy role to those with lived experience and those who use primary care.

4.9.5 Advocacy

The focus group discussed the advocacy role of supporting patients who may not feel confident enough to stand up for themselves and negotiate a complex, disjointed system. The role encourages patient and third-sector support staff to work together to ensure the best possible outcomes. Advocates in primary care could accompany the elderly and more vulnerable with appointments and support access to translators. Advocacy was raised when inquiring about what you advise someone attending

primary care for a consultation with a GP. A participant who was an advocate explained,

“.... If I was supporting someone to go to the GP, then I would ask if I could advocate for them - a mental health advocate that would be something that I would feel would be necessary - if someone was really poorly, there was, I suppose, have to settle for anybody, whoever was there (talking about GP if unable to see regular), but I would make sure they listened.”

Participant Eight

Advocacy is described as having positive outcomes to people with mental health who have had earlier poor experiences.

“... The GP doesn't usually listen, and it's quite strange how those change when somebody is there. Because afterwards, they've said that they've never spoken to me like that before. They've never listened like that before.”

Participant Eight

The idea of advocacy in primary care on behalf of the patient does not appear to be explored in the literature. However, it is recognised the pandemic was incredibly stressful to healthcare workers. A General Practice nurse role called the Professional Nurse Advocate offers restorative clinical supervision and leads to quality improvement (Brookes 2022). Advocacy is essential to those who do not have trust or require support. It provides a significant opportunity for friends, relatives, friends, and those trained to support and broker their loved one's care.

4.9.6 Practice Nurse

Participants gave positive responses to practice nurses. Participant Ten shared their positive experience and said they enjoyed the holistic experience.

“.... So, I do get the feeling. Again, this might be a bias towards nurses. I don't know that a bit more holistic than focused.”

Participant Ten

Participant Ten sees the integrated approach from practice nurses as positive.

“.... it takes account of the whole, the whole thing.... a bit more to it, you're not just a statistic going in and out of the door when you 10 minutes slots I

suppose that thing, whereas, although they still have slots it never feels as rushed.”

Participant Ten

Practice nurses are crucial members of the workforce who know little about mental health, and there is an opportunity for their future development. They are integral to the primary care workforce, having transferable skills and specialist knowledge when needed. Opportunities include working with co-morbidities such as diabetes and anxiety, backaches, and depression alongside offering expert physical and mental health care to dual diagnosis, mental health, and learning disability. Newbiggin et al. (2018) found that 5% of practice nurses have mental health education, which is not a priority in primary care mental health care literature. Participant Twelve drew on their experience regarding the gap in knowledge regarding mental health, bridged by teaching competencies in mental health.

“.... I think that if teaching competencies and mental health. That would make a real difference to that practice nurse workforce needs to be thinking part of the education and training because it just isn't there now.”

Participant Twelve

“....I never got anything - embarrassed to admit, but I probably have people in consultation rooms displaying emotional and mental ill-health. And I didn't even recognise it, and I did not know what to do with it, which is a gap. Yeah.”

Participant Twelve

4.9.7 Pharmacy and the Prescribing of Medication

The level of functioning of services based in primary care changed during the pandemic, causing stress around accessing essential medication from pharmacies and secondary care, as Participant Three expressed here.

“....I'll send prescriptions out to you, and then these people, whoever they were, the people wouldn't deliver the prescriptions to my house – I was worried. I wasn't gonna get the prescription.”

Participant Three

During the lockdown, the community, at one point, only had access to their community pharmacist as several surgeries had a closed-door policy (Parkhurst et al. 2020). Participants with lived experience were negatively affected as they found it

difficult to maintain continuity and access support and treatment. However, there were positive examples from Participant Four after their GP ensured they were contacted and supported by pharmacists throughout the pandemic.

“.... I’ve got a really good pharmacist too. I usually go to the same pharmacist. They dropped off my tablets when COVID was going on - I always speak to her - I didn’t expect it - they arrange for them to get dropped off again - they say, hello, how are you and just give them to me.”

Participant Four

Pharmacists could support prescribing and de-prescribing medication in primary care with the support of pharmacists employed within mental health trusts who can upskill primary care pharmacists in psychiatric medication. Participants found confusion about prescribing secondary care drugs and about advising regarding side effects and discontinuation.

“.... haven’t felt listened to. They don’t really feel that the GP cares. You know, they want to get off medication, but they just keep being given more.

Participant Nine

Participant Five, when feeling unwell, sought medication as a solution.

“.... I go to GP first to get extra medication.”

Participant Five

Community participants with a long history of mental health discussed the differences it made having a GP who knew about mental health medication.

“ I think they’re quite quick. Earlier this year, before the lockdown started, I wanted to talk about lowering my medication mental health medication. After about three days I got a letter to talk about it. Pleased with the response. And the speed the result I got was what I needed.”

Participant Three

All those interviewed who were prescribed medication discussed how discussing side effects was problematic with professionals.

“.... medication I was on, I was having dry mouth and very uncomfortable, and I didn’t know what was causing it. Dr said you might be naturally dehydrated - there is no living thing on this planet that is naturally dehydrated - I saw him, and he pulled out a massively thick book, flicked through it, and said, like what medication you on went on through said - it is a side effect. I hadn’t thought of

that. I thought side effects were from the start when you first start using the medicine. He said no, it could happen anytime. You're using it. You can bet on it for years, and suddenly it can start - all the time as we lessen the dosage that I was having and the frequency that side effects eased off."

Participant Two

Participants discussed how it took longer than 24 hours to sign urgent psychiatric medicines, including side effects detrimental to those in a psychotic crisis. Experiences of people being prescribed medication contraindicated their condition included those affecting the liver prescribed to alcoholics. Participant Three shared how they would go to the GP to get their prescription of Sodium Valproate a drug prescribed in secondary care and difficult to access during lockdown. Participant Three experienced a lack of knowledge on prescribing and management of side effects in primary care as the GP was unfamiliar with what was discussed and agreed upon, causing delays in prescribing,

"... and so, I go to the GP surgery I have to say," Please," put a note on for the doctors to say I've had a discussion re problems pregnancy - I know all side effects so if I don't have that note in, I won't get the tablets in time."

Participant Three

Reviewing medication and not understanding the impacts of dependence proved how important communicating messages is for morale. The individual GP and their value system, experience, and skill level indicate that those who use listening and pragmatic skills, while others who do not always use them through personal choice, are driven to reach the prescription pad.

"... latest experience was the last one, and I think it was six months ago, where ...X... was pacing up and down the surgery room. The doctor had his back to them, typing away, knowing that ...X... was struggling. Just talking negatively, I'm not, I'm not giving you any more diazepam staying low, negative, negative ...X.... up and down having a bit of an anxiety attack, he

just sat with his back to her and then said right ...X... And that's it. Your prescription will be ready at the chemist, and off ...X.... went. It was an awful experience."

Participant Seven

Participant Five believed prescribing had improved in primary care.

".... he put me on the lowest one and see how we went along - I was on it for maybe two or three rounds."

Participant Five

Alternatives to medication include advising the use of a book on CBT (Cognitive Behaviour Therapy) to prompt a decision about accessing therapy for Participant Five when in the initial stages of depression.

".... they used to give antidepressants as such and didn't really have an understanding of it, yet you're giving out medication. They don't do that as much, as far as I'm aware."

Participant Five

Medication was often used as the first choice in primary care mental health, and it was a challenge to those who wanted to reduce their medicines at annual reviews following discharge from secondary care and the psychiatrist to primary care. Participants with lived experience and addiction expressed the view that the primary care workforce could not review and prescribe medication. The literature recommends not starting antipsychotic medications in primary care for a first episode of psychosis unless done with a consultant psychiatrist. As a result, psychiatric drugs have become unfamiliar to primary care (NICE 2014). There is little literature and evidence on when to stop these drugs. Participants found medication was used to alleviate their symptoms instead of personal narratives being listened to. Participant Three described their medication as an.

"... emotional crutch."

Participant Three

4.9.8 Summary

Medication management is a disconnect between the prescribing of psychiatric medications in secondary care and the day-to-day support offered by primary care.

The disconnect showed communication problems between services and gaps in knowledge by GPs about the drugs used by psychiatric services, their side effects, withdrawal, and dosage alongside the management of a psychotic crisis. New skills were needed to communicate the impact of medication and to be able to explain potential side effects, withdrawal and whether they can be discontinued or alternatives to medication.

4.10 GP Education

4.10.1 GP Expertise

The focus group discussed the expertise and how the expectations of the general practitioner were high, being seen as someone to supply answers and solutions to any query. Participants wanted their general practitioners and staff to have personal skills, be approachable and non-judgmental, and have a combination of knowledge, compassion, experience, and personality.

4.10.2 Gaps in GP Education and Mental Health

The focus group described gaps in the knowledge of GPs and the primary care workforce, including finding and managing psychotic crises, prescribing, and early detection. The focus group agreed there is a need to reassess GP education to include primary care mental health, social prescribing and dual diagnosis of mental health and addictions. There was a discussion on the need for general practitioners to understand what triggered mental ill-health. Participant Twelve had two children who were educated to be GPs, and they compared this to their nurse education thirty years ago.

“.... I was a Practice nurse specialist in diabetes on child health - I never had any learning or support on how we support people to deal with the effects of the psychological, emotional, and mental health of living with a chronic disease and what that might mean to you, your lifestyle and your home life and they're still lacking in that area..... both junior doctors' ones on a psychiatry placement. They both did a day's worth of Mental health Training in their medical training. Ridiculous.

Participant Twelve

Participant Twelve raised the skills needed by GPs to assess and ask a question about significant relationships, their social situation and how people were feeling,

“..... Because they’ve been nudged very much into behavioural science, they do not remember looking at someone in a bed; you’re looking at how that person will manage their lives when they go home. What got them into the bed? Yeah. You can give them all the diet sheets you want, but if they can’t buy the carrots, they won’t.”

Participant Twelve

4.10.3 GP Education and Recovery in Mental Health

The participants described GPs and their workforce as either hindering or helping recovery. Factors relating to hindering recovery included the inability to respond to a psychotic crisis, failure to respond to dual diagnosis needs, and confusion around roles within the third sector, such as social prescribing. Giving lifestyle advice was seen as an essential skill, with some GPs being more skilled than others (Astaire et al. 2024). The literature shared that undergraduate practice nurses and GP education do not always teach competencies in mental health. The impact of health inequalities and adverse childhood experiences have affected the community as a whole, with primary care ill-equipped to respond. To help recovery by engaging with the community, awareness and ability can be drawn upon to develop education, including co-produced case histories. Community experts with lived experience teaching within practices, communities, and universities pre-registration and at the Continuous Professional Development level were recommended to aid understanding of mental health and its impact.

4.10.4 Soft Skills

Participants defined soft skills as character traits needed to ensure relational care enables relationships and complements GP or other primary care practitioners’ abilities. Professionals develop knowledge and skills to manage complexity over time, and helpful soft skills include being genuinely interested, being a good listener, and showing understanding and empathy. Participants expressed the need to be fair and firm and to focus on the positives, what people can do, instead of what they cannot. Participants with lived experience wanted humour and support to gain pragmatic

solutions, with expertise being critical. Younger, inexperienced GPs could be unrealistic, assuming all problems could be solved. The group wanted GPs to support and enable them to find solutions and encourage self-help so people can build on their resources and strengths.

4.10.5 Communication Skills

Communication and confidentiality are critical to the trusting relationship between GP and patient and are valued when discussing mental health. Participants thought GPs and their staff, who had education on how to recognise the early signs of mental ill health, enabled trust in their knowledge and expertise when participants' mental health deteriorated. Professional participants did not openly acknowledge the gaps in their understanding of their physical and psychological health. Community participants with lived experience had self-help strategies and built on their wellbeing including reflecting in positive, supportive environments, whether virtual or physical. Participants actively sought GPs who could support them and would doctor shop to seek understanding practices. Participants believed motivational techniques combined with the existing knowledge base would support recovery in primary care. There were difficulties in managing and tracking communication between different agencies and local treatment pathways that had been developed without the community, causing disconnects.

Knowledge management and engagement with the local demographic population would challenge jargon and communicate what is otherwise complex information. The soft skills participants required from GPs involved building rapport, understanding, and genuine interest by demonstrating they were good listeners. Being a "fair but firm" GP enabled a focus on the positive of what people can do instead of what they cannot. Participants wanted a genuine personality, one who could laugh, and there was an emphasis on this point, not at you, but 'with you' at appropriate times. Skills focused on solutions from experienced practitioners were wanted, as not all participants believed all problems could be resolved. Using an approach to building on participants' strengths and personal resources was desired

instead of focusing on their weaknesses. The discussions found these views were developed through experiences with both current health and the benefits systems. Those with lived experience particularly valued eye contact and positive non-verbal communication, as demonstrated here by Participant One, as body language and practical communication skills demonstrated empathy and understanding.

“.... I feel like they care- not from a script. It makes a difference - sometimes you talk and feel like you’re talking to a wall. They’re not listening, just asking questions, tick, tick, tick, tick, tick. It makes a real difference to mental health - I rarely have 10 minutes, so I never shut up - Some doctors even barely look at me looking at the computer or scribbling a pad. They’re not acknowledging you’re in a room. So, when they’ve got the eye contact, that straightaway is a positive body attitude rather than arms crossed, and why are you in my office?”

Participant One

Participant Nine had previously changed surgeries and discussed the importance of listening experienced at their new surgery.

“.... He (the new GP) actually round to me and looked at me....the right language. He asked questions in response to what I was talking to him about. He even asked me if I considered certain things - he was listening to what I was saying. At that time, I saw a few different three different GPs. I had a really good experience with them, but I would go to the same one, for that particular one, because he listened. Yes,”

Participant Nine

Participants appreciated they were listened to through simple acts outlined here by Participants Fourteen and Thirteen.

“.... the VDU screen pointed towards you. So, you can actually see what is on the screen. Now, ask your permission if you want to see what is on the screen. And I always say, yes, but it takes away that barrier you’re not typing on a screen out of your vision. If he types on the screen, he does it in front of you, and He will check that. You know what you’ve said is what is recorded. And it’s

not just him. The practice nurse and the one who takes the blood phlebotomist do it.”

Participant Fourteen

“.... Body language is important..... That’s important to me. That’s what came across from my GP: genuine interest in how you do it, genuinely interested in body language, facial expressions, and how she talked to me. You can tell when someone is not really interested in you when they’re telling you to know what I mean?”

Participant Thirteen

The findings showed that empathy consists of three soft skills: listening, nonjudgment, and positive body language. The community valued expertise and honesty and did not want inexperienced staff to think all problems were resolvable. Those with lived experience believed this was unrealistic and wanted support to learn how to problem-solve and build on their strengths. Participants with lived experience considered that the benefits system was constructed on weaknesses and hampered recovery.

Participants with lived experience discussed having conditions including Autism, Asperger’s, literacy skills, learning difficulties, hearing impairment, incontinence and age-related cognitive difficulties. All were co-morbidities with mental health alongside side effects and dependence on medication. A recurrent theme was a lack of access to understandable information in the consultation and good communication from primary care practices. The inability to engage with specific demographic groups and people with various conditions in primary care was a key finding as to why there may be a disconnect between primary care and the community. One example given was sending letters for appointments to a participant with mental health and mild learning difficulties who did not understand the letters’ purpose and missed invaluable health checks and appointments. Those with lived experience avoided opening letters, if possible, as they believed they had terrible news.

4.10.6 Educating the Wider Primary Care Workforce.

Staff in primary care include the receptionist, nursing, and ancillary staff. Participants wanted the team to be customer-focused, positive and focused on the strengths of what people can do instead of what they cannot. Receptionists need customer service skills and mental health awareness as a preventative measure to stop doctor shopping. The interviews show doctor shopping is caused by not being listened to, heard, or understood. Customer service skills were essential to all staff, leading to improved engagement with the local community to reduce stigma and redress perceived imbalances in diagnosis, age, socio-economic status, and education. Recommendations included working with the community to offer information on what the community and the surgery can offer. Listening to the community supports understanding the age-related needs of patients and nursing staff and enables those with disabilities. When English is not the first language, and there are diverse cultural interpretations of mental health, primary care struggles to meet mental health needs. Engagement and participation from the community ensured issues were addressed and solutions were offered from a diverse range of experiences to reflect a bio-psycho-social-spiritual-cultural model of care. Understanding and responding to those with specific communication needs, often presenting as additional needs, is an area the community can support.

4.10.7 Primary Care Workforce Ability – Hard Skills

Participants found a range of complex skills missing in the primary care workforce, including recognising potential dangers such as psychotic crisis, suicidality, medication management and early diagnosis. Understanding and enabling recovery through skills such as motivational interviewing were essential when working with mental health. All participants had experienced both psychological and physical ill health. Participants with professional backgrounds showed a lack of understanding of their own psychological and physical health deteriorating. Despite hearing traumatic stories and seeing traumatic incidences increase, supervision and debriefing were not standard practice. Reflection and personal mental and physical health complaints were ignored. Teaching GPs and their staff to self-care for themselves and each other would be beneficial, and lessons can be learned from those who manage their conditions daily.

“.... it was about October that I started to feel unwell and battled through it till just after Christmas. Then, of course, I started having what I recognise now as panic attacks, palpitations, chest pain, and all the other things that go along with it and went a couple of times to A&E. The second time I went to the doctor, his personal opinion was that I was just stressed out to the max.”

Participant Eleven

Communicating complex medical concepts that the patient understands, underpins the consultation process.

“.... communication is vital between the patient, underpins the trust, respect, and treatment if you can communicate with your patient.”

Participant Eight

Engaging with the community ensures information will be innovative, transferable, and beneficial to those it is meant. It provides guidelines requiring the dissemination of information to be enacted, as this is a disconnect between the community and primary care. Managing stress and trauma with empathic statements fits neatly into a consultation approach known as Hellmann's Folk Model (Helman 1981), which focuses on the patient's story. Pendleton et al. (1984) developed a consultation model offering empathy while drawing from the patients why they were there by thinking about other problems and using their ideas and expectations. The Pendleton consultation model uses time and resources to establish rapport, ensuring continuity. The added advantage of the Pendleton model is that it brings the patient to work in partnership by listening to their ideas and worries and setting realistic expectations. The model referred to widely in primary care literature is Neighbour (1987). The Neighbour model is a relational consultation model undertaking a five-point approach of connecting, summarising, handing over, safety netting, and housekeeping. Like Pendleton, it uses communication techniques to include the patient and determine their understanding of the problem. It includes summarising to show empathy and ensure the practitioner understands the problem from a patient's perspective. The consultation models were all devised during 5-minute consultations and heavy benzodiazepine prescribing in the 1970s. The benefit of patient-centred consultations is broad and includes understanding why the patient has attended and the ability to

respond to cues and behaviour, enabling the patient to share their hopes and fears (Levenstein et al.1986).

The current model taught in medical schools is ICE, an acronym for 'Ideas, Concerns, and Expectations '. It aims to function as a consultation model template, offering patient-centred care. Patients have a voice to express understanding of their presenting complaint (ideas), worries they may have (concerns), and outcomes they hope to achieve from consulting (expectations) (Matthys et al.2009). ICE aims to give GPs insight and awareness of the patient's life and condition, offering potential support during a mental health consultation. However, despite the broad teaching of ICE in medical schools, there appear to be limited reviews on the impact of this model in literature, particularly relating to mental health.

4.10.8 Links to Learning Theory

Understanding how people behave enables practitioners to react positively to feedback and increases motivation to allow the change required. Building the relational skills of the practitioner enables insight and self-development. The literature supports the findings regarding the practitioner's construct of their behaviour and understanding based on feedback. One way of learning new skills and behaving is by watching and observing others. The Looking Glass model (Scheff 2005) is traditionally used in medical education, where students undertake Objective Structured Clinical Examinations (OSCEs), which are watched, recorded, and assessed by their performance at different stations, such as resuscitation. The medical educators who evaluate them use their medical lens as students move from station to station. The observed practical skills fit into neat diagnostic boxes. However, they differ significantly from the skills and abilities needed to work with mental health and its complexity in communities with different individual needs and responses.

All the community participants were adults and, therefore, had views and biases developed over their lifetime. The participants wanted to share knowledge and be involved in the research. There was a willingness to teach and learn more about their condition in a primary care setting. Adult learning theory is pragmatic and self-directed, so it helps develop critical thinking skills to solve problems for practitioners and the community. Lifelong

Learning theory redresses power imbalances, creating an equal learning opportunity. Social Cognitive Theory overlaps with Behavioural and Cognitive Learning Theory, as it determines how social interaction affects learning. It examines how the person's environment can be adapted to change and regulate behaviours. It does not look at how a person began their behaviour and whether actions address the issues over time. It is a fundamental theory from a workforce perspective, as it offers positive reinforcement and learning through observing others and modelling, enabling positive role models (Bandura, Walters 1977). Social Cognitive Theory is a macro approach where change is created at a societal level through modelling behaviours (Bandura 2001).

The findings showed that either clinical or community leaders could hold positive roles. GPs do not become experts in mental health overnight; it takes many years to build experience. Behaviourism examines behaviour using conditioning (Clark 2018, Illeris 2018) with rewards and targets. Cognitive Theory looks at the individual learner and is more comprehensive than behavioural change. However, it is complex, and there is a risk of not being inclusive as it is time-consuming, with papers discussing the need for 10,000 hours to apply the theory to practice (Sloboda 2007, Kulasegaram et al. 2013). Reflective Learning Theory involves thinking about what is learned, supported by the findings by considering knowledge and beliefs carefully and purposefully. Reflective Learning Theory examines why people behave as they do and their reactions to professional and social behaviour. Recent work in psychology has explored the term 'Medical Gaslighting', with examples resonating from participants in this study of having concerns trivialised, attributed to something else or even ignored by the healthcare provider. There is evidence of bias in the literature on prescribing to Black people who were perceived as 'stronger' (Marano 2022). Reflection helps redress 'medical gaslighting' and offers an opportunity to understand intuitive behaviour from practitioners and build on positive practice whilst challenging bias and discrimination.

Schaepkens and Lijster (2023) evaluated the benefits of medical education

and argued that two gaps play a role in reflection. They confirm the research findings that the gap between theory and practice and the individual versus the communal sense can be bridged by reflection.

4.11 Discussion The Findings and Research Question One

Is there the potential to produce a learning theory for primary care mental health education that considers community perspectives?

The themes and sub-themes were mapped against the learning theory (Appendix Thirty-One) identified in the medical education literature. The research suggests that learning theory can be applied to primary care mental health education and is an essential aspect of a pedagogical framework for primary care mental health. When considering the different perspectives of participants as learners, it is clear that each individual has distinct learning styles and backgrounds. However, all require the same outcomes for skilled, relational care. No single learning theory stands out, so arguably, a combination of theories is needed. Therefore, an inclusive learning theory is necessary to ensure that primary care and the community can agree on priorities to make decisions and affect change.

In summary, the community's perspectives reflect the need for a relational perspective, with listening, understanding, and empathy being essential tools to encourage participation. Producing effective education resolves power imbalances, ensuring the community's needs are reflected. However, the push for transactional care can conflict with the pull of community care, causing a gap between primary care teams and the community.

4.11.1 Objective One

To generate a learning theory that considers community perspectives.

Collaborative Learning Theory is an inclusive learning theory that considers community perspectives and is the strongest theory generated from the findings. It offers an opportunity to learn through communicating and working with others instead of independently and synergises the learning theories in Table Nine (p.184). The

approach relies on people working together either face-to-face or virtually. The Zone of Proximal Development (ZPD) concept by Lev Vygotsky suggests that learners rely on each other to accomplish tasks they could not do alone (Doolittle, 2012).

Complexity can be simplified to develop critical thinking and reflection skills that were needed when experiencing or working with mental health and addiction. Collaborative Learning Theory is an inclusive and flexible approach that can be peer-to-peer, engaging the community or clinicians to lead, communicate knowledge and build leadership skills. The theory can support the policy-driven, integrated, collaborative approach advocated for primary care mental health in the UK. Applying an integrated care model requires community participation, long-term investment, and community-informed policy. Collaborative Learning Theory offers a framework that can help identify people's motivation and learning styles. The framework enables a flexible approach to embrace other theories and adapt to the diverse needs of those in both the community and primary care.

In summary, Collaborative Learning Theory has been proven to benefit educational development. By engaging in collaborative activity, learners utilise each other's perspectives and experiences to solve problems. Collaborative learning can help learners of all levels. Technology can enhance collaborative learning using collaborative technologies, social media, and Web 2.0 platforms. Collaborative activities can occur across geographical, cultural, and language barriers. The following table (Table Nine) shows the mapping of learning theory against the themes to show the benefits of Collaborative Learning Theory.

Table Nine The learning theory was mapped against each superordinate theme and sub-theme to inform the epistemology in primary care mental health education.

Superordinate Theme	Sub-theme	Learning Theory
Superordinate Theme - Impact of Health Inequalities and COVID-19	• Inverse Care Law • Listening to the Community • Transferable Learning • Inequalities among people from Black, Asian and Minority backgrounds • Inequalities impacting mental health during the pandemic. • Inequality, COVID-19 and education in primary care mental health	• Social Learning Theory • Transformative Learning Theory • Reflective Learning Theory
Superordinate Theme- Stigma	• Self-care and stigma for professional participants • Stigma and Diagnosis • Stigma and long-term mental health • Stigma and Inequalities	• Values Based Education • Transformative Learning Theory • Reflective Learning Theory •
Superordinate Theme – Relational Aspects	• Telephone consultation. • Relational Outcomes • Atmosphere within surgeries • Caring and compassion • Empathy and understanding • Insight • Insight as a coping mechanism • Continuity Repeating stories. • Trust	• Values Based Education • Behavioural theory • Social Cognitive Theory • Biological Model • Cognitive Learning Theory • Lifelong Learning • Constructivist Learning Theory
Superordinate Theme- Transactional Approach	• Targets and transactional care • Objectification	• Value-based education • Connectivism

Superordinate Theme – Model of Care	• Doctor shopping • Access and appointments • Improving • Access to Psychological Therapies • Time Pressure • Waiting lists for secondary care • The revolving door in primary care • One-stop service • Complexity • Disconnect • Cultural Competency	• Complexity theory • Cognitive learning theory • Behavioural Learning Theory • Value-Based Education • Social Marketing • Biological Model
Superordinate Theme – Intrapsychic	• Religion Spirituality • Adaptive coping	• Values Based Education • Social Cognitive Theory • Behavioural theory
Superordinate Theme – Primary Care Workforce	• The GP workforce • Recruiting the wider Primary care Workforce • Receptionist • Social Prescribing • Advocacy • Practice Nurse • Pharmacy and the prescribing of medication for mental health	• Values Based Education • Social Cognitive learning Theory (plus emotional intelligence theory) • Behavioural theory • Biological Model • Adult Learning Theory
Superordinate Theme – GP Education	• GP expertise • Gaps in GP education and mental health • GP education and recovery in mental health • Soft skills • Communication skills • Educating the wider primary care workforce • Primary Care Workforce Ability – hard skills • Participation Research • Reflection	• Values Based Education • Social Cognitive Theory • Behavioural theory • Biological Model • Cognitive Learning Theory (plus emotional intelligence theory) • Lifelong Learning • Reflective Learning theory (Dewey) • Transformative learning theory • Constructivist Learning Theory

4.11.2 Research Question Two

Research Question Two raised concerns about the government's community participation policy in mental health and whether it facilitates policy enactment regarding primary care mental health education. The literature review showed no evidence of policy enactment concerning primary care mental health education. However, it is argued that a community of practice model can leverage the policy. The co-produced community of practice model for primary care mental health demonstrates that it can be achieved and deliver the two related objectives.

The policy referred to is the Health and Social Care Act 2022, which aims to develop place-based partnerships locally, including health, social care, the third sector, and the community. The framework for primary care mental health education includes the framework of 4Pi to identify a clear, shared purpose. Local people will bring in local knowledge and represent the local demographics. A community of practice model for primary care mental health brings an opportunity to ensure communities' needs are met and that population health and wellbeing increase. Feedback from the local community will show whether initiatives work and that all partners are equal. The findings show that online and community services support primary care mental health, and it is crucial to build on existing services instead of starting from scratch, which can be frustrating and disengage the community. A community of practice is specific to an area, and good ideas can be shared at a scale if identified as a priority. Integrated Care Services will be able to release the budget to enable the model to be resourced. Leadership at a community level will ensure collaboration on an equal footing. Paulo Freire (2017, p.116) shared his experience that incorporating a community allows former leaders to grow with everyone else or to grow new leaders. It is a genuine cultural shift to listen to the 'world views' of the community in primary care mental health education.

4.11.3 Objective Two

To identify the meanings of shared values from the community to develop an epistemology for primary care mental health education.

The interview values were collected and mapped against superordinate

themes and sub-themes (Table Ten p.188). This process ensured that the values-based pedagogical framework was credible, accurate, valuable, and aligned with the values of the participants interviewed, ultimately contributing to the development of primary care mental health services.

Curriculum design is influenced by different epistemological perspectives, with specific views being more important to participants than others. For instance, listening and understanding were priorities in building trust in relational care. At the same time, the understanding of medication and side effects for those on antipsychotics was a priority for those with lived experience of psychosis. The curriculum emphasises a collaborative approach with real-world problem-solving to manage the complexity of primary care mental health using a social constructivist approach. Primary care mental health is influenced by the social determinants of health (Wilkinson and Pickett 2019, Health Foundation Report 2018).

The COVID-19 pandemic impacted on the social determinants at all stages of life. However, the community is not passive in response and actively seeks better services through "doctor shopping" and making complaints. Unfortunately, the increased use of private healthcare by those who can afford it is creating a two-tier system and adding to the struggles of the NHS. To be effective, community participation requires more than just token engagement; it needs to involve research conducted by the community to overcome existing barriers and contribute to a future solution (Beresford 2013, Beresford et al. 2018). Epistemology is therefore focused on social engagement on equal terms within a group setting to engage, build, and embed new knowledge.

Primary care mental health is complex, and the recommended approach for a pedagogical framework requires reflection and critical thinking. Evidence needs to be evaluated, and alternative ways of managing complexity were found to understand and manage the knowledge gained. A values-based approach to medical education includes placements with patients to increase contact and knowledge of health's social determinants, as Biswas et al. (2020) argue. A further key factor is recruitment, with placement being a key post-qualification factor (Amin et al. 2018). The

participants in this study had varying beliefs, backgrounds, and needs. The pedagogical approach selected was collaborative learning theory to create a theoretical framework for primary care mental health that reflected both the participants and the literature. The theoretical framework acknowledges reflection and practicality to address real-world issues and challenge biases and assumptions. The skill-building component encompasses interpersonal and creative approaches to managing stress, while emotional support is provided through understanding and translating values into action. The recommendation is to implement a community of practice model underpinned by Collaborative Learning Theory and a values-based framework for education.

Table Ten Superordinate Themes and Sub-themes Mapped against the Values

Superordinate Theme	Sub-theme	Values
Superordinate Theme - Impact of Health Inequalities and COVID-19	• Inverse Care Law • Listening to the Community • Transferable Learning • Inequalities among people from Black, Asian and Minority backgrounds • Inequalities impacting mental health during the pandemic. • Inequality, COVID-19 and education in primary care mental health	• Engagement • Access to resources • Power • Access to Opportunity • Participation • Autonomy • Community status
Superordinate Theme- Stigma	• Self-care and stigma for professional participants • Stigma and Diagnosis • Stigma and long-term mental health • Stigma and Inequalities	• Anti-discriminatory • Practice • Equality • Choice • Attitudes • Listened, heard, and understood. • Power imbalance •
Superordinate Theme – Relational Aspects	• Telephone consultation. • Relational Outcomes • Atmosphere within surgeries • Caring and compassion • Empathy and understanding • Insight • Insight as a coping mechanism • Continuity Repeating stories. • Trust	• Face-to-Face - • Compassion • Kindness • Positive experiences • ... Don't judge – do listen. • Listened to • Diagnosed • Trust, Rapport • Empathy • Participation • Continuity

Superordinate Theme- Transactional Approach	• Targets and transactional care • Objectification	• Continuity • Value for money • Reputation
Superordinate Theme – Model of Care	• Doctor shopping • Access and appointments • Improving • Access to Psychological Therapies • Time Pressure • Waiting lists for secondary care • The revolving door in primary care • One-stop service • Complexity • Disconnect • Cultural Competency	• Participation • Community strengths • Community leadership • Communication (non-jargon) • Growth • Respect • Self-respect service
Superordinate Theme – Intrapsychic	• Religion Spirituality • Adaptive coping	• Beliefs • Wellbeing • Peace • Love • Hope • Faith • spirituality •
Superordinate Theme – Primary Care Workforce	• The GP workforce • Recruiting the wider Primary care Workforce • Receptionist • Social Prescribing • Advocacy • Practice Nurse • Pharmacy and the prescribing of medication for mental health	• Values Based Recruitment • Connecting
Superordinate Theme – GP Education	• GP expertise • Gaps in GP education and mental health • GP education and recovery in mental health • Soft skills • Communication skills • Educating the wider primary care workforce • Primary Care Workforce Ability – hard skills • Participation Research • Reflection	• Co-production • Community Leadership • Community Teaching • Bottom-up approach. • Values Based Research • Competency • Honesty • Influence • Knowledge

4.11.4 The Discovery and Recovery Tree - Illustration One (p.356)



The Discovery and Recovery Tree (Illustration One, p.191) was built on Table Ten (p.188) to depict the various values, their sub-themes, and how they interconnect. It illustrates how these values can gain or lose importance and emphasises their role in social and relational learning. The principles underlying the tree include respecting individuals and adopting democratic approaches to ensure dignity and respect for individuals and the wider community. The key focus areas were promoting tolerance and understanding to ensure inclusivity and collaboration. The Discovery and Recovery Tree serves as a safe space where the community's values encourage curiosity and provide a response to mental health concerns. Feedback was positive on the Discovery and Recovery Tree as a visual way for members to check values.

4.11.5 Objective Three

To co-produce an educational framework informed by the community and evaluated through current literature.

The co-produced education framework is a values-based community of practice model that uses situational learning and is not new to medical education. Situational learning in the context of primary care education builds on the work of Wenger (1998). The knowledge is gained through social interaction and collaboration, and those on the outside become experts as they become more experienced. Through collaboration, the social construct of knowledge grows. The literature shows a peer-to-peer approach presents an opportunity to redress existing power imbalances through community engagement. Commissioners, clinicians, and providers must collaborate to share knowledge and materials and collaborate more effectively (NHS England 2022d). The conclusion is for a co-produced model using a human and social construct instead of Wenger's traditional, more organic model and the traditional bio-medical approach currently used in health. The approach removes the stigma and enables shared knowledge transfer from primary care to the community domain.

A horizontal learning mechanism challenges the evidenced top-down disconnect between policy, practice and the community and practice. Wenger (1998) discusses how a community of practice can set up new working methods using a horizontal approach to remove professional siloes experienced between primary and secondary care. The World Health Organisation (WHO and Wonca Working Party on Mental Health 2008) thought all staff in primary care must be trained in mental health and be motivated to apply their skills. They also recommended that mental health is included in all curriculums and that there is ongoing support and education. A community of practice model offers an opportunity for the workforce to mutually learn with the community rather than the traditional centralised model.

During the pandemic, the NHS increased the use of technology to engage professionals, and in the future, the community will use a virtual learning approach. There is an opportunity to challenge traditional power imbalances in primary care between patient and doctor, engage in dialogue, negotiate, and manage conflicts.

The adapted community of practice model for primary care mental health reflects the input from the participants to give a community view that includes diversity, experience, and knowledge. An interdependent mutual framework of people can solve problems, celebrate best practices, and learn together to find realistic priorities to impact.

Collaborative Learning Theory facilitates synergy by incorporating transformative co-production, a theoretical approach to creating mutuality between the community and services (Carr, Patel 2016). The aim is to create lasting changes by including those who use primary care mental health services in designing, commissioning, and delivering services. Applying the concept leverages the engagement policy and enables the learning theory of collaboration to respond to widening inequalities exposed by the pandemic.

Primary care mental health is an environment of imbalances, including elevated levels of unmet needs, evidenced by difficulty in accessing community-level support for mental ill-health. Heaton et al. (2016) found that co-production produced insights into a collaborative working transfer from knowledge to practice. A theoretical, collaborative model with community leadership can hold larger bodies accountable and ensure investment goes where it is needed for communities to recover. There is demonstrable evidence between social inequality, social capital, and mental health outcomes. Layte and Whelan (2014) found anxiety over how people stand socially is higher in unequal societies such as the United Kingdom (UK). Professional participants showed little insight into their mental health and were self-stigmatised due to the fear of losing their professional role and fear of professional bodies. Knowledge transfer between the community and those working in primary care includes recognition that mental health affects everyone. The community and health workers were all primary care patients and could share expertise through their experiences.

The recommendation is to establish a community of practice model that offers a pedagogical framework for primary care and mental health. Collaborative Learning Theory can be applied within the model to deliver values-based education.

4.11.6 Design

A pedagogical framework was designed following participants' feedback on the Discovery and Recovery Tree and evaluated through the literature. The design is a positive model of sharing and learning. The learning theory is collaborative, as steered by the literature, and the participants emphasised values. Implementing a community of practice model builds social capital (Lesser, Prusak 2019) by combining social theory, anthropology, and co-production. It requires structural, relational, and cognitive components adapted to include best practices (NSUN 2013) and shape a community of practice model in primary care mental health.

Clarifying and prioritising the values offers a positive environment conducive to discussions supporting wellbeing. There is a need to minimise conflict and integrate intra-psychic beliefs, building personal and clinical reflection to construct a resilient community. Values will differ within each community depending on the context. A co-produced values-based approach enables a focus on local priorities to produce meaningful results that are considered, questioned and reflected on. A community of practice offers innovation through a co-production lens to understand situated informal knowledge and apply Collaborative Learning Theory. The literature showed that policies were unclear on why participation was to happen and how it happened. Outcomes were undocumented, and strategies varied, with few being clear on purpose and outcomes.

4.11.7 The 4Pi National Involvement Standards

This study suggests that a practical framework for mental health education in primary care should follow Collaborative Learning Theory and community-agreed values. Health education standards that outline the knowledge, skills, and behaviours required of NHS professionals are agreed upon. These standards form an ethical framework based on the principle of "first, no harm," which dates back to Hippocrates and is still used in medical schools today.

The values of the NHS Constitution emphasise the importance of maintaining ethical standards while delivering excellence. This also applies to primary care mental health

education, which follows a co-production approach to demonstrate these values. Matthews et al. (2019a) evaluated patient and public involvement strategies using the 4Pi framework developed by the National Service User Network (NSUN) in 2013. The 4Pi framework has five domains: principles, purpose, presence, process and impact. Matthews et al. (2019a) found that no single strategy met all 4Pi criteria. The Mental Health Taskforce 2016 referred to the 4Pi framework for developing and improving mental health services.

The 4Pi framework enables community participation in mental health education at any level, ensuring everyone equally respects and contributes to all values. The 4Pi National Involvement Standards were mapped against the co-produced curriculum to demonstrate their purpose in applying a community of practice model for primary care mental health with the presence of those best placed to know. Members are selected based on the nature and purpose of involvement. Transparent recruitment, communication, reimbursement, support, and education processes were required. Finally, the impact can be assessed on whether the activity made a difference towards achieving the Positive Care Law. By incorporating the 4Pi involvement standards into the curriculum, values-based education can be supported, and rigour can be applied from a "bottom-up" perspective. Education aims to inform and enhance primary care mental health; therefore, it must be community-driven. The 4Pi has been integrated into the primary care mental health pedagogical framework to ensure measurable participation at all levels.

4.11.8 Moving 6Cs to 9Cs.

NHS England and Higher Education Institutions offer a values-based framework of a strategy for care called the 6Cs, which incorporate care, compassion, courage, communication, commitment, and competence. The 6Cs were initially established by Sister M. Simone Roach (Kravitz et al. 1975, Roach 2013, Bradshaw 2016), who acknowledged that caring and its components are moral virtues. An inner motivation to care is not a commodity or management tool (Bradshaw 2016). The findings reflect the original spirit of Sister Roach and the wisdom of Tudor Hart (1971) and recommend three more Cs, community, continuity, and collaboration, to be applied

as a professional standard for the NHS. This enables the 9Cs to move towards the Positive Care Law. The pedagogical framework for primary care mental health has the values and framework to ensure why collaboration with the community is needed and what needs to happen alongside an ethical framework supported by the 6Cs.

4.11.9 Contributing to New Knowledge

An example of how adopting the 9Cs is helpful in a primary care setting can be seen with the issue of jargon. It is more than a barrier; it can be managed if the 9Cs are applied. Participants shared the need to ensure communication is in a non-threatening environment with a non-jargonised approach (Kurtz, Silverman 1996). Applying standards can bring together different communities and disciplines to work towards common goals. Standards provide a flexible and accessible framework that can help achieve desired learning outcomes. In the high-pressure environment of primary care, the 9Cs framework can streamline processes, increase efficiency, and provide standardised solutions that meet the needs of patients. This can help build confidence within the community and improve the reputation of primary care. Additionally, the 9Cs framework provides a common language that can facilitate the transfer of information, accelerate innovation, and establish a community of practice model for mental health in primary care that encourages collaborative working to ensure that all outcomes are fit for purpose.

Illustration Two The Nine C's – the three added Cs are in red.



4.11.10 Summary

The evidence shows that local community leadership can address local health needs. My study proposed community participation within an educational framework to address complex issues the health service struggles with. The literature showed these included inequalities and the need to improve community mental health and wellbeing. A participatory, theoretical model at a neighbourhood level with primary care networks can hold larger bodies to account. This will ensure investment goes where needed to offer an opportunity in communities, Social Care, and the NHS to recover from COVID-19 and austerity (Papanicolas 2019). The demonstrable evidence was social inequality, social capital, and poor mental health outcomes resulted in anxiety over social standing in unequal societies (Layte and Whelan 2014). The developed framework needed to target awareness and strategies to

improve individuals' health directly and contribute to community social capital. Reinforcing the beneficial role of personal social capital (Rocco, Suhrcke 2012) through policies will enhance social determinants of health at a local level (Fidler, 2010).

Education in community venues rather than health facilities can provide more space and opportunities for building social capital. The community of practice model can potentially define primary care mental health. However, conflicts may arise during participation, which need to be managed with the right people and ethical standards. Feedback from clinicians and senior administrators suggests that the community of practice model for primary care mental health can lead to more positive and equal experiences, with the narrative taking place with their GP on a similar level. Despite this, a lack of knowledge, stigma, and insight can prevent professionals from seeking prompt help for their own mental and physical health issues. Therefore, an ethical learning framework should be implemented for personal narratives. These will build self-awareness and knowledge of where to access timely support in a confidential, supportive manner.

Values-based ethics are essential for primary care education as they influence attitude and behaviour. They can provide a helpful framework within education and set standards that all can adhere to within a community of practice model. This study recommends using the 4Pi framework, which is set by service users, along with the moral competencies of the 9Cs. An ethical framework ensures values are reflected on and applied. The Collaborative Learning Theory encourages the practitioner and the community to recognise the diversity and complexity they are surrounded by. Using values-based ethical processes enables exploration and opens the opportunity to discuss, understand and transfer knowledge. The impact is to allow the community and the primary care workforce to scaffold what they know and challenge complex issues.

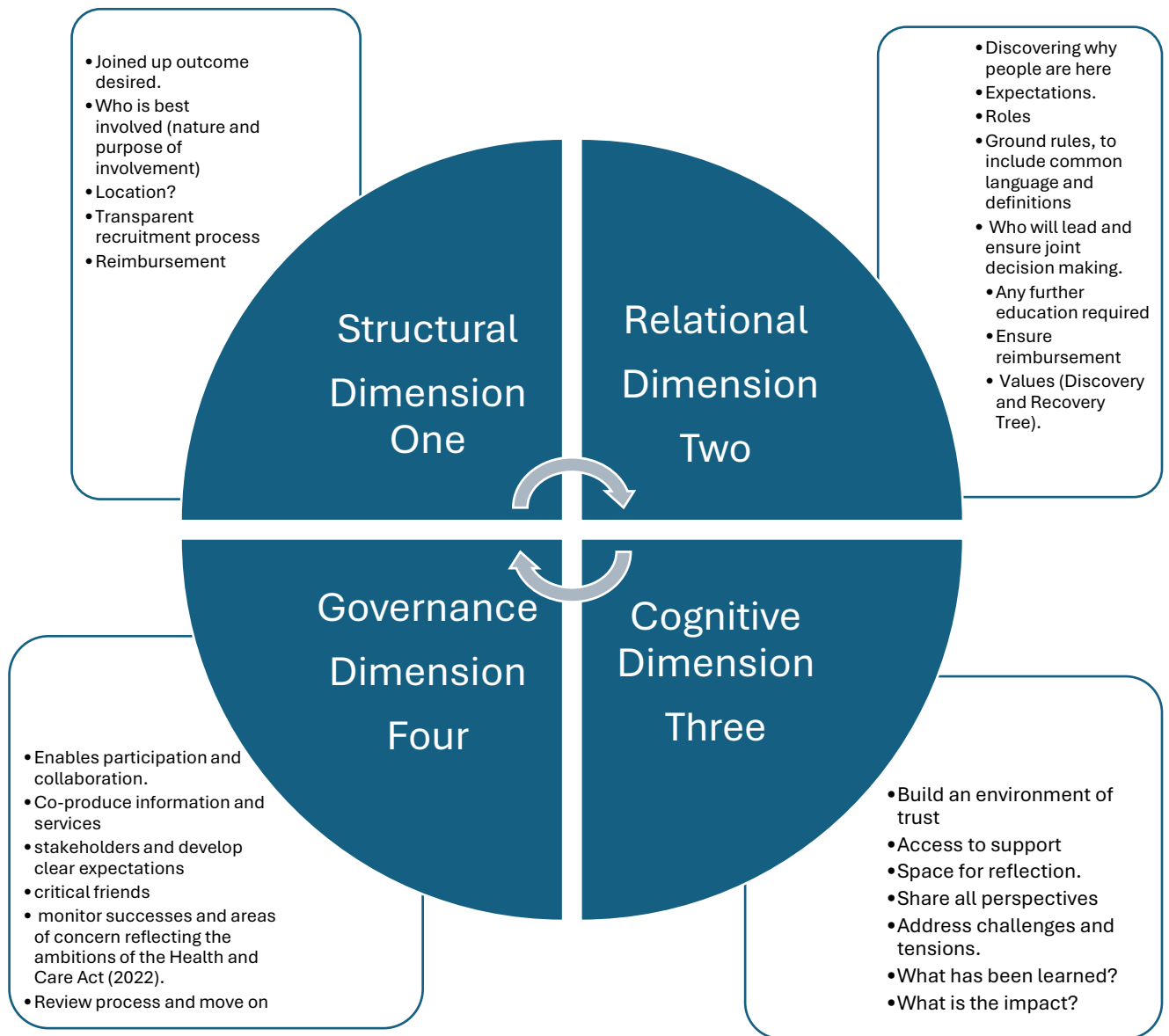
4.12 Applying the Community of Practice Model for Primary Care Mental Health

To enable the underpinning of Collaborative Learning Theory, apply the values, standards, ethics, and governance in the community of practice model for primary

care mental health. Illustration Three shows the main components of the community of practice model for primary care mental health without detail. The model includes Collaborative Learning Theory, Values, Underpinning standards (4Pi), 9Cs, and an Ethical Framework based on values integrated into four dimensions of a community in practice model. Each part interacts with the model to form a community of practice model for primary care mental health. The four dimensions are: Structural, Relational, Cognitive Level and Governance. The model works through the cycle outlined below.

-

Illustration Three Community of Practice Model for Primary Care Mental Health



Underpinning the model

Participation Standards 4Pi,

Integrated Health Standards 9Cs,

Integrated Values, Discovery and Recovery Tree (p. 356)

Collaborative Learning Theory.

4.12.1 Dimension One. The Structural Dimension

Dimension One involves building social capital by identifying who is best involved, determining the location of involvement, and establishing a transparent recruitment process that reflects the 4Pi standards (NSUN 2013). The Structural Dimension involves identifying the people who are best placed to be a part of the community of practice model due to their knowledge and connecting them. To offer a point of reference and networking externally with people who can support learning. To recruit the right people and identify the environment where the community of practice will be based. Is it to be established within primary care or the local community? The environment also needs to address issues such as hierarchy and power imbalances. It can be intimidating for communities to have their doctor and senior staff using jargon, but the environment can support engagement from the local community.

A clear leader is to be elected from the practice group's communities. Remember that professionals and the community will have their reporting methods to their peers and organisations.

The research found that the systems were complex, so it is essential to ensure support from the organisation or body being represented. Dimension One aims to counter resistance, ensure commitment and support from the organisation on recommendations moving forward, and establish a clear joined purpose, depending on the nature and purpose of involvement.

4.12.2 Dimension Two. The Relational Dimension

The second dimension is relational and builds rapport to develop understanding, empathy, norms of behaviour, shared values and a different kind of transactional relationship built on trust through listening.

Developing inclusive education is recommended to redress the social determinants of health influenced by unequal health and economic opportunities. Communities of practice create a sense of belonging and build trust through engagement, underpinned by values. Participants with lived experiences showed how critical relational care is to prevent re-traumatising by having to repeat harrowing experiences. Relational care reflects the human side of primary care, and the findings showed participants sought it through seeking alternative providers, termed doctor

shopping.

The relational dimension examines why people want to work together and who they are. It focuses on re-examining relationships and maintaining parameters through creating safe spaces for sharing and growth and for co-production to thrive.

The details set a clear purpose for the outcomes and impacts needed by reviewing the Values-based Framework. The values were shared with decisions made on language to minimise jargon and set ground rules. The Discovery and Recovery Tree (Illustration One, p.191) can be an initial discussion tool to see what values can be added and which are to be removed. Roles and boundaries need to be thought through, depending on the representation of the community of practice in the primary care mental health model. A decision is made on who will lead the facilitation and manage the process, ensuring all decisions and definitions are jointly agreed upon. The 4Pi model reflects the importance of providing support, reimbursement available when required, and education where needed.

4.12.3 Dimension Three. Cognitive Dimension

In Dimension Three, the cognitive dimension reduces the jargon by offering clarity on language and removing terminology, enabling direct community engagement. Bringing social care out of town halls and primary care management out of offices ensures accountability to the communities they serve. The word doctor comes from Latin, meaning teacher, and a fresh, informed paradigm emerging (Guba, Lincoln:116 1994) involves the GP focusing through the community lens to understand their perspectives and ensure genuine collaboration. The significant step change would enable informed discussion on what aspects of statutory provision benefit the local community, removing barriers. It provides creativity by looking at diverse ways of engagement using community-led methods. GPs working within the community of practice can enable local strategies, including preventative ones, to develop in response to local health needs and goals, which can simultaneously inform and encourage national policy.

Social prescribers, health trainers and mental health workers attached to primary care are part of the workforce and, often, the local community is ideally placed to enable the delivery and monitoring of regional strategies within the community. The

approach supports a decentralised system, a move undertaken through the Levelling Up agenda championed by NHS England (Her Majesty's Government 2022b) and developing an opportunity to supply a narrative legacy from the community for incoming members to prevent reinvention. Dimension Three focuses on ensuring an environment of trust and transparency to enable communication to flow. If trust is not there, dimensions one and two must be revisited to ensure the right people are there and everything is in place to manage conflict and celebrate success.

The strengths of a community of practice model include the premise that it is OK to make mistakes. These can be learned from and reviewed to ensure that learning has taken place. A combined wealth of knowledge and equal space for reflection maximises any gained information. The framework must be simple for all parties to contribute equally and be flexible to meet the group's needs. There is a need to ensure everyone has identifiable access to support and space for reflection so anyone struggling emotionally or physically is identified and offered support. There needs to be time for all perspectives to be shared to enable discourse and address any emerging challenges or tensions.

It is recommended that groups of six enable all to contribute and for the contribution to be valued. Six were chosen as the correct number based on feedback from community members attending the pilot to prevent tokenism. From their experience of engagement, larger groups meant they lost their voice. Impact assessment, as recommended by the 4Pi framework (NSUN 2013), would ensure the group understands what has been learned and can demonstrate activity which has made a difference towards achieving the Positive Care Law.

4.12.4 Dimension Four: Governance

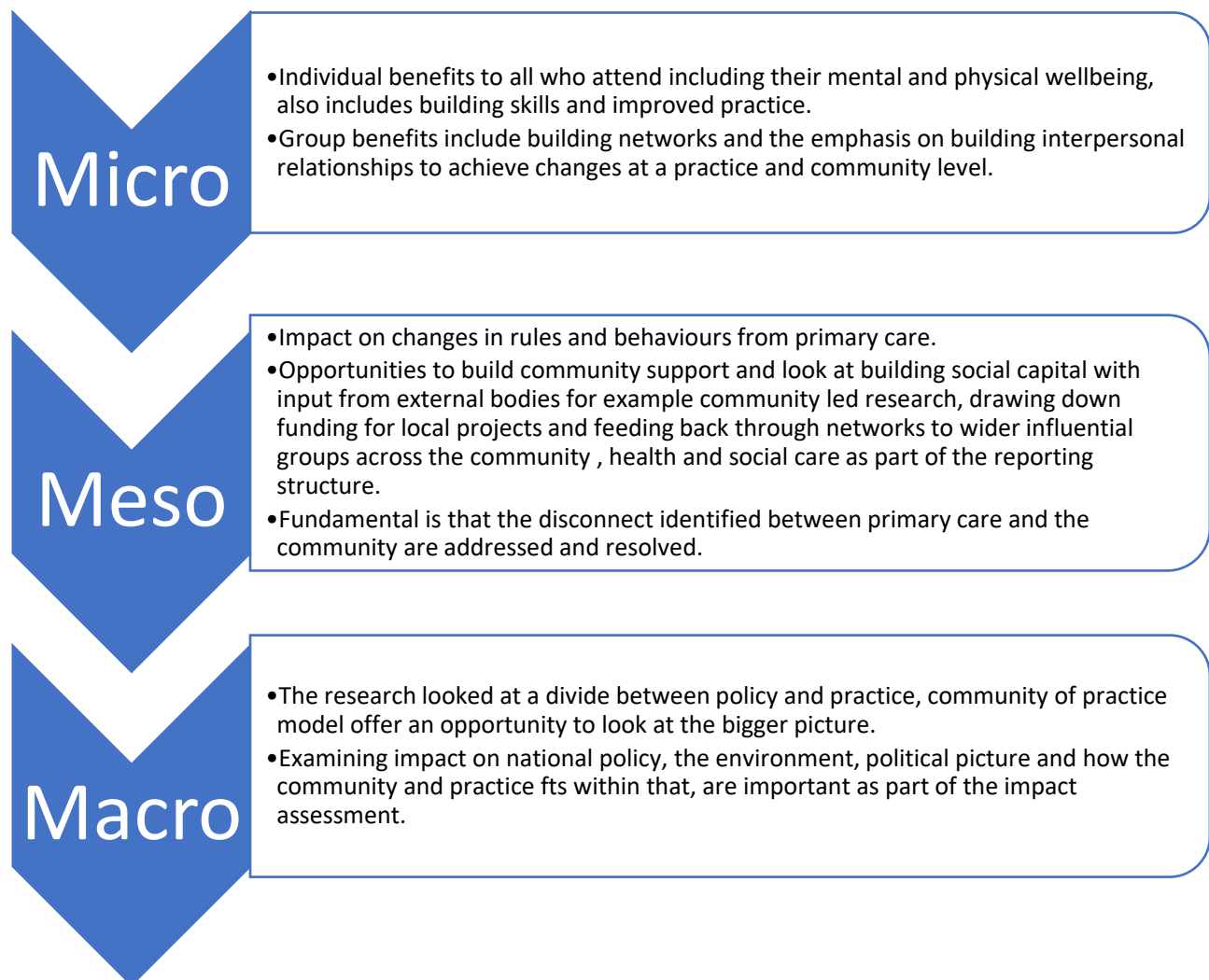
Navigating the messy, pedagogical, and political landscape affecting primary care mental health requires values-based education to include governance. The local community can actively participate in any development in health, contributing to insight and awareness plus community knowledge. Bringing voices into health for those in primary care with low to moderate mental health issues and those currently offered tokenism with long-term mental health conditions. Governance can influence local policy and allow discourse

between the community and primary care, which is not presently happening. The door is not fully open to the community, and the findings show that the community does not trust statutory services. Participants did not feel heard or knew about the engagement opportunities.

The community may be new to participating in the NHS and may need to understand its role and responsibilities. Building governance into the pedagogical framework enables involvement and collaboration. The recommendation is that the community can co-produce information and deliver services, allowing them to become stakeholders and develop clear expectations. Changing the power dynamic and seeing people as partners and critical friends aids constructive feedback and can monitor successes and areas of concern, reflecting the ambitions of the Health and Care Act (2022).

There is a role to play in measuring the impact of the community of practice model for primary care mental health, as recommended in the 4Pi. The impact can be calculated at three levels (micro, meso, macro) using a framework originally used for research (Bennett et al. 2018) and adapted to work for primary care mental health education. The micro level identifies the individual and group benefits for wellbeing and skill building, including networking, interpersonal relationships and making a difference locally. The meso level seeks to manage the disconnect between primary care and the community. It identifies the resources needed, provides external feedback, and builds external support for the identified work being done so that it is owned and valued. The macro level looks at the bigger picture by examining how policy and practice impact the outcomes of the community of practice to embed the learning and move forward together. The three levels are shown below in Illustration Four, which shows the micro, meso and macro levels. Suggestions for opportunities and the benefit of delivering a community of practice model for primary care mental health are included.

Illustration Four Measuring the Impact of the Community of Practice Model for Primary Care Mental Health.



The impact would be measured by the engagement of the broader community, including service users and carers. The benefits would enable the building of local standards or using 4Pi and best practices to influence all levels within the community. The evidence is that national policy should prioritise the inclusion and investment in communities to develop a professional network delivering blended approaches to learning. Despite the wealth of policy, more action must be taken in the workforce and education. A different outcome would be access to the skills and views of those within the community to use their lived experience and place investment in their education, family, and carers.

4.12.5 Summary

The research contributes to primary care mental health education by developing a community of practice model for primary care mental health defined by the community. This enacts the government policy of community participation through the mental health lens. It enables policy enactment concerning primary care mental health education through co-producing and delivering education at all levels. A community of practice model offers a voice and influence to respond to local needs and challenges.

Collaborative Learning Theory manages complexity within primary care mental health education and considers community perspectives. It also recognises the importance of interdisciplinary scientific papers across social and medical communities. Sharing across disciplines allows transferable learning through sharing the best evidence and practices for a community's well-being.

Involving the community in education builds relationships and enables conversations. To promote inclusion, Lea et al. (2020) supports the use of principles of involvement to guide and value participation. The paper concludes that researchers must be ready to listen to the community involved. The analysis shows in this research that the primary healthcare workforce needs to hear the community's voice. Lovell-Norton (2020:407) references Denzin (2006), discussing research practice as 'performative, pedagogical, and political.'

5.0 Chapter Five – Conclusion

5.1 Introduction

The final chapter synthesises the main research findings alongside the study's outcomes. The preceding chapters established that the literature strategy and review, qualitative methodologies, and applied methods align to address the two research questions and three objectives via the findings. This final chapter critically reviews the study's strengths and limitations and paves the way for future research opportunities.

5.1.1 Reflexive Approach

The study used a reflexive approach, so finding time for self-reflection was essential to gain the space to think and ensure no preconceived ideas crept into the thesis. Kant's four questions (p.43) guided the ethics and initially appeared simple. However, using reflexivity has enabled the researcher to understand there were many things they nor those writing in the literature know about mental health in primary care. The literature showed what is not known is hidden in undergraduate and continuous professional development education through basic competencies and toolkits. Listening to the community ensured the findings and Kant's questions inspired an understanding of values. Reflexivity was the approach to finding the truth and enabling an understanding of the complexity of mental health in primary care without being judgmental. It also helped discover how best to manage that complexity within an educational framework that is self-limiting.

5.1.2 Emerging Themes

The emerging themes were mapped against the learning theory studied in the literature, providing evidence for a Collaborative Learning Theory in response to Research Question One (Appendix Six). Research Question Two was inspired by the literature and the telephone interviews. They found a lack of community engagement in enabling policy enactment concerning primary care mental health education.

5.1.3 Kaleidoscopic Lens

Adopting a critical humanist perspective, the researcher utilised a kaleidoscopic lens to analyse the data and clarify a coherent pattern from the disparate individual parts to formulate themes, analyses, and recommendations. The kaleidoscopic lens encompassed the mental health experiences of the community during the

unprecedented pandemic, including those with lived experiences of mental health issues.

5.1.4 The Focus

This study highlighted the critical role of the GPs' ten-minute consultation in addressing the growing mental and social health crisis. Within this brief timeframe, GPs expect to assess, diagnose, manage, treat, advise, and offer coping skills, seen as a panacea for increasingly complex modern lives. Expectations of primary care by the community were high, and this study showed varied patient experiences, ranging from frustration and alienation to satisfaction.

Primary care mental health, distinct from psychiatry, encompasses numerous physical and psychological health conditions and comorbidities, including chronic conditions such as COVID-19 and diabetes. The literature lacks a clear definition of primary care mental health or a singular rule book, both from non-clinical community members and within the literature.

5.1.5 The Findings

This study found that valuing mental health as part of holistic care varies across practices nationally. Undergraduate and postgraduate education for the workforce also varied depending on the Higher Education Institution or provider. The UK Government, NHS providers, and regulatory bodies have yet to acknowledge that primary care includes a percentage of GPs and staff with poor relational skills. There is limited understanding of mental health, and burnout exists due to overwork, staff shortages, and target pressures. Support for both the community and the workforce is required, and this study proposes using values to underpin an educational framework, known as the community of practice model in primary care mental health, to act as a supportive measure. The community of practice model aims to restore hope in primary care through a collaborative approach between the clinician and the patient, rather than criticism from governing bodies, the media, and the public.

The community, including the healthcare workers interviewed, wanted investment in quality education and relational care; however, the increasing provision of apps and private care options confused pathways. A fresh approach is needed to address these issues, focusing on local community needs. The literature showed that poor outcomes reduced social capital to reinforce the Inverse Care Law. Collaborative

learning aims to overcome differences and reject populist thinking. Communities and primary care need to reset, prioritise essential issues, hear diverse voices, and address the invisible problems magnified by the lens of the pandemic, such as medical gaslighting, bias, and discrimination.

The researcher concludes that shared power allows for listening and understanding the community's and primary care expectations. Healthcare workers can collaborate with the community through a community of practice model for primary care mental health. The purpose is to jointly gain insight into personal, psychological and physical wellbeing whilst understanding their purpose and roles within an education model to share insights and knowledge.

5.2 Aim

The research contributes to knowledge from a community perspective and supports the professional advancement of primary care mental health education. A collaborative epistemology addresses the complex landscape of primary care mental health. Listening to community insights and reviewing literature on policy and practice gave an accurate picture of primary care. The researcher's critical humanist stance ensured a holistic view, capturing the unavoidable impact of COVID-19 on primary care mental health during the pandemic.

This study recommends adopting two existing frameworks, 4Pi, and the Six Cs as standards to ensure impact. Expanding the 6Cs to 9Cs ensures the inclusivity of primary care by incorporating three additional Cs: Communities, Collaboration, and Continuity. The outcomes of this research support a shift from the Inverse Care Law (Hart 1971), which highlights health inequalities found in this study, to a Positive Care Law. A community of practice model for primary care mental health can offer a delivery method, impact assessment, and governance to achieve a Positive Care Law.

5.3 Influence of Literature Reviews.

The literature review showed that the closure of the asylums and the placing of mental health in the community in 1993 resulted in historical disconnects between

policy, theory, and practice. Disconnects were found between primary care and psychiatry, resulting in the literature showing failure in physical care for those with long-term mental health problems. Engaging the community for their ability and insights enabled a response to the disconnect for mental health support by primary care.

This study included healthcare workers. During the pandemic, self-stigma and a lack of confidence among healthcare workers impacted their mental and physical health and care. Self-stigma was partly due to their inability to diagnose and understand mental and holistic physical health comprehensively.

The literature strategy enabled understanding of the disconnects, whilst the findings offer solutions from community experiences of primary care mental health. Ongoing literature searches informed the subjective data emerging from the interviews. As themes emerged, literature searches discovered what else was known and its relevance to primary care mental health.

The literature on primary care mental health practice and policy showed an absence of voices from people with mental health. The ongoing literature informed the themes, and reflexivity to ensure that the participant's voices shaped the findings and recommendations.

5.4 Health Inequalities

Health inequalities due to the pandemic are highlighted during the research. These included elevated levels of need shown through difficulty accessing medication and services, as evidenced in the literature and this study's findings. The literature review determined that the model of care, education, and the workforce in primary care were ill-structured, resulting in health inequalities consistent with the Inverse Care Law (Hart 1971).

This study found a need for continuity and a relational, compassionate practice. The term "doctor shopping" described how community members changed practices to seek their desired care. Inequalities across society, geography, class, and creed affected responses. The researcher witnessed these inequalities challenging all levels of society and impacting community wellbeing during the pandemic. Primary

care consultations are shared, intimate times between patient and doctor, characterised by inherent power imbalances and dynamics.

The literature indicated that a biopsychosocial, socio-cultural approach is necessary to analyse needs and offer support. However, the researcher recognises the differences to build trust and hope through compassion to overcome human struggles. The inequalities highlighted by COVID-19 revealed different experiences between those with mental health problems and more senior clinicians. During the pandemic, hope became essential to everyone. Critical humanism enabled the combination of optimism and facts, discovering that instilling and supporting hope through belief in human perseverance and resilience was possible.

The pandemic showed how vulnerable humans are whilst also displaying innovation and creative ways to manage mental health within the community. The community of practice model was influenced by the findings related to the Inverse Care Law (Hart 1971), incorporating values and broader themes than traditional medical models.

5.5 Methods

The methods used to capture data included one pre-COVID focus group and during the pandemic telephone interviews. The pre-pandemic focus group used Appreciative Inquiry and Disney Modelling data collection methods. The methodology underpinned the methods and included Cognitive Flexibility Theory, Grounded Theory, and Participatory Theory.

5.5.1 Focus Group

Six people from the local community participated in a pilot study using Appreciative Inquiry and Disney Modelling (Cooperrider, Whitney 1999) and Disney Modelling (Dilts 1994). The two data collection methods were replicated in the pre-pandemic focus group to examine the role of education in primary care mental health. The two methods facilitated an in-depth exploration of participants' experiences and perspectives. The results were captured on large sheets of paper (Appendix Nine), typed up (Appendix Ten), and analysed using NVivo to visualise and organise the

themes (Appendix Eleven). The themes generated from the focus group informed the development of semi-structured interview questions used in the telephone interviews.

5.5.2 Telephone Interviews

Due to the pandemic, a change in method led to conducting telephone interviews. These interviews aimed to build on the themes produced by the pre-pandemic focus group and explore additional values and themes. The data from these interviews were rich in perception and insight, significantly contributing to developing the values-based pedagogical framework. Outputs from the transcribed telephone interviews were merged to compare and contrast the findings and produce themes from the mind map (Buzan 2018) (Appendix Twenty-Four). The mind-mapping process ensured both breadth and depth of understanding of the key themes and emerging values.

5.5.3 Influence of the Literature Strategy

The literature supported the focus group's findings of a lack of knowledge about the definition of primary care mental health. The initial question explored the terms and experiences within primary care for mental health (Appendix Three). Referring back to the literature created an iterative process to maintain the context and address the finding of a disconnect between policy and practice. A reflexive approach ensured that the literature informed, supported or challenged what the participants said.

5.6 Use of Theory

The following three theoretical frameworks guided this study to achieve the research objectives:

5.6.1 Grounded Participatory Theory

This study adopted a Grounded Participatory Theory approach, which combined Grounded Theory and Participatory Research methods:

Grounded Theory (Glaser, Strauss 2017) - Allowed for an inductive approach, enabling themes and patterns to emerge from the data.

Participatory Theory - Ensured the research was collaborative and inclusive of community perspectives.

The combined approach addressed the literature review findings of a disconnect between policy and practice by actively involving participants in the research process.

5.6.2 Cognitive Flexibility Theory

Cognitive Flexibility Theory provided a framework for managing the complexity of primary care mental health. It enabled the development of two research questions by allowing the researcher to explore the complex primary care mental health environment identified in the literature review. The term "primary care mental health" was found to be unclear and was explored in the telephone interviews. By applying Cognitive Flexibility Theory the "messy education" of primary care mental health and the lack of community voices in the existing literature were addressed.

5.7 Conclusion on methods used.

The methods used in this study were grounded in robust theoretical frameworks to effectively respond to the research questions and address the research objectives. The combination of focus groups, telephone interviews, and continuous reference to literature ensured a comprehensive exploration of the role of education in primary care mental health. The resulting themes and insights informed the development of a community of practice primary care model, which has the potential to bridge the gap between policy and practice and enhance primary care mental health education through community participation.

5.7.1 Responses to Research Questions One and Two and Objectives

The application of Cognitive Flexibility Theory produced two research questions.

5.7.2 Research Question One.

Is there the potential to produce a learning theory for primary care mental health education that considers community perspectives?

The literature review revealed no learning theory to encapsulate community knowledge to inform primary care mental health education. Learning theory influences the method of education and its consequences on how people learn, ensuring that strategies meet personal and community goals. The research question posed whether there is potential to produce a learning theory for primary care mental health education considering community perspectives. The answer is a firm yes. Collaborative Learning Theory, achieved through Objective One, emerged as the most applicable theory.

5.7.3 Objective One.

To generate a learning theory that considers community perspectives.

The literature review evidence shows that primary care mental health education would benefit from a participatory approach with the community. Collaborative Learning Theory informs the goal of values-based education for primary care mental health. It allows informed decisions around the co-produced design and delivery.

The literature on learning theory was mapped against the themes and subthemes from the findings (Appendix Six). Collaborative Learning Theory emerged as the most applicable as it informed the values, beliefs, ongoing methods, and methodology of future education for primary care mental health.

Critical reflection on learning theory has influenced the community of practice model to ensure inclusion and participation through Collaborative Learning Theory. The resulting community of practice primary care mental health model shapes the knowledge to allow informed decision-making. Collaborative Learning Theory is a lens that provides clarity on context, content, and delivery, as well as how to manage the disconnect through creativity. A collaborative approach enabled the development of a community of practice primary care mental health model underpinned by standards (4Pi, 9Cs), values-based ethics, and research.

The framework offers the opportunity for values-based recruitment from the community, creating a virtuous circle, evidenced by the impact of using a community of practice model for primary care mental health education. Collaborative Learning Theory informs the goal for values-based education for primary care mental health, allowing informed decisions around the co-produced design and delivery.

5.7.4 Research Question Two

Will the government policy of community participation in mental health enable policy enactment concerning primary care mental health education?

The response to research question two is more complex. The current policy refrained from engaging communities despite the rhetoric. The onset of the Health and Care Act (2022) requires the inclusion of people and communities. However, Integrated Care Systems are at scale, with the added risk of losing local voices. Smaller Primary Care Networks and individual GP practices can, in partnership with the community, achieve enactment of the policy of participation through engagement. NHS organisations can be taken to court if they do not do this, as it is a requirement under the Equality Act and the Health and Social Care Act (2012). The recommendations show that people with lived experience must be involved in planning services to overcome challenges and use their expertise. The community expressed a disconnect between community and practice, reflecting the disconnect found in the literature between policy and practice. The Inverse Care Law (Hart 1971) was applicable. Despite a wealth of policies and centralised restructuring, the risk of not recognising nor treating mental health at a primary care level became fragmented and even lost due to competing priorities and austerity.

The literature review found the views of the wider community missing from the national policy Five Year Forward View Mental Health (Independent Mental Health Taskforce 2014), Five Year Forward View Mental Health Implementation Plan (NHS England 2016a, NHS England 2016b), and NHS Long Term Plan (NHS England 2019a). The Health and Care Act (Her Majesty's Government 2022) shares an approach to developing integrated care systems, with partnerships of providers and commissioners of health, the voluntary sector, and social care within geographical areas to plan services to meet local needs.

Each integrated care system has the task of engaging the community in developing services. The literature showed a complex environment of primary care mental health and limited evidence on participation and education. The past and current literature demonstrates the rhetoric of top-down, joined-up policy for mental health and primary care with no implementation plans (James, Moseley 2006, Politt 2003, Hannigan et al. 2018, Sheikh et al. 2021). The current answer to research question two is that the government policy of community participation in mental health does not enable participation in primary care mental health education. However, achieving the following two objectives suggests that the policy rhetoric can become a reality. These

objectives help interpret and manage the complexity of primary care mental health, offering benefits to practitioners and the community they serve (Beckett et al. 2018). Objectives Two and Three support uncovering underlying patterns to develop and build an epistemology in primary care mental health.

5.7.5 Objective Two

Identify the meanings of shared values in the community to develop an epistemology for primary care mental health education.

To enable primary care to undertake a collaborative mental health role in the community post-pandemic requires a shift away from the biomedical pedagogical model. Recognising that primary care is part of the solution when integrated within the community, at the heart of comprehensive community-based services, is essential. The ability of primary care to act on the recommendations, continue to understand local needs, and offer local solutions requires a clear understanding of the local values and assets through community participation. Although unexpected, the intrapsychic perspective of primary care emerged from the research as a theme, leading to recommendations for values-based education.

5.7.5.1 Meanings of Values-Based Education

Values-based education offers the community and primary care a transformational language based on community values. The values expressed from this study were

Table Eleven Main Themes of the Study

Relational Aspects: Compassion, empathy, and skills such as accurate diagnosis.

Model of Care: Self-respect and growth by building on community strengths, avoiding jargon or stigma, and promoting equality, choice, and being heard.

Primary Care Workforce: Values-based recruitment.

GP Education: Values-based research, competency, knowledge, co-production, and honesty.

Transactional Approach: To reduce doctor shopping, different incentives, including value for money, continuity, and the reputation of practices, need to be rewarded.

Impact of Inequalities and Long COVID-19: Inclusion of Autonomy.

Access to Services: Opportunity, participation, power, and status

Intra-psychic Theme: Respect for beliefs, wellbeing, peace, love, hope, faith, and spirituality.

included in the Discovery and Recovery Tree (Illustration One, p.191) and mapped against the themes (Appendix Twenty-Nine). Primary care is present throughout the lifespan, and continuity and relational care support recovery. The values expressed in this study underpin the main themes in Table Eleven (p.215).

The values reflect the area studied and demonstrate the needs and equity required by the whole community. By reconnecting and collaborating with the community through a collective purpose and learning together, primary care can quickly re-establish its place at the heart of the community. Moving away from the dominant medical paradigm requires a transparent ethical underpinning and community-led measurement of the impact of any education.

To address policy gaps, a co-produced primary care mental health workforce plan, including an educational framework will help support the supply and retention of locally required staff. The workforce plan can offer quality provision, clarity of function, and values-based competencies. National DES and QOF targets expend energy attempting to achieve centrally set targets linked to funding, which could be more flexible and bureaucratic instead of meeting local needs. The research has shown how certain press outlets blamed primary care for poor access. The result has been a growing hostility and a need for more belief in the line of trust the community had in statutory services. Returning to relational practice and continuity of care will restore hope in the community and challenge inequity through thought and language. Engaging communities can create education opportunities underpinned by connecting, listening, and understanding the power of shared values.

5.7.6 Objective Three.

To co-produce an education framework informed by the community and evaluated through current literature.

The co-produced community of practice model is based on the themes, sub-themes, and values identified by the community. The values-based framework, described in the previous chapter, comprises Collaborative Learning Theory and Values-based Ethics. The 4Pi frameworks recommended setting standards by adopting a values-based ethical approach to meet principles. The purpose becomes clear, the right

people are present, and the correct payment processes are followed. The "I" stands for impact (4Pi), and the suggested modified impact measurement tool proposes measurement at three levels: micro, meso, and macro. The other existing work is the 6Cs used in health education, which is recommended to become 9Cs by incorporating communities, collaboration, and continuity.

The delivery model is familiar to the community and used through informal networks like group sports. The NHS also uses a community of practice model on an internal virtual platform. The community of practice model for primary care mental health offers three steps, structural, relational, and cognitive, to inform communication and reduce jargon. The entire framework includes governance that involves community participation. The framework is not exclusive and is flexible for others to use. Outcomes from implementing a pedagogical framework support a move from the Inverse Care Law (Hart 1971), discovered through the health inequalities found in this study, towards the Positive Care Law required to deliver mental health in primary care. The move to a Positive Care Law reflects the desire to develop inspiring education that offers hope (Zembylas 2007).

5.8 Directions for Future Research

A collaborative approach can enable the community and all stakeholders' active engagement to determine the impact and transferability of the community of practice model. This study's participants believed that community involvement could significantly influence the development of mental health services, indicating the importance of participation for achieving desirable community outcomes. To further explore the benefits of the community of practice model for primary care mental health, future studies should focus on identifying the practical components of the model. This research can highlight which parts of the model are replicable. An improved, responsive mental health service can bridge the gaps between policy and practice and between the community and primary care.

Each discipline within primary care has its job description, and these are evaluated based on competency and skills by their respective regulatory bodies (Touchie, ten Cate 2016, Tucker 2017). A promising area for future research would be examining the patient feedback component of revalidation for GPs and other healthcare

professionals at national and local levels. The impact on GPs' and the primary care workforce's mental health due to the increased strain on primary care contributes to higher mental health issues and potential suicide. Detailed patient analysis is another area of research that uncovers recommendations for service improvements and enhances patient experiences.

Understanding these elements could provide insights into whether patients adhere to clinical advice and ensure that primary care offers the best mental health services, ultimately reducing admissions to secondary care. Patient feedback is non-specific and collected using varied approaches by different GPs. There is an opportunity to analyse the qualitative data within this feedback and use it to inform future education programmes (Tracy 2019).

In summary, future research should prioritise collaborative methods to engage communities and stakeholders, evaluate the effectiveness of the community of practice model, and utilise detailed patient feedback to improve mental health services in primary care. These steps create a more integrated, responsive, and effective primary care mental health system.

5.8.1 Engaging the Community in Research

Involving the community in research significantly broadens the understanding of complex mental health issues, moving beyond diagnostic labels. Collaborative research is essential for shaping future mental health curricula and education (pre-registration) to meet consumer needs better. Brett et al. (2014) emphasise that inclusion enhances the quality and relevance of research. Current gaps in the literature involve research design, the need for a standard framework, and explicit language (Bocking et al. 2019, Shippee et al. 2015). The synthesised community of practice model enables an education framework that integrates knowledge from the community and research studies and is broadly applicable. Shippee et al. (2015) offer an analytic framework with the necessary underpinnings (Appendix Thirty-Three).

The literature review revealed a need for more service user involvement in doctoral research. Troya et al. (2019) highlight the importance of capturing lay perspectives to inform clinical practice. Introducing the theory, ethics, and practice of Patient and

Community Involvement Engagement (PPIE) at early research stages can create a culture that values PPIE and avoids tokenism. The GRIPP2-SF checklist (Appendix Thirty-Four) captures best practices for involving PPIE in qualitative research and was a guiding tool for the researcher. Ensuring the wellbeing of participants through thoughtful consideration, support, education, and experience is critical, aligning with Troya et al.'s (2019) findings on the need for ethical concern for participants' conditions, capacity, and involvement level.

Jennings et al. (2018) outline three levels of community involvement. Low-level involvement includes being 'informed,' 'consulted,' or participating when researchers seek views to inform decision-making. Medium-level involvement encompasses 'involved,' 'collaboration,' or 'co-production,' focusing on an equal relationship between researchers and participants, with mutual sharing of expertise and information (Sabadosa, Batalden 2014, Madden, Speed 2017). High-level involvement, known as 'influential,' 'control,' or 'service user-led,' involves people with experience delivering and managing research. The community co-produced a semi-structured interview schedule in this study, influenced focus group member numbers, and impacted this study design (Appendix Three). Member checking engaged participants and peers through discussions, conference presentations, webinars, and posters (Appendix Seven). Future research should be collaborative to eliminate barriers to community engagement and incorporate the community narrative. A community of practice model for primary care mental health can offer insights into other areas and refine the model.

5.9 Synthesis

This study, conducted during the pandemic lockdown, highlighted the impact of inequalities on mental health and the primary care workforce. The recommendations suggested moving from the Inverse Care Law to the Positive Care Law through participation and collaboration. Jennings et al. (2018) provided a transferable framework for analysis, which this study adapted through four key steps:

1. Ensuring co-production through consultation and verification
2. Making the analysis process realistic within available resources
3. Ensuring reasonable demands

4. Managing expectations by clarifying roles and valuing participant contributions

This framework proved measurable, realistic, timely and effectively supported this study method.

The conclusion reveals a need for a published systematic whole-faculty approach to higher education community engagement in health and social care. There needs to be more evidence on curriculum design and more research evaluating student learning, particularly from the perspectives of course deliverers (Downe et al. 2007, Bocking et al. 2019). Despite this, the literature shows optimism about the impact of student learning and a willingness to engage and participate (Happell et al. 2019a, 2019b). This study underscores the need for a collaborative approach with the community to challenge the Inverse Care Law and shift towards a Positive Care Law using a community of practice model for primary care mental health.

The community of practice model offers a collaborative solution to the disconnect between policy and practice. A growing disconnect, exacerbated by dissatisfaction with the NHS, is contributing to worsening mental health in society. Engaging the community in a collaborative, values-based approach is essential to addressing these challenges and improving primary care mental health outcomes.

The key finding from the literature review (Chapter Two, p. 6) and interviews is that the community lacks an active voice in developing policies, services, and curricula for primary care mental health. Health inequalities disproportionately affect the vulnerable, yet people with lived experience demonstrate agency by "doctor shopping," selecting practices that provide relational care and continuity.

Healthcare workers' neglect of self-care has jeopardised their own physical and mental health, often delaying seeking help due to self-stigma. The pandemic exacerbated mental health issues for those with lived experiences, complicating access to necessary healthcare, medication, and continuous relational care. The inadequacies in surgery environments prompted the community to seek alternative care due to a lack of relational interactions, even with receptionists. Transactional care approaches led to overuse, misuse, and underuse of services, with

inappropriate reliance on Accident and Emergency Departments for mental health support. Primary care mental health education is not routinely included in the primary care workforce or accident and emergency staff. The workforce often lacks education or experience in psychiatric placements, leading to inadequate responses to psychotic crises and unrecognised or unmanaged mental health problems in primary care. The lack of integrated systems has created a divide between primary and secondary care, which worsened during the pandemic as access thresholds for secondary care rose.

This study highlights that primary care struggles with the complexity of mental health and often fails to understand the intrapsychic and cultural needs of the community. Despite this, the community values primary care. Its strengths can be leveraged through a values-based education model, promoting self-care, wellbeing, stigma reduction, reflection, and support for local services.

5.10 Values of this study

This study informs primary care mental health education in both theory and practice. The literature review and the findings revealed disconnects between policy, practice, and community needs that needed to be adequately addressed by existing policies. The Participatory Grounded methodology (Chapter Three, p. 61) revealed the importance of Collaborative Learning Theory and the need to reconnect community, primary care, practice, and policy through a values-based, collaborative approach.

This study does not prescribe specific changes to systems or policies but proposes an applicable Collaborative Learning Theory and values underpinning a community of practice model for primary care mental health to address these disconnects for a collaborative epistemology. The model, derived from community values and co-produced by community members, facilitates sharing the findings, member checking of themes, and developing a glossary to demystify jargon.

In a healthcare landscape with many priorities, these recommendations support the future development of community participation in primary care mental health education. Based on the findings, one actionable step is the adoption of the 9Cs for primary care mental health, promoting a collaborative and values-driven approach to

primary care. One that encourages integration into the wider NHS and streamlined pathways.

5.11 The Limitations of this study

The researcher recognises that more than this study alone is needed to revolutionise current practices. However, it is hoped to inspire further exploration and practical application in primary care mental health. This study was conducted in the Northwest of England and developed a community of practice model rooted in community participants' experiences and insights during a unique period marked by the pandemic. The findings underscore the deep-seated inequalities and vulnerabilities exacerbated by top-down austerity measures and recurrent policy redesigns in primary care.

The research uncovered significant disconnects between theory and practice, proposing community-driven solutions to bridge these gaps. However, it also highlighted the necessity for further research to contextualise primary care mental health to assess the impact on professional development. Current resources in primary care need to be more cohesive, with isolated pockets of good practice needing to be scaled up effectively.

A key takeaway from the community was the preference for relational care over transactional approaches, emphasising continuity, empathy, and a blend of experience and expertise. Unfortunately, relational care is often not prioritised in current primary care mental health policies. These recommendations counter existing policy directions rather than supporting a shift towards greater community participation and collaboration.

This study's scope was limited by time and word count, so the community of practice model has yet to be implemented. However, the primary research questions and achieving this study's objectives are met. The evidence shows that these recommendations should be integrated into practice and policy to develop a holistic and empathic primary care mental health model.

5.12 ... and Finally.

The study shows that a fresh approach is needed to leverage the community participation policy. Mental health has risen since the pandemic, and there are disconnects between primary care health professionals and the community. Empathy and understanding are the relational values required for inclusive and effective consultations in primary care. A community of practice model can implement values from a community and primary care perspective. These can bridge the gap between policy and practice in primary care mental health. Collaborative Learning Theory and grounded participatory methods, combined with Cognitive Flexibility Theory, ensure that education is relevant, responsive, and practical. Therefore, the community's and primary care workforce's mental health needs are met equally.

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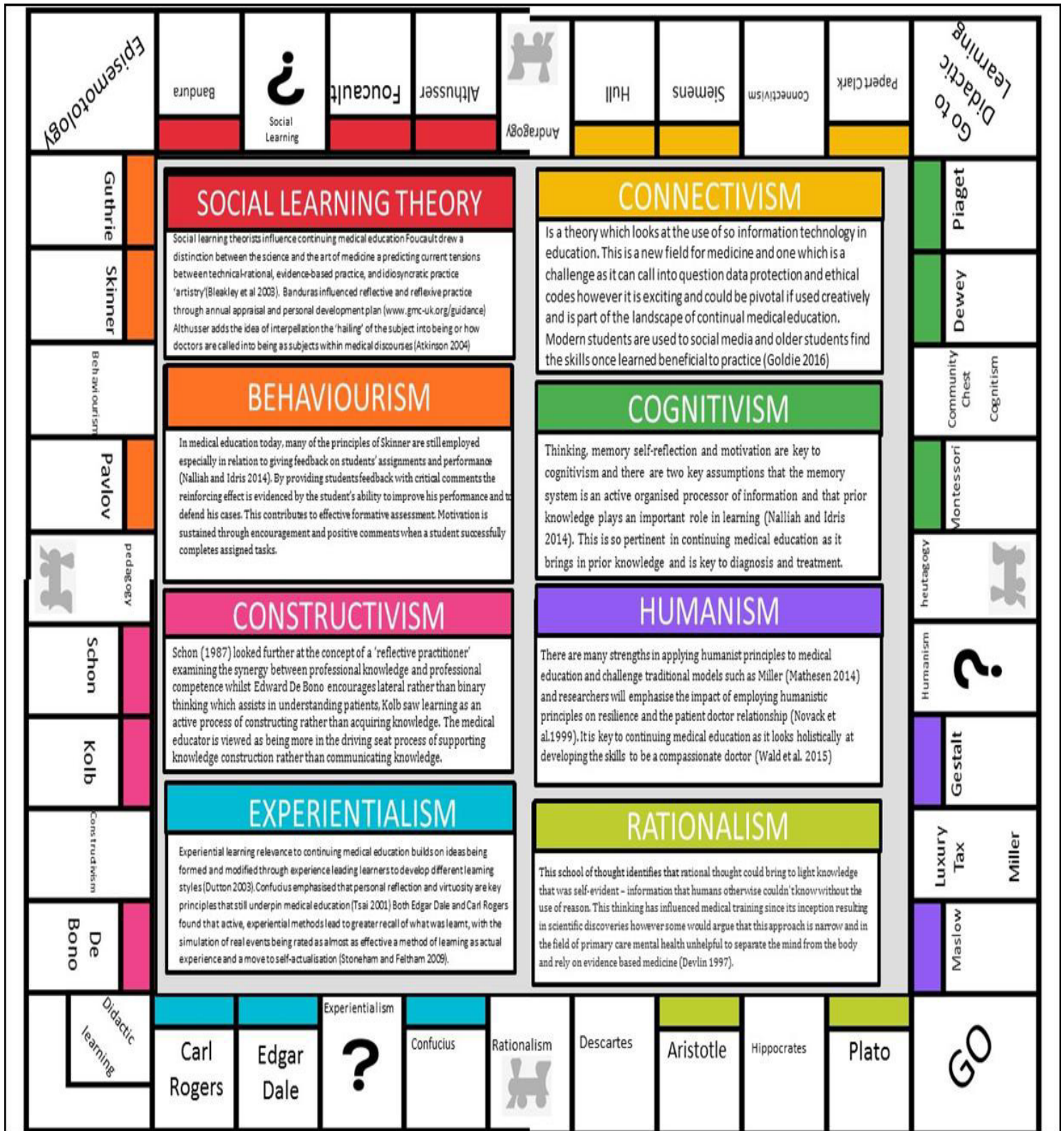
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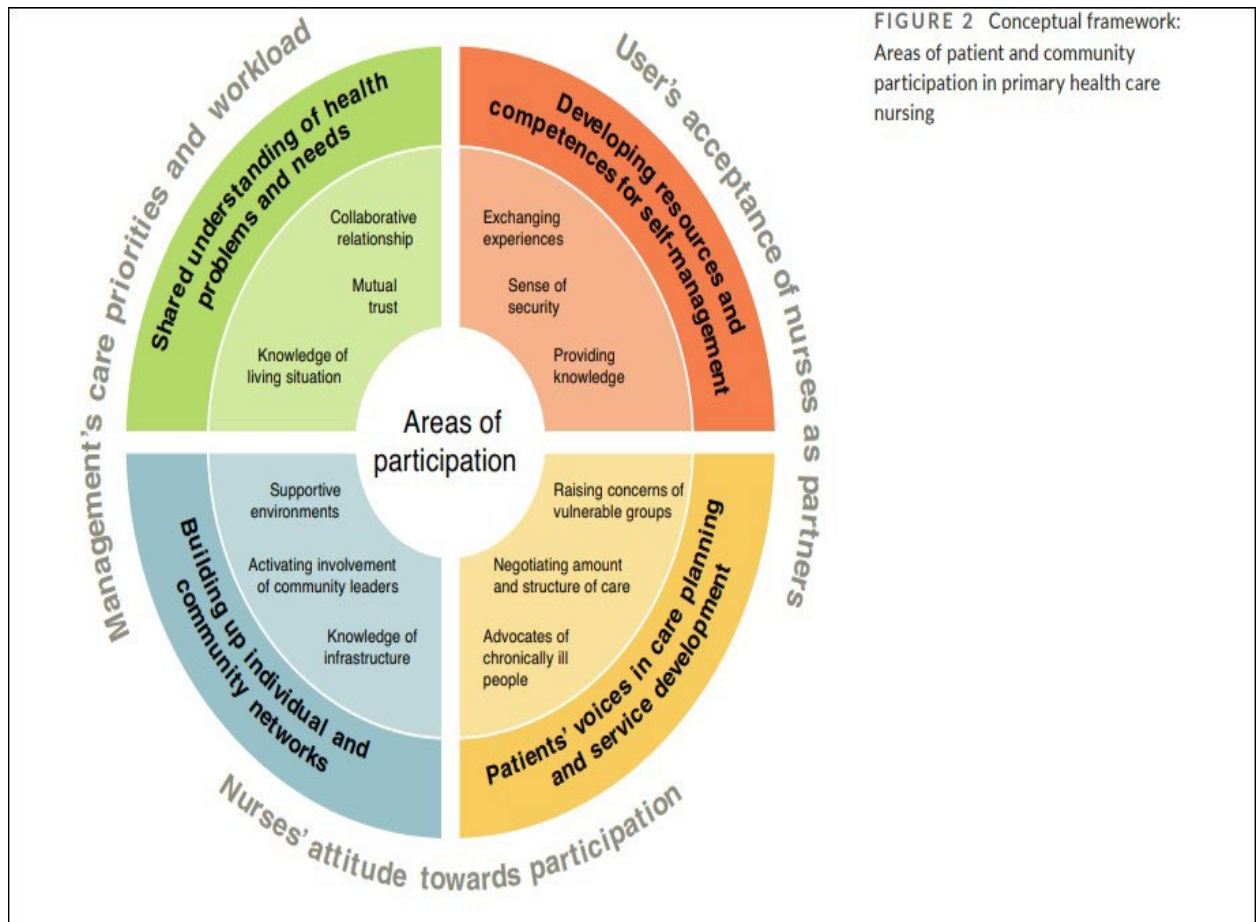
Appendix One Learning Theory and theorists relevant to medical education.

The illustration shows the volume of theories, with no one standing out for primary care mental health education.



Appendix Two

Conceptual Framework: Showing areas of Patient and community participation in primary health care nursing (Heuman et al. 2022)



Appendix Three Semi-structured Interview Schedule

What do you understand by the term primary care?

What are your current views on the primary care team in your surgery?

To be sure I understand please can you tell me your best experience of primary care?

What would you do if you/or another started to feel unwell mentally?

How would you know you are coping?

Why do you cope the way you do?

What of the experience of going to your doctor's surgery is most important to you?

Why?

What are the positives that came out of it?

Why are they positive?

What is your latest current experience of going to the surgery like?

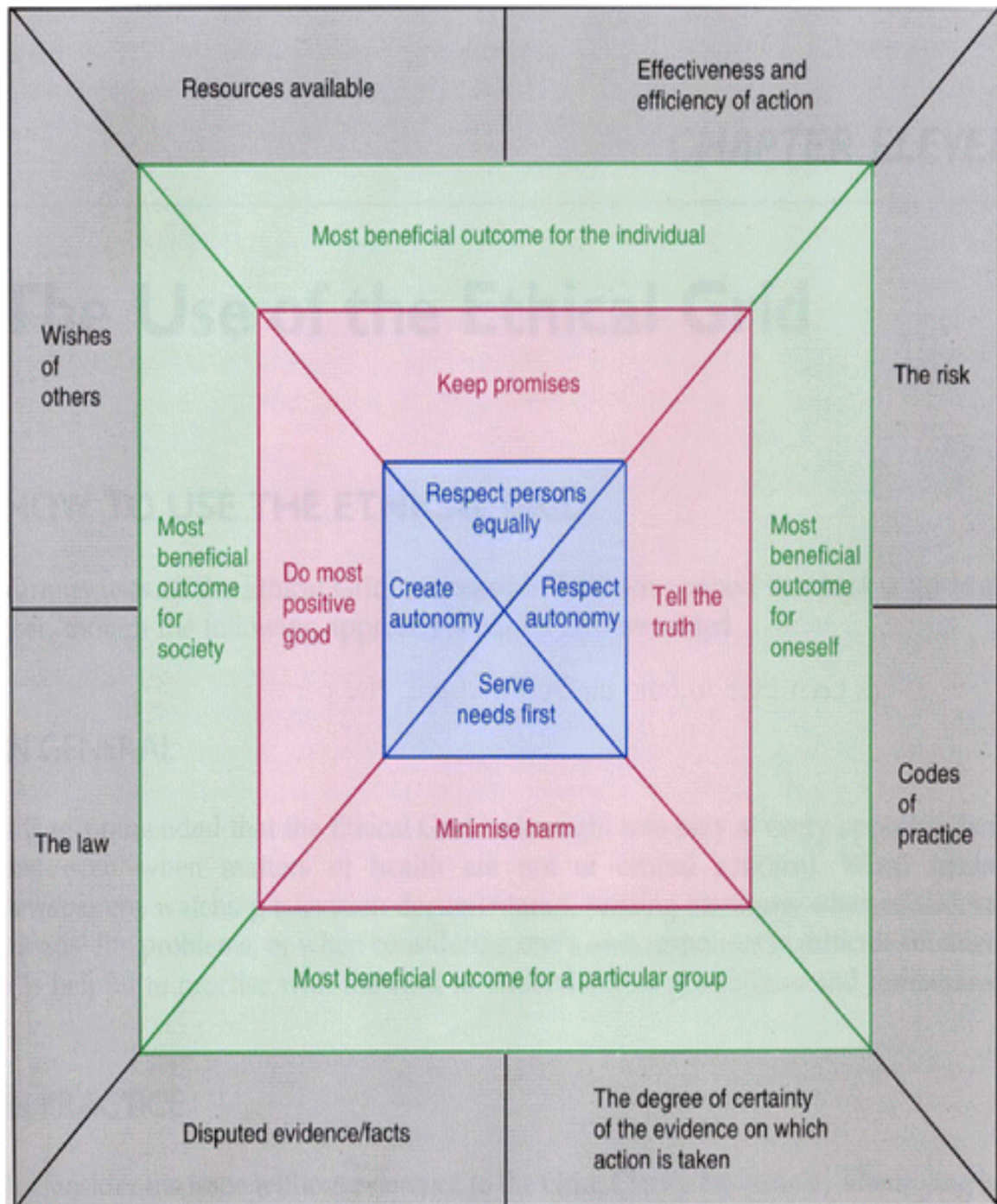
What advice would you give somebody attending their doctor's surgery?

In your future what outcomes would you want from your surgery?

Is there anything else you would like to share?

Appendix Four

Seedhouse's Ethical Grid (1998)



Appendix Five

Ethical grid as questions and mapped against BERA 2018 guidelines (Stutchbury, Fox 2009, Flinders 1998)

Rationale: Considering four dimensions	No.	Questions to consider	Responses	BERA 2011 ref.
External/Ecological				
Cultural sensitivity	1	Are the values, norms and roles in the environment in which I am working likely to be challenged by this research? How could I adapt to accommodate these norms and expectations?	The value base of primary care is first doing no harm, and the norm is to follow policy in a highly reactive, scrutinised environment. The medical model uses evidence-based medicine, but patients are not logical and seek an emotional response. Stigma is based on fear and the unknown potential, and education and awareness are key. To address this through collaboration – A final joint group of clinicians and service users to evaluate the findings	13
Awareness of all parts of the institution	2	What is the relationship between the group/individual I am working with and the institution as a whole? How does it affect the participant(s)?	The relationship is 'Top Down' and currently 'done to' both patients and clinicians. This research aims to empower the participant to be 'done with.' The pilot and the limited literature search show that people want to work together and be listened to. The policy shows the right direction of travel.	
Responsive communication – awareness of the wishes of others	3	How might my work be viewed/interpreted by others in the institution? Have I considered how the language I use could be interpreted?	Others view work as a positive contribution to education resources. The need to use language, which is understood by the public and professionals, the findings will show what this language is. It needs to be non-jargonised and clear. It also needs to be	41

			written up academically to be credible, good research and replicable.	
Responsibilities to sponsors	4	What are my responsibilities to the people paying for or supporting this research (local authority, my school, external bodies)?	Potential bias of self-owing to interest in this area Will ensure to be respectful of all Recovery Republic guidelines and ethos	32-36
Codes of practice	5	Have I worked within the BERA (2011) guidelines? Am I familiar with the University's internal approval procedure? Are other relevant codes applicable, such as the UN Rights of the Child and ESRC guidance? Am I aware of my rights and responsibilities through to publication?	Yes, the framework cross-references and is compliant with University processes. Aware of rights and responsibilities regarding publication	All 3 16/17 13
The law	6	What legal requirements relating to working with children do I need to comply with, e.g. DBS checks? Am I aware of my data protection responsibilities, including the Data Protection Act (1998)? Am I mindful of the need to disclose criminal activity?	I have no experience working with children; I am working with the whole population who access primary care, so they do not need DBS. Aware of data protection responsibilities and centre where holding research are aware of full CV and background of the researcher	13 19 27-29
Risk	7	Have I considered in advance any risks to anyone because of this research?	Yes, potentially to the organisations (university, centre where research would run) if ethical guidelines are not followed. There is minimal risk to self and some risk to participants if they are not engaged and managed within a moral framework. Findings are generic and not aimed at any organisation or group	20,23
Consequential/ Utilitarian				
Benefits for individuals	8	What are the benefits of me doing this research to the participants? Would an alternative methodology	The participants will benefit from collaborating on this research to find out what works well within primary care. This was expressed in	24?

		bring greater individual benefits?	the pilot, where the feedback showed they enjoyed the session and felt valued. They enjoyed sharing their opinions and contributing to research using their perspectives. Another methodology looked at a quantitative questionnaire and included action research. However, the pilot showed that the method and methodology chosen were the right ones, gaining results and being enjoyed by all.	
Benefits for groups/organisations	9	What are the benefits of my research to the school/department? Could these be increased in any way? Could my work be relevant to a school's development planning or self-evaluation in any way? How will I ensure those affected by the research know about my findings? Can I justify my choice of methods to my sponsors?	Benefits are to my work producing themes that can bring into education the interpersonal skills and what is of value to the patient. Methods have been piloted and refined so they are justifiable	31,35, 37
Most benefits for society	10	Is this a worthwhile area to research? Am I contributing to the 'greater good'? Is it high quality and open to scrutiny? Am I open to improving my work by responding to constructive criticism? Will the work be accessible and made available to maximise its significance? How will I commit to communicating its findings to all potentially interested parties?	Yes, it is worthwhile as there is a gap in the literature which this could inform. Findings can be disseminated across primary care networks and will be of interest. Supervision will be vital to ensure the research stays on course and is responsive to criticism.	4, 38-39 44 46-47 50-51
Benefits for the researcher	11	Am I able to get enough data to author a good thesis? Am I aware of my publication rights? What might I learn from this project? Will it help	The pilot produced lots of data that was not collated, and by capturing it, there will be more than enough to aim for saturation. Yes, I am aware of publication rights as	37 40-41 49

		me achieve my long-term life goals?	published before. I continually learn the discipline of being a researcher. This work will aid in developing meaningful education with underpinning values.	
Deontological				
Avoidance of wrong – honesty and candour	12	Have I been open and honest in advance with everyone who might be affected by this research? Are they aware they can withdraw, in whole or in part, if they wish? If not, can I justify any covert aspects of my research? Have I avoided anything that could be considered coercive? Have I made grievance arrangements and communicated these?	There are no covert aspects. The research was changed following recommendations from the original pilot group. All participants will be met individually before the research so that they know they have the right not to attend or withdraw at any time and are aware of grievance procedures, contact numbers and access to someone immediately if there is an issue.	10-11 13-16 18 36
Avoidance of harm	13	Are any sensitive issues likely to be discussed or aspects of this study likely to cause discomfort or stress? Can I ensure that I will either attempt to prevent or have thought about how to alleviate any distress caused? How will I reduce my imposition on those involved in the research?	The pilot session was made interactive and fun using appreciative inquiry, which enabled people to be relaxed, and there was no evidence of distress. A facilitative style was used, and the session was designed to be led by the group. The interview questions in the primary research are intended to reflect the themes arising from these sessions so participants will steer them. Reflexivity is crucial to this type of research.	20-21 23
Fairness	14	Have I treated all participants fairly? Can I treat all participants equally? Am I using any incentives relatively? Will I acknowledge everyone involved reasonably? Do those involved want to be recognised rather than anonymised?	The objectives and underpinning value must reflect the need to be fair to all participants and to ensure they are acknowledged if they so wish.	9 16 18 22 24-25

Telling the truth	15	If there is any need for covert research, how will I deal with this? What will I do if I discover something the participants/school/department do not like? How will I report unpopular findings? How will I deal with the misrepresentation of my study by others? What are the implications of a commitment to exposing any malpractice revealed to me?	There is no need for covert research. If something people do not like arises, it is not my role to be dramatic; I must seek advice from the University to ascertain the next steps. I will not use information that is malicious or damaging. This is a positive study. If a finding is unpopular, I will find out when it is published and stand by any publishable material if it is deemed the right thing to do. Any malpractice or misrepresentation will be managed in partnership with the University.	14 41-42 45
Keeping promises	16	Have I clarified access to the raw data and how I will share findings including at publication? How will I ensure confidentiality?	The raw data is accessible by me only, encrypted, and stored securely, and it will not be kept following analyses. Confidentiality will always be maintained.	12 25 (28?) 31
Relational/Individual				
Establishing trust	17	Who are the key people involved? How can I build a constructive relationship with them? What do I need to do to earn the trust of participants? Do I need to include gatekeepers, and if so, how will these relationships be developed and managed?	Supervisor – be a proactive and responsive clinical lead at the centre where research is held, remain engaged, and keep informed of progress and dates, Participants keep informed and engaged, be open and honest with all to build trust and rapport, Lecturer be engaged and responsive,	13 19
Avoiding imposition	18	Am I making unreasonable or sensitive demands on any individuals? Have I minimised any bureaucratic burden on those I invite to be involved?	No all-bureaucratic responsibility on self apart from reading the initial engagement letter. What will be needed is time. As research progresses, participants will be asked to volunteer to attend the next stage of telephone interviews and have the right to decline at any time.	20,21

			They will be made aware of any paperwork to be potentially read for final themes, and they can step out at any time.	
Respecting autonomy	19	Do individuals fully appreciate that participation is voluntary and will gain their informed consent? Or, if I plan to undertake covert research, can I make a vigorous defence of this choice? Will I offer participants the chance to withdraw data? If so, have I considered how practically this can be accommodated? Have I negotiated access to the participants? Are the participants clear about their roles, including my own, related to expectations?	Yes, all participants will have informed consent. A lesson from the pilot was the need to explain what this means in lay terms, and this will be done on an individual basis before the focus groups and interviews. Data can be withdrawn at any time, and due to the data collection method, this can be done as it is captured visually and verbally. All-access is negotiated, and a further lesson from the pilot is to clarify again at the beginning of the session.	20,21
Collaboration and reciprocity	20	Have I considered negotiating mutually beneficial arrangements? Have I made myself available when those involved might wish me to be, e.g. to answer queries?	Yes, the centre will benefit from further education, and part of the research will be for Q and A sessions at the centre.	11,12
Confirmation of findings	21	What steps will I take in my methodology to ensure the validity and reliability of my findings? Can I involve participants in validation? Will I report to those involved in an accessible way?	The outcomes from the focus groups will be collated and themed. The next stage is individual interviews to examine these themes. Finally, an open invitation was sent to all who attended to share the findings and any final comments. This will ensure conclusions are valid and reliable and saturation is reached. Reporting back in various ways using a visual tool and written reports.	31
Respect persons equally	22	How will I demonstrate my respect for all participants? Have I treated pupils in the same way as teachers? Have I ensured a fair	It is important that the research objectives are achieved and the Golden Rule is always applied. I am very grateful for the keenness of	All 9 49

		representation of those involved in any authorship?	the participants who wish to be engaged and will not jeopardise that. No disrespect will be tolerated at any time.	

Appendix Six

Staffordshire University Ethics Approval



Life Sciences and Education

ETHICAL APPROVAL FEEDBACK

Researcher name:	Lisa Hill
Title of Study:	Walk a mile with me in my shoes
Award Pathway:	Doctorate
Status of approval:	Amendment approved

Thank you for your correspondence requesting approval of a minor amendment to your previously approved application that were highlighted in your email to me dated 06 April 2020.

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Ethics Committee.

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

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

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

A handwritten signature in grey ink, appearing to read 'R. Naemi'.

Signed: Prof. Roozbeh Naemi

Date: 06.04.2020

Ethics Coordinator
School of Life Sciences and Education

Appendix Seven

Presentations and Posters as Post Graduate Researcher Doctorate in Education Studies

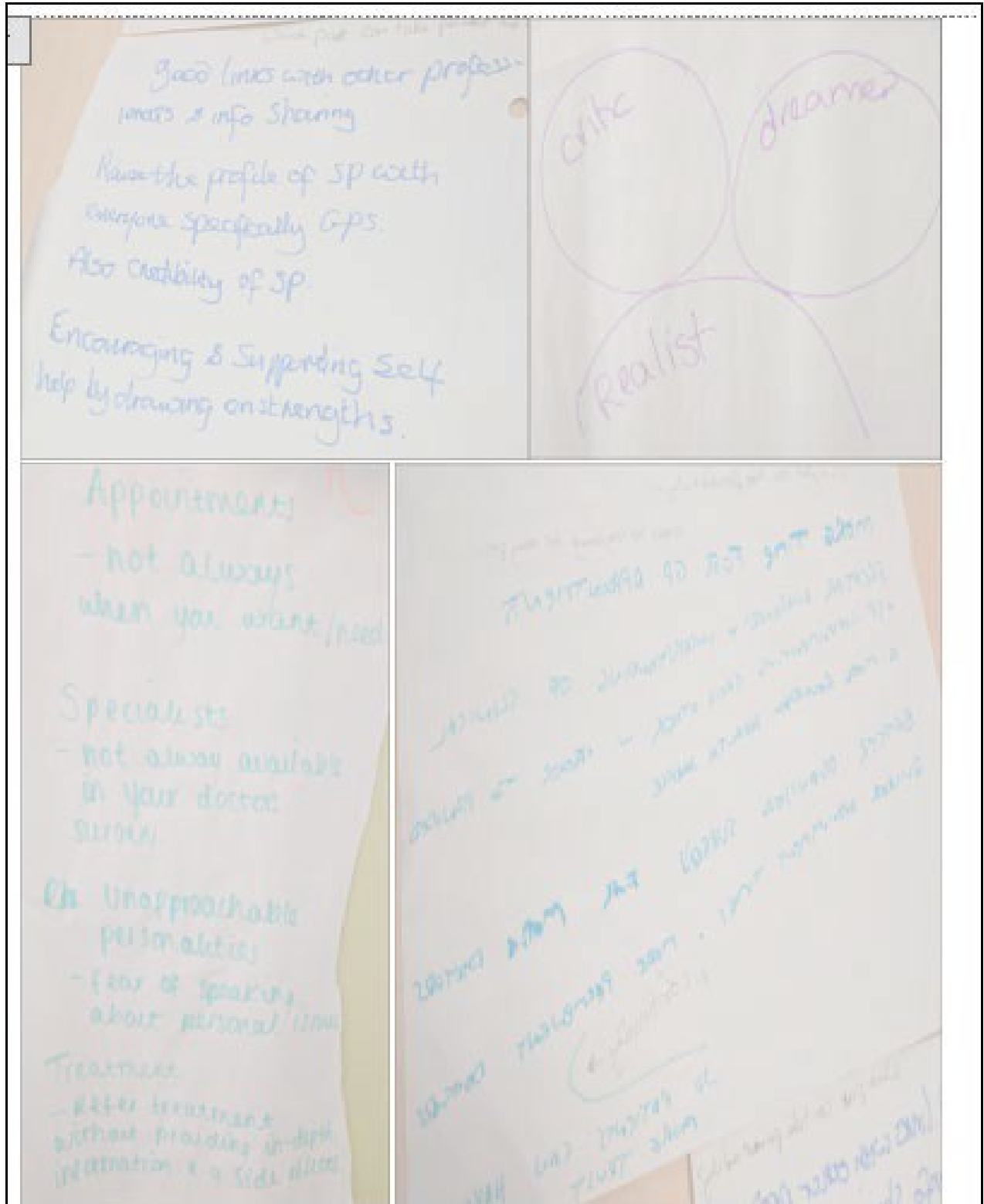
Presentations and Posters	Year
Poster Presentation - European General Practice Research Network Sarajevo Poster on pilot and research proposal	2018
Poster Presentation - European General Practice Research Network Lille Poster on method and methodology	2018
Presentation (webinar) - Research Sandwich Session Staffordshire University Topic Reflexivity	2019
Presentation - European Community-based Mental Health Service Providers (EUCOMMS) Krakow Overview of study	2019
Poster presentation - European General Practice Research Network Vigo. https://www.egprn.org/file/324cbacb-0c68-4f22-aa41-c8ef808d723b/Programme-Book-of-the-8_2019.pdf Poster on Method and methodology	2019
Presentation – webinar European General Practice Research Network Digital medicine and e-health. Overview of study	2019
Presentation - European Forum Primary Care Mental Health Bergen Findings – member checked	2022

Presentation (webinar) - European Community-based Mental Health Service Providers (EUCOMMS) Findings – member checked	2022
Publications	
European Forum Primary Care Position Statement for Primary Care Mental Health http://euprimarycare.org/2020/06/04/efpc-mental-health-working-group-statement/)	2020
Ref.: Ms No. PHC-D-20-00073 European Forum for Primary Care – Position Statement Mental Health 2020 Journal – Cambridge Press - Primary Health Care Research & Development https://scholar.google.com/scholar?hl=en&as_sdt=0%2C5&q=lisa+hill+mental+health&btnG=	2021

Appendix Eight Sample of Feedback on Focus Group

❖ "What did you think of the structure of the session?" ❖ liked mickey mouse ❖ like positive way of thinking and remembering good things ❖ liked being listened to	❖ everyone laughs
❖ F"Going forward do you feel that you shared your knowledge? ❖ Shared information i had ❖ yes shared it ❖ F How did you know? ❖ Because people listened and commented ❖ Because of you and how you come across i could share ❖ We could talk and felt you were interested you really want to know	❖
❖ "Why?" ❖ You listened ❖ We all listened and were interested in our stories and lives	❖
❖ "Why not?" ❖ Think we did ❖ yes	❖
❖ "What did you most like about the session?" ❖ Liked listened to ❖ Our points of view were listened to ❖ Liked sharing ❖ Being positive	❖
❖ "What do you think can be improved about the structure, format, and/or materials?" ❖ Don't know what that means ❖ F this is the way it is designed ❖ Liked mickey mouse and positive things ❖ ❖ Felt could ask you any questions ❖ Difficult question lot easier to ask if they are answered ❖ The next thing i liked was the tables and the sweets	❖
"The researcher was looking to identify <i>'What does a competent primary care practitioner look like?'</i>. Did we answer the question? Yes No not yet	

Examples of Sheets from Focus Group – Disney Modelling



1. Local
 2. Available
 3. Welcoming
 4. Approachable
 5. Lots of information available
 6. Not to be cross questioned
 7. by other sheep
 8. Choice of who to see
 9. Time
 10. Appr. Approachable
 11. Timely referrals
 12. Not feel like you're
 13. Wasting time
 14. To be listened to
 15. Repeat you satisfied
 16. at outcome
 17. Have all knowledge to hand

1. Local
 2. Available
 3. Welcoming
 4. Approachable
 5. Lots of information available
 6. Not to be cross questioned
 7. by other sheep
 8. Choice of who to see
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 11. Timely referrals
 12. Not feel like you're
 13. Wasting time
 14. To be listened to
 15. Repeat you satisfied
 16. at outcome
 17. Have all knowledge to hand

Appendix Ten Sample of typed up sheets used for member checking.

FG1

FG2 26.4.20
NMVO

Question 1

1st question

What do you understand by the term primary care?

Dreamer

Cover anything health and social

For everyone all the time

Whenever you need it

Wherever you need it

Very available

Have an answer anything

Approachable

Happy place

Pass on problems

Non judgemental

Lots of skills

Solutions to a query

For everyone to get the best quality of response from a GP

For every GP to be well qualified (knowledgeable)

For every GP to have a good personality (approachable)

For every GP to be well experienced

For every GP to be a good problem solver

Critic

Appointments

Not always when you want/need

Specialists – not always available in your doctors surgery

Unapproachable personalities fear of speaking about personal issues

Treatment refer treatment without providing in-depth information e.g. side effects

Not enough GPs

Not enough funding

Gaps in educational learning when training

Younger GPs not experienced

Sample of Typed-Up Focus Group Sheets.

Not all GPs have personality due to stress, time limits etc

Not all problems can be solved

Quality depends on experience, knowledge and funding

Solutions not always given

Excessive numbers at surgeries

Different ethnic origins, language, interpreters needed

Realist

Promote social prescribing to GPs – more

GPs to refer in to third sector so they can cope with medical issues rather than social issues which take up time

Also discuss with patients about linking in with advocacy so that other issues can be raised where the patient may not feel confident enough to do so

Advocate – patient and third sector support staff to work together – to ensure the best possible outcomes

Recruitment drive for GPs sell IT massive shortage nationwide

Funding – all government committees but need clear focus and direction

Reassess GP training clinical and social prescribing and mental health and addictions

Character/personality tests re primary careworkers 'are you right for the job?'

Ask primary care workers what they understand by their role and purpose

Some issues/problems will require intensive treatments 1-1

Some primary care workers assume superiority re patients

Talk with the patients 'what do they want?' – achieve - outcome

2nd question

What are your current views on primary care team in your surgery?

Dreamer

Local]

Available appointments

Welcoming

Approachable

Lots of information available

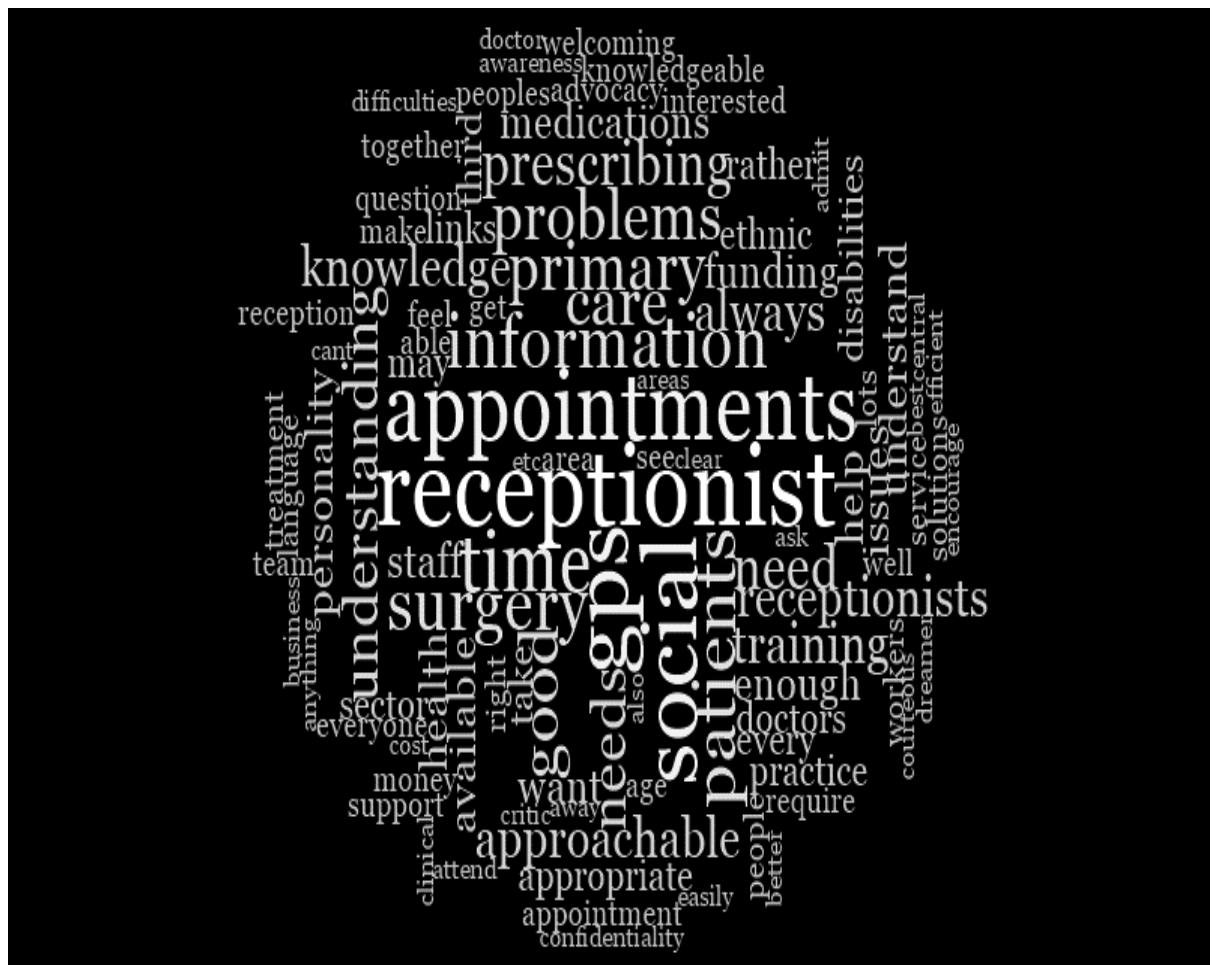
- Not to be cross-questioned by other staff
- Choice of who to see
- Time
- Approachable
- Timely referrals
- Not feel like you are wasting time
- To be listened to
- To feel you satisfied at outcomes
- Have all knowledge to hand
- A good listener on reception
- An organised surgery
- A reliable surgery
- An understanding doctor
- A good welcome on reception
- Good timekeeping for appointments
- Easy to make appointment
- Short waiting list
- A personal doctor
- Critic
- Confidentiality
- Speaking to receptionists 'what are you here for' - Sensitive topics might not want to be discussed in public
- Information advertised re certain demographic groups (e.g. hearing impaired, age) may not be able to read or understand information
- Limited to things to talk about one health problem per appointment
- Prescription times – waiting for GP to sign can take 24 hours – what if this is needed straight away?
- Respect receptionists
- Trust receptionists
- Realise time limits and restraints on GPs and staff
- Doctors have other duties than appointments
- If you wait there may be an emergency
- All medical records in same surgery no need to see same GP

Appendix Eleven NVivo produced an analysis showing words used 3 or more times.

Word analysis focus group	Count	Weighted Percentage (%)
receptionist	14	1.63
appointments	12	1.40
GPs	12	1.40
social	12	1.40
time	10	1.17
information	9	1.05
patients	9	1.05
surgery	9	1.05
care	8	0.93
good	8	0.93
primary	8	0.93
problems	8	0.93
need	7	0.82
needs	7	0.82
prescribing	7	0.82
understanding	7	0.82
always	6	0.70
approachable	6	0.70
knowledge	6	0.70
receptionists	6	0.70
education	6	0.70
available	5	0.58
enough	5	0.58
funding	5	0.58
health	5	0.58
help	5	0.58
issues	5	0.58
medications	5	0.58
personality	5	0.58
staff	5	0.58
understand	5	0.58
want	5	0.58
appropriate	4	0.47
disabilities	4	0.47
doctors	4	0.47
ethnic	4	0.47
every	4	0.47
links	4	0.47
may	4	0.47

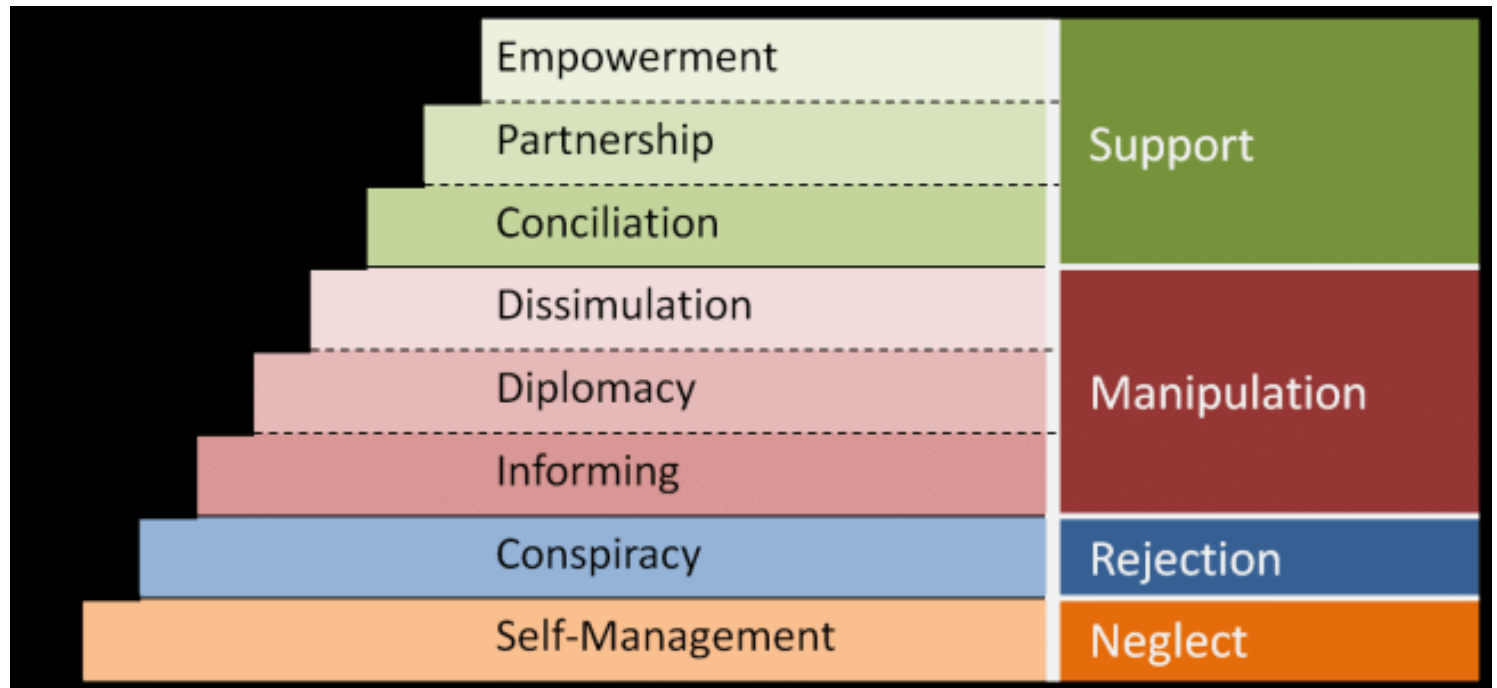
practice	4	0.47
rather	4	0.47
sector	4	0.47
take	4	0.47
third	4	0.47
able	3	0.35
advocacy	3	0.35
age	3	0.35
appointment	3	0.35
area	3	0.35
everyone	3	0.35
feel	3	0.35
get	3	0.35
interested	3	0.35
knowledgeable	3	0.35
language	3	0.35
lots	3	0.35
make	3	0.35
money	3	0.35
people	3	0.35
peoples	3	0.35
question	3	0.35
reception	3	0.35
require	3	0.35
right	3	0.35
see	3	0.35
service	3	0.35
solutions	3	0.35
support	3	0.35
team	3	0.35
together	3	0.35
treatment	3	0.35
welcoming	3	0.35
well	3	0.35
workers	3	0.35

NVivo emerging themes from pre-pandemic focus group



Appendix Thirteen

Ladder of Community Participation (Chogguil 1996)



Appendix Fourteen

Wording of Recruitment Flyer

Recruitment flyer on the wall at the Recovery Republic centre notice board in the reception.

Volunteers are being invited to attend an afternoon workshop with Lisa who is researching primary care and what happens at the doctor's surgery. The afternoon is looking at your positive experiences and challenges to examine:

'Walk a mile with me in my shoes. A qualitative study exploring the involvement of the public in developing continuing medical education in primary care mental health.'

It will be working in a small group using a technique called Disney Modelling and using your preferred way to tell your stories to be that through art, music or being listened to.

Lisa would welcome your valuable comments and the opportunity to hear about your experiences.

If you would like to know more, you can speak to Lisa Hill at the centre on

Appendix Fifteen

Information Sheet for Participants – Focus Group

Working Title: ‘Walk a mile with me in my shoes. A qualitative study exploring the involvement of the public in developing continuing medical education in primary care mental health.’

Thank you for your interest in this study which you are invited to take part in. This study is designed to explore how and whether members of the public could be involved in the development of primary care mental health education.

Before you decide if you are happy to take part, it is important that you understand what the research is about, why I am inviting you to take part, and exactly what is involved.

Please take the time to read the following information carefully.

What is the research about?

The aim is to identify what members of the public think a person working in primary care needs in the way of skills and abilities. To do this, I want to ask different people about their experiences of primary care so that I can work out what works well and what we need more of.

Thank you for coming forward to be part of this study and offering to share your insights and knowledge.

What does it involve?

If you agree to take part, you will:

Attend a whole afternoon focus group with other people. We will use a technique called Disney modelling which was used by Walt Disney with his creative team. This technique will use your preferred way of communicating whether it is through art, music or discussing and being listened to which will allow you to share your thoughts and if you wish your experiences.

You will then be asked to complete an interview with the researcher (Lisa) who is working on the project. If you consent this will last for approximately 30 minutes and would take place at a time and location that is convenient for you (see information sheet). However, if you prefer you can choose to just attend

the workshop.

Are there any risks or benefits?

There are no personal risks or disadvantages involved in taking part in the research. However, we will be talking about your views and experiences of primary care, which might be upsetting. Should this raise emotional distress please notify the researcher who will then immediately contact Dr Taylor, the person supporting this research from The Recovery Republic and who is also the safeguarding lead, who will be at the centre whilst this research is happening. You can then access support either at the time or after the completion of the study. You have the right to withdraw at any time during this process. If you decide to go ahead, you will be asked to sign a consent form to show that you fully understand what you agree to. The Ethics Committee at the School of Life and Education at Staffordshire University has approved the research.

There are no personal benefits for the people who take part, but any knowledge that is gained will be considered in how we might do things differently in future to improve education in primary care.

Your participation is completely voluntary. You can change your mind with what you have contributed for up to two weeks after you have taken part and you don't have to give a reason for doing so. If there is anything that you would prefer not to answer, you do not have to.

Will I be identified in the report?

You will not be identified by name and nothing you say will be attributed directly to you in the final report. The anonymity of everyone who takes part will be protected in the final document.

Any personal information that you provide will be confidential and accessed only by the researcher. Transcripts of the interviews will be stored securely whilst the research is being undertaken and will be destroyed in accordance with the University and Faculty procedures that are in force when the project is completed. The researcher has a duty of care and if anything said causes concerns about your own or another's safety the researcher will have to break

confidence and inform Dr Taylor as safeguarding lead of the Recovery Republic.

FOR FURTHER INFORMATION

This study is being undertaken towards the completion of a professional Doctorate in Education at Staffordshire University. If you have any queries or questions related to this research, please contact me, Lisa Hill at ht907621@staffs.ac.uk.

If you have any concerns about this research, please feel free to contact my course leader, Dr Gill Forrester. Her email address is: gillian.forrester@staffs.ac.uk

‘General Data Protection Regulation 2016 (GDPR).’

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). The data controller for this project will be Staffordshire University. The University will process your data for the research outlined in this information sheet. The legal basis for processing your data for research purposes under GDPR is a ‘task in public interest.’ You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including correction, erasure, objection, and data portability. Questions, comments and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner’s Office, please visit www.ico.org.uk.

Thank you for taking the time to read this information sheet.

Appendix Sixteen Participant Consent Form

Please read each statement and tick the box next to it to indicate that you agree with the statements.

I have read the participant information sheet and the nature and purpose of this research have been explained to me.	☐
I understand that my participation in this project is voluntary and that if I change my mind, I can withdraw at any time and can change your mind with what you have contributed for up to two weeks after you have taken part. I can do this without prejudice and without giving a reason.	☐
I understand that I do not have to answer every question if I do not wish to and I don't have to give any explanation.	☐
I understand that confidentiality will be maintained throughout this project, and that I will not be identified in the final report.	☐
I confirm that quotations may be used in the report if the quotations are anonymised and do not reveal my identity.	☐
I confirm I have been given the opportunity to ask questions about the project and my participation in it.	☐
I understand that my data will be securely stored in accordance with Staffordshire University protocols and current data protection guidelines.	☐
I confirm that I agree to take part in this research project.	☐
I agree that any interview that I take part in may be audio recorded.	☐

I have read the information sheet regarding the General Data Protection Regulation 2016 (GDPR) and I give my consent for my data to be processed in accordance with the GDPR. I recognise that this data is for research purposes and may be used in publications presented at conferences or teaching in the classroom.	
Participant Name (please print)	
Signature	
Date	
Researcher Name	

Appendix Seventeen

Initial Invitation – Focus Group – Disney Workshop

Dear

Thank you for expressing an interest in attending the Disney workshop. It is an afternoon session running 1-4 pm on the.....

It will be a small group facilitated by myself, Lisa Hill. who is studying experiences of primary care. The workshop will be as creative as you are and is designed to examine primary care through your eyes.

Please come along and share your experiences.

I am very happy to come and meet with you beforehand, to discuss this with you if you want more information. I have attached a participation sheet and consent form which I will go through with you at a time that is convenient to you or you can email me directly.

Email – ht907621@staffs.ac.uk if you have any queries.

Appendix Eighteen

Participant Information Sheet 2 semi-structured telephone interview

Title of question: Working Title: Walk a mile with me in my shoes. A qualitative study exploring involvement of the public in developing continuing medical education in primary care mental health.'

You are invited to take part in a telephone interview to discuss the themes produced from the focus group that you recently took part in. Before you decide if you are happy to take part, it is important that you understand what the next stage of the study is about, why I am inviting you to take part, and exactly what is involved. Please take the time to read the following information carefully.

What is the project about?

The main project aims to identify what a person working in primary care needs in terms of skills and abilities. I am examining people's experiences of primary care to determine what work and what we need more of. I also want to use this information to develop education to people working in primary care. This is an exploration of the main themes produced so far from the focus groups. Thank you for offering to take part in this interview, which will enable you to discuss in further detail what was shared at the focus group.

What does it involve?

If you agree to take part, you will be interviewed by the researcher (Lisa) who is working on the project. This interview will be at a time to suit you and recorded so the researcher can ensure she correctly gathers your responses. The interview will last for approximately 30 minutes and will take place at a time that is convenient for you.

To help you to decide whether you want to take part, the interview questions are attached. I will be exploring the findings from the Disney workshop to get your views.

Are there any risks or benefits?

There are not likely to be any personal risks or disadvantages involved in taking part in the research. However, we will be exploring your opinions and experiences of primary care which you may find upsetting, particularly at this current time. Should this happen, you can access support directly from the researcher or the safeguarding lead for the Recovery Republic, Dr Taylor, the person supporting this research from The Recovery Republic and who is also the safeguarding lead, either at the time or after completion of the study.

If you decide to go ahead, you will be asked to sign a consent form to show that you fully understand what you agree to. The School of Life and Education Ethics Committee at Staffordshire University has approved the study.

There are no personal benefits for the people who take part, but any knowledge that is gained will be considered in how we might do things differently in future to improve education in primary care.

Your participation is completely voluntary. You can change your mind with what you have contributed for up to two weeks after you have taken part and you don't have to give a reason for doing so. If there is anything that you would prefer not to answer, you do not have to.

Will I be identified in the report?

No. None of the information that you provide will identify you or be attributed directly to you in the final report. The anonymity of everyone who takes part will be protected in the final document.

Any personal information that you provide will be confidential and accessed only by the researcher. Transcripts of the interviews will be stored securely whilst the research is being undertaken and will be destroyed in accordance with the University and Faculty procedures that are in force when the project is completed. The researcher has a duty of care and if anything said causes concerns about your own or another's safety the researcher will have to break confidence and inform Dr Taylor as safeguarding lead of the Recovery Republic.

FOR FURTHER INFORMATION

This study is being undertaken towards the completion of a professional Doctorate in Education at Staffordshire University. If you have any queries

or questions related to this research, please contact me, Lisa Hill at ht907621@staffs.ac.uk.

If you have any concerns about this research, please feel free to contact my supervisor Dr Gill Forrester. Her email address is: gillian.forrester@staffs.ac.uk

‘General Data Protection Regulation 2016 (GDPR).

Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR). The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined in this information sheet. The legal basis for processing your personal data for research purposes under GDPR is a ‘task in public interest.’ You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you. You have the right to access information held about you. Your right of access can be exercised in accordance with the GDPR. You also have other rights including correction, erasure, objection, and data portability. Questions, comments and requests about your data can also be sent to the Staffordshire University Data Protection Officer. If you wish to complain to the Information Commissioner’s Office, please visit www.ico.org.uk. ‘

Thank you for taking the time to read this information sheet.

Appendix Nineteen Poem written by a Participant during Lockdown

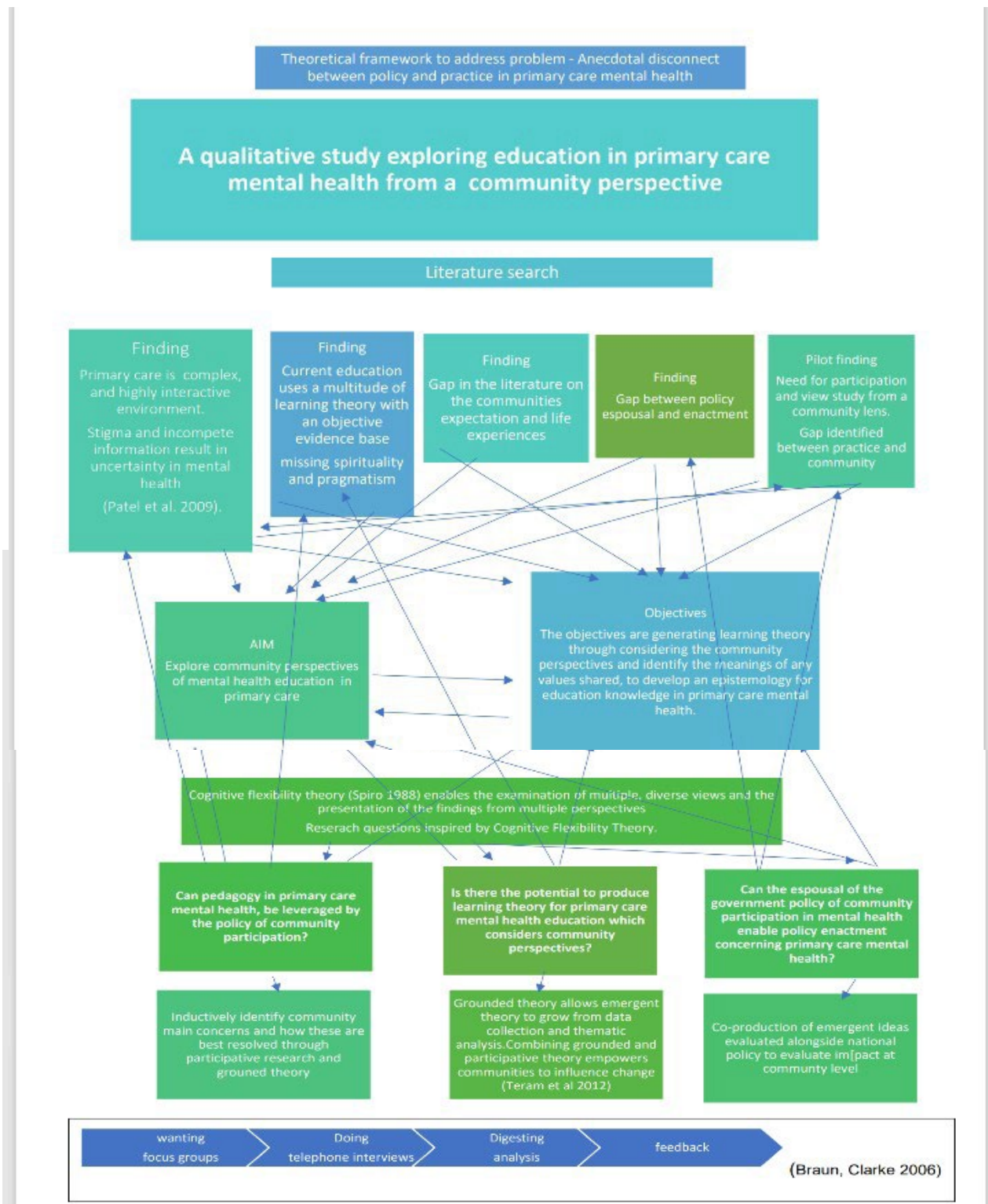
Cycles

Simplifying the complicated with the sensory gift of natural surroundings,
Sounds of bird calls, the field of flowers in their fragile steadfastness, the sight of bluer
than ever skies, sunshine, and clouds, last noticed in a distant childhood,
Smells of cut grass, evocative of its own colour, early pollen and its ability to overwhelm.
All of this providing a taste of a world I have known that has slipped past my senses for
many a year.
As my world is pausing a child re-emerging, drinking in and replenishing my inner world.
Of which I am grateful, the magnificence of this Earth has not been lost, it's cyclical
seasons may spin past. picking up pace each year.
Learning not to concern myself with the fleeting time, or the passing of ages. If I am here,
or when I am not.
Forever is now,
The baking of the soil, it cracks on the scolding rays of sun. Soon the skies leaden,
unburdening, much to the relief of scorched ground, which thirstily soaks up
rejuvenating water, balm to skin.
Interrupted by a myriad of delicate crystals, forming, taking hold deeply, growing, rootlike.
Creating on underground network that binds and freezes.
An eventual reprieve as daylight is extending milky, soft phrase to touch, then melt. The
frost is retreating, quicker than it came, softening a hardened ground.
Then, from deep beginnings, life is coaxed forth roused from a slumber.
Delicately poised.

18th of May 2020.

Appendix Twenty Concept Mapping Exercise

The following illustration shows the results of the concept mapping exercise following the literature review. The results underpin the methods and methodology and shape the questions and objectives.



Appendix Twenty-One Sample of Initial Coding and Timings

disconnect 1° + 2° - 18.59, 55.38,

access/appointments	36.55, 37.16
advocacy	
atmosphere surgery	
attitudes	47.04,
compassion/caring	9.24, 25.13, 26.59, 29.30, 41.51, 43,
community	
complexity	15.36, ~~45.13~~ 58, 59.52,
confidentiality	
continuity	08.19, 10.40, 10.46, 24.52, 27.12, 36.55, 39.07
covid 19	1.01.19,
cultural competence	
disconnect due to language	
Doctor shopping	
education	14.11, 22.10,
empathy/understanding	21.13.
experience	
GP expertise	09.37
GP skills	
inequalities/stigma/	58.16, 58.29, 58.40,
medication	19.43, 25.53, 1.00.19,
mind and body	
model of care	23.12, 25.44, 29.16, 31.54, 38.31,
nurse	
objectification	
one stop	
outcomes	54.12
patients as experts/insight/coping strategies/health literacy	04.52, 17.06, 29.06, 30.42, 32.20, 33.06, 33.42, 43.14, 45.37, 46.04, 53.43
personality	
psychiatry	
reception	
referral	
relational	40.18, 54.55,
religion	
risk	
social prescribing	
Special needs	
spirituality	
support for recovery	3
term primary care	05.56, 07.03,
third sector	
transactional	
trust	13.48
waiting list	

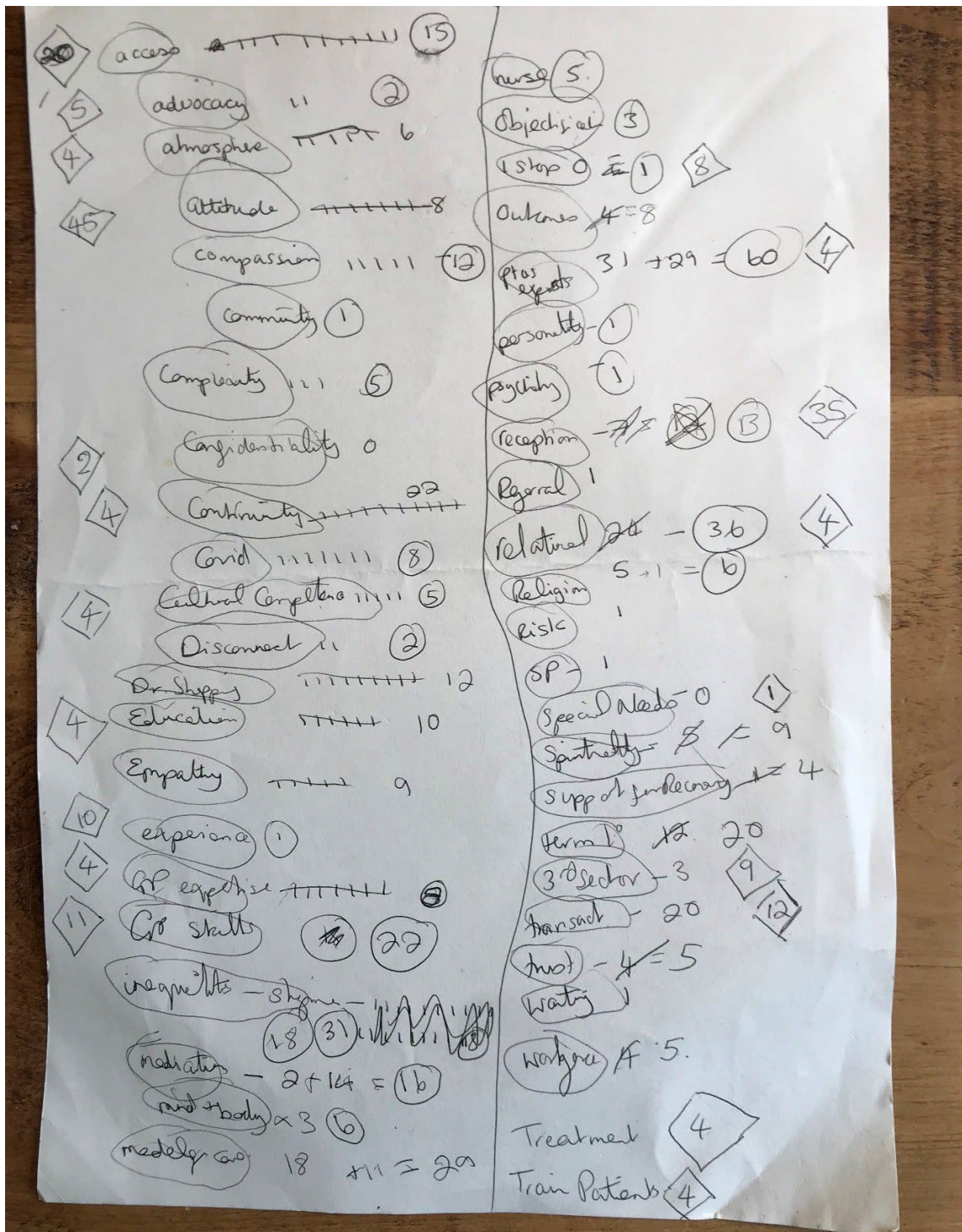
passive - 43.49, 44.49,

Appendix Twenty=Two

Sample of Coding showing Timings to Relisten

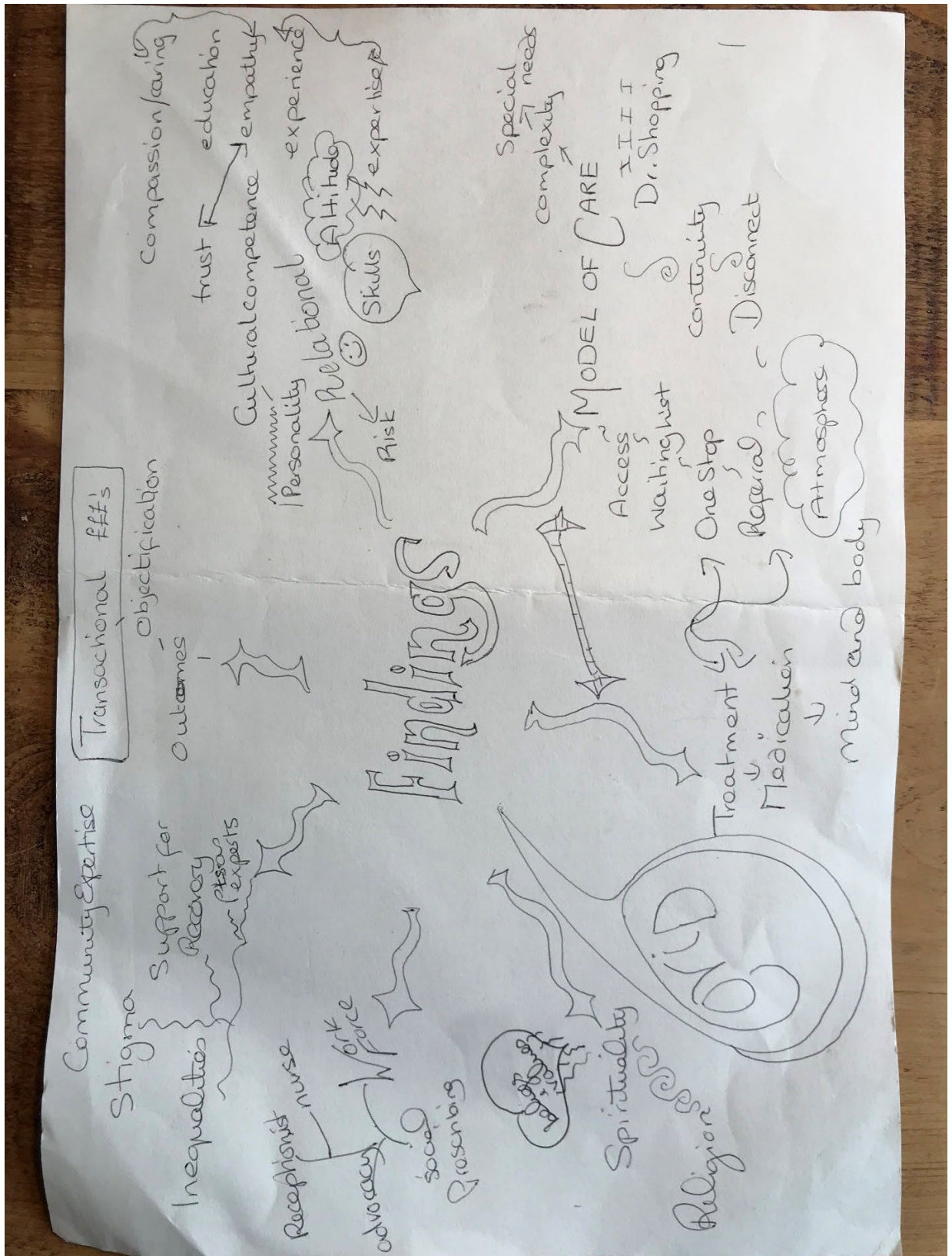
② 3rd sector 01.02 05.53 23.43 Experience	① 00.25 Term 1 ^o Care 01.50 08.02 Train pts.
Education	⑫ medication 18.55 (cross reference front) Sharon's experience)
One Stop	⑧ Religion 13.15 11.17 15.50
Objectification	③ GP skills 03.17 03.50 04.44 14.57 18.55 Cultural Competence 13.15, 11.17, 15.50 Sunday - 17.26.
Model of Care	⑪ complexity. 18.10 Atmosphere surgery
Transactional	⑮ Reception 25.21 Reception ⑭ 21.04
Personality/attitude → ⑩ 17.26	Confidentiality
GP numbers	Appointments
Patients as Experts ⑤ 05.40 08.51 09.48 19.133 22.29	⑦ Spirituality 13.56 Holding onto / dependence 15.50 16.43 16.26
GP expertise	⑨ Relational 02.44 04.24 04.54
Specific needs.	⑫ Dr. Shopping

Appendix Twenty-Three Coding from Telephone Transcriptions and Pre- pandemic Focus Group, linking themes.



Appendix Twenty-Four

Mind map of the findings, emerging themes and sub-themes from focus group and telephone interview



Appendix Twenty-Five Example of themes emerging from transcribed themes.

Row Labels	Count of Field1
relational	1
objectification	1
third sector	1
advocacy	1
personality	1
atmosphere surgery	1
Special needs	1
attitudes	1
workforce	1
community	1
outcomes	1
compassion/caring	1
reception	1
complexity	1
risk	1
confidentiality	1
support for recovery	1
continuity	1
trust	1
covid 19	1
nurse	1
cultural competence	1
one-stop	1
disconnect due to language	1
patients as experts/insight/coping	
strategies/health literacy	1
Doctor shopping	1
psychiatry	1
education	1
referral	1
empathy/understanding	1
religion	1
experience	1
social prescribing	1
GP expertise	1
spirituality	1
GP skills	1
term primary care	1
inequalities/stigma/	1
transactional	1
medication	1
waiting list	1
mind and body	1
access/appointments	1

Appendix twenty-Six Sample of Transcription

15:28

Yeah, because you know you want

15:30

something done something done quickly so id want some.

15:37

advice on that problem yes so I would like to be heard.

15:42

And the positives that come out of that as well as response quickly as many other positives that come out of that.

15:50

Oh yeah, I mean, it makes me feel that I've got ⁸faith in the GP it makes me feel I've got faith in the practice. It also makes me feel more human that are not just being looked at as a number, because I have been to GPS where they've just picked the pen up straightaway or started typing straight away and at that point, you really lose the will, to really talk about what's going on because you know you're not being heard anyway. So, yes. Yeah, it makes you feel more human. ⁹

16:20

⁹ And, is that why just the why so positive is that human element.

16:26

Yeah, Yeah.

16:29

I'm interested in your use of words and because others have used the same words, and you've said about it gives you faith when you go to a GP surgery. Yeah. When you say faith belief.

16:43

⁹ Yeah, in that context, It means, it gives me a belief. I'm being like heard and that I mean something. At that moment, and that my condition or my problem means something at that moment. So yeah, it makes me feel comfortable that that's what I meant by say

17:03

thank you.

17:09

You'd haven't been for about five years for yourself. If you've been for anybody else in the last five

17:16

people yes course yes yeah

Appendix Twenty-Seven

Example of colour coding related themes to develop links to individual transcriptions.

access/appointments	36.55, 37.16	
advocacy		
atmosphere surgery		
attitudes	47.04,	
compassion/caring	9.24, 25.13, 26.59. 29.30, 41.51	
community		
complexity	15.36, 59.32	
confidentiality		
continuity	8.19, 10.40, 10.46, 24.52, 27.12, 36.55, 39.07, 50.16.45, 17.48	
covid 19	1.01.19,	
cultural competence		
disconnect due to language		
Doctor shopping		
education	14.11, 22.10	
empathy/understanding	21.13,	10.01,
experience		
GP expertise	9.37,	
GP skills		
inequalities/stigma/	58.16, 58.29. 58.40	
medication	19.43. 25.53, 1.00.190	9.22,
mind and body	43.39, 44.49	
model of care	30.01, 18.59, 55.38, 23.12, 25.44, 29.16, 31.54, 38.51	
nurse		
objectification		
one stop		
outcomes		52.42 19.13, 10.33, 14.42
patients as experts/insight/coping strategies/h	4.52, 17.06, 29.06, 30.42, 32.20, 33.06, 33.42, 42.14, 45.37, 47.04, 53.43	
personality		

Appendix Twenty-Eight

Examples of mapping transcription against initial times identifying times when discussed.

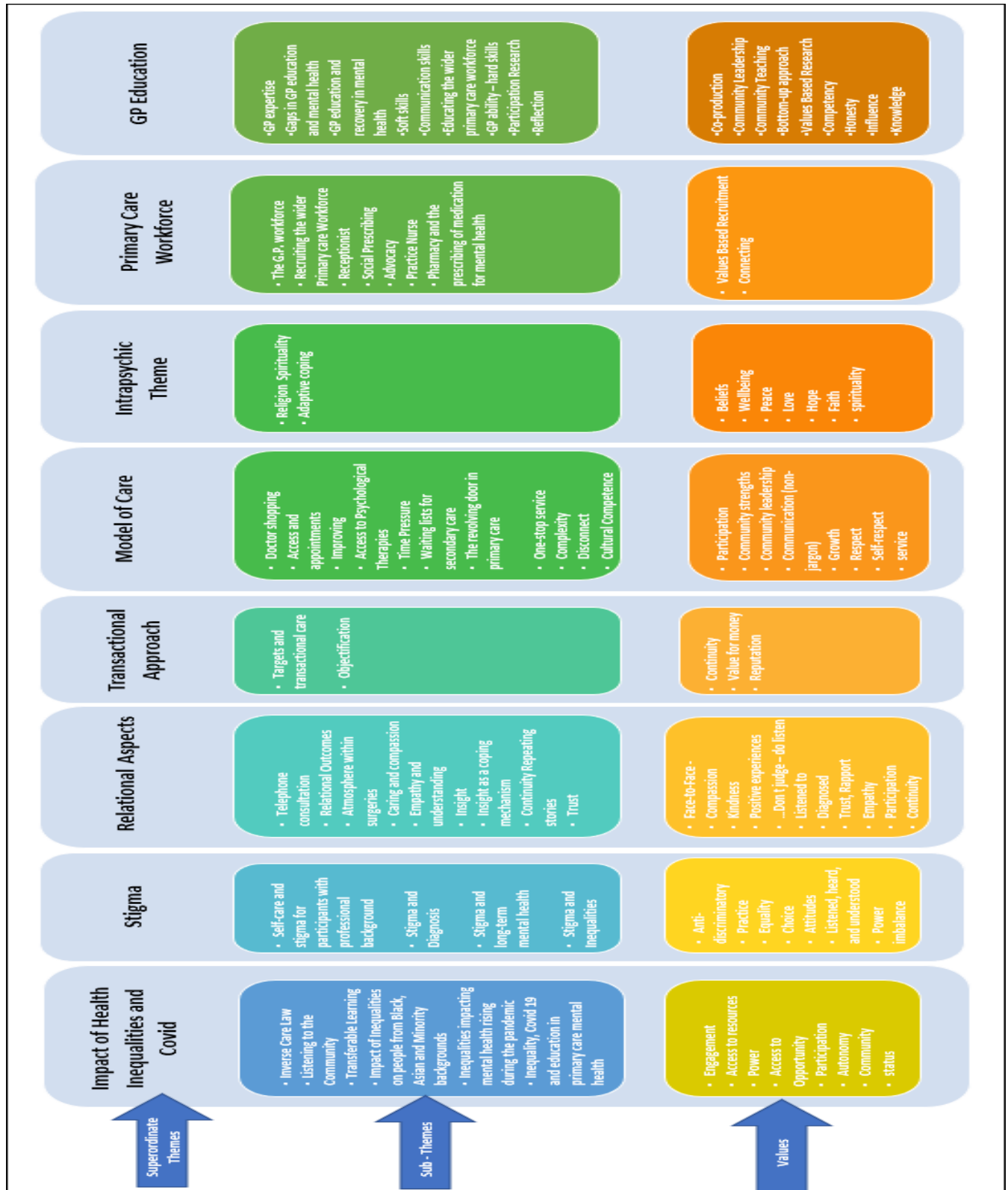
Example Relational theme mapping against transcription

			paper 1 (a)	Paper 2 j	Paper 3 F	Paper 4 M	Paper 5 Mi	Paper 6 J	Paper 7 H	Paper 8 P	Paper 9 D	paper 10 C	Paper 11 C	Paper 12 G
attitudes			14.52	17.26	15.56, 25.5	7.16			32.31					
compassion/caring						18.29, 24.1	13.32,			50.02		9.41		
confidentiality														
continuity			09.45,14.23			5.3, 05.50, 9.34,1023,	13.23,39.59,			13.53				
cultural competence				13.15,11.17,15.50,17.26						21.27				
education									40.17		12.30,12.4	6.05,28.11		
empathy/understanding						5.3,09.17			28.08, 28.51,30.59					
experience										15.41,				
GP expertise					32.23	23.47	10.45,			16.34,19.24,30.25		25.04		
GP skills			3.31,05.49	03.17,03.5	24.51, 28.29.	46.52, 55.59, 48.38,	52.12, 24.	10.25, 28.51,						
personality						10.43								
relational			30.57	15.50, 16.1	15.32,44.2	4.54		33.18,		41.04, 42.3	03.55,04.3	2.43,8.07,10.17,19.44,	30.26	
trust						6.35			32.31	15.35	18.12			

Example Model of care mapped

			paper 1 (a)	Paper 2 j	Paper 3 F	Paper 4 M	Paper 5 Mi	Paper 6 J	Paper 7 H	Paper 8 P	Paper 9 D	paper 10 C	Paper 11 C	Paper 12 G
access/appointments			02.46,21.4	20.41,	17.13, 25.31				3.19, 4.58,34.36, 35.42,38.02					
atmosphere surgery					42.27,42.48				4.06	30.25, 31.34				
complexity				18.1		7.33,	30.09,							
continuity			09.45,14.23			5.3, 05.50, 9.34,1023,	13.23,39.59,			13.53				
disconnect due to language										43.20, 44.59				
Doctor shopping				02.44, 04.1	13.43, 15.35, 17.40		41.10,		3.13	32.39				
medication			3.31	18.55										
mind and body			07.40,08.35						11.02					
model of care					28.55, 51.43		13.32, 23.1	58.08	34.36		08.10,8.51	4.00 - 5.22, 25.13, 28.55		
one stop														
personality						10.43								
psychiatry												6.23		
referral				25.21										
special needs														
third sector				01.02,05.33,23.43										
waiting list						9.58								

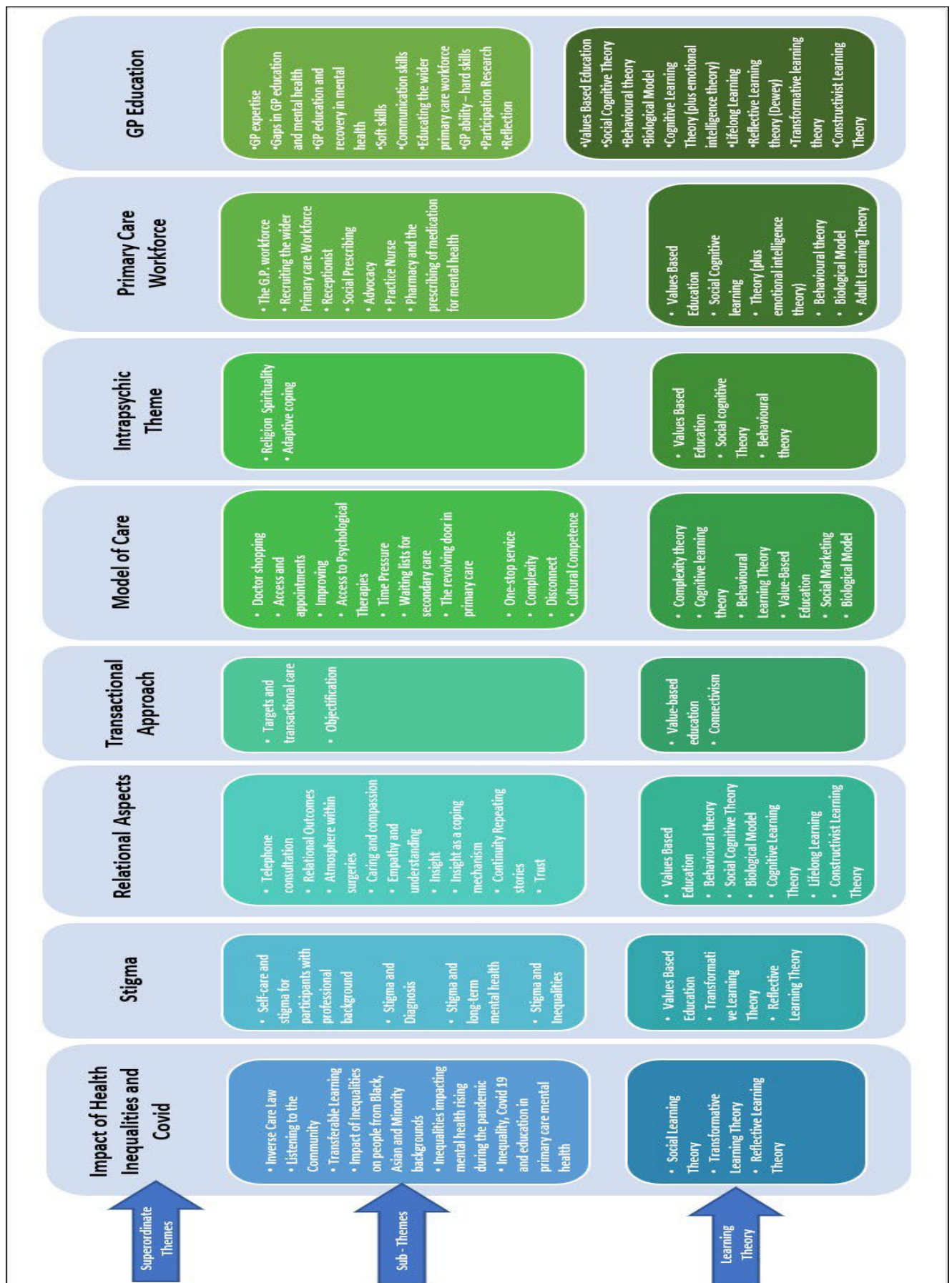
Appendix Twenty-Nine: Themes and subthemes mapped against values.



Appendix Thirty Themes and subthemes mapped against the policy.



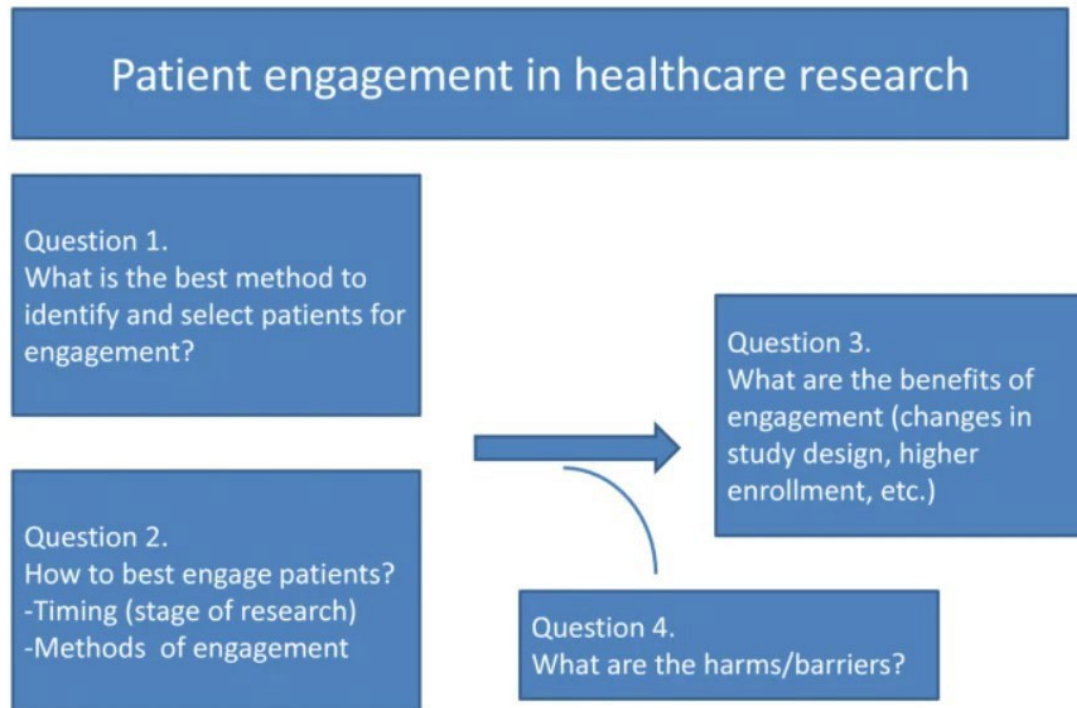
Appendix Thirty-One Themes and subthemes mapped against learning theory.



Appendix Thirty-Two Themes and Sub-Themes



Figure 1



Analytical framework.

Appendix Thirty-Four Gripp2 Short Form

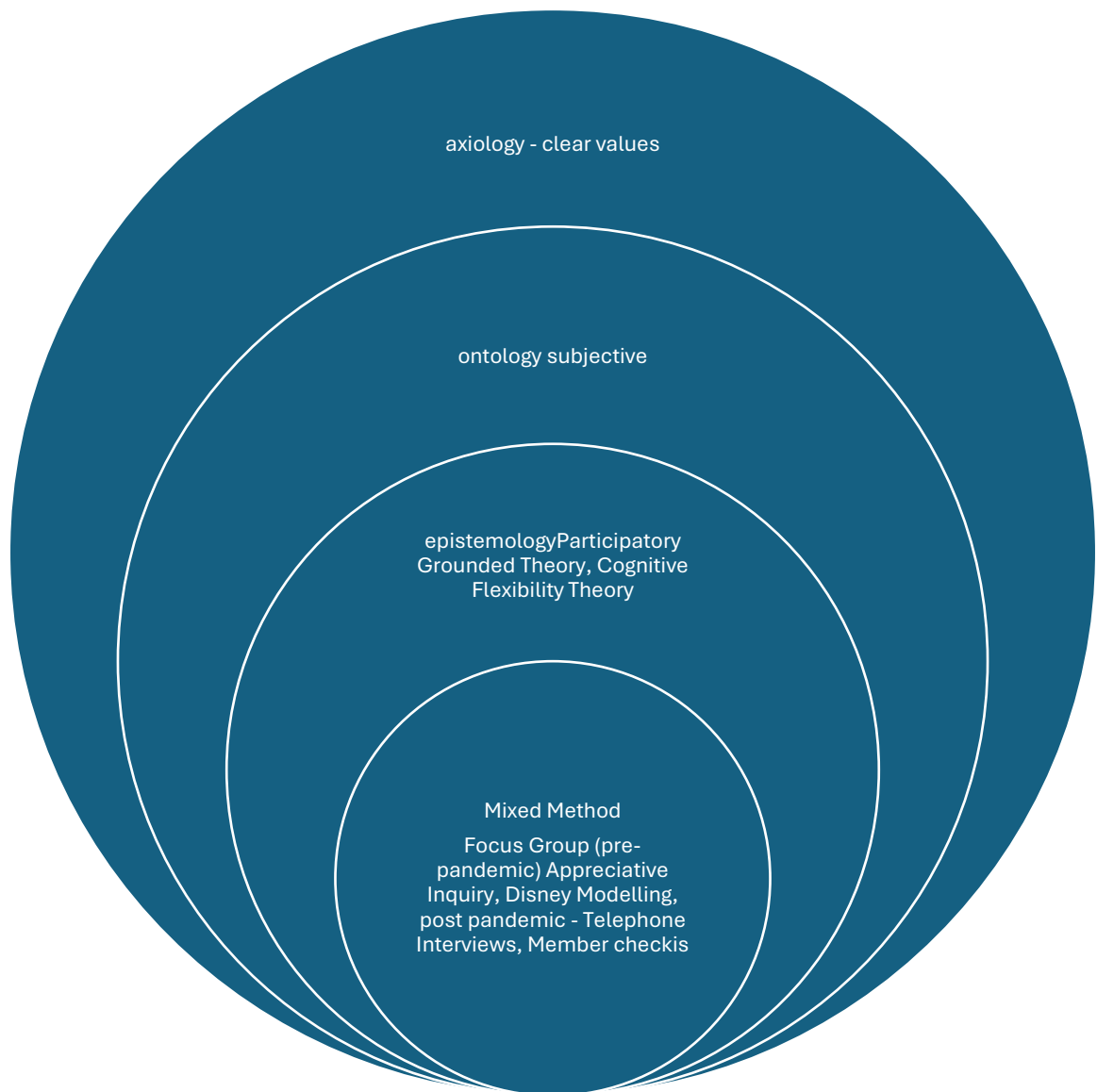
Table 2 GRIPP2 short form

Section and topic	Item	Reported on page No
1: Aim	Report the aim of PPI in the study	
2: Methods	Provide a clear description of the methods used for PPI in the study	
3: Study results	Outcomes—Report the results of PPI in the study, including both positive and negative outcomes	
4: Discussion and conclusions	Outcomes—Comment on the extent to which PPI influenced the study overall. Describe positive and negative effects	
5: Reflections/critical perspective	Comment critically on the study, reflecting on the things that went well and those that did not, so others can learn from this experience	

PPI=patient and public involvement

GRIPP short form (Troya et al.2015)

Appendix Thirty-Five: Overview of methodology and method adapted from Saunders et al. (2007)



Appendix Thirty-Six

I Keep Six Honest Serving-Men (following the story "Elephant's Child" in "Just So Stories") by Rudyard Kipling (1902)

**I keep six honest serving men (They taught me all I knew)
Their names are What and Why and When and How and
Where and Who.**

I send them over land and sea, I send them east and west.

But after they have worked for me, I give them all a rest.

I let them rest from nine till five,

For I am busy then,

As well as breakfast, lunch, and tea, For they are hungry men.

But different folk have different views. I know a person small.

She keeps ten million serving men, Who get no rest at all!

**She sends 'em abroad on her own affairs, From the second she opens her
eyes.**

One million How's, Two million Where's, And seven million Whys!

Illustration One Discovery and Recovery Tree

