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Exploring the value of mental health nurses working in primary care in England: a qualitative study

Authors: Kristina McLeod *RMN, MSc,* City, University of London, School of Health Sciences

Alan Simpson PhD, RMN, Centre for Mental Health Research, City, University of London and East London NHS Foundation Trust, London

Contact: Kristina Mcleod – Richmond Wellbeing Service, Kew Foot Road, Tw9 2TE. Tel: 07983523690. Email: kristina.mcleod.1@city.ac.uk

Relevance Statement

This study offers an insight in to the implementation of a new mental health nurse led service in the developing area of primary care. This study highlights how mental health nurses can integrate into primary care and add to the quality of care delivered in this under researched area. It highlights specific valued skills of mental health nurses working in this role, as well as implications that may arise in the delivery of this service. This study may inform nurses and commissioners on what to consider when implementing care within primary care services and suggests areas for further research.

Accessible Summary

What is known on the subject?

Primary care and, in particular, general practice (GP) is often first point of access to healthcare. International evidence suggests that health care systems oriented towards primary care may produce better outcomes, at lower costs, and with higher user satisfaction. Despite this, there are noted deficiencies and variations in the quality of care in primary care for patients with mental health problems.

What this paper adds to existing knowledge?

Emerging models of providing mental health services in primary care are poorly understood. This paper evaluates a mental health nurse led Primary Care Liaison Service (PCLS), developed in 2011 in inner London.

The findings suggest that this type of service can improve the quality of care for people presenting with mental health problems within primary care, specifically due to: improved integration; clinical effectiveness; patient centred care; access; and efficiency. The study also highlighted challenges such as staff retention within this new role and setting appropriate referral criteria.

What are the implications for practice?

This is a relatively new service and the cost-effectiveness is not yet fully understood; however, commissioners may want to consider the potential benefits of a similar service in their area. The extent to which the findings are transferable will depend on service configuration and local demographics which can vary.

Further research within this area could give more detail on the impact of such teams on health outcomes, recovery rates, impact on rates to secondary care referrals and Accident and Emergency attendances, and its cost-effectiveness.

Abstract

- ***Background:*** General practice is typically the first point of access to healthcare. However, emerging models of providing mental health services in primary care are poorly understood.

- ***Aims:*** To explore what value a Primary Care Liaison Nurse (PCLN) service, established in 2011, can bring to people with mental health problems in primary care.

- ***Participants:*** Ten interviews with seven general practitioners and three senior practitioners working in primary care mental health services.

- ***Method:*** Semi-structured interviews, based on a topic guide of six open ended questions with prompts, were used to elicit participants' experiences and perspectives on the value of a PCLN service. Thematic analysis, based on a 6-phase approach, was used to describe and explore the data collected.

- ***Findings:*** Five main themes were derived from the thematic analysis of interviews relating to: integration; clinical effectiveness; patient centred care; access; and efficiency.

- ***Conclusion:*** This study suggests that the PCLN service can improve the quality of care and is generally highly valued by its professional stakeholders. The study identifies particularly valued elements of the service, including having a duty worker, as well as aspects which could be improved, such as referral criteria.

- Key Words: community mental health nursing; mental health; primary care; primary care liaison nurse

Introduction

Primary care is the first point of access to health care outside of hospitals, with general practice (GP) surgeries a central point for continuity of care and interactions between other healthcare providers. International evidence suggests that health care systems oriented towards primary care may produce better outcomes, at lower costs, and with higher user satisfaction (World Health Organisation 2008).

Primary care is well positioned to provide timely and accessible healthcare services to people with mental health problems (Department of Health 2011); one-in-four of all full-time GPs' patients need treatment for mental health (JCPMH 2012). Some 90% of all patients with mental health problems, including around 40% of all those with serious mental illness, only make contact with health services through primary care services (RCGP 2007). The need to provide effective care for these patients is well-established, with mental illness reportedly the single largest cause of disability in the UK and costs the economy around £70 billion every year (OECD 2014). Furthermore, the life expectancy for people with severe and prolonged mental illness is, on average, 15 to 20 years lower than the rest of the population (Lawrence 2013). There has been a long debate about who should be referred to specialist mental services or who should receive care in a primary care setting and how the interface should be most efficiently configured to promote joint working between professionals (Gask 2009, Lester 2004). However, there are noted deficiencies in the primary care for these patients and a call for more support in primary care services (Ramanuj et al 2015, Reilly et al 2012, NHS England 2016).

Common mental health problems such as depression, anxiety, obsessive-compulsive disorder and post-traumatic stress disorder are most prevalent in primary care (NICE 2011).

A survey suggested 17.6% of people between the age of 16-64 in England met the criteria for at least one common mental disorder, with more than half of those experiencing co-morbid anxiety and depressive disorder (9.0%). However, around two-thirds of adults assessed as having symptoms sufficient to warrant treatment were not in receipt of medication or counselling (McManus et al 2009).

To increase the number of people receiving psychological therapies for depression and anxiety in England, the Government created the Improving Access to Psychological Therapies (IAPT) programme in 2008 (Department of Health 2013). This followed the publication of National Institute for Health and Care Excellence (NICE) guidelines for common mental health problems, which strongly supported the use of certain psychological therapies and the development of the *stepped care* approach (see figure 1), (National Institute for Health and Clinical Excellence 2011). The IAPT programme has reportedly increased access to treatment with more than one million people having used the new services, recovery rates in excess of 45%, and 45,000 people having moved off benefits (Department of Health 2012). However, there is evidence that the demand for these interventions continues to outstrip capacity in many areas and considerable variation in quality of care still persists in primary care settings (NICE 2011, NHS England 2016).

In some areas, services have expanded the stepped care model to include a Primary Care Liaison Nurse (PCLN) service, which is a mental health nurse led service. Such models are intended to ensure that there is a seamless, integrated mental health care pathway for patients with mental health problems across primary and secondary care. This study seeks the views of professional stakeholders that refer into this expanding service, to offer an

insight into its implementation and effectiveness in practice. It may also offer an insight into the role of mental health nurses working in this developing area of health care.

There are few studies specifically on mental health nurses working in primary care services. A previous study on mental health nurses working in primary care suggested that there were improved outcomes for patients receiving treatment by community mental health nurses although this was not significantly different to those receiving GP care (Gournay and Brooking 1994). However, primary care has gone through radical changes with the introduction of IAPT; additionally there has been increasing international evidence of effective ways of working at the interface between primary and secondary care (Gask and Khanna 2011). This includes studies showing strong efficacy for collaborative care, specifically, structured care involving a greater role for non-medical specialists integrated into primary care (Gilbody et al 2006, Richards et al 2013). The majority of studies are from the US and there are variations between study heterogeneity in terms of how collaborative care is implemented. However, positive relationships include the use of case managers with a specific mental health background (Gilbody et al 2006, Richards et al 2013), such as the PCLN service. In the UK, NICE recommends collaborative care for patients with moderate to severe depression and a chronic physical health problem only. However it also highlights the importance of choice in treatments for mental health problems (NICE 2011). This study focuses on how this model of care is implemented in practice; investigating the value of mental health nurses working in primary care services and how it can inform mental health care delivery.

Figure 1. Stepped care model.

Methods

Setting

This study focuses on a new Primary Care Liaison Nurse (PCLN) service, set up in 2011 in response to increasing numbers of patients with complex mental and physical health problems being seen in GP practices.

The team – made up of 12 PCLN's (qualified mental health nurses), an operational manager and consultant psychiatrist – aim to provide care and treatment to patients at a primary care level in conjunction with the existing primary care and IAPT services. The team has been integrated with the existing primary care service within the stepped care model (figure 1 above) at step 3c, with each PCLN working across five GP surgeries. The service catchment area is across two local authority administrative areas within London (see figure 2 below for details of the area).

The PCLN team offer: initial bio-psychosocial assessment; risk assessment and management; triage and screening through a daily duty system; care planning and review; engagement through case management; evidence-based interventions; crisis management; GP liaison and facilitated discharge.

Figure 2. Local demographics

Aim

In light of increasing referrals into the team and recent expansion of its catchment area, the study aimed to explore what value a PCLN service can bring to primary care, from the perspective of two key stake holders - GPs and IAPT practitioners. A qualitative semi-structured interview approach was chosen to draw out detailed experiences and their

implications for service delivery and change in an evolving primary care mental health service.

Participants

Purposive sampling was used to recruit participation amongst 48 GPs and 33 IAPT therapists and managers across two inner London boroughs, who refer into the PCLN service. To recruit participants, emails were sent to potential research participants to take part in the study, to share their views and experiences of working with a PCLN service.

All participants who responded to the email were interviewed and included 7 GPs and 3 senior IAPT practitioners, with the remaining 71 not responding. All participants made direct referrals in to the service but some also had commissioning and managerial responsibilities. Out of the 10 participants, 8 were female and 2 were male. Participants were sought outside the first author's direct role as PCLN and all GPs were unknown to the author prior to interviews taking place. However, although IAPT practitioners were sought out of the author's capacity as a PCLN, they had prior knowledge of the author's profession.

Ethics

The City University School of Health Sciences Ethics Committee approved the research. Participation was voluntary, those who did not respond by the end of June 2016, were assumed to have declined the invitation. Signed consent was taken prior to interviews taking place. The digital recordings did not contain any names and were destroyed once transcribed.

Design

One-to-one, semi-structured interviews were carried out in the participant's work place, usually GP practices or in therapy hubs based in hospitals, to elicit the participant's experience and perspective of having a PCLN service available to them. These semi-structured interviews were conducted by the author using a topic guide of six open ended questions with prompts. Due to the close proximity of the researcher's role to the study, reflexive questions were considered, addressing any distortions or preconceptions of the researcher, to minimise researcher bias in both the interview process and analysis (Dey 1993).

A topic guide was used to avoid having the researcher leading the interview process but rather facilitate participants' own descriptions of their experiences and perceptions (Streubert et al 1995). Open-ended questions were asked and included experiences of referring in to the service and working alongside PCLNs as well as their expectations and thoughts on the patient experience and outcomes following referral into the PCLN service. Participants were asked to discuss any negative or positive outcomes they may have experienced, along with what value, if any, they thought PCLNs can bring to primary care mental health services. The order of questions differed slightly once interviews started to allow elaboration on certain points that were made early on in the interview and to help the interview flow. Interviews varied from 16 to 47 minutes with an average of 22 minutes and took place between April and June 2016. The interviews were audio-taped and transcribed verbatim by the first author, using Microsoft Word 2010.

Analysis

A thematic analysis was used to provide a rich description of the data set, with a recursive, six-phase approach, as outlined by Braun and Clarke (2006), taken to provide rigor. This study was based on the social constructionism framework, which provided a useful lens for interpreting and understanding the views of participants (Rasmussen et al 2014) – constructed through interactions with their colleagues, clients and the social context in which they work (Lukeman and Berger 1996) – on participants view of the PCLN service. Systematic coding was applied to all the data to take a more inductive analytical approach to develop themes. Codes were analysed and refined using Patton's (1990) dual criteria for judging categories developing into broader themes. The themes were then reviewed to ensure they reflected the data and were useful in identifying implications for clinical practice and research to ensure validity of findings (Guba and Lincoln 1989).

Findings

Five main themes were derived from the thematic analysis of interviews relating to: integration; clinical effectiveness; patient centred care; access; and efficiency. Figure 3 illustrates these findings alongside the additional subthemes and broad codes that were identified.

Figure 3. Findings tree.

Integration

Several aspects of integration were raised by participants. These included the benefits brought on by co-location and sharing IT systems, and the significant importance of building relationships with the GP, therapists and wider community. Participants reported benefits

of having PCLNs on site, in terms of accessibility and better communication. They felt these aided discussions on patient care, valuing face-to-face conversations to ask questions, raise concerns about patients and jointly decide on a plan of care.

"When you speak face-to-face you convey more things. For example, with our nurse, we have discussed a case together and we arrive at a joint point that is better". (GP2)

However, GPs expressed different views on how the PCLNs' physically integrate in to their practice, valuing either monthly multi-disciplinary team meetings, or separate ad-hoc discussions on patient care.

Further to co-location, participants reported the importance of building relationships with PCLNs for helping integration. Specific skills that were valued were being: open to discuss cases (IAPT3), approachable (GP2, IAPT2), primary care facing (GP), collegial (IAPT2), pro-active and willing to liaise and engage in practices (GP8), and good communicators (GP3). Advantages from these skills were that PCLNs were then more primary care focused and helped share clinical responsibility. Additionally, all IAPT practitioners noted the advantages of having PCLNs allocated to certain GP practices; "[PCLNs] can give me more insight into the vibes of the surgery than we would have" (IAPT2). Moreover, GPs noted the PCLNs' ability to integrate with the IAPT service, "the primary care team have regular links with different therapists, such as CBT, counsellors or depression alliance so they will be able to triage the patient and see what they might need." (GP1)

Conversely, participants were dissatisfied when these relationships broke down. The GPs noted that a high turnover of staff were a barrier to building working relationship with nurses. IAPT practitioners also found this to be an issue, highlighting the retention of staff as problematic for the service and the difficulty of hiring 'good staff' within the PCLN team.

"in my commissioning role and some things are to do with the system – so I would say the PCLN changes a lot, if that person is changing a lot then it is very difficult especially if they are not in your building."(GP6)

Clinical effectiveness

All participants reported valuing the clinical knowledge and experience of PCLNs working in the service.

"I think interestingly psychiatric nursing is the one area where GPs, which may be due to confidence levels over mental health, can happily work with the CPN as expert, although the GP will often be retaining medical responsibility." (GP4)

Specific skills highlighted were PCLN's ability to make decisions around patients' care, ability to assess and manage risk, recognise and prevent relapse and give medication advice. Participants highlighted the ability to case manage patients with 'complex needs' or 'chaotic presentations', guiding the patient through service pathways.

"I think it's [the] level of experience [of a PCLN]. Someone who is clinically trained, well trained who holds that role – gives us, GPs, the confidence to triage, the ability to risk assess – their ability to signpost and I think it makes the patient's journey a lot more straight forward." (GP5)

"I think it comes down to their ability to decision make. My assumption is that they are better decision makers and it's that layer that's in between, does this patient need to go up the ladder or down the ladder." (GP8)

The most frequently highlighted and emphasised positive aspect is the ability to assess and manage risk; "they [PCLN] also know issues surrounding safeguarding which is quite important" (GP1). Medication advice and review was also highly valued by all participants.

"I think the PCLNs have good in depth knowledge of medication and like I said stabilisation work, so to be able to put people in a position to engage more effectively in therapy." (IAPT1)

In addition to PCLN clinical skills, having a consultant psychiatrist available to the team via the PCLN was highly valued by all and seen to enhance the clinical input PCLNs provided.

"The nurse told me she can liaise with the psychiatrist for an appointment to be seen sooner rather than [if] I refer on" (GP2)

Patient-centred care

Aspects of patient-centred care were highlighted as an additional value of having a PCLN service within primary care. This was specifically raised in relation to the huge number of patients with complex and often co-morbid diagnoses that neither the GP nor IAPT worker had the time to address.

"I know her medication is reviewed and I know her bio-psychosocial factors are included, and I know that's what I would do in clinic, it's just an extension of my work." (GP5)

In these cases, having a flexible approach to where patients could be seen was highlighted as valuable and stigma reducing; "I know that [PCLNs] see patients in GP surgeries but their main base is in the community, which I think is a good model, as they do cover a number of practices and this frees up room in the GP practice" (GP1). GPs also expressed feeling more

comfortable discussing referrals into the service - if it was seen as less stigmatising for patients.

PCLNs were valued for their ability to build therapeutic relationships with patients, as well as support patients' physical and mental health problems together; "if you get a diagnosis of diabetes in primary care, you probably have five different places that you need to be referred to… but if you have severe mental illness you probably won't get to any" (GP4).

Access

All participants identified a need for PCLNs in terms of covering a huge gap in mental health services where, previously, there was no other resource. PCLNs were highlighted as 'bridging the gap between step 3 and secondary care' (IAPT3), whilst also emphasising the importance of PCLNs being distinct in the care they provide (GP3). This was seen to expand service capacity in primary care:

> "…they are dealing with more unstable cases and complex people, people who can't really make use of structured therapy or secondary care services won't see because there's no imminent crisis or risk or psychosis, but their problems are severe and they are real. In other IAPT services where I have worked, the absence of that has really been felt so I see it as actually one of the most important teams we have." (IAPT2)

The PCLN service was seen to support access for patients who are hard to reach, hard to engage or who may have problems leaving their homes. GP4 noted that "it's difficult to get people engaged in to services, to get everything they need, the primary care mental health service, very much the PCLNs, are at the heart of that."

However, whilst all valued flexibility in the types of patients that could be referred to the PCLN service, some GPs were often unclear of patient criteria of referrals. For example, GP8 reported, "they take people on who have been stepped down from secondary care that have been discharged". Similarly, another stated that, "what I would like to see PCLNs doing, is seeing patients recently discharged from secondary care… a huge cohort of patients being discharged from the old community mental health teams and they are asking us to see these patients 5-7 times a year which is a huge huge workload" (GP3). This GP saw no role for PCLNs without this responsibility and would prefer to extend the role with a PCLN full time in their surgery to cover these recently discharged patients.

Further issues with the interface between PCLNs and secondary care were noted, "one of the big frustrations is that you refer someone to secondary care and they say, no it's not for us and they refer to primary care and they say, that's not for us and then there's the poor GP going 'well who's going to take this responsibility?'" (GP6). It was highlighted, "that more work is coming from secondary care in terms of discharge work and they are being expected to see more complex things" (GP8). This was also noted in all IAPT interviews where:

> "… we are all picking up more inappropriate referrals and more complex
>
> presentations, so it went through everyone, but the PCLNs were more directly
>
> exposed to that because of the nature of the people they generally treat." (IAPT1)

Efficiency

Value was also seen in the short waiting times for patients between referral and access into the service, "I think the GPs are referring more to them than they often are secondary care because they feel they are more capable of dealing with it and seeing people quicker as well" (GP8). Faster access to care gave GPs reassurance about treating patients in primary

care. Furthermore, participants noted the added benefits of a duty worker being set up in the team.

> "Having PCLNs really helps, even if it's just a query, or call in to them on duty on whether it is useful to refer on or not." (IAPT1)

More broadly the service was also noted to "keep people out of secondary care that previously would have gone" (GP8). This may be due to the ability of PCLNs to manage risk effectively and, as a result, reduce burden on already pressurised services such as accident and emergency (A&E) departments.

> "It's about risk management – so something has happened acutely that has made their long term condition worse and about having to overcome that crisis and avoiding them going into secondary care for example." (GP1)

> "I'm so glad that someone can do that within primary care, because we do get out of our depth too fast – and all you can say is go to A&E and that's not really satisfactory." (IAPT1)

Discussion

The main aim of this study was to find out what value PCLNs can bring to primary care mental health services from the perspective of different professional stakeholders that refer in to the service. By conducting semi-structured interviews with practitioners and commissioners that refer and work alongside the new PCLN service, details of the service could be drawn out. Comments were generally positive regarding the PCLN service's contribution to primary care. Specifically, the thematic analysis identified benefits relating to improved: integration; clinical effectiveness; patient-centred care; access; and efficiency. The study identified particularly valued elements of the service, including having a duty worker, as well as aspects which could be improved, such as referral criteria and staff turnover. The extent to which the findings are transferable will depend on service configuration and local cultures and population demographics.

The general positive views are not wholly unexpected based on previous research from the UK. In particular, a study exploring how GP registrars feel about dealing with mental health issues found that they felt confident in detecting mental health issues in their patients; however, were less secure about the management of mental health problems due to time constraints, lack of knowledge of referral pathways and local resources, and a limited understanding of the psychology of mental health problems (Lucas et al 2006).

This study identified the potential for PCLN services to cover previously unmet demand, with IAPT practitioners referring patients who are not ready for intensive therapy and whose mental health needs are complex but not severe enough to go to secondary care. Another UK study, on the impact of graduate mental health workers, providing Step 2 care

(see figure 1 above), showed significant contributions were being made within primary care mental health service. However, inappropriate referrals were being made by GPs who thought that such services should be focused on clients with more severe difficulties (Ferrand et al 2007). This suggested focus on clients with more severe difficulties, is an area which PCLNs are seen to cover.

Despite positive views suggested in this study, it should be recognised that mental health nurses have had differing degrees of success at implementing care at a primary care level. A previous UK study found evidence that referral of unselected primary care patients with common mental disorders to a specialist mental health nurse resulted in no additional benefit over usual GP care (Kendrick et al 2006); however, there are clear differences to this study. As well as being a decade old and therefore prior to the introduction of IAPT, the mental health nurses used in this study were based in secondary care services, so did not offer the potential integration benefits identified here. That study also excluded serious mental illness and participating GPs referred roughly one patient each so may not reflect all patients presenting with common mental disorders.

There has been significant international policy interest in developing the interface between primary and specialist care (WHO 2008). Wang and colleagues (2007) in their review of worldwide use of mental health services argue that, policy makers need specific designs they can implement to achieve levels of unmet need for mental health treatment, including in more developed Western nations. As mentioned previously, many studies on successful collaborative care models in primary care are from the US and highlight the need for further research to help clarify whether this system of care can be translated and implemented in other settings (Gilbody et el 2006). Broadly speaking, this study goes someway to filing this

gap in the literature, specifically the use of mental health nurses in this setting. There are

particular comparisons with international studies worth noting:

- This study found that positive aspects of a good PCLN in relation to integration

  included being primary care facing, collegial and, due to co-location, the working

  relationships between the nurse and GP/IAPT. This finding is supported elsewhere.

  For example, Haggerty and colleagues' (2012) investigation on the impact on waiting

  times of co-located primary care mental health services in Canada, albeit between

  psychiatrists and physicians, found that the shared care site offered services more

  than 40 days sooner and also helped to reduce wait time on the non-shared care

  sites.

- Similar models to the PCLN service has been implemented elsewhere, such as, the

  Mental Health Nurse Incentive Program (MHNIP) in Australia. This sees mental

  health nurses work alongside GPs, supporting the treatment for patients with

  complex common mental health problems. A previous evaluation of MHNIP

  highlighted it was seen as significantly enhancing primary care services for those

  with mental health problems and allowing GPs to play a greater role in the

  management of mental health conditions (Meehan et al 2013). A further study has

  recommended that MHNIP provides integrated care for physical and mental health

  (Happell et al 2013).

- International research also supports the finding that there can be challenges in

  sustaining an effective relationship between the GP and PCLN, with GPs noting a

  high turnover of staff. Retention of staff has been identified repeatedly as a major

  issue within the mental health workforce, and linked to an increased risk to patient

safety and of suicide (NCISH 2015), along with increased organisational costs. Page

and Hoge 2010, conducted a review of the literature and found that interventions to

decrease burnout and counter professional isolation are significant factors to

address, although reported there are few studies to draw conclusions of such

interventions.

While all participants identified a need for PCLNs in terms of covering a huge gap in mental

health services, some GPs were often unclear of patient criteria of referrals. Specifically, the

study identified problems in referrals between the PCLN service and secondary care. This

suggests that the PCLN service, clinicians referring to the service and commissioners – along

with other stakeholders – may benefit from working towards ensuring clearer and more

consistently understood criteria and developing agreed local protocols (Simpson 2006).

The PCLN service is a relatively new, developing service and the cost-effectiveness is not yet

fully understood; however, in general terms, a key implication of the study – with its broadly

positive findings – is that commissioners may want to consider the suitability of a similar

service in their area. In particular, the study suggests potential for PCLN services to cover

previously unmet demand, with IAPT practitioners referring patients who are not ready for

intensive therapy and whose mental health needs are complex but not severe enough to go

to secondary care. The Joint Commissioning Panel (2013) – a new collaboration co-chaired

by the Royal College of General Practitioners and the Royal College of Psychiatrists – have

highlighted aspects of a good primary mental health care service incorporating NICE's (2011)

stepped care model guidelines. These aspects include being patient-centred, integrated,

accessible, community-linked, and providing sufficient capacity. This study illustrates that

these aspects can potentially be enhanced with a PCLN service being integrated into the stepped care model within primary care mental health.

Study limitations and further research

This is a relatively small study in one locality with a response rate of just over 12 per cent of potential participants. GP practitioners who responded to the study were likely to have a special interest in mental health, therefore may not reflect GPs across the board. Moreover, the general positive views of participants towards the service may have been expected given the nature of the service in providing additional capacity, expertise and case management.

The interviewers' profession in this research is a primary care liaison nurse which can offer more in-depth discussions in the interviews. However, while attempts were made to minimise the researcher's possible bias during data gathering, this could have affected the participants' responses. In some instances, the language used in the interviews suggested some participants associated the PCLN service with the researcher. For example, some referred to "your service" while others stated "the service".

Although validity and reliability are contested terms in qualitative research (Lecompte and Goets, 1982 and Guba and Lincoln, 1994), certain strategies can be seen to reduce the gap between the social reality researched and representation of findings. Due to limited resources, some of these strategies were not used in this study; this included having a second person independently code the raw data; returning transcripts to participants for comments or correction; and seeking feedback from participants on findings (Tong et al 2006).

Despite these limitations, the study highlights that the PCLN service can potentially improve the quality of primary care and is a highly valued service amongst its professional stakeholders. Similar studies could seek to expand the range of participants, including interviewing patients and PCLNs themselves, which could provide more insight into some of the issues highlighted, such as retention of PCLN's. Further research is required to provide more detail on the impact of such teams on health outcomes, recovery rates, families and carers, the impact of reduced referral rates to secondary care and A&E, and cost-effectiveness.

References

Braun, V. & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3, 77-101.

Department of Health (2011). No Health Without Mental Health. Available at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215811/dh_124057.pdf. Accessed: 19 June 2016.

Department of Health (2012). IAPT Three-year report: The First Million Patients. Available at: http://www.iapt.nhs.uk/silo/files/iapt-3-year-report.pdf. Accessed: 6 June 2016.

Dey, I. (1993). Qualitative Data Analysis: A user friendly guide for social scientists. *London: Routledge.*

Ferrand, P. Duncan, F. & Byng, R. (2007). Impact of graduate workers upon primary care mental health: a qualitative study. *Health & Social Care in the Community*, 5, 486-493.

Gask, L. Khanna. (2011). Ways of working at the interface between primary and specialist mental healthcare. *The British Journal of Psychiatry* Jan 2011, 198 (1) 3-5; DOI: 10.1192/bjp.bp.109.075382

Gask, L. Lester, H. Kendrick, T. Peveler, R. (2009). Primary Care Mental Health. *RCPsych Publications*.

Gilbody, S. Bower, P. Fletcher, J. (2006). Collaborative Care for Depression A Cumulative Meta-analysis and Review of Longer-term Outcomes. *JAMA International Medicine*,2321-2314 (21)166 doi:10.1001/archinte.166.21.2314

Guba, G. & Lincoln, Y. (1989). Fourth Generation Evaluation. Beverly Hills CA: Sage.

Guba, G. and Lincoln, Y. (1994). Competing Paradigms in Qualitative Research. *Handbook of Qualitative Research, Thousand Oaks, Calif: Sage.*

Haggarty, J. M, Jarva A. Cernovsky. Z Karioja. & K. Martin L. (2012). Wait time impact of co-located primary care mental health services: the effect of adding collaborative in Northern Ontario. *Canadian Journal of Psychiatry* 57, 29-33.

Happell, B. Platania-Phung, C. & Scott D. (2013) Mental Health Nurse Incentive Program facilitating physical health care for people with mental illness? *International Journal of Mental Health Nursing* 22, 399-408.

Joint Commissioning Panel for Mental Health. (2013). Guidance for commissioners of primary mental health care services. Available at: http://bit.ly/1muPjNu. Accessed: 6 June 2016.

Joint Strategic Needs Assessment. (2014). Annual Public Health Report. Available at: www.jsna.info. Accessed: 8 June 2016.

Kendrick, T. Simons, L. Mynor-Wallis, L. Gray, A, Lathlean, J. Pickering, R. Harris, S. Rivero-Arias, O. Gerard, K. Thompson, C. (2006). Cost-effectiveness of referral for generic care or problem-solving treatment from community mental health nurses, compared with usual general practitioner care for common mental disorders. *The British Journal of Psychiatry*, 189 (1) 50-59.

Lawrence, D. (2013). Life expectancy gap widens between those with mental illness and general population. Available at: http://www.bmj.com/press-releases/2013/05/21/life-

expectancy-gap-widens-between-those-mental-illness-and-general-popula. Accessed: 6 June 2016.

Lecompte, M. D. Goets, J. P. (1982). Problems of Reliability and Validity in Ethnographic Research. *Review of Educational Research*, 53: 31-6.

Lester, H. Tritter, J. Sorohan, H. (2005). Patients' and health professionals' views on primary care for people with serious mental illness: focus group study. *The BMJ*, 330, 1122.

Lucas, H. Scammell, A. & Hagelskamp, C. (2006). How do GP registrars feel about dealing with mental health issues in the primary care setting? A qualitative investigation. *Cambridge Journals*, 6, 60-71.

Lukeman, T. Berger, P. (1966). The Social Construction of reality: A Treatise it's the sociology of Knowledge. *Garden City, New York: Anchor Books*, 51-55, 59-61.

McManus, S. Meltzer, H. Brugha T. Bebbington, P. Jenkins, R. (2009). Adult Psychiatric Morbidity in England 2007: results of a household survey. *NHS Information Centre for Health and Social Care*. Available at: http://content.digital.nhs.uk/pubs/psychiatricmorbidity07. Accessed: 25 August 2015.

Meehan, T. & Robertson S. (2013). The mental health nurse incentive program: Reactions of general practitioners and their patients. *Australian Health Review*, 37, 337-40.

National Confidential Inquiry into Suicide and Homicide by People with Mental Illness, NCISH (2015). Healthy services and safer patients: links between patient suicide and features of mental health care providers. Manchester: University of Manchester.

National Institute Clinical Excellence (2011). Common Mental Health Problems:

Identification and pathways of care. Available at:

https://www.nice.org.uk/guidance/cg123/chapter/1-guidance. Accessed: 6 June 2016.

NHS England (2016). Five Year Forward View for Mental Health. Available at:

https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-

FYFV-final.pdf. Accessed: 10 May 2016.

OECD (2014). The Social and Economic Costs of Neglecting Mental Health Care. Available at:

http://www.oecd.org/health/uk-needs-to-tackle-high-cost-of-mental-ill-health.htm.

Accessed: 6 June 2016.

Paris, M. Hoge, M.A. (2010). Burnout in the Mental Health Workforce: A Review. *The Journal of Behavioural Health Services & Research*, 37 (4), 519-528.

Patton, M. (1990). Qualitative evaluation and research methods (2nd ed.) *Thousand Oaks, CA: Sage.*

Ramanuj, P. P., Carvalho, C. F., Harland, R., Garety, P. A., Craig, T. K., & Byrne, N. (2015). Acute mental health service use by patients with severe mental illness after discharge to primary care in South London. *Journal of Mental Health*, 24(4), 208-213.

Rasmussen, P. Muir-Cochrane, E. & Henderson, A. (2015). Child and adolescent mental health nursing seen through a social constructionist lens. *Nurse Researcher*. 23, 2, 13-16.

RCGP General Practice Foundation (2007). Adult Mental Health Assessment. Available at http://rcgp-innovait.oxfordjournals.org/cgi/reprint/1/3/180.pdf. Accessed: 6 June 2016.

Richards, A. Hill, J. Gask, L. Lovell, K. Chew-Gragham, C. Bower, P. Cape, J. Pilling, S. Araya, R. Kessler, D. Bland, M. Green, C. Gilbody, S. Lewis, G. Manning, C. Hughes-Morley, A. Barkham, M. 2013. Clinical effectiveness of collaborative care for depression in UK primary care (CADET): cluster randomised controlled trial. *British Medical Journal*, 347, f4913.

Roberts, T. Robinson, M. Stewart, C. Smith, F. 2009. An integrated mental health clinical rotation. Journal of Nursing Education, 48, 454-459.

Simpson, A. (2006). Shared care and inter-professional practice. IN G. H. Rassool & R.G. Hussein (Eds), Dual Diagnosis Nursing (pp.130-139): London, Wiley-Blackwell.

Streubert, H. Carpenter, D. (1995). Qualitative research in nursing: Advancing the Humanistic Imperative. Philadelphia, PA: J.B. Lippincott Company.

Tong, A. Sainsbury, P. Craig, J. (2006). Consolidation criteria for reporting qualitative research (COREQ): 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care,* 19, 6.

World Health Organisation (2008). Primary Health Care. Available at: http://www.who.int/whr/2008/whr08_en.pdf. Accessed: 6 June 2016.

Wang, P. Aguilar-Gaxiola, S. Alonso, J. Angermeyer, M. Borges, G. Bromet, J. Bruffaerts, J. Girlolamo, G. Graaf, R. Gureje, O. Haro, M. Karam, E. Kessler, R. Kovess, V.   Lane, M. Lee, S.Levinson, D. Ono, Y. Petukhova, M. Posada-Villa, J. Seedat, S. Wells, E. (2007) Worldwide Use of Mental Health Services for Anxiety, Mood, and Substance Disorders. *Lancet*. 370(9590): 841–850. doi: 10.1016/S0140-6736(07)61414-7