

## **Health Sciences and Practice Mini Project**

**Graduate Primary Care Mental Health Workers: the process of  
introducing the role into primary care trusts**

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### ***Executive Summary***

Amidst widespread concern that the demand for mental health care resources will continue to outstrip supply, the NHS Plan (2001) made provision for 1000 new Primary Care Mental Health Workers tasked with:

- providing brief evidence-based therapeutic interventions and self-help;
- strengthening the information base of mental healthcare services available to clients and promoting this knowledge amongst clients and within the community;
- assisting in the development of practice-based information systems, audit and outcome measurement.

The introduction of this role was intended to address a number of issues in the provision of mental health care. First, the new role, located within primary care trusts, was to help facilitate the transition towards primary care becoming the major arena of community mental health care rather than providing a limited ‘gatekeeper’ function, guarding access to specialist mental health services available within secondary care. Secondly, it was intended to ameliorate inter-professional conflict in mental health care by avoiding the inclusion of the new workers in any existing professional category nor creating a new professional category for them. Thirdly, the role was intended to facilitate the supply of basic therapeutic interventions of demonstrated effectiveness, particularly cognitive behaviour therapies. Fourthly, the role was intended to help cement partnership between health services, social services and the voluntary sector. And fifthly the role was intended to help reduce the stigmatisation of mental illness in the community.

The introduction of this new role into the NHS has been problematic however. There is scepticism about the viability of the new role amongst other mental health professionals and there are concerns about the viability of career pathways for the new role holders post-qualification. In short, there is uncertainty over the viability of this new role (and hence of training people for it) yet considerable confidence in the declared need for the role. There is therefore a need to:

- identify how the role-holders are being employed (as distinct from how the NHS plan intended them to be employed);
- assess the perceived viability of the role within the primary care community;
- identify any implications for learning and teaching.

The University of Surrey undertook therefore a project with the following aims:

- to identify the profile of employment for the role;
- to assess the impact of training and employment by assessing attitudes to the role within employing primary care trusts;
- to communicate the results of the study to Primary Care Trusts in ways which allow obstacles to effective learning and teaching to be identified.

To profile the pattern of employment, role holders in six PCTs were invited to complete activity reports for a typical week of employment. The most common area of employment was in audit, evaluation and practice development. Less time was devoted to mental health promotion and, with the exception of one PCT where large amounts of time were devoted to clinical work from the outset, very little time was given to clinical work.

To assess the impact of the role in primary health care delivery, a questionnaire was designed to illuminate shifts in attitudes held by NHS staff to the new role. The results of the quantitative analysis of this questionnaire were of limited conclusiveness. But the questionnaire also allowed respondents to comment on the introduction of the role into the PCT. Analysis of these comments in terms of force field analysis illuminated the processes of adoption of role by PCTs. A workshop with role holders allowed a series of factors to be identified which facilitated the adoption of the role (enabling factors) and a series of factors which hindered it (resistance factors).

Comments provided by respondents to the questionnaires were analysed in terms of these enabling and resistance factors. This analysis allowed three distinct models of adoption of the new role to be identified. A **precision skill model** was evident whereby role holders interacted with clients in very limited and strictly defined clinical encounters. The success of these limited encounters facilitated the adoption of the role within the PCT. But the limitations placed on the role contributed very little to the longer term feasibility of the role in terms of career development.

A second model of adoption, a **knowledge co-ordination model** was evident in which any direct face to face clinical encounters with clients was strictly limited; and the role focused on 'sign-posting' clients to a range of service providers within the community through use of the telephone. This model allowed more of the policy objectives of the role to be met than any other model strengthening links within the community and working to reduce stigmatisation in terms but it limited the extent to which role holders gained experience of providing face to face therapies.

Thirdly, a **limited clinician** model was evident within which the role holders were regarded as apprentice clinicians in mental health. A wide range of different therapeutic measures were regarded as feasible for delivery by the role holders from an early stage with supervision and oversight by GPs. This maximised the delivery of brief therapies but it minimised the extent to which the role could facilitate other policy objectives of the role.

The training of the PCMHWs would, it is concluded, benefit from more focused attention on the process of organisational adoption by PCTs.

## ***1 Introduction***

It is unlikely that the gap between the perceived need for mental healthcare services and their provision has ever been so acute. Lester et al. (2004) remind us of the scale of the need for mental health care in the UK. Depression is the third most common reason for consulting GPs in the UK and suicide is the most common cause of death amongst the under 35s. Mental health problems figure in one in four consultations in primary care and

account for 28% of the total number of years lived by people with disability and for 10.5% of the global burden of disease. Seven per cent of the primary care drug budget is spent on anti-depressants and the total cost to the economy is greater than breast cancer, ischaemic heart disease and diabetes put together. And these figures understate the extent of people who are not “ill”, who do not meet the criteria of entitlement to statutory services but find the task of coping with life events too difficult to bear and who, if left unaided, may become ill or even at risk of suicide. As the report from the Scottish Development Centre for Mental Health (2004) noted, “...primary care mental health needs cannot be defined in terms of discrete problems that fit into discrete service functions”.

As the demand for mental health care resources becomes clearer, so too do the problems in acquiring the necessary resources. While the nursing population increased slowly between 1997 and 2001, the nursing workforce with mental health qualifications has failed to keep pace (Genkeer et al, 2003). Since many nurses work part-time and staff retention remains a challenge, the actual shortage may be considerably worse. As people live longer and improvements in medical science create more opportunities to help them stay alive, the gap between demand and supply of mental healthcare is likely to widen. Shortages amongst psychiatrists, social workers and psychologists combine together to exacerbate the shortage. Within primary care, only 2% of nurses have mental health qualifications yet 43% report being involved in the identification of acute depression and anxiety.

The problem is larger too than simply a shortage of people in the traditional categories of career. Norman and Peck (1999) remind us of serious levels of mistrust between different professionals trying to work together in community mental health teams. Their work demonstrates the extent to which separate professional loyalties and different paradigms of required competencies pose threats to teamwork and inter-professional collaboration needed to care for peoples’ mental health, particularly when resources are scarce. This is perhaps to simplify a tension within health organisations between organisational values and professional values (Worthington, 2004). In a study of the cultural changes in primary care organisations needed to implement NHS reform, Marshall et al. (2002) identified two principal barriers to changing the culture within primary care. The first was the long history of GP autonomy, held to be incompatible with the type of clinical governance and collective responsibility inherent in the NHS reforms; the second was a sense of being under pressure to deliver results for short-term political reasons.

Worthington’s thesis goes further and suggests that there are widespread assumptions amongst healthcare managers, particularly Human Resource Managers, that the quality of healthcare output can be improved by raising the quality of the organisation providing it by, for example: improving teamwork, changing culture, creating new patterns of delegation and re-ordering the allocation of tasks across professional categories. Worthington suggests that a major reason for the apparent failure to improve healthcare outcome measures is that these organisational assumptions are not shared by healthcare professionals who regard healthcare output determined primarily not by organisational changes, but by the quality of professional capabilities amongst the multitude of professional groups, each with their particular loyalties that constitute the healthcare workforce. In mental health, psychiatrists, psychotherapists, psychologists and nurses constitute only some of these disparate professional groups.

As part of a battery of measures to combat the shortfall in mental health care, the NHS Plan (2001) made provision for 1000 new Primary Care Mental Health Workers (PCMHW) by 2004; an important landmark in recognising mental health as one of the most prevalent sources of demand within primary care. The creation of this role, alongside widespread change within the UK health service, resulted from a concern to improve the quality of organisational outcomes in the health services rather than to create a new professional avenue to add to the number of different professional categories that already exist in mental healthcare. The introduction of the role contributed to another important landmark in making primary care the main focus for addressing mental health care. As Lester et al. remind us, primary care services have traditionally provided a limited, 'gatekeeper' function; guarding access to specialist mental health services available within secondary care. The shift towards a primary-care-led National Health Service requires significant changes in this model of service provision; placing demands upon primary care to provide integrated patient-focused care via relationships with, but not dependency on, secondary care. It also entails identifying the opportunities and risks of new ways of delivering mental health care whereby primary and secondary care providers collaborate in developing an integrated, patient-focused mental health service.

Part of this approach might be to strengthen the role of family doctors as first-line therapists. Nowadays, between 20-25% consultations are about mental health. It features in up to 40% of cases presenting in primary care, exclusive of the further 77% cases of mental healthcare need which may still be being missed. Fewer than 35% of GPs have taken any continuing education relevant to mental health and 98% of practice nurses have no post-registration mental health training.

A further part of the approach is to provide more therapists and more psychiatric nurses in the community. But Norman and Peck (1999) describe some of the systemic problems in inter-professional working in community mental health teams, describing "disagreements between mental health professionals about what constitutes mental health and illness and....debates about effective approaches to treatment ....that stunt the development of community mental health teams."

An important component of meeting the demand, however, is to increase the number of people with capabilities in basic therapeutic interventions of established effectiveness. A further component has been to recognise the need for partnership between health services, social services and services in the voluntary and non-statutory sectors. Cementing these partnerships requires people with the capability to manage the knowledge (with necessary ICT skills) of what is available; of what works and what doesn't; and of what is appropriate for a particular client across the wide range of available services. A third component is the need to promote understanding of mental health and well being in the community, avoiding the stigmatisation of mental illness and facilitating the sharing of knowledge within the community.

Reflecting these needs, the role of PCMHW has been created to:

- provide brief evidence-based interventions and self-help;
- strengthen the information base of mental healthcare services available to clients and promote this knowledge amongst clients and within the community;

- assist in the development of practice-based information systems, audit and outcome measurement.

This new role - part counsellor, part mental healthcare promoter and part knowledge-manager - has been designed to map closely the profile of needs emerging in primary care. But the role falls outside the traditional role categories of psychologist, psychotherapist or nurse and it has not emerged unscathed from critique. Bains et al. (2004) refer to the scepticism about the viability of the new role amongst psychologists and other mental health professionals; a scepticism centred on the amount of unsupervised client contact with people holding limited competencies from one year's training and no professional identity within any of the established healthcare professions. There is concern too about the viability of career pathways post-qualification, recognising that many entrants will see their employment as stepping stones towards careers as either health care managers or as psychologists and/or therapists.

Consequential concerns arise as to whether the employment of PCMHWs will reflect the Trusts' needs or whether it might be skewed by the need to ensure adequate career pathways. A concentration on tasks which provide an employee with research skills relevant to a future career rather than on tasks which reflect the community needs (therapeutic interventions, for example) might be an example of such skewing.

One of the paradoxes in the provision of mental health care in the community is that there are both strictly controlled avenues into professional caring roles, controls imposed by the various professional bodies, and at the same time a remarkable absence of control over those who claim some capability to help those in mental anguish; those working, for example, in the voluntary sector, in NGOs and in faith communities. The creation of the new role might yet be an important step in limiting the degree to which there is dysfunctional professionalisation in mental health care whilst at the same time safeguarding clients from completely unscrutinised attempts to provide care by willing, but insufficiently capable, volunteers in the community.

In summary, there seems to be a conflict between the degree of uncertainty over the employment viability of this new role (and hence of the utility of the training) and the considerable confidence in the declared need for the role. An important step in reducing the risk of investing in training for the role would be to ensure coherence between the learning outcomes of the training course and the employment of PCMHW in the trusts.

There is therefore a need to:

- identify how the role-holders of the new role of PCMHWs are being employed (as distinct from how the NHS plan intended them to be employed);
- assess the perceived viability of the role within the primary care community;
- identify any implications for learning and teaching.

## **2 *Project aims and report status***

The University of Surrey delivers a twelve-month post graduate certificate programme to prepare students to undertake their new role of PCMHW in primary care trusts in London

and South East England. The aim of the project described in this report was to evaluate the impact of the training and employment of PCMHW on the delivery of primary mental health care and to disseminate the utility and value identified. This document is the final report of the project. It is hoped to publish journal articles in the academic press based on the results of the project.

The success of any training programme depends, in part, on the coherence between the learning outcomes of the course and the pattern of intended employment of those undergoing the programme. The project had three objectives:

- to identify the profile of employment of PCMHWs in relation to the tasks anticipated of their role in the NHS modernisation agenda;
- to measure the impact of their training and employment by assessing the shift in attitudes to their utility within employing primary care trusts;
- to communicate the results of the study to Primary Care Trusts in ways which allow obstacles to effective learning and teaching to be identified.

### **3**      *Methodology*

Three methodological requirements were identified to meet the project objectives. The first was to profile the pattern of employment of PCMHWs in the PCTs. The second was to measure attitude shifts within the primary care trusts and determine how these employment profiles met expectations of the role as perceived by those managing and delivering mental health care in primary care trusts. The third was to create opportunities to meet with Primary Care Trusts to communicate results in a manner which would facilitate learning about the development of the role and the training needed for it. This third aim is a continuing task with the representatives of those PCTs on the Stakeholder Steering Group of the University's post graduate programme in primary care mental health.

#### **3.1**      *Profiling employment*

To profile the pattern of employment, fifteen PCMHWCW students on a work-based postgraduate training programme for their role were invited to complete activity reports for a typical week of employment after six months in post. The completion of these activity reports formed part of the students' reflective learning processes. Each role holder estimated the percentage of time devoted in a week to a series of components of their roles. They were invited to assess how typical this allocation of time was and appended notes about their work in a particular week. The categories of work used in the logs were based on amplifications of the roles expected of PCMHW, as described in the NHS plan. The format for completion of activity reports is shown at Appendix A.

#### **3.2**      *Assessing impact on primary health care*

To assess the impact of the role holders' learning and employment on primary health care delivery, the role holders (i.e. the course members) developed a questionnaire that would allow the attitudes held by other NHS staff to the utility and value of the PCMHW role. Attitudes were determined at two points: early and late in the course. The difference

between the before and after results were intended to provide an indirect measure of the impact of the students' learning and employment.

A total of 83 participants returned questionnaires over the two periods, all of whom were staff members from the six PCTs covered in the study. The participants represented four categories of staff: general practitioners, managers, specialists and administrators.

### **3.3 *Communicating and learning from the results***

Reports from the two studies (employment profiles and attitude shifts) will be presented within workshops to be held with PCTs. These will include some PCTs who are already employing PCMHWs and those considering employing them. Discussions with the former will enable teething problems with the learning and teaching processes to be identified. Discussions with the latter will disseminate understanding of the PCMHW role and the learning and teaching processes.

## **4 *Employment profiles***

Fourteen activity reports were provided by role holders approximately eight months into their new role who worked across six different Primary Care Trusts in South East England. Three of the fourteen respondents provided two activity reports based on employment weeks more than two months apart. Thus, seventeen activity reports were generated in total. In order to limit the risk of unnecessary identification, the PCTs have been colour-coded and referred to as: Red, Orange, Yellow, Green, Blue and Indigo PCTs. Feminine gender is used in the text throughout, regardless of whether the role holders were male or female and, to ease reading of the text, the role holders will be referred to as 'respondents'. Masculine gender is used to refer to all members of staff of PCTs other than PCMHWs.

### **4.1 *Provision of brief therapies***

Three of the respondents worked in the Red PCT, where only one of them reported spending any time at all in therapeutic work, and this was providing information and self-help material rather than therapeutic encounters. She estimated the time spent as amounting to 5% of the week, which she regarded as normal. The remaining two respondents were looking forward to working with self-help therapies based on cognitive behavioural therapy, but a degree of frustration was evident in that they had been so far unable to put therapeutic skills they had learnt on the course into practice. One reported being involved in the development of self-help material but had not had the opportunity to give it to clients.

Of the two respondents working in the Orange PCT, one had commenced significant amounts of work in brief therapies. She estimated that 45% of her time was typically spent in working with individuals with mild to moderate mental health difficulties, several afternoons per week being committed to face-to-face client work with more time spent in telephone work with clients. The respondent estimated spending 10% of her time in finding out information for service users.

Neither of the two respondents in the Yellow PCT had done any therapeutic work but both looked forward to commencing it and believed that referrals were imminent.

A marked contrast was evident in the Green PCT, where 70% of a respondent's time was spent in introducing individuals to a computer presented self help cognitive behavioural therapy (CBT) programme in six different General Practices. The use of such therapies was identified in the early conceptualisation of the role as the paradigm case of therapies that are relatively simple to administer and of proven effectiveness.

Of the five respondents in the Blue PCT the first estimated spending between 15% of her time providing brief therapies. A second and third respondent provided separate activity reports, 2 months apart. One reported that face-to-face work with clients had started in the second activity report, estimated as 20% of her time. For the third respondent, it had still not started, nine months into the role. The fifth respondent had not started but expected to commence face-to-face client work within a few months.

In the Indigo PCT, 5% of one respondent's time was estimated as spent developing self-help material on mental health and employment, and in clinical supervision in preparation for brief CBT sessions with clients.

In summary, after nine months in employment, only one of the fifteen role holders reported any significant level of working with clients in therapy, although all saw this work as a crucial part of the employment to which they aspired. Only three of the fifteen reported any level of employment directly related to therapy work and seven of the eleven reported zero employment in therapeutic related work.

Two months after the activity logs were completed, discussions were held with the informants to assess any changes in the employment profile. In three of the seven PCTs, (Red, Orange and Green) there was regular contact with clients; although in one of these PCTs (Green), where client contact was most extensive, there was a somewhat exclusive reliance on the presentation of electronically delivered cognitive behavioural therapies rather than a broader repertoire of brief therapies. In two of the PCT's (Red and Indigo) there was a clear strategy and management vision of how the role might develop in the future. Both these PCTs had collaborated in the development of this strategy and vision. It was one in which there was more emphasis on one-to-one work with clients; not so much for the provision of brief therapies, but on the provision of information about the appropriateness of different services – 'signposting' in the phrase adopted in the NIMHE document.

In a further PCT (Yellow), there was considerable concern amongst the respondents that there was little vision and little agreement in the Trust about how the role might be used and a continuing shortage of client contact by role holders. In one of the Trusts, a lack of confidence in the new role by GPs had been identified as an obstacle to gaining client contact by role holders. A key informant of this observation was made by the clinical supervisor of the role holders, a clinical psychologist, and the question arose as to whether the resistance to the new role extended beyond the GPs.

#### **4.2 *Mental health education, promotion and networking***

In the Red PCT, there was an expectation by two of the three respondents that presentations about mental health issues to sections of the local community, to schools for example, was about to start. But it hadn't started nine months on and there was some frustration around the slow start. Considerable effort in the same PCT had been devoted to compiling a resource directory of services available on a CD ROM and activating a self-help phoneline as part of a wider framework of pathways to wellbeing in mental health.

In the Orange PCT, between 15 and 30% of time was estimated by the two respondents as spent in mental health education, promotion and networking; the role holders who reported the 30 % figure regarded this as normal. In none of the other six PCTs did the combination of presenting to primary care practitioners and networking with voluntary and community bodies amount to more than 20%. Comments reflected some frustration in this area that presentations to GPs about new services arranged by the PCT were prevented by GPs being sick or otherwise unavailable. Comments provided by respondents suggested there were considerable expectations by line managers that much work was needed in this area, but there were organisational and culture barriers to the work commencing.

#### **4.3 *Practice development, clinical governance and auditing skills***

It was in these areas where the bulk of the employment lay. Estimates of time ranged from 70-80 % in the Red PCT. In the Orange PCT, one respondent estimated to devote 15% of their time to liaising with non-statutory agencies for the purpose of auditing health care activities. Five percent was estimated to be devoted to clinical audit and evaluation of mental health care services within the Trust.

In the Yellow PCT, between 40-80% of employed time was estimated by the two respondents as falling within this category. In the Green PCT, where CBT had been adopted with alacrity, only 20% of time was estimated as being devoted to this area. In the Blue and Indigo PCTs, 40-50% of time was estimated as being in practice development and auditing.

<b>n</b>	<b>PCT</b>	<b>Percentage of time devoted to clinical work with clients</b>	<b>Percentage of time devoted to mental health promotion</b>	<b>Percentage of time devoted to practice development, clinical governance and auditing</b>
3	Red	0-5%	<10%	95% (approx.)
2	Orange	10-45%	15-30%	20-40%
2	Yellow	nil	10-20%	40-80%
2	Green	70%	5-10%	< 20%
4	Blue	20%	5-20%	>50%
1	Indigo	nil	2%	85% (approx.)
n=14				

**Table 1 Employment profiles of the six Primary Care Trusts**

## **5 Determining the impact of the role on the PCTs**

There is a separate question from that of how people are being employed in the role: how do people in primary care regard the role? The second research task was to assess the impact of the role within the primary care community. Two questionnaires were distributed to staff in the six PCTs. The first, designed to determine the expectations of the impact of the PCMH roles, was administered within a few months of the role's implementation; the second was to elicit how PCT staff evaluated the impact of the role after the first year.

The impact questionnaire, following questions regarding demography, was composed of a quantitative scale that measured PCMH impact and perceived functionality, and qualitative questions about the impact of and concerns regarding the role. The questionnaire is shown at Appendix B. It also allowed respondents to provide remarks on how the role was perceived in the PCT. These qualitative aspects of the study are analysed below.

Four categories of personnel were apparent amongst the forty-three respondents who provided qualitative data in their completed questionnaires. Three raters agreed on titles for each of the four categories: "Managers" (n=11), "Specialists" (n=18) "Medical General Practitioners" (n=10) and "Administrators" (n=4). Managers included mental health professionals employed by the PCTs and working as commissioning agents for mental health services. Specialists included psychologists, psychotherapists and counsellors working directly with clients. The comments made by respondents to the questionnaire are analysed below in terms of the PCT in which each served.

### *Red PCT*

No GPs from the Red PCT commented. Amongst the Specialists, there was concern by a health visitor and by a counselling psychologist that the PCGMHW role is ill defined; presenting confusion amongst clients and the risk of unnecessary duplication of services.

Further, a Manager commented that there was a need to distinguish between services which contributed to health, and those which contributed to other aspects of social well being that might need to be funded separately from health care provision.

A high proportion of time was spent by the ‘Graduate Workers’ in struggling to define new forms of service in mental health care in a PCT in which there was considerable uncertainty about how the mental health agenda was going to play out.

*Red PCT: follow-up*

There were no comments made in the follow-up questionnaire by members of the Red PCT.

*Orange PCT*

Three GPs from the Orange PCT mentioned the enormity of the task before them in mental health care, referring specifically to the need to reduce waiting lists for counselling services and to provide more self-help guidance for eating disorders and obesity. The only comment concerning the feasibility of the role was the magnitude of the task ahead in relation to the numbers of PCGMHWs.

Both of the Specialists, a health promotion specialist and a psychologist, that completed a questionnaire from the Orange PCT, saw the integration of services in mental health and the better mutual understanding of what each service could provide as the most important area to which the new role could contribute. Both felt that the number of people employed in the new role was tiny in relation to the need.

Two Managers from the Orange PCT envisaged enhancement of the role, contributing perhaps to the formulation of policy for mental health. With appropriate supervision and regular evaluation, there was optimism about the value of the role.

*Orange PCT: follow-up*

Three GPs commented on the success of the role. One remarked that the role’s introduction had had a very positive impact on chronic health care cases and felt the service provided by the new role had been a “quality service”. All three were very positive about the success of the role.

A Commissioning Partnership Manager from the Orange PCT felt that the new role had helped the PCT to be seen as “doing things; not just commissioning them”. It was an excellent way of enhancing mental health service in primary care. There was, however, recognition that recruiting targets were not being met and that this may jeopardise the future of the role.

A Practice Manager from the Orange PCT regarded the impact of the role as very positive. It had a “positive impact” with many success stories and he had been impressed by innovations such as arranging appointments by text messaging with mobile phones.

A secretary and receptionist in the Trust described the PCGMHWs as part of a team.

Amongst the Specialists, a clinical supervisor felt that “workforce development is a concern” and there was a “major moan” from a clinical supervisor about the course provider.

In summary, there is little qualitative evidence of any major shift in the Orange PCT of the positive appreciation of the role that was evident in the initial questionnaire. The role was highly regarded in the both the initial study and in the follow-up. The only concern raised in the follow up study was that of workforce development for the role.

#### *Yellow PCT*

Three Medical General Practitioners (GPs) from the Yellow PCT took the opportunity provided by the questionnaire to identify areas of need that PCMHWs might profitably address. These included cases arising from alcohol and substance abuse, obesity and workplace stress. They also identified shortages of resources that the new role might alleviate. These included the need for better awareness of common mental disorder amongst clerical staff, better links with voluntary and statutory agencies, more self-help information and the need for group work to alleviate the shortage of counselling resources.

Each of these GPs alluded to the magnitude of the problems that might be alleviated by the new role: namely, long waiting lists for counselling and lack of self-help guidance for eating disorders and low self-esteem. Two of the GPs had concerns about the feasibility of the role. One referred to the breadth of the role and the risk of being spread too thinly and referred also to a risk of overlap between the work of practice-based counsellors providing one-to-one counselling and the provision of brief therapies by PCGMHWs.

Three Specialists, two of them counselling psychologists and one of them a mental health nurse working to reduce the incidence of heart disease (by alleviating associated lifestyle risk factors), provided comments. The nurse believed that reducing the surrounding stigma associated with mental illness and helping to reduce stress associated with propensity to heart disease were both important areas of potential work for the new role holders. The two counselling psychologists thought that providing more self-help in mental health care services and helping to integrate voluntary and/or statutory services were key areas of useful PCMHW employment. A fear was expressed that the role might become an opportunity to get counselling ‘on the cheap’ and that it was too broadly defined. In particular, there was concern that the boundaries of the role in relation to the services provided by psychologists had not been adequately defined.

The two Managers who commented from the Yellow PCT had very positive views about the importance of the new role and of its potential enhancement. They did not mention any of the risks identified by the GPs.

#### *Yellow PCT: follow-up*

Five GPs provided comments in the follow-up study. There were more negative comments than positive ones, suggesting possibly that they regarded the role less favourably with the passage of time. One GP was “generally positive” but concerned about the lack of feedback on the success of the role. The GP was also concerned whether clients did actually turn up for therapy with the PCMHW and how many were “wasting time”. A second GP commented that the success of the role was limited because of the “need for a supervisor to

oversee everything” and did not feel there was satisfactory communication with GPs. A third GP didn’t know much about the role but did not intend to make use of the service. A fourth GP, a mental health lead, was very positive about the role and about the potential for their use in CBT, but he felt there had been many “teething difficulties”, a lack of clear direction within the PCT, a lack of supervision, and a lack of “linkage” with other services offered within the PCT.

Amongst the Managers from the Yellow PCT who commented, a Primary Care Services Manager felt “a real need for clear direction” about the role. But where the role had been understood, there had been a benefit to counselling services. He felt that “if it continues to be [seen as a source of] cheap counselling staff, it will not be retained”. But he saw a dilemma: if the PCMHWs were employed only in administrative or knowledge management tasks, they would not be attracted into the role, yet if they were employed as counsellors ‘on the cheap’ they would not be likely to remain in the post.

Amongst the Specialists in the Yellow PCT, a counselling psychologist expressed a sense of confusion about the role and the need for a workshop to explain how many patients might be seen by the PCMHW, for what purpose and for what outcomes.

In short, the introduction of the role into the Yellow PCT had proved a difficult experience; one in which the initial enthusiasm about the role had not been followed up by clarification of expectations about the role by the time of the follow-up study.

#### *Green PCT*

Four GPs from the Green PCT commented, two of whom were mental health leads. Both described with enthusiasm a vision of promoting the care of people with common mental health problems within primary care, expanding the role of counsellors and, specifically, of developing the use of CBT. They identified a risk of the role being spread too thinly and the risk of the role becoming bogged down in administrative tasks. One of the four wanted more CBT resources but expressed reservations about the feasibility of electronically mediated CBT.

Amongst the Specialists who provided comments from the Green PCT, was a health visitor, two counsellors and a mental health nurse working in child and adolescent mental health. All four expressed reservations about the role, encompassing fears concerning: expectations of the role being too high; fear that the role would be regarded as a clinical role when it is not; and concerns that role holders are being overtrained to take up clinical skills which are beyond the boundaries of the role.

The Manager that responded from the Green PCT took the view that the introduction of the role and the calibre of people employed in it are helping to make a hitherto untapped workforce available, in an area of acute need. There was a recognition too that, once the role was more established there would be considerable demand for PCMHWs and, accordingly, considerable financial implications.

Two Administrators responded from the Green PCT. One, a receptionist, felt that she and, significantly perhaps, many others, knew too little of the role. The second, a Practice

Manager saw the education of non-clinical staff in mental health awareness; a key task for the role.

*Green PCT: follow-up*

Two of the four GPs who commented in the follow-up questionnaire were positive about the success of the role. It was an “excellent resource within the current context”, reported one. Another reported no concerns about the use of CBT. A third GP wanted “more joined up management to make best use of them [in order]to allow signposting to develop and exploit the full potential of the role.” This was a reference, surely, to the somewhat exclusive use of the role. A fourth GP was “in the dark about progress” of the role.

Amongst the Specialists, a clinical supervisor of the role holders expressed considerable dissatisfaction with the course, describing a poor mutual understanding by the university and PCT of the PCT’s needs for the limited role of the PCMHW. A Health Visitor had no concerns about the success of the role.

Amongst the Managers, a business manager thought it “would be great to see...[the role] expand”. A Practice Manager felt “ very well briefed” and the weekly service provided to the surgery was “good value”. Another Practice Manager was “only aware of [the] e-CBT role” and a receptionist who helps administer the service was “not sure what the PCMHWs did, apart from providing an initial meeting with clients and showing them the computerised facility. The role holders’ line manager felt that the university course made too many assumptions about skill levels of the role holders.

In short, what had been introduced as a very limited role, with a clear focus on offering electronically mediated CBT, was received into the PCT with increasing enthusiasm by managers and GPs who were aware of what the service offered. Specialists, including clinical supervisors, had concerns throughout at limiting the boundaries of the role.

*Blue PCT*

No GPs from the Blue PCT provided comments in the initial questionnaire. Two Community Development Co-ordinators, a mental health nurse and a counselling psychologist responded. The counselling psychologist was concerned that role holders should not be employed beyond their clinical capability, but was satisfied with the role and with the important contribution it could make in health promotion. The nurse expressed concern about the accountability of the role. These positive comments were matched by the four Managers in the Blue PCT, one of them expressing concern that there was inadequate human resource planning for the role in that many role holders would want to move on quickly, thus creating a high turnover rate. Two Administrators expressed reservations about the competence of the PCMHWs to address the full range of capabilities expected of them.

It would seem that there was general, but limited, approval of the idea of role at the time of the first questionnaire. Within this approval, caveats were expressed about the deployment of the role.

*Blue PCT: follow-up*

The only GP who commented from the Blue PCT remarked that he had “absolutely no knowledge whatsoever of [the role]... or their clinical, or any other, remit...”

Of the three Specialists who commented, a counselling psychologist was confident that he would refer patients to the PCMHWs. A nurse consultant remarked that this was a new role...[whose introduction will take] time and leadership.” She felt their direction needs improvement and that they were not visible enough in primary care venues. A Talking Therapies Co-ordinator in the Trust was impressed by the approach to work taken by the PCMHWs and believed the role was helping make patient-centred care a reality.

Of the Managers, one commented that “we need to be more together on specific interventions and outcomes – ensure there are specific tasks with clear outcomes – it takes time.”

In short, the limited approval of the role at the time of the initial questionnaire did not improve by the time of the follow-up study. The introduction of the role had limited positive impact in the Blue PCT, with far more concerns expressed about its management as opposed to satisfaction at its success.

#### *Indigo PCT*

No GPs commented. Amongst the Specialists, a Public Health Specialist was eager for the role to be employed in the development of health awareness websites. A psychiatric research worker, working in a number of localities, urged better training in early diagnosis and management of common mental disorders. A Community Mental Health Nurse saw mental health promotion as the primary area of employment for the role.

#### *Indigo PCT: follow-up*

No comments were provided by staff from the Indigo PCT in the follow-up questionnaire.

## **6 Organisational Change in the NHS**

Wright (2002) outlines the scale of current and anticipated changes in the NHS organisation as the health care demands and expectations of an increasingly ageing society are weighed against the limitations of current resources. The Wanless report (2002) anticipated unprecedented scales of investment in health care lifting the annual spend from about £68B to £184B in 2022-3, increasing the number of full-time NHS employees by 300,000, and achieving radical reform in the staff skill mix to achieve greater productivity. The associated modernisation agendas in health and social care are arguably the most wide-ranging organisational development challenges that have been tackled since the inception of the NHS.

It is important to note, therefore, that the introduction of the role of Graduate Primary Care Mental Health Worker is not taking place as a one-off ‘innovation’, but as part of a complex series of organisational changes in which even the employing organisations of the role, the Primary Care Trusts, are undergoing reforms and amalgamations. It is also unsurprising that fresh attention has been given to organisational and cultural change within the NHS. The extent of these changes has given rise to the institution of the NHS Service Delivery and Organisation National Research & Development programme, a

research programme on change management within the NHS. One of the products of this initiative has been the review of tools for the study of organisational change within the NHS by Iles and Sutherland (2001). They distinguish between developmental change, transitional change and transformational change in the NHS. Developmental change is either planned or emergent incremental change to enhance or rectify a particular aspect of organisational functioning; typically, skills development, new processes or the introduction of new roles. Transitional change seeks to move from a known existing state of an organisation to a new desired state and typically involves, according to Lewin (1951), three phases of: unfreezing an existing equilibrium, moving to a new state and re-freezing in new equilibrium. Transformational change is a more radical shift in assumptions, structure, processes, culture and strategy which is unknown until it emerges from the death of the previous organisational state.

If Norman and Peck (1999) and Worthington (2004) are correct in suggesting conflict, both amongst professional categories and between professional and managerial assumptions, then Lewin's (1951) force field analysis offers a particularly appropriate tool with which to study the change process that is inherent in the introduction of the PCMHW. It is appropriate in so far as the introduction of the role was both more than a developmental change in that the role entailed working across a number of professional categories, but the change was also less than transformational change in so far as it represented a step towards a specific goal described in the NHS Plan.

Force field analysis is a diagnostic tool that allows driving, or enabling, forces to be assessed alongside restraining or resistance forces, thus allowing the resultant net effect to be assessed. Lewin argued that enabling, or driving, forces inevitably incur resistance forces. Reducing resistant forces is therefore preferable to increasing enabling forces because it allows movement towards the desired state to take place without increasing resistance to the driving or enabling forces.

But what *were* these enabling and resistance forces? It proved possible to amplify the profile of employment in the PCMHW role by means of data reported at a one-day workshop hosted by Canterbury Christ Church University in late 2004. The students were able to share and discuss their activity profiles with role holders from other Trusts in order to compare their experiences and reflect on the significance of them.

## **7      *Enabling and Resistance Factors –The Canterbury Christ Church Conference***

The opportunity was provided to the project's principal investigator to chair a series of meetings at which the employment profiles of PCMHWs were described in presentations by role holders from across the UK. The ensuing discussions were summarised by the project's principal investigator at the meeting.

Three key expectations of the role of Graduate Primary Care Mental Health Worker were defined in the NHS plan: providing brief therapy techniques; developing and enhancing support networks to promote mental health across the community; and providing audit and evaluation for primary care mental health services provided. The first of four conclusions

reached at the workshop was that each of these expectations is feasible. Brief, one-to-one therapies are being provided across a range of categories of need with the limitations of the therapists' competencies being recognised. Examples were provided of networks being developed through meetings and information sharing. The capabilities of these networks and their contributors were promoted through exhibitions of services in public spaces and rooms, thus helping to reduce the stigma attached to the use of mental health care services. Graduate Primary Care Mental Health Workers also spoke of their contributions to audit and evaluation of services.

The second conclusion reached was that four *resistance* factors can be identified, each of which inhibit further adoption of the role. First, there are fears that the professional competence of role holders is insufficient for the tasks being undertaken.

Secondly, role holders are frequently located, geographically and organisationally, in a manner that limits the effectiveness of the role. Thus, role holders are often placed in headquarters where maximum contribution to audit and evaluation across a PCT might be made but with minimum contribution to providing therapies to clients. There were cases, too, where role holders were required to account for their work to members of professions or administrative groups who have little understanding or sympathy with the purposes of the new role. The provision of clinical supervision for therapeutic aspects of the new role by counsellors or psychologists who lack confidence in the feasibility of the new role has also inhibited the adoption of the role.

The third resistance factor is the absence of professional status by the role holders, which has been a barrier to acceptance in some Trusts. In a sector where allegiance to external professional bodies by nurses, counsellors, psychotherapists, doctors, psychologists and social workers is strong, the absence of either a professional body or regulating authority for the role holders has created a negative impression of the feasibility of the role. There is of course a paradox here. Enhancing the professional status of the PCMHW through the creation of a new professional loyalty would be to exacerbate the potential for inter-professional conflict and dysfunctionality in mental health (Norman and Peck, 1999) that the new role is, in part at least, intended to reduce.

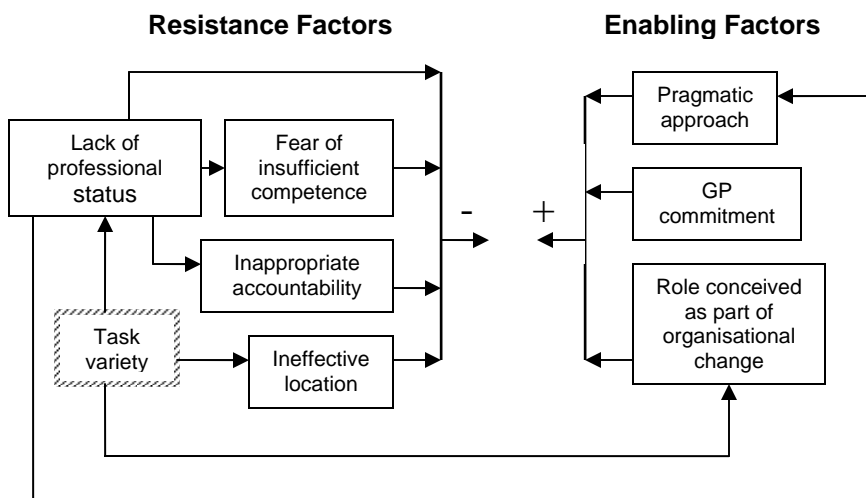
And the fourth resistance factor identified at the workshop concerned the synchronicity with which the new role was introduced at the same time as a major organisational change programme. The pursuit of major organisational change programmes inside Trusts at the same time as the commissioning of the new PCMHW roles within PCT headquarters has created uncertainty about the future of the role at too early a stage of its development.

As well as these four resistance factors, a number of key *enabling* factors were also identified. First, in PCTs where general practitioners expressed a commitment to the need for the role and a commitment to openly discussing the extent of unsatisfied demand for mental health care, the likelihood of the role's acceptance was enhanced. Secondly, where concerns for quality and high levels of competence in the delivery of services were not allowed to become a refusal to accept anything less than perfection, there was much readier acceptance of the role and an earlier contribution made to meeting peoples' needs. And thirdly, where the development of the role was seen itself as an important change

management programme, there was encouragement towards accepting the role as being feasible.

It was recognised that the enabling and resistance factors were not necessarily independent factors. The lack of professional status contributed to fears of insufficient competence and inappropriate accountability. The variety of tasks expected of the role, although not identified in itself as either a resistance or enabling factor, contributed to both the lack of professional status and inappropriate location, it being difficult to choose an optimum location for all of the tasks.

One of the resistance factors was also identified as contributing in part to one of the enabling factors. The lack of professional status contributed in part to the role being conceived as an intrinsic part of organisational change. The task variety also contributed to this. Resistance and Enabling factors, together with the relationships between them are shown diagrammatically in Figure 1.



**Figure 1 Resistance and Enabling Factors**

## **8 Discussion**

How apparent were the four resistance factors in the adoption process of the new role in the six PCTs studied? And to what extent were the enabling factors revealed?

In the Red PCT, considerable effort was invested in developing mental health care services in a manner which would use all available resources cost effectively whilst not allowing the new PCMHWs from being swamped by excess demand. Yet there was evidence that neither GPs nor mental health professionals had been persuaded of the value of the new role; a psychologist expressing concern about service duplication and a manager eager that health care financial resources were safeguarded for health care outcomes. No issue of competence was apparent and no clear evidence of anxiety about professional status.

This was a PCT with considerable financial problems making use of personnel in another PCT to re-engineer new services for the modernisation agenda. It would be consistent with the evidence to suggest that the leadership of the change management process of

introducing the new role was given insufficiently attention compared to that given to the management of the new mental health care services; a possible case of an imperfect change management process for the new role at a time when other aspects of new mental health care agenda were being imaginatively and vigorously addressed.

In the Orange PCT, it was clear from the comments of all that considerable effort was invested in preparing GPs for the new role. There was some disquiet about the training for the role (apparent in the follow-up study), but there was a clear consensus that all involved in the PCT had high expectations of the role; they were realistic about what could be achieved with small number and appreciation of the role was sustained in the follow-up investigations. The evidence is consistent with all three of the enabling factors becoming operational. General Practitioners had been successfully introduced to the role and were open about the extent of unsatisfied demand for mental health care. Secondly, concern for quality and high levels of competence had not been allowed to escalate into a refusal to accept anything less than perfection. And thirdly, the development of the role had been seen as an important change management programme in itself.

The Yellow PCT had provided a case in which all four resistance factors were identifiable, to the point where it is difficult to regard the introduction of the role as a success. Minimal client contact and very little mental health promotion were achieved. GPs were less favourably disposed at the end of the period than at the beginning. A Manager felt confused about the role and a counselling psychologist involved in supervising the role was unclear about the purpose of it. Fear of insufficient competence by role holders and the lack of professional status combined to create a circumstance in which it had been difficult to engineer a coherent organisational design for the role. No overt change management process had been initiated for the role.

In the Green PCT, by contrast, the role had much overt success. Considerable preparation had gone into the organisational design for the new role and GPs had been carefully prepared. Good organisational design and a carefully articulated process of introducing the role helped overcome the two resistance factors of poor organisational design and the absence of a specific change management process. But this success was perhaps achieved at the expense of not addressing the other two resistance factors: fear of inadequate competence and the lack of professional status. The PCMHW role was introduced successfully but had marginalised the role into one of very limited competence associated with delivering electronically mediated CBT.

The Blue PCT generated no clear markers of success by the time the study completed. There was little one-to-one client work. Professional counsellors and mental health practitioners expressed little faith in the role and were concerned that the role holders might present themselves as 'counsellors'. In short, the resistance factors of fears about the professionalism of the role holders and the associated lack of professional status were apparent, alongside the very limited organisational design for the role which had taken place.

The evidence from the Indigo PCT was limited, but for much of the time of the study there was only one role holder in post. It is noteworthy that much of the careful organisational design that was apparent in the Red PCT had been generated by a partnership with the

Indigo PCT. It is possible that further study may reveal the outcomes of the investment in organisational design in the Indigo PCT.

## **9** *Conclusions from the Qualitative Study*

Although there was evidence of significant and imaginative investment in the process of introducing the role in the Indigo Trust, the limited nature of the evidence suggests it may be well to lay the case of the Indigo PCT aside.

Of the remaining five PCTs there were two clear success stories: the Orange PCT and the Green PCT. These success stories are interesting because the manner of introducing the role was very different, whilst both exemplified careful processes of organisational design.

Of the remaining three PCTs, two of them - the Blue and Yellow PCTs - reflected the difficulty of introducing the role when there is no clearly defined change process in the organisation. The Red PCT is a more difficult case to analyse. There was a detailed plan organised for the reform of mental health services in which the PCMHWS had an important part. Indeed, they were even presented with the impressive new title of 'Mental Health Advisors'. It was a plan worked out in collaboration with the Indigo PCT. But it was not a plan that catered specifically for the new role; and it was not a plan that was capable of implementation in the Red PCT without additional leadership and without further dedicated financial resources.

The profile of employment in respect of providing brief therapies was one of slow adoption of a commitment to this aspect of the role in four of the six PCTs, the key resistance factors being the attitudes of GPs and some of the mental health professionals. But there were two significant exceptions to this. In the Orange PCT, there was a willingness for the PCMHWS to begin work in brief therapies very early. In the Green PCT, the PCMHWS were employed in the delivery of electronically mediated cognitive behaviour therapy within the first few months.

Mental health promotion work took place at an early stage in all PCTs and role holders never estimated less than 5% of their time to be devoted to it. This aspect of the role was both the easiest and the most difficult for Trusts to engage with. It was the easiest in so far as the engagement by role holders in promoting mental health care and liaising with others in the community for its provision provided very positive messages for beleaguered Primary Care Trusts and was the easiest for the role holders to commence work on. It was the most difficult, however, in so far as it required the collaboration of other professionals whose commitment to the role was not yet fermented.

In summary, role holders felt most warm about the audit and evaluation work when it was part of a transparent process towards the creation of new pathways to care. They felt least warm about it when they felt they were being used as office juniors and administration assistants.

In five of the six PCTs, three models of adoption were apparent. The first model, what might be called a **precision skill model**, was where the role holders interacted with clients in strictly limited boundaries such as facilitating electronically mediated cognitive

behavioural therapies; a model exemplified by the Green PCT. The second model, the **knowledge co-ordination model**, was where the commitment to the role reflected fears of the role holders being swamped by excessive demand. Consequently, the key commitment was more to the use of client time for sign-posting to other service providers rather than the PCMHWs adopting a clinical role themselves. This model was evident in the Red PCT. The third model may be described as the **limited clinician role model**, where a range of different therapeutic interventions were regarded as feasible for delivery by the role holders in so far as the prevailing organisational culture would allow. This can be seen in the Yellow and Blue PCTs; both of which reflected the difficulty of introducing the role without a clear organisational change plan.

## 10 The Quantitative Study

The purpose of the quantitative study was to establish the nature of both the predicted impact at the onset of the role (“*expectation*”) and the actual impact after twelve months (“*evaluation*”) of the PCMHWs. It also aimed to determine whether there was any shift in the responses over the space of the year. That is, did the PCMHWs meet the expectations of the PCTs?

### *The PCMHW Impact Questionnaire*

This questionnaire consisted of seventeen items relating to aspects of primary care mental health services; each having a seven-point Likert scale ranging from a high negative impact to a high positive impact. These items measured the nature of the impact that PCMHWs would have (in the first instance) or had (at the follow-up). There were an additional three items on a five-point Likert scale which asked respondents whether they would utilise a PCMHW themselves or recommend one to a colleague or client (*Perceived Functionality Scale*).

A unique code was allocated to each respondent, allowing the *expectation* and *evaluation* to be matched for each participant. Due to practical and structural issues within the PCTs, a number of staff were unable to complete both questionnaires. The frequency of participants who returned questionnaires from each PCT are summarised below.

***Table 2: Participants who returned questionnaires***

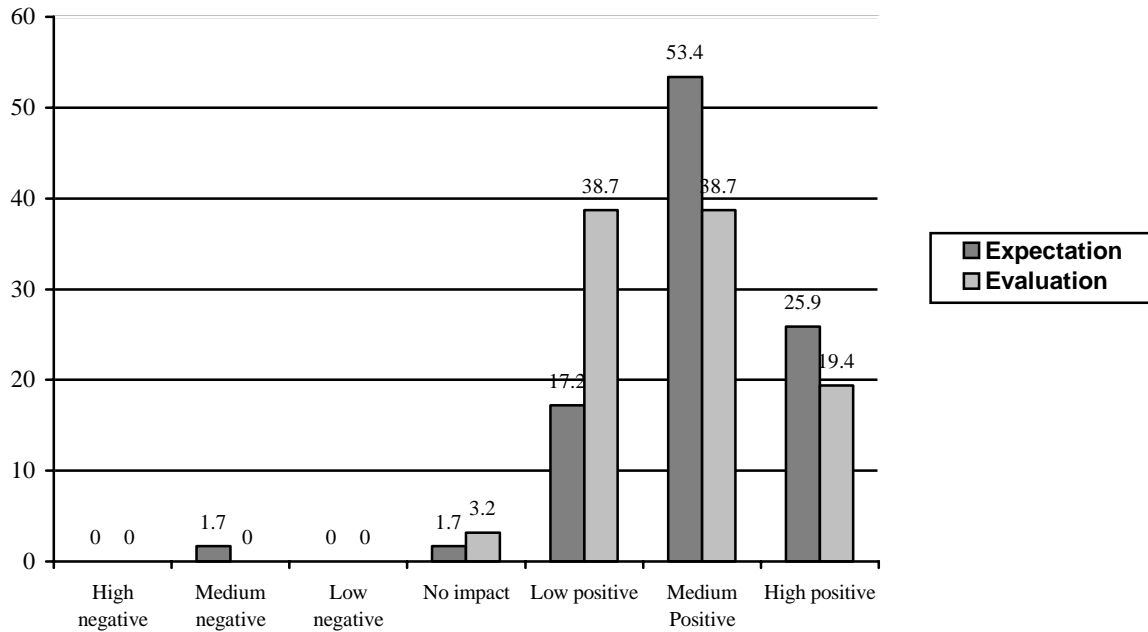
PCT	Questionnaires returned			Total
	Both	<i>Expectation</i> only	<i>Evaluation</i> only	
<b>Orange</b>	9	8	5	22
<b>Indigo</b>	0	5	0	5
<b>Red</b>	0	5	0	5
<b>Blue</b>	6	5	1	12
<b>Yellow</b>	8	11	3	22
<b>Green</b>	6	7	4	17
<b>Total</b>	29	41	13	83

The first intake of questionnaires was analysed for reliability and validity. Using *Cronbach’s alpha*, both the Impact Scale ( $n = 62$ , *Cronbach’s alpha* = .960) and the

Perceived Functionality Scale ( $n = 50$ ; Cronbach's alpha = .767) were found to be reliable. A factor analysis revealed one distinct factor for each scale: the impact of the PCMHW on primary care mental health services (eigenvalue = 10.44), and the perceived functionality of the PCMHW (eigenvalue = 2.00).

It was found that the *expectations* of the PCMHWs were almost exclusively positive: only one respondent predicted a negative impact, and one predicted that there would be no impact. In the *evaluation*, one respondent indicated that there had been no impact of the PCMHWs, the remainder rated the impact as having been positive. Furthermore, the majority of the respondents (58%) regarded the strength of the PCMHWs' impact as being medium or high. Figure 1 presents the percentages of each category of response for the expectation and the evaluation.

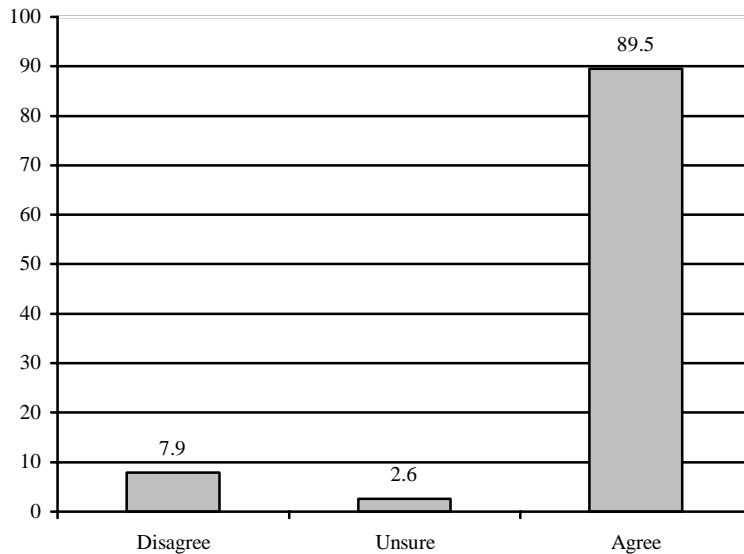
*Figure 1: Distribution of responses for expectations and evaluations of the impact of the PCMHW role*



Although the follow-up evaluations were positive, a repeated measures T-test of the respondents who returned both *expectation* and *evaluation* questionnaires revealed that the mean *evaluation* ( $m = 5.43$ ) was significantly lower than the mean *expectation* ( $m = 5.75$ ) [ $t(22) = 2.25, p < .05$ ]. A repeated measures ANOVA indicated that there was no significant difference between PCTs [ $F(3,27) = 1.5, p > .05$ ].

The results of the Perceived Functionality Scale found that twelve months after the role was introduced, 89% of respondents believed that the PCMHW could be effectively utilised. A repeated measures T-test indicated that the mean score for perceived functionality after one year was not significantly different from the mean response at the onset of the role [ $t(22) = 2.01, p > .05$ ].

*Figure 2: Percentage of levels of agreement to whether PCMHWs can be effectively utilised after one year*



The results of this quantitative study indicate that, while PCT staff evaluated the PCMHWs as having had a positive impact on primary care mental health services, this impact did not quite meet the expectations that staff had at the onset of the role. There are a number of potential explanations for this finding. It is possible that the expectations were simply too high to be realistically met; either because of an overestimation of the capabilities of the PCMHWs, or due to an overly optimistic vision of the PCT’s capacity to incorporate them. Another suggestion is that the *expectation* scale was poorly defined: it invited the respondent to “*indicate the level of impact you envisage PCMHWs having on the following areas of mental health services in primary care...*” without actually specifying a time frame in which that impact might be achieved.

Alternatively, the results could be reflective of a fluctuating vision of the role of the PCMHW. There was much excitement about the introduction of the PCMHW role but, with the many complications and concerns that arose throughout the first year, it is not surprising that people could feel slightly less optimistic at times. It would be useful to test this theory with further quantitative evaluations of the impact of the PCMHWs.

## ***11 Transferability of learning***

What might academics in other clinical contexts learn from this study? The varied tasks undertaken by Graduate Primary Care Mental Health Workers and the absence of professional categorisation for the role places limits on the transferability to other clinical areas. But the quest to find more cost effective human resources to bridge the gap between supply and demand in healthcare will continue to encourage innovative new roles within the National Health Services and more effective inter-professional capabilities.

A key question is how will we learn to introduce these new roles and capabilities into primary care? It is considered that the force field analysis constructed to map enabling and resistance factors for introducing the role into primary care trusts might prove a useful learning mechanism for introducing other new roles into primary care. The map suggests a series of questions to be addressed before introducing a role.

**Perceptions of competence:** How will the perception of role-holders' competence (by other professionals and by the public) be safeguarded? What role will professional bodies have in these safeguards? What role will GPs have in safeguarding it?

**Professional Status:** Will there be one professional organisation involved in the design of the role or several? What will be the relationship between the new role and existing professional bodies? What role will the professional bodies have in identifying required competencies? How will possible avenues of career progression be articulated?

**Accountability:** How will the relationship between line management and professional accountability be managed? Is the accountability appropriate for the tasks expected of the role?

**Location:** Is the primary geographical location of the role appropriate to the tasks expected of it? Is there appropriate office space and clinical accommodation in GPs surgeries for the role?

**Task variety:** Is the spread of tasks in the role sufficiently coherent?

**GP Commitment:** Do GPs have sufficient confidence in the capabilities of the role? Are they sufficiently supportive? Are the expectations by GPs of the role realistic?

**Pragmatism:** Is there a manageable balance between professional expectations of the role, GP expectations and whatever line managers in PCTs expect from the role? How is this balance to be managed?

**Organisational Change:** Is the role simply being introduced into an unchanged organisation or is sufficient attention being given to develop the organisation into one in which the new role will cohere? Is there too much organisational change going on that will inhibit the feasibility of the new role?

**Models of adoption:** Which model of adoption fits the organisation best: a **precision skill model** with limited and precisely defined expectations of the role; or a **knowledge co-ordination model** in which networking and knowledge signposting capabilities rather than clinical skills are maximised; or a **clinical apprentice** model?

## 12 Conclusions

Working in audit and management was the most easily adopted aspect of the role, although it ran into obstacles created by misgivings about the feasibility of the role by other professionals. The promotion of health care services within the community also provided early opportunities for the role holders to commence work.

Three distinct organisational models were apparent in the process of adopting the role of PCMHWs by Primary Care Trusts. A **precision skill model** was evident in the Green PCT whereby role holders interacted with clients in limited and strictly defined clinical encounters. The use of electronically mediated Cognitive Behavioural Therapy provided an avenue by which the extent of these encounters could be managed. A different model, a

**knowledge co-ordination model** was evident in the Red PCT whereby direct face to face clinical encounters with clients were limited and the role focused sign-posting clients to a range of service providers within the community through use of the telephone. Thirdly, a **limited clinician** model was evident in the Orange PCT within which a wide range of different therapeutic were regarded as feasible for delivery by the role holders from an early stage with extensive supervision and careful oversight by GPs.

There were cases of two PCTs (Blue and Yellow) in which it would be difficult to consider the adoption of the role a success. In both of these cases, no clear strategy was evident in the PCT for managing expectations about what the role could deliver and for overcoming the key resistance factor, the acceptance of the role by GPs and by Mental Health professionals.

The training of the PCMHWs would, it is concluded, benefit from more focused attention on the process of organisational adoption by PCTs. The study was a limited pilot study. Although the qualitative material proved of more value for the present study than the quantitative material, there is considerable scope for developing both aspects of the study in the future.

## Appendix A Activity Log

	% of time in week	How typical L = unusually low, N = typical H = unusually high	Notes
<b>Clinical:</b>			
Providing information and self-help material to service users			
Working with individuals with mild to moderate mental health difficulties			
<b>Mental health education, promotion and networking:</b>			
Presenting information about mental health <b>issues</b> to sections to the local community.			
Informing primary care practitioners and users about local statutory and voluntary <b>services</b> to whom people can be "signposted".			
<b>Practice development, clinical governance and auditing skills:</b>			
Help co-ordinate primary care mental health teams			
Liaise with non-statutory agencies.			
Monitoring requirements of, and changes in legislation			
Helping in clinical audit & evaluation of psychological/mental health services within primary care, constructing questionnaires and disseminating data.			

## Appendix B Questionnaire

### Demographic Information

1. Your Age (please tick)

Under 20     20 – 29     30 – 39     40 – 49     50 – 59     60+

2. Your Sex (please circle)  
Female

Male /

3. What is your job title?

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*A number of items in this questionnaire refer to “primary care” or “your PCT”. Where these terms are used, please respond with regards to the Primary Care Trust in which you work, or the Primary Care Trust in which your practice is based.*

4. Which Primary Care Trust (PCT) do you work in / is your practice based in?

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5. What is the total time you have worked in the NHS, **including** your current position?

---

6. Do you have any training in Mental Health?  
No

Yes /

Please specify

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## **Primary Care**

*This section relates to mental health services in primary care. Your responses should be in relation to the PCT you named in Question 4.*

*Please indicate the degree to which you agree with the following statements.*

*SD = Strongly Disagree    D = Disagree    U = Unsure    A = Agree    SA = Strongly Agree*

---

7.	Primary care services are sufficient for clients with common mental health problems.	SD	D	U	A	SA
8.	Clients with common mental health problems take up too much practice time in GP surgeries.	SD	D	U	A	SA
9.	Staff members in primary care are generally aware of the mental health services available in their PCT.	SD	D	U	A	SA
10.	Primary care services are well integrated with voluntary services for mental health.	SD	D	U	A	SA
11.	Common mental health problems are best treated with medication.	SD	D	U	A	SA
12.	Mental health service provision is inadequate in primary care.	SD	D	U	A	SA
13.	Members of the community are generally unaware of mental health services provided in primary care.	SD	D	U	A	SA
14.	Individuals with common mental health problems are usually unaware of the voluntary services available for their mental health needs.	SD	D	U	A	SA
15.	Staff members of primary care mental health services are generally well informed about the relevant local voluntary agencies.	SD	D	U	A	SA
16.	Mental health services provided in primary care are well promoted.	SD	D	U	A	SA
17.	Clients with common mental health problems are generally satisfied with the mental health services provided in primary care.	SD	D	U	A	SA

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18. It is appropriate for clients with mental health problems to be treated using primary care resources.

---

SD D U A SA

*Please consider the list below, and tick the box next to the service areas in your PCT that you believe need some improvement.*

*On the right hand side, please indicate how you would prioritise the areas you have selected for improvement. These should be ranked from 1 up to 7, where 1 is the most important area to be improved, and 7 is the least important. You may leave blank the areas you have not selected as needing improvement.*

<b>(Please tick)</b>	<b>Area for improvement</b>	<b>Importance</b>
<input type="checkbox"/>	Providing therapeutic services for clients with common mental health problems.	_____
<input type="checkbox"/>	Providing self-help information to clients with common mental health problems.	_____
<input type="checkbox"/>	Promoting mental health.	_____
<input type="checkbox"/>	Links between voluntary mental health services and primary care.	_____
<input type="checkbox"/>	Access to information about mental health services.	_____
<input type="checkbox"/>	Links between primary care and secondary care mental health services.	_____
<input type="checkbox"/>	Database systems in GP surgeries.	_____

19. Do you have any suggestions for additional areas for improvement in mental health services in primary care?

---

## **Graduate Mental Health Workers**

*Please consider the information below when completing the following section, which relates to expectations that current staff members have about the role of Graduate Mental Health Workers (GMHWs) in primary care.*

Throughout the United Kingdom, a substantial number of Graduate Mental Health Workers have been employed by various Primary Care Trusts. The function of these roles is to work towards achieving the standards set by the National Service Framework for Mental Health (1999).

GMHWs are all university graduates, many with a degree in psychology or a related discipline, and all with an interest in mental health.

The roles of the GMHWs will vary according to the particular needs of each PCT. However, it is expected that the duties will fall within one or more of three main areas: clinical work; networking; and mental health promotion. In order to achieve this, GMHWs are likely to be involved in a number of different projects, working with a variety of staff members in PCT offices and GP surgeries.

*Please indicate the degree to which you agree with the following statements.*

*SD = Strongly Disagree    D = Disagree    U = Unsure    A = Agree    SA = Strongly Agree*

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20.	GMHWs are a useful addition to primary care.	SD	D	U	A	SA
21.	Employing GMHWs is a waste of NHS resources.	SD	D	U	A	SA
22.	It would be useful for GMHWs to provide information about mental health to socially excluded groups in the community.	SD	D	U	A	SA
23.	GMHWs might obstruct progress in primary care.	SD	D	U	A	SA
24.	Clients will respond positively to GMHWs.	SD	D	U	A	SA
25.	GMHWs' support for people with common mental health problems will reduce the pressure on secondary care services in specialist mental health.	SD	D	U	A	SA

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26.	GMHWs might cause current primary care employees to become uncertain about their roles.	SD	D	U	A	SA
27.	It would be useful to have a GMHW evaluate the current information available to clients with mental health problems.	SD	D	U	A	SA
28.	It would be risky for a GMHW to deliver brief interventions to clients.	SD	D	U	A	SA
29.	GMHWs will be helpful for giving service information to clients with mental health problems.	SD	D	U	A	SA
30.	GMHWs will <b>not</b> be able to improve links between primary care services and the community.	SD	D	U	A	SA
31.	It would be useful to have a GMHW evaluate the current information available to staff in GP clinics.	SD	D	U	A	SA
32.	I can see myself utilising the services of a GMHW.	SD	D	U	A	SA
33.	I would recommend the services of a GMHW to a colleague.	SD	D	U	A	SA
34.	I would recommend the services of a GMHW to a client.	SD	D	U	A	SA

*Please consider the list below, and tick the box next to the service areas in your PCT that you believe could be improved by Graduate Mental Health Workers.*

*On the right hand side, please indicate how you would prioritise the areas you have selected for improvement by GMHWs. These should be ranked from 1 up to 7, where 1 is the most important area to be improved, and 7 is the least important. You may leave blank the areas you have not selected being able to be improved by graduate workers.*

<b>(Please tick)</b>	<b>Area for improvement</b>	<b>Importance</b>
<input type="checkbox"/>	Providing therapeutic services for clients with common mental health problems.	_____
<input type="checkbox"/>	Providing self-help information to clients with common mental health problems.	_____
<input type="checkbox"/>	Promoting mental health.	_____
<input type="checkbox"/>	Links between voluntary mental health services and primary care.	_____
<input type="checkbox"/>	Access to information about mental health services.	_____
<input type="checkbox"/>	Links between primary care and secondary care mental health services.	_____
<input type="checkbox"/>	Database systems in GP surgeries.	_____

35. Are there any other areas that you feel could be improved by GMHWs?

\_\_\_\_\_

36. Do you have any concerns about the proposed roles of the GMHWs, as described in this questionnaire?

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37. On the scale below, please indicate how much overall effect you envisage Graduate Mental Health Workers having on mental health services in primary care.

The scale runs from extremely negative to extremely positive.

For example, if you think that GMHWs will have an extremely positive effect on mental health services, you would select “7”; if you think they will have neither a positive nor a negative effect, you would select “4”; and if you think they will have an extremely negative effect, you would select “1”.

1	2	3	4	5	6	7
<i>Extremely negative</i>			<i>Neither positive nor negative</i>			<i>Extremely positive</i>

38. How familiar were you with the GMHW roles prior to this questionnaire? (please select)

Not at all familiar       Slightly familiar       Very familiar

39. Would you have benefited from a workshop regarding the GMHW role? (please circle)

Yes / No

40. Would you have benefited from receiving some literature about the GMHW role? (please circle)

Yes / No

*Thank you for completing this questionnaire.*



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