What is the impact of Chaplaincy in Primary Care?
The GP perspective.

ABSTRACT

People often attend primary care with sub-clinical or non-medical issues such as bereavement, distress, or loneliness for example. Often what is needed is to have someone listen, but GP appointments are inappropriate for this. Community Chaplaincy Listening (CCL) is a listening service delivered by chaplains in Scotland, developed to help people in primary care with problems like these. Evaluations have shown recipients feel more peaceful, less anxious and have a better outlook on life as a consequence. However, the impact from a referring GP perspective is not yet known. This perspective is essential for all stakeholders, but particularly future service commissioners.

AIM

To assess the impact of chaplaincy listening services on clinical practice in primary care.

METHOD

Survey design. Numbers, reasons for referral, and observed benefit of the service from GP perspective were requested from 62 participating practices across Scotland 2016-2017. Descriptive statistics were compiled in SPSS v 23 and content analysis within NVivo11.

RESULTS

A total of 58 (24%) GPs responded from 22 (35%) practices across Scotland. The average number of people referred to CCL over a 12-month period was 20, but ranged from one to 120. People were mainly referred for bereavement issues, low mood, anxiety problems, loneliness or other non-medical issues. The main benefits for GPs were reduction in surgery attendance, increased time for more seriously ill patients,

and some possible changes in psychotropic medicine prescribing. One in three GPs experienced at least one patient refuse the service, mainly because of its religious connotations, but also because they didn't like 'talking therapy'.

CONCLUSION

Responding GPs clearly identified the positive impact it had on time and ways of working in their clinical practice. For many, Community Chaplaincy Listening embodied the shift away from the 'fix me' culture towards one of self-management, current tenets of health policy. Future prospective studies should now be constructed to quantify these benefits in detail.

INTRODUCTION

Community Chaplaincy Listening© (CCL) is a listening service delivered primarily by chaplains in primary care in Scotland (Mowat & Bunniss, 2012). It was designed to help people with a range of issues. For example, if a patient presents to their GP with 'persistent physical problems' (NHS Education for Scotland, 2014) refractory to treatment, or non-medical problems such as bereavement, then the GP may refer the patient to CCL. If the patient agrees then they meet with the chaplain at an agreed time. Patients have around 50 minutes per session to talk through their troubles with the listener, and are free to attend as many sessions as they need.

The chaplain's intervention has been defined as '*careful, agenda free listening'* (Mowat et al., 2013, p. 36). One chaplain described her listening role as:

> "*Helping people unravel the events going on in their lives so that they can make meaning, find purpose and strength and a hopeful way forward*" (Mowat et al, 2013, p. 39).

BACKGROUND

Community Chaplaincy Listening developed from local chaplaincy practice in Scotland in 2010. It was standardised through a series of action research cycles (Bunniss, Mowat, & Snowden, 2013) so it could be coordinated in a national project under the governance of National Education for Scotland (NES)(Mowat & Bunniss, 2012). As of 2017, CCL has been delivered in every health board in Scotland, and the most recent research showed that patients reported feeling less anxious, more at peace, and experienced a better outlook on life following CCL (Snowden & Telfer, 2017).

Comparable services elsewhere in UK have been similarly positively reviewed. For example, Kevern & Hill, (2015) found a significant improvement in patient wellbeing in a pre-post study of chaplaincy in primary care in England. Macdonald (2017) conducted a retrospective study of primary care chaplain interventions and found that patient wellbeing was not only improved but also maintained at 80 days. The

improvement was equivalent to that seen in related cohorts taking antidepressants (Macdonald 2017).

However, despite the clear patient benefit, the benefit to the referring GPs is less well understood. For example, it is unknown exactly what type of person GPs referred or why. Macdonald (2017) termed the people he referred as suffering 'modern maladies', such as chronic fatigue syndrome or ME. Kevern & Hill (2015) referred to their participants as suffering 'subclinical mental health issues'. It is also unknown what GPs expect from the service, or whether there are any observable clinical consequences of referral. These elements are important and currently missing pieces of the puzzle.

Current health policy in Scotland advocates self-care; prevention rather than cure, and integration of services targeted to individual needs wherever possible (The Scottish Government, 2016). Worldwide aspirations mirror these, with person-centred care driving global health policy (WHO, 2015). The current chief medical officer in Scotland's strategic overview is called 'Realistic Medicine', likewise advocating an integrated, interdisciplinary and holistic view of health (Calderwood, 2017).

The main stumbling block with this agenda is turning these ideals into action. Chaplaincy could play a leading role here. Chaplaincy has an authentic set of skills and practice entirely coherent with these 'realistic' principles, and has been working in an holistic, person centred manner throughout its history. Somewhat ironically, they are unlikely to be heard because medicine dominates health discourse. In order for chaplaincy in primary care to be listened to, GP backing is essential, and the best way to obtain GP backing is to demonstrate the clinical impact of their interventions. The purpose of this study was therefore to articulate the clinical benefit of CCL from GP perspective.

AIM

To assess the impact of chaplaincy listening services on clinical practice in primary care.

Objectives were:

- To establish how often GPs referred to the service

- Understand the reasons for referral
- Explore the clinical benefits of the service from GP perspective
- Establish any barriers to referral

METHOD

Design

Survey design.

Process

A bespoke survey was constructed with the aim of meeting the objectives in as short a time as possible (Streiner & Norman, 2008). It is well known that GPs are very busy and so the brevity and clarity of the survey was key (Baird, Charles, Honeyman, Maguire, & Das, 2016). The questions were a mixture of closed and open quantitative and qualitative items (table 1) designed to cover all the elements of practice likely to be impacted on, informed by the seminal '*What Chaplains Do*' by Mowat & Swinton, (2007).

A pilot survey was sent to all six practices participating in CCL in one health board area of Scotland in early 2016. A link to the survey was sent by email, with a short supporting explanation about what the survey entailed, guarantee of anonymity for respondents and an assurance that the survey would be very quick. A reminder email followed two weeks later. Following success of this, the same method was used nationally. The link to the survey was emailed directly to the 56 remaining surgeries across all health boards in Scotland where CCL was known to be used. Reminders were sent as in the pilot, and data gathering finished at the end of 2016.

Analytic plan

Results were imported into SPSS version 23 for descriptive and inferential analysis where relevant. All text was imported into NVivo version 11 and coded using content analysis (Drisko & Maschi, 2015). Content analysis is similar to thematic analysis in that it looks for commonalities, but differs slightly in that it doesn't seek to build theory. In brief, if something is mentioned often by different participants then this is treated as a common theme (Vaismoradi, Turunen, & Bondas, 2013).

Table 1. GP survey questions

- How many patients have you referred to CCL in last year?
- What are the main benefits of CCL from your perspective?
- Did any of the people you referred refuse to go? If so, why?
- What is your main reason for referring your patients to a chaplain?
- What action would you have taken if CCL had not been available?
- Has CCL changed your prescribing in any way?
- Does CCL help with time management?
- What benefits do GPs feel they personally get from the service in their practice?
- What are the challenges of the service that could be improved on?

Ethics

Ethics permissions to obtain the data were given prior to data collection (WS/13/0165). Anonymity of participants was assured, and individual details of participants was not requested, only the surgery they were associated with. Results are summarised below. Quotations are not labelled at all because some surgeries are very small, increasing the risk of identification.

RESULTS

In total, 22 practices responded (35%) with a total of 58 (24%) general practitioners completing the survey.

How many patients have you referred to CCL in last year?

Responses ranged from ‘one or two’ to ‘50+’, ‘about 10 patients per month’ and ‘dozens! I refer very regularly!’. From those GPs that cited an exact figure, the median response was 20 per year with a range of one to 120.

What are the main benefits of CCL from your perspective?

Attendance and prescribing were mentioned by the majority. Practically all respondents mentioned or referred to these:

> *Less attendance at surgery, also …feeling more positive/better re things.*
>
> *Less attendance, less prescribing, somebody with time and willingness to listen.*
>
> *Patient feels supported. Improvement of symptoms. Less reliance on practice. Improved presentation/coping skills, less pressure to prescribe.*

All felt the service was beneficial, although some were a little more restrained in claiming impact on attendance:

> *Reported patient benefit. Difficult to be sure if patients would have attended more if service not available, however positive feedback and I feel patients have benefitted.*
>
> *Ability for patient to move forward, improvement in general well-being, improvement in mood, less GP appointments (at least short term).*

One of the largest categories was the saving of time for the GPs and other referrers:

> *Would like to thank those who provide the service for helping my patients at their time of need and give me more time to do the job I need to do too.*
>
> *Feel it is a valuable service and relieves pressure on clinical staff.*

Ease and speed of access and a new way of managing people in surgery with 'lower-level' problems were seen as benefits:

> *…increased options for managing patients with lower-level symptoms.*
>
> *Short waiting list and seeing people within the practice are both positive factors*
>
> *I have received excellent feedback from my patients re this service- any who have used it say how worthwhile it has been. One lady who was really suffering with bereavement came away saying the weight had been lifted from her -this is amazing as patients can wait weeks sometimes months to access counseling locally and my patients can access this service within a week*

The last quote suggests that the act of listening is empowering in itself:

> *…all of the above, more confidence for patients to deal with and gain control of their symptoms and lives in general, greater well-being, more motivation. Less reliance on doctors and taking more active role in their own health rather than the prescribed tradition passive role of "fix me".*

Did any of the people you referred refuse to go? If so, why?

35% of responders reported yes to this question. Reasons were primarily to do with the perceived religious element of the service, even when reassured this was not the case:

> *Some worried about religious aspect despite reassurance*
>
> *did not want anyone religious even though told then no religious content*
>
> *One or two that I mentioned it to did not want to see a "religious" person – even though I reassured them!*
>
> *Concern re word chaplain.*

Others just didn't want 'talking therapy' of any kind:

> *I had some that had problems to accept counselling in general at the time, but they did not decline primarily because of the kind of service on offer*
>
> *"don't like talking about things"*
>
> *Didn't want talking therapy.*

For a small group, refusal was a function of time or circumstances:

> *Housebound.*
>
> *Usually a time issue eg time off work.*

Finally, one GP mentioned level of distress being an important criterion for referral:

> *Not the right time - distress too high*

What is your main reason for referring to a chaplain?

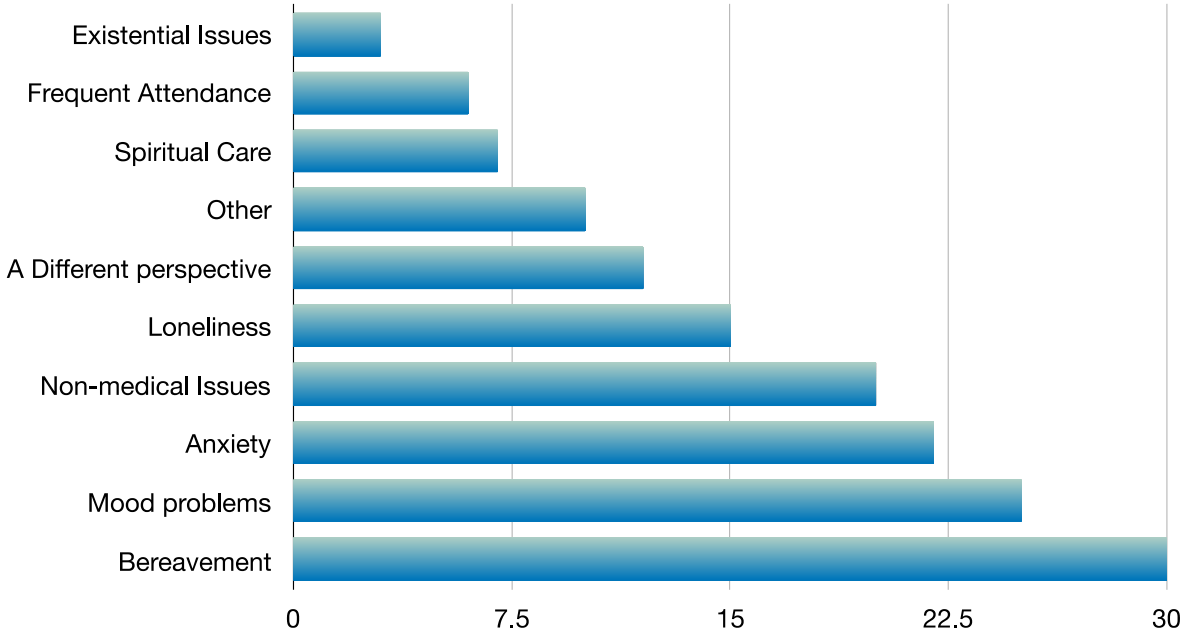

Figure 1. Reasons for referral)

Figure 1 shows the main reasons were bereavement, mood, social/non-medical issues, anxiety and loneliness. When reflecting on rationale to refer patients, the most prominent theme was that GPs felt these patients needed more time than they could give them:

> *…sometimes able to pass on to listening service where pts really need more time to talk than I can really give.*
>
> *As patients often have multiple issues form bereavement to finances and can't do this credit in 10 mins-I know they just want to get it all out but I can't spend the 40mins plus they need…*

10 mins gives time for clinical diagnosis but often people need to talk through a problem/issue and the allotted 10 mins simply does not suffice.

Especially where problems were perceived to be non-medical, some GPs reflected on the need to move these patients on for the sake of the medically unwell people they have yet to see:

I feel [CCL] cuts down on time I spend with patients who need a listening ear but are generally otherwise mentally well.

What action would you have taken if CCL had not been available?

Many responders to this question expressed frustration with existing resources. The majority of the responses mentioned psychiatric services, and how difficult it is to get a referral accepted:

Often CPN referral, which is often "bounced", often prescribing drugs, sometimes psychiatry referral, often many over running consultations with me…

CPN/ PCMHT referral with huge waiting lists.

We have very few alternatives - no local psychology, no local counselling. We refer to CPN.

Possibly referral to Adult Psychiatry.

Referral to counselling or self-help resources

Refer to counselling.

Counsellor.

Suggest self-referral to [local counselling services] or would consider CPN referral.

Some would have to resort to online resources:

Websites or helplines or clubs.

Online resources, refer to 'living life' telephone CBT.

Others suggested they would continue to see the patient themselves:

Given them the list of counselling services in [xxx] ended up seeing them more myself.

Patient/s usually keep booking to see me as waiting times for counselling in [xxx] is 12 weeks!!

Repeated GP appts for non-medical support.

Probably seen them more myself while waiting for other support such as counselling.

Ongoing counselling by me …

Sometimes there is no other option other than to continue to see the patient oneself but with less time and less effect

Some would have reluctantly considered prescribing

CMHT referral, antidepressant prescribing.

Primary mental health referral and inappropriate medication whilst waiting.

CRUSE, CPN, continued GP care, possibly medication.

CMHT referral [and] greater pressure to prescribe psycho pharma.

Has CCL changed prescribing?

GPs did not to use this service in place of medications. Rather it was reported that CCL was useful in combination with medications. Although patients with low mood and depression were often referred; the decision to prescribe anti-depressants was not affected by the service. Reasons for referral to chaplaincy tended instead to be for 'non-medical' or 'sub-clinical' issues:

I see medication as a tool that some people may need to enable them to use a listening service and not as an alternative.

Antidepressants are a treatment for a clinical condition with a set list of criteria.

Often a 'multi-pronged' approach necessary…

Anxiety disorders were seen slightly differently. A number of GPs reported the service having a positive effect on their patients with anxiety. Patients were presenting less with anxiety after referral and some doctors manage to avoid prescribing anxiolytics as a result:

The patients present less to me with anxiety, when they are using [CCL] service

In some patients with acute distress, we can often provide a listening appointment quickly and allow another outlet for the distress and avoid anxiolytics. Level of antidepressant prescribing is unchanged.

What benefits do GPs feel they personally get from the service in their practice?

Most responses to this question went on to reiterate the benefits articulated in the earlier questions. However, a significant minority described the negative personal impact of having to manage complex issues without wider support:

We may deal with 30 or even up to 60 patients in a day. When one or more has existential or emotional problems and "needs" listened to, while the waiting room is full and there could be medically urgent things waiting, it is an additional emotional stress on me over and above the usual effects of doing counselling – and we have no de-briefing or supervision - just rush on to the next patient who is angry about waiting so long.

DISCUSSION

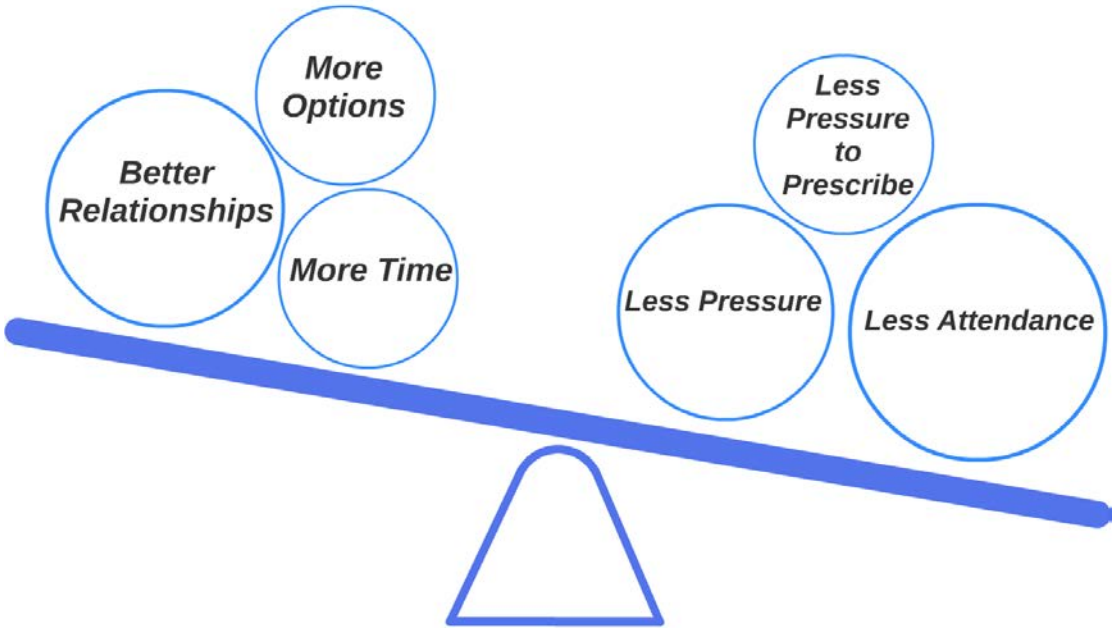

Figure 2. Reasons for and outcomes of referral to CCL

The first objective was to establish how busy the CCL service was by ascertaining numbers of referrals. However, due to low sample size and variation in responses it is difficult to estimate. Fifty-eight GPs responded to the survey, approximately one quarter of those the survey was sent to. However, it is unknown if non-responding GPs referred anybody to CCL. Further, the range in responses was very large, making any estimated average unreliable. Future attempts to gather this information will need better record keeping on behalf of the GP practices, and more specific questions from future researchers.

In relation to referral criteria, it appears that those suffering from bereavement, low mood, anxiety and social challenges were commonly referred (figure 1). This aligns with an earlier study, where bereavement had been the main reason for patient self-referral, closely followed by relationship difficulties (Bunniss, Mowat, and Snowden 2013), suggesting bereavement is likely to be a generalizable criterion. The low mood and anxiety discussed by the GPs here may have been a function of relationship difficulties but this is unknown.

The wider literature pertaining to GP referral to chaplaincy is sparse. Kevern and Hill (2015) found that there was no clear 'trigger' for referral to the chaplaincy service, but like Macdonald (2017) described a set of ‘sub-clinical’ issues. Macdonald described the set of relevant sub-clinical issues he regularly sees as ‘modern maladies’. These included obesity, chronic fatigue syndrome and diabetes, though he didn’t necessarily claim that these would necessitate referral to chaplains in his study. So, whilst bereavement is likely to be a generalizable factor, further research is needed to better understand the range of ‘lower level symptoms’ GPs use for referral.

The most consistent benefit of the service to GPs was time: time saved and time used elsewhere. For example, CCL saved GPs time so they could spend it with other, more seriously ill patients. One GP described this as having more time ‘to do the job I need to do’, inferring that some of the time otherwise would be not spent in this way. The time taken from referral to seeing a chaplain was described very positively as ‘quick’, ‘easy’ or ‘speedy’, whereas by comparison waiting lists for alternative resources (CPN, Psychiatry) otherwise took a lot of time and were otherwise unsatisfactory. Pressure was an associated theme; pressure on GP time but also pressure to take action, to prescribe. CCL relieved that pressure by providing not just a viable

alternative but a preferable one. Recall one GP describing CCL as am ‘outlet’ for distress and alternative to anxiolytic.

Alternatives to CCL were by comparison considered inadequate. For example, as well as wasting time, referrals to other services were sometimes knocked back, often after a long wait. CCL therefore helped GPs to help a group of people with issues not severe enough to fall under the remit of other clinical services such as specialist psychiatric support. This is important. The stress and frustration created from having to manage non-clinical issues in an environment completely unsuited to doing so (the ten minute appointment) is known to be a recipe for burnout for GPs (Imo, 2017). A recent survey in the British Medical Journal found that only 8% of 15,000 GPs (BMA 2015) felt they had adequate time with patients. Consider again the last quote in the results section. This GP describes dealing with up to 60 patients a day, all with their own needs, but always with the feeling that there were other people waiting with more serious ‘medical’ issues. The fact that CCL had a positive impact on time alone makes it significant. The fact that it was also clearly beneficial makes it *important.*

Accessibility was also key. That the service was available quickly and locally was mentioned frequently, and the impact of all this time saving and pressure relieving was notable improvement in individual patient well-being. Some GPs evidenced this by describing a reduction in repeat appointments and improvement in ‘confidence’ with certain patients. The literature also describes qualitative improvements in the therapeutic relationship too. MacDonald’s (2017) study described better consultations with patients who had seen a chaplain, as did earlier research where GPs reported their consultations had become more focussed with patients that had been referred to chaplains (Mowat, Bunniss, and Kelly 2012; Bunniss, Mowat and Snowden 2013).

Some GPs discussed the service as an adjunct or alternative to prescribing, although this was quite rare, and prescribing psychotropics instead of services was certainly seen as an undesirable last resort. Most stated that having the service as a referral option did not affect their decisions to prescribe in cases of depression. Previous studies have shown that some patients who were being prescribed psychotropic medication found they no longer needed to take it after a listening service appointment (Bunniss, Mowat, and Snowden 2013), but caution is needed here, as with MacDonald (2017), who showed that primary care chaplaincy was associated

with an improvement in well-being comparable to that seen in a similar cohort taking antidepressants. Note that neither Macdonald or Bunniss et al were claiming chaplains were better than antidepressants, just that they can have a similar impact on levels of well-being in certain cohorts of patients. This is an important distinction. Depression, is a clinical condition requiring clinical treatment, particularly where moderate or severe (Rimmer, 2018). All referrals to CCL were by contrast for *non-clinical* issues, so using prescribing levels as a metric for chaplaincy efficacy is inappropriate without very clear and specific inclusion and exclusion criteria.

Comparisons are inevitable however. Some GPs suggested CCL provided a service comparable to psychology. They also referred incorrectly to 'therapy' in some cases. This suggests that at least some of the GPs may need a better understanding of the role and function of CCL. CCL is a 'listening' service, psychology is not. Similar to diagnostic medicine applied by psychiatrists, psychologists use 'case formulation' to construct therapeutic goals (NCS 2016). CCL by contrast *simply listens*. There is no agenda other than that (Snowden et al., 2018). Another consistent challenge with the service was the issue of religion. Some GPs reported that patients rejected the service when they thought it was faith based. Again, this suggests that some GPs could benefit from further information.

In summary, although the GPs were overwhelmingly positive about the service from both their own perspective and the patients, there is still some way to go in supporting some GPs to gain a better understanding of what the service is and is not. Some GPs articulated a deep understanding of when to refer and why, consistent with the principles of CCL. Others clearly did not have such a deep understanding, or they would have been able to assuage patient fears about the service being religious, or 'therapy'. Nevertheless, it was very clear that responding GPs highly valued the service. They identify clear clinical benefits to them. CCL provides a better alternative to other statutory agencies for people with subclinical issues such as bereavement, anxiety, non-clinical low mood and other non-medical problems where simply having the space to talk and have someone listen is more coherent that taking up a valuable GP appointment. As a consequence of referral GPs noted clear improvements in their patients, and were also able to use their own clinical time more efficiently, focusing better on those patients with complex medical problems.

Limitations

This was a small survey of self-selecting GPs who all had a positive view of CCL, so it is unclear as to whether these GPs are entirely representative of all referring GPs. Due to the open nature of the survey, specific demographics were inadequate. For example, it was impossible to come to an accurate estimate of how many people were referred. Subsequent surveys should include more specific questions, constructed from the responses to this survey. From GP perspective, more accurate record keeping about who was referred and why would also support a more accurate audit of practice.

Conclusion

GPs found CCL© beneficial for patients and themselves. They found that patients with a range of sub-clinical but highly distressing conditions responded very well to the listening service. It was easy to provide referrals quickly due to the accessibility of the service. These patients then attended surgery less, allowing GPs to concentrate on medical issues when they did. The service gave GPs more time with other patients, and reduced pressure on them to prescribe or refer to inappropriate services.

It is clear that some of the GPs (and patients) need to be better informed about healthcare chaplains. The misconception that CCL was faith based, or 'therapy' is one that needs to be countered, for example. Nevertheless, the fact that chaplaincy listening is a working example of the person-centred, interdisciplinary principles of global health strategy; using the right expertise at the right time to support individuals in distress better help themselves, should not be lost on policy makers. The fact that this evidence positively impacted on GPs makes it less likely that it will be.

More research is needed to better understand what type of person or problem responds best to chaplaincy in primary care. Likewise, the benefits evidenced here such as GP time saved and changes in prescribing need to be measured prospectively. If this shows, as expected, that some people with chronic conditions manage themselves more effectively as a consequence, leaving GPs free to focus on the complex medical issues they are trained to manage, then large multicenter trials should be funded to support health strategists around the world articulate the untapped resource of having chaplains listen to people in distress.

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