

Research papers

A different ball game altogether: staff views on a primary mental healthcare service

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ABSTRACT

Qualitative interviews of staff were used to evaluate a primary care mental health service that combined replacement and consultation-liaison models. An urban general practice in the UK, with a high prevalence of severe mental illness, expanded the primary care team with two occupational therapy staff, extended the general practitioner role, and arranged visits from a psychiatrist, in order to provide care for people with enduring psychotic conditions.

The staff identified key features of the new service. These process components were: expansion of the primary team (extended roles and new staff); the primary care base; the nature of the interventions (care management and occupational therapy); and the focus on the complex needs of people with severe and enduring problems. Staff reported the impact these features had on clients and themselves. Clients had improved access to care, had their social and

practical needs met, and engaged in community integration. These benefits to clients had a positive effect on staff morale, as did staff feelings of being valued and being involved in a dynamic enterprise. Staff also appreciated how extension of their roles had utilised and developed further their existing skills and knowledge. The features of the new service combined to improve communication and the co-ordination and continuity of care. However, the primary care-based mental health staff reported feeling isolated and the stress of competing demands within their multifaceted roles. A challenge for similar initiatives was identified as finding ways to provide a wide skill mix, staff support and staff cover within a small primary care team.

Keywords: occupational therapy, primary care mental health workers, psychosis

Introduction

The importance of primary care for the treatment of most patients with mental health problems is well established.¹ An early model of the interface of primary and secondary care proposed that people with psychiatric difficulties could pass between five levels of care.² However, secondary care cannot

be resourced to take over the care of the large number of people with common but disabling mental health problems, and this model does not describe how to co-ordinate the general healthcare of those with severe and complex conditions, who are still primary care patients for their other health needs. General practitioners (GPs) have become frustrated by bureaucratic referral processes and poor liaison between primary and secondary care

services.³ Another problem is that of people disengaging with specialist services and 'falling through the net'.⁴ Between 25% and 40% of GP patients with conditions such as schizophrenia are in the sole care of GPs.⁵ This article focuses on models of primary care for this group of people.

New models for primary mental health services

It has been suggested that the provision of special services in general practices can 'shift care further away from secondary care while still meeting patients' needs'.⁴ Government policy has encouraged the development of new staff roles and new models of teamwork.⁶ New models that place mental health staff in primary care have been categorised into two types: the 'consultant-liaison' model and the 'replacement' model.^{7,8} Both models aim to remove barriers to GP referral, and encourage closer communication between all staff concerned with a patient's mental healthcare. The mental health workers involved may include counsellors, psychologists, community nurses or nurse therapists, occupational therapists (OTs), psychiatrists, social workers, advocacy workers and graduate primary care mental health workers.

Replacement model

In this model (also termed the attached mental health model), mental health workers are placed in primary care to take referrals from other primary care staff and assume the responsibility for the management of the patient's mental health problems.^{9,10} They provide therapeutic interventions, practice-based assessment and monitoring clinics, medication adherence, or social casework. Using this model, small multidisciplinary primary care-based teams in Manchester reduced levels of overall need, need for information and need for help with psychotic symptoms.¹¹ There has been some tentative evidence that replacement model workers achieved significant short-term effects on the clinical behaviour of GPs, with reductions in psychotropic prescribing, mental health referral and consultation rates.⁷

Consultation-liaison model

In this model, mental health workers, who are based in secondary care, 'reach into' primary care to provide collaborative care and support, in order to help primary care staff to manage patients' mental health problems. They do not take over responsibility but offer education, expert advice and some direct assistance with clinical care. Case discussions

and feedback between primary and secondary staff are central to this model.⁹ One study in London compared community mental health teams (CMHTs) that adopted the consultation-liaison model with standard CMHTs.¹² Results showed changes in referral patterns for patients with severe mental illness, with significantly lower psychiatric inpatient and outpatient utilisation rates but greater use of primary care psychology services and CMHTs. There is some evidence that the consultation-liaison model has a direct effect on GPs' prescribing behaviour when used as part of complex, multifaceted interventions.⁷

Combined models

Innovative schemes have often not complied with these two distinct models, as they have been designed as a unique response to local situations with variations in: type of worker, type of patients and referral categories, number of workers, location, the type and intensity of interventions offered. An example is a project in Liverpool where a small multidisciplinary team worked with five practices to provide direct care to patients with severe mental health problems and also assisted primary care teams in dealing with common mental health disorders using the consultation-liaison model.¹³ Results showed improvement in patients' health and social functioning and reduction in inpatient bed use and in the waiting time for new assessments.¹⁴ GPs were significantly more satisfied with access to community mental health nurses, overall communication and overall service delivery.

Qualities of new models of primary mental healthcare

It has been found that primary care-based mental health services may be viewed as having the qualities of acceptability, accessibility, continuity of care and interprofessional communication.¹³ The purpose of the present study was to further illuminate the potential of these initiatives by investigating the impact on key staff and the effects on working relationships and patient care.⁷

Methods

The intervention

Setting and patients

The setting for this study was an urban general practice in the UK with a prevalence of severe

mental illness of 15.8 per 1000 practice population. This is high when compared to a prevalence of 1.7 per 1000 reported by a previous study.¹⁵ The surgery piloted a new service for their patients with psychotic conditions and social disabilities who had lost contact with the local secondary level CMHT.¹⁵ This was in order to focus on the complex needs of people with severe and enduring problems. The new service started in April 1997 and a total of 37 patients were identified from patient records, and referred to the new service during the first two years. Other patients who were already engaged with the CMHT continued as before.

Service model

This service primarily used the replacement model with attached workers based in the surgery. The practice employed two mental health workers (a senior OT 0.8 whole-time equivalent (WTE) and an occupational therapy support worker 0.2 WTE). The primary care team also extended existing staff roles. This included the GP taking part in care programme meetings held in the surgery, and acting as the medical link person with local group homes and hostels. In addition, using the consultation-liaison model, a consultant psychiatrist visited the surgery for one session every two weeks to liaise about patients the GPs wished to discuss, and to attend care programme meetings.

Therapeutic interventions

The attached workers provided care management and occupational therapy. They also developed partnerships with local groups and organisations, to aid patients' access to mainstream activities and to reduce their social isolation. The service is detailed in a related publication.¹⁶

Study design

The aim of the present study was to investigate the impact the new service had on key staff from their viewpoint. The study was one part of a case study of a particular service development, that employed mixed methods to complement each other and to answer different research questions.^{9,17} Quantitative methods were used to measure patient outcomes, costs and patients' satisfaction, while qualitative evaluation methods were selected to enable understanding of the processes and outcomes of a particular innovation within a unique context.^{16,18-20} The qualitative findings are reported in this paper.

Sample

A purposive sample using 'typical case sampling' was used to select key people involved in delivering the new service, to investigate the staff's 'lived' experience.¹⁹ The sample included the two primary care-based mental health workers. The OT was carrying out an evaluation of the new service, in the role of a research-practitioner.

Data collection

A semi-structured interview approach was used, designed by the interviewer and the research-practitioner. The interviewer was an occupational therapy undergraduate student who was selected as an outsider with some expertise in the area. The timing of the interviews was towards the end of the two-year study period 1997-99. Participants were asked for permission for the interviews to be taped and transcribed. An audio diary was recorded by the research-practitioner as participant observer at key intervals during the study period.²¹ The format was to report what was going well, what was difficult, and ideas for solving problems.

Data analysis

A qualitative framework analysis was carried out with the intent to generate both evaluative and strategic findings.²² The analysis used the five stages of framework analysis:

- 1 familiarisation
- 2 identifying a thematic framework/index
- 3 indexing
- 4 charting
- 5 mapping and interpretation.

Results

The interviewees and the conduct of the investigation

The eight key staff that were interviewed are listed in Box 1. The community psychiatric nurse (CPN) was not directly involved in caring for the sample of GP patients referred to the new service, but acted as a secondary care link nurse for the surgery. The OT carried out a dual role of research-practitioner during the period of data collection, but she did not participate in qualitative data analysis until nearly two years after terminating her role as a practitioner in the GP surgery.

Box 1 The interviewees

Code	Job	Employer
GP	General practitioner	GP
OT	Occupational therapist	GP
OTS	Occupational therapy support worker	GP
PN	Practice nurse	GP
P	Consultant psychiatrist	NHS trust
CPN	Community psychiatric nurse	NHS trust
RHM	Residential home manager	Ind
RCW	Residential care worker	Ind

Employers: fund-holding general practice (GP), NHS trust – secondary care (NHS trust), independent sector residential home (Ind)

Phases of the framework analysis*Familiarisation, identifying a thematic framework and indexing*

During familiarisation, topics were noted in the margins of the transcribed texts. Initial topics were identified separately by the outside interviewer and research-practitioner and combined with the interview schedule to produce the framework of index headings below. Texts were then marked with the index codes (see Box 2).

Charting, mapping and interpretation

Charting was done by summarising textual statements for each index heading under each interviewee/case. An example of a section of the charts for just one index heading is shown in Appendix 1. The transcripts of the audio diaries were also summarised using a matrix that charted the index headings under four themes:

- going well
- hard

Box 2 Index headings and codes

I. Interventions – needed and beneficial

- I.OT: Occupational therapy
- I.SW: Social work
- I.CBT: Cognitive behavioural therapy
- I.CARE: Care

T. Therapy process

J. Job of the mental health worker

- J.S: Self in the job

M. Management and administration

- M.S: Setting up
- M.R: Running
- M.L: Leaving

P. Primary care based

- P.C: Communication
- P.T: Team
- P.A: Accessible locally
- P.S: Small project
- P.CT: Culture
- P.P: Primary–secondary interface

C. Community development

R. Research and evaluation

- balances
- solutions.

An example of the section headed 'Hard' is shown in Appendix 2. Mapping and interpretation was done by searching for patterns and themes running through the charts and going backwards and forwards between the original text and successive maps. The interpretation thus evolved through several versions. The result consisted of two related parts: features of the service and the impacts on staff in relation to the process components of the new service, as represented in Box 3.

Seeing clients benefit

All the staff (except the OT research-practitioner) when comparing with prior services were extremely enthusiastic about how the new service had benefited the people with severe and enduring mental health problems. They used phrases such as 'no doubt' (GP), 'definitely ... it's improved the quality of patients' lives' (OTS), 'extremely positive' (P), 'a big impact' (CPN), 'beneficial, very much to the clients' (PN), and 'tremendous' (RHM). The residential care worker commented that compared with the previous ten years she had worked with the clients in her care: 'it's a total change of life; different ball game altogether' (RCW). Observations were particularly made about improved accessibility for GP patients, how the individual needs of clients were being met and people were being helped to integrate within the community. The OT was more measured in her evaluation of the benefits to clients, pointing out that improvement in patient outcomes was balanced by problems and risks.

Improved accessibility for patients

According to all the staff, the direct benefit for clients of basing the new service in primary care

was its accessibility, especially for clients who had difficulty engaging, and those who needed help because they were the most deprived (P, OT, CPN, PN). These were people who would otherwise: 'walk on the streets, who have no access to mental health services' (CPN). People found the surgery accessible because of the lack of stigma and fear attached to walking into the surgery.

'people can relate very easily with what's happening here, the fact that patients can access the service very easily.' (GP)

The surgery was a familiar place where people were welcomed and respected and the receptionists were particularly welcoming to people whatever their dress or behaviour, treating everyone as important (OT). Relapse prevention strategies had been helped by the staff being familiar with each person's fluctuations over a long time, and building on their strengths (OT). The smallness of the site was user friendly and not intimidating (RCM), and the mix of people in the waiting room made it a lively and interesting place to be (OT). The surgery was conveniently near to where clients and carers lived (P) and the service could respond flexibly and quickly to clients' crises (OT). It was easy to make an appointment to see a therapist, doctor or the visiting psychiatrist by asking the receptionists on the front desk (GP). The primary care staff were seen to make themselves accessible to clients by telling them they were 'here if you need me' (RCW). Indirect care was also seen to have benefited from the large amount of support to local people that was possible through the service being based in primary care. Without this:

'lots of things would suddenly disappear ... like care, carers, care staff who are being supported and therefore care would slip in an indirect way.' (GP)

Some of the staff complained that there were more local clients with severe mental health problems, such as severe depression, who could benefit from a primary

Box 3 The impact of the new primary care mental health service on key staff

Features of the primary care mental health service

- Primary care based
- Expansion of primary care team (extended roles and new staff)
- Interventions: care management and occupational therapy
- Focus on the complex needs of people with severe and enduring problems

Impacts on staff

- Seeing clients benefit: improved accessibility, individual needs met and community integration
- Effects on staff morale: hopefulness, being included and valued, dynamism, isolation and role stress
- Staff skills and knowledge utilised and developed
- Improved communication, co-ordination and continuity of care

care-based service, but did not have access because they did not fit the current referral criteria which was limited to people with psychotic conditions.

Individual needs of patients met

Individuals who 'had not been looked at before' (RCM) were now having their needs identified, and they were seen to co-operate with healthcare after long periods of non-engagement (OTS). Their practical and social needs were being met through care management and activity-based occupational therapy within mainstream community settings. For example, the CPN praised how people had had their welfare benefits sorted out and their isolation reduced through attending community groups such as gardening and social clubs. The residential care worker explained how residents were now less institutionalised, were calmer, and had stopped having regular fights, whereas before they would:

'vegetate in their rooms and not bother to go anywhere ... just switch off'

or

'cause arguments and fights cos of nothing to do.' (RCW)

The residents now participated in activities and this motivated them to shave, bathe and change their clothes, 'to make an effort, it makes a difference' (RCW). The practice nurse noticed that people were now less likely to be demanding unnecessary appointments and turning up with a:

'bizarre ailment or unusual ailments that they've suddenly developed that maybe are not physical ... they're more occupied, [have] more other things to think about.' (PN)

Community integration

Several staff commented on the benefits of the community development aspect of the service that enabled access to activities. They were impressed with how these options had helped the client group reduce their isolation and be part of the local community:

'It's just like a ball rolling all the time ... because she work's really hard to get our fellers in places we'd never even think about. Like she's got a gardening group on a Monday and quite a few of the fellers love gardening ... and now they've started a swimming group up.' (RCW)

The OT gave the opinion that the community development work was greatly aided by building on the good relationship that already existed between the GP surgery and the community. The GP added:

'this is what happens in the local community – the sort of perspective which has been so important about this.' (GP)

The practice nurse recognised that the community integration activities and information about them needed sustaining:

'If these things continue to run, then maybe it won't be so much of a disadvantage, but because these things fall down through lack of supervision because nobody's there running them, then yeah, we're going to go back to square one ... people are going to become more hospitalised ... we are going to be unaware of services doing things to help the client ... if it falls down totally it will be very disadvantageous.' (PN)

Positive and negative effects on staff morale

The new service had an impact on the feelings experienced by different staff. These included positive feelings of hopefulness, being valued, inclusivity and a sense of dynamism. Negative effects concerned the mental health workers' feelings of isolation.

Hopefulness

An attitude that appeared to change was that of despair towards the client group. It appeared that staff perceived the benefits to clients as having a direct impact on themselves as they cared about the clients. Improved quality of life of this client group was important for their own feelings of satisfaction and hopefulness.

'I hope they're [the new service] going to continue because it does everybody good, from fellers to staff. Everybody... . They [clients] are a lot calmer and it helps our job.' (RCW)

'And the fact that for the clients there's not been a hospitalisation has been very good... . For carers as well, it's beneficial, because we all know what everybody's doing... . You've always got an extra person to fall back on, ... if the clients are a little stressed, [the OT] knows them so well.' (PN)

'I think that there's no doubt that it's improved the quality of patients' lives. I'm convinced about that ... I've seen changes in people that haven't been possible in the past. People, you know, for 13 years have rejected services, not had a service or even refused to co-operate with ... and are doing now. I think that's significant.' (OTS)

Being included and valued

The staff from the residential care homes pointed out how they benefited in the way the primary care-based service involved them so that they became much less isolated. They now felt part of the local community and a network of various local organisations. They reported that they were suspicious at first, as they had previously experienced being put down and ignored by many professionals who did

not understand the needs of their residents and how difficult their jobs were, or how much they cared.

'We were a bit, em, I wouldn't say dubious, at the beginning, but we didn't quite know what might be achieved, but ... it's been tremendous. Very good, very positive, very good for everyone.' (RHM)

Dynamism

An additional boost to morale was reported by the OT who found that it was much easier and quicker to get things decided and acted on in the surgery, compared with working in a large NHS trust. Within the context of a small organisation she felt she had been given a lot of responsibility and autonomy. The OT experienced the culture of this particular GP surgery as one of: 'expectation of success, of quality, patient-centred work, excitement, learning, going forward', whereas in some community mental health teams she had observed 'some very demoralised people, very burnt out, who feel powerless to change things'.

Isolation

Although both occupational therapy staff expressed appreciation of the supervision they received and the enthusiasm and commitment of the primary care team, they did report feeling isolated at times. The isolation came from being specialists within a more generic team where people did not speak the same language as mental health workers or experience the same stresses. For example the OT recounted a visit by a CPN manager:

'it was so lovely because we talked the same language and I was feeling a bit, oh, I was having a low day, and I just said a few words, and he knew exactly what I meant, and gave me the support and said: 'yes, it is hard, it is draining', and that was wonderful. So although other [primary care] staff here might get drained for different reasons, they're not getting drained in quite the same [way], you know we're not quite the same.' (OT)

Another source of isolation was that much of the time spent by the occupational therapy staff was out in the community with clients, rather than in the surgery building.

Staff skills and knowledge utilised and developed

The impact of extending staff roles was firstly, to allow experienced staff to fully utilise their existing skills and secondly, to increase learning and skill development in a variety of ways.

Utilising existing skills

The GPs' expanded role within care programming was valued by all the interviewees as helping to improve co-ordination of care. The GP was enthusiastic about having his role extended, inferring that his skills, knowledge and commitment were now fully utilised. He felt it was important for the GPs to have recognition for the responsibilities that they were taking and the success of their expanded role:

'as a GP I feel they ought to acknowledge the fact that in their city something very good's happening, that's happening not in their hospital, that's happening in primary care ... it's quite nice to actually say: well look, you know, we do things as well, you're not the only people who do things.' (GP)

'I respect and admire [him] because he's out to get something and he gets what he wants, and he has done some mental health before, and like I think if he wasn't as compassionate this would never have taken off.' (CPN)

It was pointed out by the GP, CPN and OT that not all GPs would want an expanded role within community mental healthcare:

'I just wish there was a few more GP surgeries who took an interest in mental health like the way this surgery has ... you just go to other surgeries and they don't want to know.' (CPN)

The support worker and OT explained how it had been possible for their roles to be shaped by the needs of the clients. Other staff commented that they were very restricted in the amount of time and range of interventions they could offer, compared with the new occupational therapy staff, whose roles seemed to meet people's needs more comprehensively (CPN, RHM, RCW).

Interviewees commented on the importance of the information gathering and networking that had been carried out in order to find local activities and opportunities to suit each client.

The OT reflected that much of her mental health work was what she called the core work of an OT: continual assessment of each individual's functional performance, goal negotiation, the selection and grading of activities, support and education of carers and the adaptation of activities and the environment. However, she thought that she had extended the scope of this last intervention further than conventional occupational therapy, by instigating major changes in the local social environment. It was also commented that anxiety management for people with psychosis has been extremely beneficial for many clients (RHM, OT).

Developing staff skills and knowledge

A spin-off from having mental health staff in the surgery, was increased education. The data suggested

a 'rubbing off' of skills, knowledge and attitudes between the members of the team.

The visiting psychiatrist described her expanded role in the surgery as educating GPs and disseminating information to them; giving on-the-spot expertise and making herself accessible to the primary care team. Increased learning was also reported from specific interventions to educate and support carers, both residential care workers and relatives. This included regular monthly seminars for unqualified staff from private and voluntary organisations.

The OT reported that she had developed new skills, taking on a role as a 'social worker' in order to help clients to get adequate accommodation, money and food. This role was particularly valued by residential care staff, who commented that, in order to benefit clients, it needed authority, determination and persistence when dealing with statutory and voluntary agencies. The OT's expanded role led to a lack of role clarity, for instance one interviewee thought the OT was a social worker. The OT reported experiencing considerable stress from the competing demands of her different roles, more so than when she had worked in a multidisciplinary community mental health team.

Improved co-ordination, continuity and communication

The main benefit of having mental health staff as part of a primary care team was seen as the close communication between them and other primary care staff, through proximity and daily contact. The interviewees also all valued the expanded roles of the members of the primary care team as improving communication and the co-ordination of care.

The practice nurse appreciated having the mental health staff in the surgery to give 'extra back up with disturbed patients' when an individual's behaviour was difficult to manage; and also liked the way the OT facilitated access by helping people organise themselves so that they remembered appointments.

Increased collaboration between members of the primary care team and the psychiatrist was reported. The psychiatrist saw the effects of this as a more co-ordinated and cohesive service for clients, the avoidance of gaps and duplication in care, greater bonding between the psychiatrist and the primary care team and improved relationships between the surgery and the secondary mental health team.

Having care programme meetings held in the surgery at times convenient to the GPs, made it possible for the GPs to attend most of the meetings.

All the interviewees commented on how these care programme meetings had engendered excellent co-ordination and communication amongst the people involved. The data suggested a sense of ownership of care programming by the primary care team, carers and clients.

An interesting aspect of how being based in primary care impacted on communication, was the perception that the association with the GP surgery gave authority to the mental health staff in the minds of clients and professionals in other organisations. Both the support worker and the residential care staff commented on how this authority led to requests being taken seriously and acted on.

Discussion

The findings

Access for patients

The staff's views that access to mental healthcare was improved and stigma reduced by the primary care-based service is in close agreement with similar studies and Department of Health guidance.^{13,23,24} Peer group support, found by some patients in specialist mental health settings, was promoted in the present study by some of the group activities being targeted at people who had severe mental health problems but who were held in mainstream community settings.²³

Continuity, communication and staff education

The findings suggest that primary care-based services can remove some of the barriers that GPs have perceived between primary and secondary mental healthcare, and thus facilitate effective co-ordination and continuity of individuals' care.¹² In the present study, this was aided by long-term relationships between patients and the primary care team, and close working between mental health and generic staff.²³ The present study confirms that placing mental health staff in primary care opens opportunities for increased face-to-face contact between mental health staff and GPs to discuss patients' care and management in detail and to facilitate two-way education.¹³ The study also supports the need for primary mental health services to be designed flexibly to maximise communication with local populations and to work in partnership with local voluntary and independent sector resources.²⁴

Effects on staff morale

The staff's observations suggested that positive patient outcomes had a positive effect on staff morale. This supports the proposal that hope is an important component of care for both patients and staff.²⁵ In contrast, in the present study, the voices of the mental health staff based in primary care often revealed doubts, questions and difficulties as has been reported in other multidisciplinary primary care teams.²⁶ Both studies reported problems with role definition and strain, and the amount of time and resources needed to attend to people's social, financial, occupational and housing needs. New graduate primary care mental health workers have also reported concern about unclear roles.²⁷ Rather than have one or two part-time mental health workers added to one primary care team, it may be more feasible for a cluster of surgeries to employ a small team of mental health staff who can offer a range of different skills, cover for each other during absence and support each other.

New and expanded staff roles

The present study explores how both the generic primary care staff and the mental health staff placed in primary care extended their roles in order to meet the needs of the client group, and this mirrors recent government recommendations.¹ The role of the occupational therapy support worker was to work with people to achieve individually negotiated goals concerning their daily occupations, spending several hours with them at a time. This is similar to that proposed for the new support, time and recovery (STR) workers.²⁸ One problem identified by the present study was the need for GPs' expertise and efforts to be better recognised. The need for training and enhanced payments for GPs who take on extra responsibility for mental healthcare has been recognised by the Department of Health and *The NHS Plan* includes a proposal to develop 1000 GPs with a special interest (GPSI) in mental health.^{29,30}

The methods

Qualitative methods within this case study design have aided understanding of the successes and failures of a real-life complex intervention that was influenced by a specific context.³¹ Staff opinions were revealed that would not have been accessible to quantitative research.³² Nevertheless, although this study of primary mental healthcare is focused on practical and policy issues of current importance, it is limited in its contribution because the case that was studied was unusual.³¹ Distinct features of

the case preclude the results from being typical of all primary care teams: a very high prevalence of people with psychotic disorders who had lost contact with community mental healthcare. However, other studies have found that inner-city surgeries have high numbers of people with severe mental illness and that up to 40% of these patients lose contact with secondary services.^{5,15,33} The features of this case may therefore be seen as typical of an important minority within general practice.

One challenge to the trustworthiness of the findings is the risk of bias from the research-practitioner and the interviewer.³⁴ The participant observer had the advantage of easy access to the site and insider understanding of the situation, but risked distorting the results of the study.²⁰ This could be for example by being 'co-opted' or 'swallowing the agreed-upon or taken-for-granted version of local events'.³⁵ Attempts at reducing bias were made in five ways. The research-practitioner used an audio diary to consciously reflect on her role throughout the study.³⁶ Some of the conflict inherent in the dual research-practitioner role was avoided by the research-practitioner ceasing to be an employee of the GP surgery when doing the analysis and reporting the results.³⁷ Quantitative methods were used to complement the qualitative investigation, and the staff views about benefits to patients were confirmed by the quantitative study which found that 92% of the cohort engaged with the new service, and those completing 12 months contact showed statistically significant improvements in social functioning, clinical symptoms and Health of the Nation Outcome Scales (HoNOS) scores.¹⁶ An external researcher conducted the staff interviews to avoid potential bias that may have been caused by a participant interviewer. Lastly, attempts have been made to report the methods and analysis in a transparent way, in order to assist the reader in judging whether the findings are verifiable.³⁸

Conclusion

As few studies have yet been reported, many of which are case studies, there is a need for extensive and robust research on models of delivering primary mental healthcare. This includes investigating how to provide some of the benefits of conventional large community mental health teams, such as a variety of skills and roles, staff support and staff cover for absence, within a small primary care team.

There is much evidence that specialist secondary care teams for people with psychotic conditions benefit people at risk of repeated hospitalisation

(National Institute of Clinical Excellence (NICE) guideline for schizophrenia) However, this article tentatively proposes that, in order to respond to local needs,¹ a primary care-based mental health service may also be beneficial for people with severe conditions, because it is qualitatively different from secondary care in that:

- primary care is able to engage and maintain people through its accessibility and reduced stigma, especially those who fail to engage with secondary care
- as part of a local neighbourhood, a GP surgery can enable people to be integrated in local communities and reduce their social isolation
- attaching mental health workers to a primary care team and expanding existing staff roles can utilise and develop staff skills and knowledge and improve communication in order to deliver effective and co-ordinated care
- the generalist function of primary care encourages a holistic approach to people's physical, social and mental healthcare
- primary care offers continuing care over many years, so can take over people's mental healthcare once they are discharged from specialist teams.

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CONFLICTS OF INTEREST

None.

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Appendix 1: Example of charting using one index heading

Index heading: P.C: primary care based – communication

GP

- Easy to arrange meetings, case discussions (p1)
- Physical daily contact within the primary care team (p1)
- Education both ways (p1)

OT

- Enabled close communication with GPs (T1.8)
- In a meeting between primary care and community mental healthcare teams, different language used. GPs like clarity of terms (T1.8)
- Need to make appointments to talk to some GPs, even though in same building (T1.25)
- Able to have small focused meetings with staff that are effective (p1)
- Each GP communicates differently (p5)

- Close communication with local community agencies, improved relationships (p5)
- Acting as information channel (p5)

OTS

- Can pass on concerns of patients, go directly to GP if someone is suicide risk (p2)
- Communication quite good, staff understand the project but not the specifics of our roles (p6).
- Communication good with GPs – being in the building – can leave message or informally chat (p7)
- Communicating with other professionals – they really listen when I say I am from a GP surgery (p7)
- Surgery staff benefit from increasing their understanding about the complexity of mental health issues (p9)

PN

- Shared care record – biggest impact – not duplicating/stepping on each other's toes, leaving gaps or losing patients. Patients can't pull wool over our eyes (p1)
- Would like mental health staff to discuss more how things are going with the new service (p4)
- Have lot of communication about clients (p4)

P

- Has improved the relationship with the community mental health team (p1)
- Created a bond between team members (p1)

CPN

- The primary-based mental health worker has close contact with and access to GPs and psychiatrist, rather than the CPNs just meeting with GPs once a month (4)

RHM

- Other agencies trust the surgery staff, have authority, which helps our residents get what they need (p2). Communication is good and regular, can pop in. The OT will always speak to care staff about the person (p3)

RCW

- Now we help each other, we give them relevant information they need (p1)
- Getting in touch, it's a lot better and easier, being so near, not intimidating (p4)

References to text: p = page; T = audio log tape.

Appendix 2: Example of one section from the matrix for the audio diary

Index code	Going well	Hard	Balances	Solutions
I.OT		Takes time to integrate formal assessments into practice		
I.SW				
I.CBT				
I.CARE		Care workers' needs – respect, encouragement, time		
T		Chaotic and disturbed Vulnerable to stress. e.g. moving home Communication difficulties Internal contradictions Barriers to attempts to manage psychotic symptoms Reluctant or slow to change, plus sudden leaps		
J		Time demands competing: admin, clients, liaison, community development Too many roles and hats, mind-boggling, unsure, learning Challenging client group		
J.S		Stressors: multiroled, new project set up and running, isolated from colleagues, overwhelmed by social work-type demands		
M.S		More demanding trying to do everything at start		
M.R		Demand continues		
M.L		Maintaining shared care records and GP notes Problem ending therapy with patients who are slow to trust Insecure funding to continue new service		
P.C		Some GPs may not be interested in mental health		
P.A				
P.S				
P.CT		Pressure to see a lot of patients each day		
P.P		Problem of older age group accessing services appropriate to them		
C		Failure to get funding for group advocacy and befriending projects		
R		Questions about evaluating a service while it is still evolving; differentiating between service elements and staff elements (competency, staff off sick) Research outcome measures difficult to administrate Bias: pressure to succeed due to high expectations (new project and wanting clients to benefit) and due to dual role of research-practitioner		

