

Healthcare professionals' perceptions and experiences of physiotherapy for people with mental illness

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DOI:

[10.1136/bmjopen-2022-061227](https://doi.org/10.1136/bmjopen-2022-061227)

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Document Version

Publisher's PDF, also known as Version of record

Citation for published version (Harvard):

Hemmings, L, Heneghan, NR, Byrd, E, Stubbs, B & Soundy, A 2022, 'Healthcare professionals' perceptions and experiences of physiotherapy for people with mental illness: a protocol for a systematic review and meta-ethnography', *BMJ open*, vol. 12, no. 8, e061227. <https://doi.org/10.1136/bmjopen-2022-061227>

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BMJ Open Healthcare professionals' perceptions and experiences of physiotherapy for people with mental illness: a protocol for a systematic review and meta-ethnography

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To cite: Hemmings L, Heneghan NR, Byrd E, *et al*. Healthcare professionals' perceptions and experiences of physiotherapy for people with mental illness: a protocol for a systematic review and meta-ethnography. *BMJ Open* 2022;**12**:e061227. doi:10.1136/bmjopen-2022-061227

► Prepublication history and additional supplemental material for this paper are available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2022-061227>).

Received 19 January 2022
Accepted 03 August 2022



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ABSTRACT

Introduction There is a high global prevalence of patients presenting with physical and mental health comorbidities. Physiotherapeutic interventions, such as exercise, can have positive benefits for physical and mental health. However, poor accessibility and negative experiences of healthcare services for those with mental illness (MI) have been consistently observed within literature with recent research identifying poor experiences of physiotherapeutic interactions and processes such as referrals and discharges. One way to help improve physiotherapy services for this population is to understand the personal experiences and perceptions of healthcare professionals (HCPs) toward physiotherapy for patients with MI. Qualitative-based evidence syntheses are suited to bring this data together with the aim of improving physiotherapy services for patients with MI. This review will systematically search and synthesise existing evidence around HCP experiences and perceptions of physiotherapy for people with MI.

Methods and analysis A systematic search and seven-phase meta-ethnography will be undertaken. A comprehensive search of electronic databases (CINAHL plus, MEDLINE, Pubmed, Embase and Psycinfo) and search engines as well as grey literature (unpublished primary research such as theses) will be completed. Searches are planned to take place in July 2022. Eligibility criteria include: (a) qualitative data, (b) perceptions identified from HCP, including physiotherapists, assistants and HCP referring into physiotherapy, about physiotherapy for patients with MI and (c) are primary studies.

Ethics and dissemination This work is exempt from requiring ethical approval due to review methodology with data accessed from published works. This systematic review is expected to provide insight into experiences and perceptions of HCP around benefits and barriers to accessing physiotherapy for patients with mental health illness. Findings will be used to inform further research and co-develop recommendations to overcome barriers and optimise facilitators to care for this population. Findings will be disseminated via peer-reviewed journal, conference presentations and to key stakeholder groups.

PROSPERO registration number CRD42021293035.

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ This is a protocol for a meta-ethnography to develop understanding of healthcare professional (HCP) perceptions of benefits and barriers to physiotherapy for patients with mental health illness using a comprehensive search strategy informed by pilot scoping of MEDLINE database.
- ⇒ Using a meta-ethnography will enable consolidation of knowledge and an ability to provide clarity through synthesis of original data exploring experience and perceptions of HCPs.
- ⇒ Qualitative synthesis and meta-ethnographies solely explore previous qualitative literature and, therefore, any quantitative findings will not be included within the synthesis, which may present a gap in findings and this review is reliant on existing qualitative data to inform findings and may highlight further gaps in the literature, which require further investigation or consideration.
- ⇒ Synthesis and re-interpretation of perceptions and experiences will identify common realities across included studies as well as generate higher order interpretations allowing for theory development.

BACKGROUND

Physical and mental health and the challenge of comorbidities

Links between physical and mental health are widely recognised^{1,2} with evidence supporting a bidirectional link between the two.^{3,4} Evidence shows a decreased life expectancy for those with mental illness (MI) of up to 30 years.¹ Increased physical health comorbidities and difficulty accessing physical healthcare⁵ are strongly associated with these stark figures.¹ Lifestyle, medication and maladaptive coping strategies are all seen to impact the physical health of those with MI and, who experience an estimated 40% increased risk of stroke, diabetes and cardiovascular disease¹ and up to 50% greater risk of pain and arthritis.^{6,7}

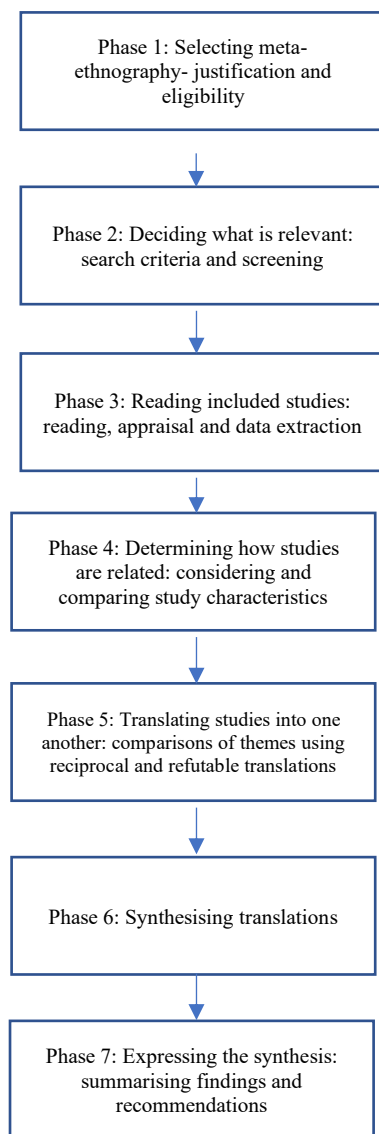


Figure 1 Meta-ethnography seven-stage process adapted from Noblit and Hare [30] and France *et al.*²⁹

Due to the high prevalence and inter-relationship of such comorbidities, integration of physical and mental health within healthcare services is vital.^{2 8} Integration of these complex needs is called on, globally, across physiotherapy services^{9–12} with recognition of a role in promoting quality of life and movement potential encompassing physical, psychological, social and emotional well-being.⁹ Due to respiratory, neurological and musculoskeletal comorbidities being of high prevalence for those with MI, there is also a growing acceptance that physiotherapists will work with this patient group irrespective of professional speciality.¹²

The COVID-19 pandemic has brought the importance of integrating physical and mental health to the forefront

within rehabilitation services such as physiotherapy.¹³ Predicted increases in global prevalence of MI^{14–16} has resulted in calls for strategies to promote integration of physical and mental health across rehabilitation services.¹³ Achieving optimal integrated physical and mental healthcare requires a multidisciplinary approach^{17 18} with communication and referrals between different professionals, something perceived by patients to be lacking within physiotherapy services.¹² Understanding barriers from the perceptions of the wider multidisciplinary team (MDT) is, therefore, deemed vital to develop awareness around processes and barriers across care pathways. The importance of integrating physiotherapists and other allied health professionals into mental health MDTs is recognised within literature.¹ Understanding of healthcare professional's (HCP) experiences and perceptions will help identify recommendations to drive integration in clinical practice.

Due to high prevalence of physical comorbidities within this population,^{1 2 6} physiotherapists are likely to see people with MI with potential regularity. This professional group has skills in management of musculoskeletal, neurological, respiratory and functional presentations all of which are found to be highly prevalent in those with MI.^{1 6} Their role within the MDT addressing a multitude of comorbidities experienced by those with MI is, therefore, of great importance across specialities.^{12 19 20} Furthermore, exercise is the cornerstone of physiotherapy and widely identified as beneficial in the prevention and treatment of MI.^{4 21 22} This professional group, therefore, also have potential to help address this increasingly prevalent global health challenge.^{1 23} The role of the physiotherapist for patients with MI is, therefore, multifactorial and access for this population crucial.

Recent research demonstrates poor access and negative experiences of physiotherapy processes and interactions for those with MI¹² and supports previous findings around experiences of wider physical healthcare for those with MI.^{10 24–28} Barriers to access and experience have been linked with decreased adherence to treatment and exacerbated symptoms of both physical illness and MI.¹² Four major factors have been identified as impacting negatively on accessing physical healthcare for those with MI: (1) prolonged waiting times and lack of integration between services,¹² (2) diagnostic overshadowing, where an assumption is made that the physical complaint is a result of mental health,^{12 24} (3) negative attitudes toward MI, such as patients lacking rehabilitation potential²⁶ and (4) perceived, potentially misunderstood, lack of patient motivation or adherence leading to premature discharge from physiotherapy.¹² These barriers have been seen to occur at multiple stages of healthcare pathways and can involve a number of different HCPs. To understand barriers across pathways, it is, therefore, vital to understand the perceptions of those referring into services as well as those working in physiotherapy services.

Looking more broadly, different HCP groups' experiences and perceptions of access to care for patients with

MI supports further investigation of access into other services, including physiotherapy. A number of potential barriers and facilitators are found to exist, which impact on healthcare delivery and experience of services for those with MI. Major barriers identified include poor awareness, negative attitudes and ongoing stigma within society and healthcare toward mental health.^{18 24 25} All of these factors are perceived within physiotherapy-focused literature to have a negative impact on patient experience and outcomes.^{10 12} In contrast, there is evidence that illustrates facilitators to care include positive experiences of services and interactions,^{12 24} patient empowerment^{24 27} and staff awareness of both physical and mental health needs.^{10 24 28}

Due to service user reports of poor access to physiotherapy care,¹² it is now vital to understand HCP perceptions of barriers, facilitators and experiences specific to physiotherapy care. Understanding physiotherapist and HCP experiences of working with patients with presentations requiring physiotherapy input and MI is vital to enable identification of barriers and facilitators to physiotherapeutic management.

This understanding will enable development of further research and recommendations to promote access to integrated physiotherapy services, where staff are able to consider symptoms of both physical and mental health in a holistic manner, rather than delivering a siloed care approach. It is hoped that this, in turn, will optimise healthcare outcomes for patients presenting with comorbid physiotherapeutic need and MI.

Study aim

Review-based research is needed, which can bring together understanding of experiences and perceptions of physiotherapy management or referral for patients with MI. A qualitative-based review that can consolidate knowledge and seek to further understanding is best situated to achieve this aim. A meta-ethnography will allow for identification and understanding around the benefits and barriers to physiotherapy care for this population.

The aim of the current review is to explore HCP's experiences and perceptions of physiotherapy for people with MI.

Research objectives

1. To explore HCP experiences of delivering/referring into physiotherapy services for patients with MI.
2. To explore HCP perceptions of the role and benefit of physiotherapy for patients with MI.
3. To identify perceived barriers and facilitators faced by HCPs when managing/referring patients with comorbid physiotherapeutic presentation and MI.
4. Use the evidence to consider processes and models for supporting patients with MI to access physiotherapy care.

METHODS

Patient and public involvement

Patient, carer and public involvement has been used to guide the rationale for this study. The research topic has been discussed with patients, carers and public and experts by experience within three focus group discussions involving males and females between the ages of 30 years and 80 years. Within discussions, people with lived experience and carers for people with MI discussed the importance of this area of work and highlighted the need to improve integration, access and experience of physiotherapy for those with MI. Those involved in discussions recognised the need to integrate physical and mental health considerations and discussed personal experiences of physiotherapy adding weight to the rationale and need for this research.

Research design

The review will follow a seven-phase meta-ethnography design²⁹ (see figure 1). The protocol for this review has been developed using three principle guidance documents: Noblit and Hare's original proposal,³⁰ the recent eMERge guidance²⁹ for meta-ethnographies and the Preferred Reporting Items for Systematic review and Meta-Analysis Protocols (PRISMA-P) checklist.³¹ The JBI manual for evidence synthesis³² has also been used as a supporting document. The phases of the meta-ethnography can be seen in figure 1.

Phase 1: selecting meta-ethnography

The review will follow a subtle-realist meta-ethnography approach with both first-order data (original comments and quotes) and second-order data (author interpretations and themes) being collated and third-order data (synthesis team interpretations) constructed. An important part of a subtle-realist stance is representation of a common reality rather than focus on obtaining 'a single truth'.³³ This meta-ethnography will take an inductive approach to identify common realities through synthesis of first-order and second-order data across studies, and interpretation of these to develop third-order constructs.³⁴ A meta-ethnography approach also allows for theory development through this re-interpretation of first-order and second-order data²⁹ as opposed to simply aggregation of themes from eligible studies.³⁵

Eligibility criteria

The SPIDER concept tool³⁶ has been used to develop eligibility criteria, where S is sample, Pi is phenomenon of interest, D is design, E is evaluation and R is Research types, due to its relevance for studies considering qualitative data sets.³⁶

Sample

Participants that are HCP, including student HCP, working/studying in any country. Studies should include a population of any HCP group that either directly deliver physiotherapy care (physiotherapists or support workers) or refer into physiotherapy services (eg, doctors, nurses,

occupational therapists and dieticians). HCP included within studies must have a clinical or clinical management role. Staff working in academia will be included if they also have a clinical role (clinical academics).

Phenomenon of interest

To be included, articles must focus on identifying HCPs' experiences and perspectives of physiotherapy for patients with MI. Patient-perceived benefits and barriers to other healthcare services have been identified at different levels of the referral pathway, both by HCP referring into a service and those working within the service itself.^{12 24 27}

To obtain insight into barriers throughout the pathway, literature considering the perceptions of all HCP will be considered. Due to potential differences in treatment approaches across countries, all physiotherapeutic input and interventions will be considered, including psychodynamic physiotherapeutic approaches and body awareness techniques. However, interventions must be delivered by a physiotherapist to be included. Studies exploring experiences involving non-physiotherapeutic interventions or those not delivered by a physiotherapist will be excluded.

Design

Studies which include qualitative data, including but not limited to different types of grounded theory, phenomenology, ethnography, narrative, action research and case studies. Mixed method designs will be included if there is clear inclusion of qualitative data, including qualitative data collection, analysis and interpretation.

Evaluation

Qualitative methods, including survey with open-ended questions, interviews, field diaries and vignettes will be included. These methods should capture the unique experiences and perceptions of physiotherapists working with patients with MHI or of other HCPs referring into/working alongside physiotherapists within this population.

Research type

Only primary research will be included in this review, and opinion pieces editorials and conference proceedings will be excluded.

Exclusion criteria

Studies not written or interpreted into English will be excluded.

Studies exploring only patient perceptions of physiotherapy will be excluded.

Phase 2: deciding what is relevant

Search strategy

The comprehensive search strategy has been informed by an initial scoping search of the MEDLINE database alongside methodological and subject-specific expertise within the research team and previous studies.^{32 37}

A draft search strategy, comprising four facets, as written for MEDLINE has been developed:

Physiotherap*.mp. OR Physical Therapy Specialty/ OR Exercise Therapy/ OR Allied Health Personnel/ Physical Therapists/ OR Physical Therapy Modalities/ OR physical therap*.mp.

AND

'Attitude of Health Personnel'/ OR experience*.mp. OR perception*.mp. OR perspective*.mp. OR confidence.mp. OR Attitude/ OR Health Knowledge, Attitudes, Practice/

AND

Qualitative Research/ OR narrative.mp. OR grounded theory/ OR ethnography.mp.

OR phenomenology.mp. OR thematic analysis.mp. OR qualitative.mp. OR theme.mp.

AND

Mental Health/ OR Mental Disorders/ OR psychiatric illness.mp. OR Anxiety/ OR Depression/ OR Schizophrenia/ OR Bipolar Disorder/ OR Psychological Distress/ OR Dementia/ OR Mood Disorders/ OR Psychotic Disorders/ OR mental health.mp. OR mental illness.mpaf

Medical subject headings terms (/) will be searched for alongside keywords in title and abstract fields with Boolean operators AND or OR and truncation (*). No date limits will be included (see online supplemental appendix 1 for pilot search using MEDLINE).

Electronic databases will include CINAHL plus, Ovid MEDLINE, Embase, Pubmed and Psycinfo,³⁸ which will be searched from inception to present (see online supplemental appendix 2 for search strategies for these databases). The review will seek to identify both published and unpublished data, as grey literature, such as theses, may provide valuable insights.^{33 39} ProQuest dissertation and thesis will, therefore, be searched from inception to present. Reference lists of all eligible studies will be scanned for further eligible studies. Electronic search engines (ScienceDirect and Google Scholar) will be searched for the first 300 results.⁴⁰ Key journals (the three most common journals in which included studies are published) will be searched via contents pages for relevant studies. Searches will be completed independently by the lead author (LH) and co-author (EB) in July 2022.

Phase 3: reading included studies

Screening of articles

All studies will be screened following a two-stage process by two independent reviewers (LH and EB).

1. Titles and abstracts will first be screened for relevance and any duplicates removed. This will be completed by one reviewer (LH) with 10% of records excluded checked by a second reviewer (EB).³⁷ Full texts will be accessed once eligibility criteria (above) are met or it is not possible to establish whether this is met via the title and abstract alone. Authors will be contacted if there is insufficient information to establish whether a study meets criteria. The lead author will make two attempts to contact these authors, via email, across a 4-week interval.

2. All relevant full texts will be screened to identify those for inclusion in the final review. Study selection within this stage will be decided by two reviewers (LH and EB) with discussion and involvement of a third reviewer (AS) as required.

Data management

A PRISMA flow diagram will be completed to record the process and records of studies excluded and reasons for this. Any disagreements between reviewers will be resolved through discussion or involvement of a third reviewer (AS). The bibliographic tool, Endnote (Clarivate Web of Science), and Microsoft Excel V.2010 will be used to organise and store literature within this review.

Quality appraisal

Following screening, all included studies will undergo quality check using JBI Checklist for Qualitative Research.⁴¹ This tool has high levels of validity and coherence^{39 42} and good applicability to qualitative reviews.³⁵ The quality assessment process will be completed by two reviewers independently (LH and EB) with a third reviewer (AS) to resolve disagreements remaining after discussion. Studies will not be excluded based on quality⁴³ with the purpose of appraisal being to identify the quality of available evidence and direct future recommendation via the certainty assessment.

Data extraction

Data on study characteristics, including study sample, data collection methods, data analysis methods, study outcomes and study conclusions, will be extracted.⁴⁴ A second data extraction tool (JBI QARI) will record first-order and second-order constructs (themes, quotes and original author interpretations), including verbatim quotes, with data extracted from all sections of each of the primary studies.²⁹ This data extraction sheet from JBI QARI will be used due to its validity and recommended use within qualitative reviews.³⁵ This process will be completed by the lead researcher (LH) and checked for accuracy by a second reviewer (EB).

Phase 4: determining how studies are related

Phase 4 will examine how the studies are related to provide context for the meta-ethnography. A grid process, with consideration of information within the data extraction table, will be used to highlight similarities and differences across studies to determine how the primary studies relate to each other. This will consider relations between findings, methods and other contextual findings.²⁹ This phase will be led by the lead researcher (LH) with discussion with the second reviewer (EB) and wider research team (LH, EB, AS and NRH) throughout to aid credibility.

Phase 5: translating studies into one another

Themes from the primary studies will be compared with other themes across studies²⁹; this stage hereby differentiated a meta-ethnography from other forms of qualitative synthesis.²⁹ Similarities/matching themes (reciprocal

translations) and contradictory findings (refutable translations) will be considered and recorded across all studies.³⁰ First-order, second-order and third-order constructs will be tabulated to enable clear and transparent development of interpretations and themes.

Phase 6: synthesising translations

This phase will consist of synthesis of translations and reviewer interpretations to enable development of final themes. These interpretations will be discussed in depth within the review team (LH, EB, AS and NRH) to allow multiple perspectives and decrease any bias.²⁹ Transcripts will be re-read to ensure sound interpretations, which are grounded within the original studies. Final themes will be recorded in tables including first-order, second-order and third-order constructs and explained alongside these constructs within the results and discussion sections of the final write up.

Confidence in synthesised evidence

The Confidence in the Evidence from Reviews of Qualitative Research (CERQual) framework will be used to evaluate the strength in review findings.⁴⁵ The quality of the findings will be considered across all four CERQual components: methodological limitations, relevance, coherence and adequacy of data.

DISCUSSION

Physiotherapy for patients with MHI is recognised as important for both physical and mental health.^{12 19} However, patients report barriers to access and experience within this service.¹² This lack of access has potential to negatively impact on the physical and mental health of this population, who already experience substantial disparities in physical health outcomes and life expectancy.^{1 5} Where physiotherapists are ideally placed to promote physical and mental health for this population,^{19 46 47} it is now vital that we develop our understanding of the benefits and barriers to physiotherapy for those with MHI. This understanding will inform development of strategies to promote equitable access to physiotherapy for this group.

Previous research identifies patient perceptions of barriers to physiotherapy to exist across pathways and among different professional groups.¹² This review seeks to add depth to this previous work and expand our understanding of barriers to physiotherapy by bringing together perceptions and experiences of HCP. Through a review of qualitative data, we hope to broaden our awareness of how physiotherapy for patients with MHI is perceived across the MDT and the barriers experienced when managing patients with complaints conducive to management through physiotherapy and comorbid MHI.

Strengths and limitations of this study

Utilising a meta-ethnographic review will enable clear understanding around experiences and perceptions

of these factors across physiotherapy pathways. This approach will allow consideration of evidence, which can help further current knowledge through the proposal of models, processes or theory.²⁹ This review is reliant on existing qualitative data to inform findings and may highlight further gaps in the literature, which require further investigation or consideration. The meta-ethnography will focus on establishing inferential generalisation and/or theoretical generalisation rather than establishing the representativeness of findings.

It is recognised within our stance and approach that all perspectives are subjective and we are hereby seeking to synthesise multiple subjective perspectives to increase confidence in findings as opposed to identification of a firm truth.

Ethics and dissemination

Understanding the barriers to physiotherapy for this population will allow us to identify strategies for improving access for this at-risk group, a current research priority within physiotherapy.⁴⁸ Findings from this review will be used to inform processes and co-produce models and recommendations to improve access and experience of physiotherapy for patients with comorbid MHI. To optimise impact of the study, a multifaceted dissemination plan will ensure maximise reach. This will include submission to a peer-review journal and presentation at a national or international conference (Physio UK or International Conference of Physiotherapy in Mental Health). Findings will be widely disseminated and used to develop future research via journal publications, conference presentations and sharing of findings with key stakeholders. Due to the review nature of this research, there are no ethical issues identified and ethics approval is not required. All named authors have contributed to the paper meeting all four of the International Committee of Medical Journal Editors' recommendations for authorship⁴⁹ and will support dissemination of findings.

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Contributors All named authors have contributed to the paper meeting all four of the International Committee of Medical Journal Editors' recommendations for authorship, contributed to methodological design, including methodological framework consideration, selection criteria, data extraction strategy and extraction criteria and read, provided feedback and approved the final manuscript. LH is the guarantor. LH, AS and NRH drafted the manuscript with critical revisions from BS and EB. LH developed the search strategy. AS and NRH provided methodological input and support. LH, BS and EB provided expertise around physiotherapy and mental health.

Funding The authors have not declared a specific grant for this research from any funding agency in the public, commercial or not-for-profit sectors.

Competing interests None declared.

Patient and public involvement Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

Patient consent for publication Not applicable.

Ethics approval Not applicable.

Provenance and peer review Not commissioned; externally peer reviewed.

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