International research

Multidisciplinary primary care mental health teams: a challenge to communication

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ABSTRACT

Recent national guidelines have caused primary care trusts to explore new ways of providing mental healthcare for patients with mild to moderate mental health problems. This study examines communication in a new team in one primary care organisation. In order to provide mental health services within the primary care organisation, general practices were grouped together in ‘clusters’. While this allowed the primary care organisation to provide a range of services to the patients within its locality, it also created several potential difficulties as a consequence of bringing together different working practices, different professional groups and different cultures. This paper examines the mechanisms for communication within the teams and the issues that arose across these interpractice and interprofessional boundaries.

Multiple qualitative methodologies were used to explore these issues. The first was participant observation carried out at a residential conference run by the primary care organisation to develop its mental health strategy. The data from this early stage of the study were used to develop a framework for a series of focus groups with healthcare professionals who were members of the primary mental healthcare teams. Focus groups were carried out with GP mental health leads (n = 13), district nurses (n = 8), health visitors (n = 7) and counsellors (n = 8). Finally, semi-structured interviews (n = 10) were carried out with primary care mental health team key workers and general practitioners (GPs) (n = 3).

Four themes emerged from the data: communication within the primary care mental health team (PCMHT), communication with the rest of the primary health care team (PHCT), communication with patients, and confidentiality.

This paper highlights the difficulties of interprofessional communication that need to be addressed if the ‘cluster’ model is to be an effective mechanism for delivering primary care mental health services.

Keywords: communication, interdisciplinary working, mental health, primary care, primary care mental health teams
Introduction

Primary care mental health services have undergone a number of changes in recent years. In response to national guidelines in the National Service Framework and the modernisation plan, primary care has taken a lead role in delivering brief psychological interventions to patients with mild to moderate mental health problems. As a result, clinicians in the primary healthcare team have become more aware of primary mental health issues, and in some cases taken on more formal roles in relation to providing mental healthcare.

A northwest of England primary care organisation (PCO) responded to the changing role of primary care in mental health by implementing cluster working. This model of working brings together groups of three or four practices into 'clusters', served by a core primary care mental health team (PCMHT). The team works across all the practices sharing resources and expertise, but with designated staff for each cluster. This model of working and the costs associated with it are described in more detail elsewhere. Nixon and co-workers suggest that this way of working delivers measurable benefits to service users and primary care professionals, and may have the potential to reduce the utilisation of specialist services.

Research has shown that communication is an essential component of the success of multidisciplinary teams, however it can be problematic. Atwal and Caldwell reported that ideological differences, unequal power relations and poor communication presented problems for interprofessional healthcare in hospitals. Hanafin and Cowley also reported that public health nurses describe good working relationships across disciplines where feedback was frequently received, but where it was not, working relationships were reported as being not good. Cromwell described a 'team spirit' model of working and emphasised the importance of 'getting to know each other', 'addressing differences' and 'developing a shared vision'. The importance of effective communication is crucial. In addition Madge and Kahir reported that teams succeed or fail depending on the dedication of their members. Uncertainty about the aims and objectives of teams can lead to the breakdown or disruption of a team. In the mental health environment, boundaries are highlighted which exist between different professional roles, and the potential problems that occur when individuals seek to preserve their individual professional identity within the multidisciplinary environment. For some role 'blurring' may occur, and this can lead to stress and confusion.

As the 'cluster model' of working in primary care mental health is being adopted on a wider scale in the UK, it is important to carry out research on how the model works in practice. This paper aims to report how a new primary care-led mental health service, using a multidisciplinary team approach managed communication issues within the team and externally. Through research employing qualitative methods, a clearer understanding of the processes involved in the communication that facilitated or hindered the implementation and delivery of the model across a primary care organisation is gained. This research can inform primary care trusts on how a team approach to providing mental health can be managed and incorporated into primary care.

Methods

Setting

The study took place in a northwest of England PCO. The organisation was responsible for a registered urban population of approximately 100 000 people and it included 13 general practitioner (GP) practices with 66 GP principals working in them. Local health needs assessment work had identified high levels of mental health morbidity in the city, and as result the PCO had made mental health one of its priority areas for service development. Ethical approval was gained from the local ethics committee.

Theoretical approach

Multiple qualitative research methods were used to describe, understand and explain the interactions within the teams. This approach allowed us to document difficulties or obstacles involved in these interactions and how these were perceived and dealt with, and it provided insights into why particular approaches were successful or unsuccessful.

Data analysis drew on the principles of grounded theory. A grounded theory approach does not set out to test a hypothesis but aims to make sense of what is happening by developing a theoretical basis to account for the emerging 'story'. The theory that emerges is grounded in informant data.

Reducing bias

All data from focus groups and interviews were tape recorded and transcribed. Data were collected and analysed by a research assistant AB, with support and input at all stages from the project steering
group. To help reduce bias the study researcher was independent from the service.

To further reduce bias in the project, the study steering group consisted of a mix of academic and managerial staff working alongside the researcher and the clinical mental health staff. The steering group did not engage with the data collection directly or provide direction on data analysis, however they did discuss ideas regarding themes with the researcher as they emerged and provide an expert viewpoint in relation to these.

Sampling

The sampling frame included all the members of the PCMIHT and those primary care professionals who were actively involved in the delivery of the new service. The method of sampling was purposive – a non-random method of sampling that aims to select groups of people whose inclusion in the study helps to test and develop emerging theories and explanations. Participants are included because their inclusion allows a particular aspect or issue that is relevant to the research aims and objectives to be explored. All staff involved in the initiative were invited to get involved in the study, however a small number of staff (n = 3) felt that other professional commitments took priority over the research study and declined to take part. Despite this, the sample obtained provided an adequate representation of the primary care mental health team.

Observation

The study began with a period of participant observation at a weekend residential conference. This conference brought together the PCMIHT and the GP mental health leads to provide them with an opportunity to share issues and ideas, and to strengthen new relationships. The researcher (AB) joined the conference as a participant observer who took detailed notes to record her observations of the conversations, discussions and interactions that took place. This early data formed the basis of a framework and topic guide used for the focus groups and semi-structured interviews. The topic guide was not modified substantially after it was devised; however it was not rigid and remained flexible and responsive to individual comments within the interviews and focus groups.

Focus groups

A total of six focus groups (n = 6) took place with GP mental health leads (n = 13), counsellors (n = 5), health visitors (n = 12) and support workers from the PCMIHT (n = 3).

Focus groups differ from one-to-one interviews in that they enable the interaction between participants to furnish important data that might take the debate to a further stage, sometimes via the synergy of the group and at other times, through debate and/or reflection. Similarly, focus group methodology has the potential to challenge peoples’ taken for granted realities by participants qualifying and explaining their reasoning and occasionally, altering the viewpoints of other participants.

Semi-structured interviews

Interviews (n = 10) took place with all members of the core PCMIHT. GPs were also interviewed (n = 3). These GPs were practice mental health leads who in their day-to-day work were more involved with organising and delivering the care of mental health patients, than the nurses or many of their GP colleagues.

Combining methodologies

Using several qualitative methods allowed us to meet the aims of the study within the context of a city-wide mental health service. Observation provided us with a framework and topic guide for the focus groups and semi-structured interviews. The focus groups generated discussion and debate through mutual and common interests which led to shared insights and experiences, while the interviews allowed us to gain individual insights from core members of the team who were closest to the new way of working.

The different methods of data collection also provided triangulation, which ensured that the relevant issues were explored using different methods and by comparison, the validity and reliability of the findings could be determined.

Analysis

Data were analysed using winMAX software and followed the principles of grounded theory. The process was ongoing and iterative. Emerging themes from interviews and focus groups were then assimilated and described.
Themes reflect data collected in all parts of the study. The analysis presented in this paper focuses on different aspects of communication that the respondents described.

Findings

Four themes emerged from the data. These were: communication within the PCMHMT, communication with the rest the primary healthcare team, communication with patients, and confidentiality.

Communication within the primary care mental health team

An important focus of communication for the PCMHMT was the regular allocation meetings held weekly in each practice. At these meetings, a patient’s referral and case management were discussed and the case management assigned to a primary care mental health worker. Some members of the PCMHMT and some GP leads suggested working together in clusters allowed discussion and feedback on referrals which helped both sides come to an agreement about what was appropriate. As this mental health team leader explains:

‘They look to me for feedback as to how many people they’re referring, are the referrals appropriate and I suppose I’m looking to them to say, “Have you any suggestions...?”’ (Interview team leader B)

The meetings were also a link between the PCMHMT and the rest of the practice. For those primary healthcare team members who attended they were an important way to increase their knowledge and confidence about mental health.

The PCMHMT consisted of individuals with a range of skills, so patients could be discussed and referred to mental healthcare professionals with the appropriate skills. As a result mental health workers no longer felt pressurised to take on work they were not confident about as this counsellor observes:

‘... I did so much work before that I should never have touched, just stuck with it. Sometimes it worked out all right but sometimes it didn’t. I’m not a giver-upper, so I hung on in there – I don’t get that any more.’ (Focus group counsellor A)

One GP had increased his personal level of understanding and involvement and had improved the communication between partners and the team by attending the allocation meetings. However, the majority of the GPs did not believe that this would be a good use of their time; this was despite feeling isolated and ‘on the outside’ (GP1 and GP2) because of lack of regular contact and feedback from the PMHCT.

For the allocation meeting to work well, communication with other members of the primary care team, especially the GPs is important. This is discussed further below, but one aspect was especially important – the quality of the referrals from the GPs, as this PCMHMT leader highlights:

‘The quality and quantity of information on that referral is crucial to the type of treatment received by the patient ... It’s not so bad if I’m doing the assessment, because I will actually cover every area. But if I’m trying to triage, then I need as much information as possible so that the patient doesn’t have multiple assessments ... now I have to do far more assessments when I haven’t got that information, because it would be unfair for that patient if I actually put them through to a counsellor, when what they actually needed was something very different ... an alcohol or a drug problem.’ (Interview team leader D)

Inadequate information led to patients being allocated to the ‘wrong’ mental health worker for their initial assessment and therefore needing to be referred on to another.

Communication with the rest of the primary healthcare team

This theme highlights the importance of communicating the role and activity of the PCMHMT with a wide range of primary care team members. In addition it suggests that multiple methods of communication are important.

GPs who were not mental health leads wanted more information about their patients. In particular, as this GP suggested, they needed more direct feedback about what had happened to their patients following referral as they progressed through the care pathway:

‘As I say, the feedback’s not quite right, but it’s getting there. It would be interesting to see the views from some of the other partners, because there have been some negative comments from people because they’ve had experiences about people coming back more than once – but when you look into it ... it’s often problems accommodating the patient – they’ve turned down several appointments from the team, but you never hear of that when they come in to complain.’ (Interview GP2)
The GP is suggesting that the communication needs to work both ways. In this instance if the GPs knew patients had not turned up they would be able to explore the reasons with the patient and feed it back to the team. GPs wanted more specific and regular feedback from the team about their patients so that they would be more informed when seeing patients again. The same GP went on to emphasise how important this two-way communication was:

‘Communication is the main issue, because where there have been tensions, it’s because communication has been poor and that works on both sides – both from GPs and the team...’ (Interview GP2)

Another GP, described how communication had improved over time since the mental health team had been set up and its role established:

‘... I think now that we know the people by face and name, I would think communication has improved – it’s probably the biggest factor. I suppose before we’d have been waiting there for replies on the phone, now there’s actually somebody there who’s going to help sort that out ...’ (Interview GP3)

One GP mental health lead observed that his colleagues who were not mental health leads felt more distant and on the margins of the PCMH IT, which made communication with the team more difficult:

‘Although I’ve felt part of the team, I think it’s true to say that my other colleagues don’t feel like that and I think it’s because they don’t feel part of the process. Although I feed back to them at practice quarterly meetings and what we’ve done at the bimonthly meeting – what the thrust is, they don’t feel ownership of it.’ (GPS mental health lead)

It was not just clinicians who needed to be included in the flow of information from the PCMH IT and the attempts by the team to build relationships in the practices. The respondents suggested that reception staff were in a key position to facilitate the effective working of the service, because they were the first point of contact for patients. Despite this, the relationship between them and the PCMH IT was at times problematic as these two counsellors indicate:

‘There is this underlying resentment of passing on messages – for really fully interacting with the counsellors. There are a great deal of ruffled feathers, there are now many, many therapists trailing up and down the stirs with receptionists saying, “We don’t know who you are!”’ (Focus group counsellor S)

‘... the receptionists down there don’t know who they [the patients] are ... We have to carry on building relationships.’ (Focus group counsellor A)

Both counsellors suggested that the reception staff were unaware of who they were and what they were doing in the practice. This was inevitably more of a problem where there had been recent changes in personnel. In the two practices above the reception, staff lacked information and as a result the counsellors had to be especially aware and work hard to make themselves known and to build relationships.

The support workers were valued by the team leaders as key facilitators of communication between different professionals and provided an essential pivotal role in the teams. (Support workers were graduate mental health workers trained in brief therapeutic techniques to work in primary care. Support workers had an important role in organising group sessions and in helping to facilitate some of the groups e.g. anxiety management and phobia support. They also had responsibility for a small caseload of patients, for example, they supported people who had phobias on a week-by-week basis.)

‘They are the glue that holds it all together. Without them, I mean when they’re on holiday, it becomes a nightmare.’ (Interview team leader L)

The information primary care staff wanted from the PCMH IT was integrated into the practice computer system so that it was available to all the clinicians to support the communication process as this GP highlights:

‘... so when I talk about feedback, we need it as part of clinical computer records – much needed, robust, clinical computer systems on a uniform basis ... and not only applying to one doctor in a multi-doctor practice.’ (Focus group GP2 mental health lead)

However, while electronic communication was found to be important, the respondents suggested that this alone was insufficient and that communication was also needed face-to-face or by phone. Face-to-face sessions with team leaders about patient progress were valued and considered important by several of the GP leads, from the two focus groups:

‘... they [patients] would be referred and you might get an answer back on a piece of paper and that was it, whereas now at least once a week we can have a chat as to what we’re doing with the patients, what’s going on and what the team leader feels about the patients ... it works much better.’ (Focus group GP2 mental health lead)

‘... there’s nothing to beat the face-to-face consultation, you know, “Can I just catch you for a second ... what do you think about that?”’ And having them in-house, present in the surgery several days a week, albeit not necessarily for very long – it’s a great opportunity for us to share information, which has been very valuable.’ (Focus group GP1 mental health lead)
'We've been talking a lot about feedback and I suppose what I call "eyeballing" is the best way to get feedback.' (Focus group GP3 mental health lead)

Communication with patients

The third element of communication that the respondents highlighted was with patients, in particular the way in which the PCMI's role and purpose was explained to patients. Several of the respondents, especially among the counsellors found that the letter which the PCMI sent out to invite patients was misleading and gave patients an incorrect perception both of their own problem and the treatment they were going to receive, as the counsellor describes below. She argued that it could undermine the relationship that she had begun at the initial assessment:

'I had someone come back to me and say, "I got a letter from the anxiety management group. What have you said?"' I was so glad she felt secure enough to come back and yell at me ... whereas others may have thought, "That counsellor!" and you've totally lost them. So that's an issue.' (Focus group S counsellor)

Another counsellor suggested that the term 'mental health team' caused confusion and was off-putting unless it was carefully explained. The stigma of 'mental health' appeared to worry patients, and illustrated this by giving an example of a patient who had failed to attend after several initial invitations. The counsellor reported the conversation as follows:

"'Well me' and the patient replied, "What a relief! I said mental health team and I don't feel I'm 'mental health' and to be seen by a 'team'." I thought, "No wonder they've DNA'd [did not attend]'.' (Focus group counsellor R)

Not only did the patient not feel she had a mental health problem but she was also concerned that her problems were going to be shared by a team of people. This introduces the notion of 'confidentiality', which is discussed further below.

Other counsellors from different practices explained how they had 'agonised over the letters' (Focus group S counsellor) and altered them to make them less threatening for patients. There was a consensus amongst the respondents that the patients needed to be better prepared for what was arriving through the post as this GP explained:

'... I think a letter is very, very obvious ... it arrives on the doorstep ... going out from the mental health team. They [the team] don't know what the GPs have actually said to the patients, so if we've said something very casual, "Oh, I'll just ask them to have a chat with you" ... then a letter with mental health team flashed across the top arrives.' (Interview GP1)

The GP went on to emphasise that the GPs as the main referrers have a crucial role in making sure they accurately describe the team to patients so that when they receive the letter they are not put off, but go on to engage with the team:

'... It's no good getting access [to the team], having options, if the patient doesn't turn up. So we've got to make sure we do engage ... contact and communication. I mean we as GPs have a crucial role in selling the team and the services to them and I think if we don't do that then it will fail from there. Nobody else can pick up the pieces if we've mismanaged that if you like. So I think there is a professional development role for GPs there.' (Interview GP1)

This GP described how he built the idea of referral up gradually during the consultation, first mentioning aspects of their condition, then moving on to a possible diagnosis and then introducing the idea of medication and/or referral to the PCMI. He suggested that he tried to 'wrap it up' in the context of the rest of primary care team and 'normalise it' through explanation of who was in the team and what they did (Interview GP1).

Health visitors (HVs) and counsellors described how the stigma of 'mental health' was still frightening for people. They agreed that the 'selling' of the team and service were crucial. As one HV said:

'I think if you explain it properly - I mean I always say "mental health team", but I explain who's there, who's involved and what we hope to achieve ... if you try to break it down, it really helps.' (Focus group health visitor A)

This demonstrates that it is important to be open with patients about how teams function especially for vulnerable groups who may be sensitive about confidentiality.

Confidentiality

This theme emerged from the data as the respondents described the different interpretation that different healthcare professionals placed on the term confidentiality. The PCMI members who had the most difficulties in this area were the counsellors. They found it difficult to share information on patients because of their views on patient confidentiality, and felt strongly about their patients' rights to confidentiality. This created a tension between them and the other members of the team who wanted
to share information about patients in order to decide how best to allocate them.

Counsellors understood the value of sharing information, which resulted in more appropriate and quicker referrals, but it also ran against their views on confidentiality. They struggled with an ethical dilemma. The counsellors drew on a particular ethical code on confidentiality that seemed at odds with other members of the PCMHFT and the primary care team. Although they knew that there were benefits to patients in sharing patient health information at the allocation meetings, they were uncomfortable with sharing information, which they considered should stay between counsellor and client. They therefore found it extremely difficult to share information at the meetings. They also thought that patient confidentiality was a risk when information was displayed on a computer screen. This counsellor described her concerns:

'... in these allocation meetings, something has come up, this information that is known to the health visitor, the CPN and to me and suddenly, it is no longer confidential...’ (Focus group counsellor F)

The ethical code of counsellors prevented them disclosing information about patients that other members of the team might disclose, as this counsellor explained:

'... content is something that you are very, very reluctant to disclose unless you felt that they may harm themselves or somebody else, at which point you try to get their permission to disclose their information, but without their permission, under the code of ethics, you shouldn't ... if it was a life and death situation, then the process is slightly different.' (Focus group counsellor S)

As this counsellor indicated only extreme life/death situations would allow them to break their client’s confidence. Counsellors did not share the approach to confidentiality that is adopted in general practice where the boundaries are the physical limits of the building and those who work in it, as this counsellor describes:

'I think there is an assumption that if it is within the practice it is confidential, as if the boundary is the building in a way and that everybody from the receptionist to the senior partner has “it” and they live within that framework ...’ (Focus group counsellor A)

They were also concerned that letters sent to patients’ homes, which clearly came from the mental health team might if opened or read by other members of the patient’s family breach that individual’s confidentiality; patients, may not wish family members to know about their problem, and patients had other concerns related to the letters.

The GP in the following extract highlighted a problem that the counsellors’ reluctance to disclose information on their clients could create for GPs:

'The confidentiality issue with counsellors can actually become a hurdle – when you think of all the confidential issues that are divulged to GPs in surgery ... it can in turn help interpret physical symptoms ... for example, if people have been abused and they won’t attend for smears, it can help by the way you approach that – rather than sending out letters ...' (Interview GP3)

Although some of the counsellors suggested ways to overcome the dilemma they had, there was no consensus among them about how to resolve the situation:

'I was put in a difficult position recently at a meeting. It was over a husband and wife and I was seeing one of them and I just made it very clear from the beginning that I was sorry that I was not going to discuss this.' (Focus group counsellor R)

The counsellors were clear amongst themselves about where the boundaries of client confidentiality lie, however, as in the example above, these are not for the rest of the primary care health team and the PCMHFT.

The counsellors also faced ethical dilemmas when carrying out the initial mental health assessments on patients, which took place at the first appointment after the allocation meeting. This was because of the need to feed back information to the team after the initial assessment, in order to decide on what was the most appropriate treatment for the patient. The counsellors viewed this as a conflict of interest and a breach of confidentiality. It made it difficult for them to then continue to work with the patient as a counsellor. This counsellor describes how she had struggled with this and had been advised to ‘change hats’ (Focus group counsellor S) when in allocation meetings:

'You’re part of the mental health team when you’re doing a mental health assessment – you’re an assessor, but once you go into counselling you become that person’s counsellor. At that point you cannot bring it back to any further allocation meeting – certainly not with the content, perhaps with process and especially if you feel you need to refer them ...’ (Focus group counsellor S)

A health visitor who is also a counsellor agreed:

'I try to separate it from the counselling. I try to do the assessment first if I’ve had a referral, because it’s very difficult to offer counselling if you’re doing an assessment. So I explain that first we’ll do the assessment and then the counselling. I’ve had occasions when it was not possible to do the assessment straight away, then I would discuss with them what information was going back to the team ... I think it’s paramount really, sharing
what will go back, how it’s stored and what the 
boundaries of confidentiality would be on the 
counselling as well, which are quite strict.’ (Focus 
group counsellor Y)

The respondent suggested that one solution to this 
was to inform patients fully and accurately about 
specific information that will be shared and with 
whom. This links back to the communication theme 
and forms an important aspect of communication 
with patients.

Discussion

This study examines one way of providing mental 
healthcare in primary care. Of particular interest is 
the way that the model brings together different 
practices in ‘clusters’. In order to work effectively, 
communication with all the stakeholders is crucial. 
The study examines this in more detail and high-
lights difficulties that need to be addressed but also 
areas where communication works well. In the study, 
although primary care staff embraced the commu-
nication changes necessary to work across organi-
sational boundaries and disciplines there were 
difficulties. As part of this new way of working, 
mental health practitioners had to extend their 
knowledge and skills, and communicate with a 
team of healthcare professionals from different back-
grounds. They also had to learn new systems and 
processes of working. In addition these changes 
ocurred in a variety of different settings in which 
each general practice in the clusters had its own 
culture, identity and ways of communicating.

The study was designed to allow us to examine in 
depth the processes involved in delivering the ser-
vice. Other PCOs might want to treat the results with 
cautions because of the very specific focus, however 
the underlying principles arising from the findings 
may provide useful information for the develop-
ment of other new NHS services. Most significantly 
the findings suggest that it is important for PCOs to 
consider a strategy for communication in the areas 
highlighted here when developing new services. 
Another factor that facilitated the success of the 
circle model in this PCO, which might not neces-
sarily be transposed into other organisations, was the 
presence of clinical and managerial champions and 
commitment from all the practices involved in 
developing the service. Studies in other areas have 
demonstrated that models of care cannot be im-
posed on organisations without the necessary emo-
tional commitment from personnel involved with 
the changes. However, this study highlights that 
even when a model is accepted and embraced, the 
details of how a service works should not be over-
looked. Communication between team members 
and organisations is a good example of this. This 
study has demonstrated that attention to these areas 
should be part of the ongoing daily management of 
the process. The study also highlights areas where 
it is necessary to do more work in order to clarify 
key areas such as confidentiality, where staff have 
different approaches and ethical stances. Brown 
and co-workers demonstrated that lack of effective 
communication and leadership leads to blurred 
roles and encourages professional silos in multi-
disciplinary services.

Participants felt that if communication was not 
working between different practitioners, and sys-
tems for communication were not in place, then 
the effectiveness of the team and the service delivery 
were threatened. A number of problems could be 
addressed in the practices by effective electronic 
systems. However this should accompany rather 
than replace face-to-face discussions. Face-to-face 
or telephone discussion are necessary to build re-
lationships, communicate important messages or 
information and track the progress of patients. 
Once these relationships are in place it becomes 
easier to challenge some of the traditional processes 
and systems. One example given in this study was 
the quality of the referrals that GPs made to the 
PCMHT. These could only be improved by face-to-
face meeting and discussions.

Another important consideration is the effective-
ness of cluster working was the awareness that other 
members of the primary healthcare team had of the 
different roles within the primary care mental health 
team. Integration into the practices was especially 
problematic for counsellors who relied on reception 
staff being aware of their presence. To overcome 
this, time could be set aside for the primary health-
care team to meet with the PCMHT, for example 
during educational half days when all practices in 
the PCO close for education and development work. 
This was especially important in those practices 
where there had been changes in personnel.

In addition to communication within the PCMHT 
and between the PCMHT and other members of 
the primary care team, communication with patients 
was important. In particular the referring GPs, ‘sold’ 
the idea of the PCMHT and explained what it was 
and its function, then patients were far less likely to 
take up either the offer of referral or an appointment 
if they were referred.

While communication and the sharing of inform-
ation was crucial to the success of the clusters’ 
patient confidentiality remains paramount. A sig-
nificant problem arose in this area because of the 
different ethical position taken on confidentiality
by one group in the PCMHFT, the counsellors. At the
time of this research this issue remained largely
unresolved. One possible solution to this might be
to improve communication with patients about this
issue. First, the patients need to be informed what
information about them will be shared, with whom
and why, and second, the patients need to be asked
to give their informed consent to the sharing of this
information. By doing this, the counsellors may
become more comfortable about breaching what
they view as patient confidentiality. Kell argued that
although the privacy of patients and their need for
protection from harm are values respected by all
professions, these words are also open to interpre-
tation. Improved clarity in this area would allow
counsellors to join a multidisciplinary team, in
which the definition of confidentiality may differ
from their own. In addition the professional bodies
that regulate and support the different disciplines
need to guide their membership on how to adapt to
their changing roles in primary care mental health.

As interdisciplin ary teams continue to develop,
roles and cultures may become more cohesive; how-
ever the relationship between specific teams such as
the PCMHFT and the rest of the primary healthcare
team is an ongoing challenge. Roles within the
PCMHFT were valued and respected by other team
members as well as those outside, which facilitated
communication. Over time, the relationships in the
team strengthened and this in turn enhanced the
process of communication. Specifically the primary
care mental health workers played a key role in
facilitating communication as well as delivering
clinical care. Group meetings, which occurred regu-
larly, such as allocation meetings, where decisions
could be discussed and patients appropriately
directed to members of the team, allowed the qual-
ity of patient care to be improved. Fitzsimons and
White, and Milligan et al argued that when philo-
osophical approaches between professions are evi-
dent, and different disciplines are forced to work
together without gaining a common understand-
ing, dysfunctional teams might arise which may in
turn compromise patient care. This study did
not uncover dysfunctional teams, suggesting that by
addressing the communication issues highlighted,
the cluster model had been established effectively,
although the problem of developing a mutual un-
derstanding on patient confidentiality was clearly one
area that needed more attention.

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CONFLICTS OF INTEREST

None.

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