

Reflective voices: primary care mental health workers' experiences in training and practice

Rosemary Rizq, Manminder Hewey, Laura Salvo, Matthew Spencer, Helena Varnaseri and Jaymeeta Whitfield

School of Human and Life Sciences, Roehampton University, London, UK

Background: The role of the primary care mental health worker (PCMHW) in providing self-help and signposting to people referred for mild-moderate anxiety and depression is currently being complemented by low-intensity workers training under the government's improving access to psychological therapies (IAPT) programme.

Aim: This study aims to explore the experiences of five PCMHWs working in the context of a newly designed primary care mental health team in London. **Methods:** Thematic analysis of participants' written reflective papers provides a qualitative exploration of issues and concerns raised by PCMHWs during a fortnightly reflective practice group. **Results:** Themes emerging from participants' written accounts highlight: difficulties in applying academic and skills training to the real-life world of clinical practice; difficulties in managing issues of risk and complexity; role confusion; and the need for a visible and coherent career structure. **Conclusions:** The study highlights the psychological impact on PCMHWs of managing complex client referrals. This is discussed in the context of the high volume case turnover anticipated by IAPT training curricula. Implications for the training and education of IAPT low-intensity workers are briefly considered.

Key words: IAPT; low-intensity worker; primary care mental health worker; qualitative analysis; reflective practice

Received 4 November 2008; accepted 1 July 2009; first published online 10 December 2009

Introduction

The role of the primary care mental health worker (PCMHW) was initially introduced in the government's National Health Service (NHS) plan (Department of Health, 2000), where '1000 new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness' were promised in order to improve access to effective mental health care in primary

care trusts. Since 2003, the graduate worker post has been developed to offer easily accessible low-intensity support via self-help packages, computerized cognitive behavioral therapy (CBT) and improved access to mental health information for both patients and carers.

With the recent introduction of the improving access to psychological therapies (IAPT) programme across the UK, the notion of equitable and timely access to a range of evidence-based psychological therapies via a stepped care approach has become central to planning and commissioning mental health services in primary care.

This study discusses the experiences of five new PCMHWs recruited into a newly designed primary care mental health team in 2008 to deliver psycho-education, guided self-help and signposting to

Correspondence to: Dr Rosemary Rizq, Senior Practitioner, BPS Psychologist Specializing in Psychotherapy, Principal Lecturer in Counselling Psychology, Research Centre for Therapeutic Education, School of Human and Life Sciences, Roehampton University, Whitelands College, Holybourne Avenue, London SW15 4JD, UK. Email: r.rizq@roehampton.ac.uk

© Cambridge University Press 2009

community services for individuals presenting with mild-moderate depression and anxiety. Patients presenting with more complex psychological needs were referred to counselors and psychotherapists offering more specialized psychological interventions. Other professionals in the team included Gateway Workers, offering support and liaison between primary and secondary care services; Vocational Advisors, supporting individuals back into work; and Community Development Workers, developing and strengthening networks of community resources.

Clinical training for these newly recruited PCMHWs was delivered in-service alongside more general Primary Care Trust (PCT) training, management, service induction and support. Training in cognitive-behavioural techniques and clinical practice included weekly lectures, skills training and role-play delivered by the CBT service lead. Seminars, lectures and workshop were delivered by specialists from various disciplines within the PCT, providing training on wider organizational aspects of the NHS. Part of the PCT support network included a fortnightly reflective practice group, which aimed to recognize the particular demands and difficulties of a new profession integrating into existing mental health services and facing the realities of 'front line' clinical work, often for the first time. The PCT decided that it was important to establish a forum for these practitioners to meet on a regular basis to discuss and reflect on their work.

The idea for this research arose out of work undertaken within the reflective practice group, which the main author (Rizq) facilitated. During 2008, the PCT attracted funding that enabled it to plan for and recruit a further 18 low intensity trainee through the IAPT project. The established group of five PCMHWs felt that articulating and reflecting on their experiences in the first few months of clinical practice within the PCT could be useful not only to the PCT itself, as it developed and expanded its low-intensity service, but could also be valuable to share with incoming IAPT workers, who would be facing issues and demands similar to their own.

Research on the PCMHW role

As yet, there is very little research on the effectiveness, role or experience of PCMHWs. Bower

et al. (2004) examined staff views about the new PCMHW role. Using a case study design, incorporating interviews with 46 managers and clinicians, expectations and issues relating to the proposed implementation of the PCMHW role were explored. The relevance of client work involving brief therapies was highlighted by participants, but a number of differences in role expectations were identified that the author who suggests: 'this ambiguity reflected traditional interprofessional tensions concerning expertise, authority and legitimacy in the psychological therapies' (p. 342). An earlier study (Bower, 2002), examining models of mental health care in primary care, suggests that problem solving therapy, group psycho-education, self-help and some models of 'collaborative care' may be considered relevant to the proposed role of PCMHW.

Since then, other researchers have considered the role and identity of PCMHWs in more detail. O'Connor's (2006) reflective narrative paper, for example, considers the struggle of PCMHWs to establish a role, suggesting that their identity is negotiated relationally and formed by the interaction of key stakeholders involved. A recent report by Chambers (2008) gives a first hand account of how her role as PCMHW in Cornwall and Isles of Scilly PCT has expanded since the implementation of the government's IAPT programme. Her account discusses the various professional requirements of the role, including delivering self-help and brief solution-focused therapy to clients referred for mild-moderate anxiety and depression, issues of service redesign, mental health promotion and the need for close collaboration with other primary care colleagues.

From reflective practice to practice-based research: methodology

Design

The previous research identifies issues of professional identity and role ambiguity, as well as the changing picture of mental health services in primary care following the rollout of the IAPT programme. To date, however, this seems to be very little research on the subjective experience of PCMHWs in this new, somewhat ambiguous, and fast-changing professional role. This study sought to investigate PCMHWs experiences via a

Primary Health Care Research & Development 2010; **11**: 72–86

thematic analysis of reflective papers written in the context of work undertaken over a period of eight months in a reflective practice group.

Thematic analysis has been discussed by Braun and Clarke (2006) as providing either an essentialist method, reporting experiences, meanings and the reality of participants or a constructionist method, which explores the way in which events and experiences are the effects of discourses operating within the social environment. It can also occupy a contextualist position, which acknowledges 'the ways individuals make meaning of their experience and, in turn, the ways the broader social context impinges upon those meanings' (p. 81). In acknowledging that this study does not aim to provide a fully worked-up qualitative study, as would be usual with methods such as interpretative phenomenological analysis (eg, Smith, 2004) or grounded theory (eg, Charmaz, 2002), this study's use of thematic analysis necessarily adopts a stance broadly in line with the first position.

Context and sample

Five PCMHWs had been recruited into the service during 2008. A pilot reflective practice group was setup by the PCT to establish the acceptability and utility of a regular forum for these PCMHWs to reflect on clinical and emotional issues arising from their client work, and to support their integration into the PCT.

All five participants attended the reflective practice group on a fortnightly basis during 2008. There were four female participants and one male participant, with ages ranging from 25 to 40 years. The group had a varied background. Three had a psychology degree and two of these had gone on to complete masters' degrees. Two participants had extensive experience in mental health fields, one in a variety of voluntary sector organizations, the other in mental health administration.

Procedure

After eight months of attending the reflective practice group, the PCMHWs discussed ways of sharing their early experiences of training and clinical practice to inform future PCMHWs and IAPT workers entering the service. A joint decision was taken by all participants to prepare individual written reflective papers based on their subjective experience of the role to date.

Primary Health Care Research & Development 2010; **11**: 72–86

Using the reflective practice group over a period of some weeks, group members all discussed ideas about some of the issues and topics that had been raised so far, and identified salient areas of interest for further exploration and elaboration. As facilitator, my role was to promote discussion and dialogue on these issues, and subsequently to collate a series of jointly constructed and agreed question topics. These included:

- Reasons for taking up the post.
- Experiences of inservice training.
- Experiences of client work.
- Working within a multi-disciplinary team.
- Future professional development.

Using the above topics as a guide, each of the five members of the group wrote a reflective paper about these topics, offering a subjective view of their experiences, feelings, concerns and plans in as much detail as possible. A written account was offered for several reasons: time constraints meant that a full-scale qualitative research project, incorporating face-to-face interviews with each member of the group and verbatim transcription of each interview was not feasible; written accounts, whilst offering perhaps a limited amount of information nonetheless potentially provided a different kind of arena and reflective space for the PCMHWs to consider and amplify topics of interest that had arisen within their group.

Group members wrote up their reflective papers over a period of a month. The papers were then collected in and a thematic analysis was conducted along the lines suggested by Braun and Clarke (2006). This included close reading and re-reading of each individual paper, examining each in turn for emerging themes and concerns. After themes and sub-themes had been extracted from each individual paper, a cross case analysis was undertaken and a master list of domains and themes emerging from the corpus of papers was constructed. Finally, the analysis was written up in narrative form.

Validity issues

Drawing on recommendations for qualitative research (eg, Elliott *et al.*, 1999; Yardley, 2000) several steps were taken to ensure the rigour and validity of the finished report: confidentiality issues were discussed extensively in the group and

with individual participants; consent to use material from the reflective papers was sought and probed on several occasions during the research cycle, and opportunities were provided for participants to withdraw at any time. In addition, each participant was involved in establishing appropriate areas of interest for the study, and all participants agreed to share and disseminate their accounts. A first draft of the analysis of their reflective accounts was returned to participants for further discussion and amplification; and their additions, comments and changes were then incorporated into the analysis. This jointly authored development paper thus aims to provide a subjective view of PCMHWs' experiences that has a high degree of 'testimonial validity' (Stiles, 1993). The overall aim of the study is to highlight areas of success and difficulty, to share best practice and to inform future service provision, particularly in the light of the current expansion of IAPT programmes.

Results

Three domains and 11 themes emerged from participants' accounts. These are summarized in Table 1 below. The thematic analysis is then presented, offering verbatim extracts as illustration.

Domain 1: training and preparation

'Under pressure to catch on quickly': feelings of excitement versus anxiety

A number of feelings about their new professional role emerged from the group. Common to all was a sense of excitement and anticipation where taking up the new post was seen as the start of a professional career in mental health.

However, for several participants, excitement was mixed with anxiety, partly due to limited knowledge about the role of PCMHW:

There was little information regarding the role on the web. What information was available seemed conflicting. Therefore, although I had great expectations of the role my positive expectations were clouded with the anxieties I held. (Participant 3)

Three participants with psychology degrees all spoke about using the job as a stepping-stone to

Table 1 Themes emerging from reflective accounts of primary care mental health workers experiences (n = 5)

Domain	Themes
Domain 1: training and preparation	<ul style="list-style-type: none"> • 'Under pressure to catch on quickly': feelings of excitement versus anxiety • 'There wasn't much time to do anything else': taking it all in. • 'This is something we will have missed out on': wanting recognition • 'We were going to be working with people, not robots!': training is helpful but limited
Domain 2: undertaking clinical work	<ul style="list-style-type: none"> • 'These sessions on the whole are good ones': developing clinical confidence. • 'I've found it particularly hard coping with patients that cry': managing anxiety in clinical work. • 'All I could do was keep calm': managing risk and complexity • 'I'm not a counsellor!': role confusion • 'I do not sit comfortably': managing ambivalence about data collection • 'A daunting environment': additional resources for sharing, normalizing, and supporting.
Domain 3: professional development and career plans	<ul style="list-style-type: none"> • 'This may prove to be quite monotonous': wanting more.

an eventual career in clinical psychology. However, for those who did not have a background in psychology, there was some anxiety about how they would mix with other PCMHWs in the group. One PCMHW already had considerable experience in the mental health field, and had been concerned about finding little in common with psychology graduates:

I thought that there would probably be a lot of young new psychology graduates that I would be starting with, and was a bit anxious about that thinking that I wouldn't have very much in common with them. (Participant 2)

Others felt worried about their relative inexperience in a mental health field. In the following extract, we can see that, for one group member, a challenging experience at interview already setup

Primary Health Care Research & Development 2010; 11: 72–86

expectations that training would be ‘very intensive’ and that a ‘sense of self’ or identity might be called into question:

At all of the four interviews I had had for PCMHW posts, negative feedback had centred on my inexperience. This was a great anxiety and worry for me. Having my inexperience questioned on all four occasions had made me question my capability even more. I was therefore grateful that I had been given the role but under a pressure to ‘catch-on’ quickly. I had a daunting expectation that the role would be very intensive and would question my sense-of-self. (Participant 1)

The notion of establishing a footing in a mental health field was common to all PCMHWs, with the role seen as providing opportunities for a wide range of clinical experience and career advancement. The tension between clinical and academic work was also raised, with several group members commenting on the necessity for theoretical and clinical work to go hand in hand:

I was conscious that clinical work in a lecture theatre was going to be immensely different from that in real life. In my previous volunteer role, I felt that without regular clinical training to facilitate my job, I was unable to observe how clinical theory and practice would interact, often leaving me confused and discouraged. (Participant 1)

‘There wasn’t much time to do anything else’: taking it all in

The group all discussed the intensity of their ‘in-house’ clinical training in CBT. For most, this seemed to result in a sense of pressure – both to absorb large amounts of academic and theoretical information, as well to understand and demonstrate new skills, techniques and clinical expertise, all in a relatively short space of time.

Participants pointed out that the training appeared on occasions to be quite rushed, and this seems to have contributed to a sense of pressure:

The CBT training given to me in preparation for my role although quite rushed and intensive has been mainly a positive one. (Participant 5)

Primary Health Care Research & Development 2010; **11**: 72–86

All commented on the way in which intense periods of clinical training seemed to alternate with long periods with apparently very little to do. This was experienced as frustrating and bewildering, as one of the group pointed out:

My first week in the role was to undertake CBT training which was quite intensive to start off with, but as time went on training sessions were fewer and far between. During the first few weeks, there wasn’t much time to do anything else and I was still unclear as to what we were meant to be doing besides that. A lot of time was spent reading the books that we support clients on and getting familiar with them. (Participant 4)

Conversely, others were more aware of the constant pressure from the PCT to start clinical work. One PCMHW highlighted the conflict between feelings keenly motivated on the one hand to start clinical work – and indeed this is why all the participants in the group had accepted the role – and anxious on the other about being prematurely pushed into undertaking clinical work:

We were given two days per week tuition for two months and one day a week for another two months and there was always an impetus for us to start meeting clients. I was of course eager to begin meeting clients and working, but at times I have felt not entirely prepared, and in hindsight I wonder whether we were slightly rushed into clinical work. (Participant 3)

‘This is something we will have missed out on’: wanting recognition

Given that all the PCMHWs had taken up their roles with the expectation of starting a career in mental health, it was not surprising that all highlighted the need for professional recognition of their training. The issue of comparison with future cohorts seemed significant:

We will not obtain any formal qualification from the training we received as we did not attend a university or college for it ... our training was relatively short in duration ... and not consistent over time. This raises questions as to what we may have missed during our in-service training in comparison to training offered by a university or college. (Participant 4)

The wider issue of qualification in the current professional climate was also raised:

I am aware that my career is unfolding in a culture that appreciates formal evidence of achievement and this is something that we will have missed out on. (Participant 3)

However, another participant took a slightly different view, feeling that the flexibility of in-service training was an advantage:

I feel [there] is an advantage of not being committed to a university training programme, there has been flexibility with regard to our training. Our manager encourages us to suggest what types of training we feel would be beneficial. I have found this bottom-up principle important in that it allows us as PCMHWS to have some autonomy and choice. (Participant 1)

A further issue was raised by another participant who felt that the lack of formal qualifications would impact on client confidence in the PCMHWS role:

I feel that it is imperative for me, firstly, on a personal level to have some visible evidence, and secondly, it would be reassuring to patients. (Participant 5)

'We were going to be working with people, not robots!': training is helpful but limited

Group members all highlighted and articulated the tension between academic/skills training in CBT and the real-life world of clinical practice. As they moved into clinical work, the difficulties of working with real clinical issues and problems – and real people – seem to have been experienced as 'daunting':

Our CBT training was helpful in that it seemed to adopt a neat pathway format. We would ask the questions or present the treatment rationale and we would get the answers that would lead us to the next question and so forth. This made sense in the majority of cases – but we were going to be working with people not robots this issue was daunting (Participant 1)

Participants also highlighted the variety of issues they found themselves facing on their first

foray into clinical work. Although they were prepared to receive referrals for mild-moderate depression and anxiety, they were unprepared for the range and complexity of psychological issues that they were eventually presented with as one PCMHWS comments:

As naïve as it may sound now, I realised that clients' problems did not fit neatly into the boxes I had created during CBT training. (Participant 2)

The need for training and awareness of more complex problems was raised. One respondent highlighted what seemed to have been experienced as a painful distinction between training and reality:

I have discovered already with the very limited experience I have gained in this role that in reality what we have been trained to do and what we actually get presented with are two different things. I do not believe we have had training of any sort when it comes to dealing with more complex issues such as major bereavements, relationship issues, housing, drugs and alcohol, etc. (Participant 5)

One of the PCMHWS felt that future training in the IAPT model should address this, to ensure that practitioners are better prepared to offer support and better signposting:

There is also an issue with regards to the structure of the training course which was designed to fit the needs of the Improving Access to Psychological Therapies (IAPT) and therefore very much focused on assessments and support for clients with mild to moderate depression, anxiety disorders and panic. In theory this may be useful, however training of future PCMHWS should be wider ranging so that they are prepared to see clients presenting more complex issues as this is likely to happen. The better prepared we are, the more adequate support we can provide clients, even if this is in terms of advising them on treatment options. (Participant 4)

The emphasis on offering clients an assessment and treatment rationale was questioned. Several participants felt that this did not prepare them adequately for offering subsequent support to

Primary Health Care Research & Development 2010; 11: 72–86

clients where they sometimes found themselves at a loss to know what to do:

I felt that the CBT training focused mainly on delivering the assessment and treatment rationale, but glossed over the remaining sessions that were also part of the treatment. (Participant 4)

A related concern was raised over difficulties in managing the end of a treatment programme with a client. One of the group felt the need for clear guidance and advice from trainers about how to finish work with clients in a helpful and therapeutic way:

During our training we never received a formalised protocol on how to carry this out. I have obtained some ideas from my supervisor and by talking to other PCMHWs who have discussed this during their own clinical supervision. However, a formalised version that all adhere to would be helpful. (Participant 2)

Domain 2: undertaking clinical work

'These sessions on the whole are good ones': developing clinical confidence

PCMHWs all discussed the importance of engaging in clinical work, and the fulfillment derived from working with and helping their clients. Evidence of the client's improvement or stated satisfaction with treatment emerged as an important factor in group members' sense of professional fulfillment, as one of the group members described:

I find it satisfying when a client I am supporting on a CBT-based programme is improving or when a client that I have assessed is pleased with the information provided for the recommended courses of treatment. (Participant 5)

Whilst some group members initially questioned the value of using a self-help workbook with their clients, strong feelings of satisfaction emerged when their clients engaged with this medium. This same group member also described feelings of professional fulfillment in undertaking work with a depressed client:

She has been able to go through the therapy using the self-help book to get her through

Primary Health Care Research & Development 2010; 11: 72–86

her tough times, and has commented on how it has worked well for her. She has also enjoyed the structured telephone support sessions as she feels that talking to someone on a regular basis has given her the additional support. In her words: 'I really look forward to your calls' My sessions with her were for me very rewarding as she engaged in sessions very well'. (Participant 5)

One of the group was surprised at the positive therapeutic benefits emerging from a single session with a client. The possibility of acknowledging and addressing problematic feelings in such a short time seemed to offer a sense of hope and conviction that these sessions could be 'good ones':

I have been surprised by how positive the more brief encounters have been. Many potential clients that only attend an assessment session leave either signposted to another service or at least to consider their options. These sessions are on the whole good ones, because an attempt has been made to address their problematic feelings. (Participant 3)

'I've found it particularly hard coping with patients that cry': managing anxiety in clinical work

However, many participants described ways in which they struggled to deal with a range of emotions in themselves and in their clients during clinical work. There were many examples of how participants found coping with strong emotions in their patients particularly demanding:

The main struggle I have experienced is with patients who become emotional or tearful, I have found it particularly hard dealing with patients that cry as I find this quite distressing and sometimes hard to cope with. (Participant 5)

Others discussed how they felt frustrated and anxious when clients chose not to work in the prescribed way. One group member described feelings of self-doubt and irritation that ensued from a client's refusal to accept and work with the agreed self-help book:

I struggled because the client was not working with the book despite my encouragement.

I feel naturally this made me reflect and question my skills. This struggle also created feelings of frustration. Not only had I questioned my ability, but it felt as though the client had tried to mould the programme to suit his needs rather than accepting the programme, and its limitations as they stand. (Participant 1)

The emotional impact of clients was something that other participants raised. The group seemed to feel that a wider discussion during their CBT training of concepts that might have helped to make sense of and manage some of the difficult emotions likely to arise during clinical work was necessary:

the concepts of transference and counter-transference were never discussed during our training, and the impact that some of our clients problems may have on us and how we might be able to recognise this, especially when we are supporting clients on a CBT-based program. Although we have been reflecting on this during our reflective group meetings it was never emphasised elsewhere, such as during our training or in clinical supervision. (Participant 4)

'All I could do was keep calm': managing risk and complexity

Difficulties in managing feelings aroused by client work were particularly evident when group members found themselves involved with complex cases involving risk issues. In theory, PCMHWs should not receive high-risk clients from referrers; in practice, nearly all the group members had had to manage significant risk issues in their first few months of work, sponsoring feelings of alarm and acute anxiety. One PCMHW describes taking a telephone message from a suicidal client:

We often give our work numbers to clients in case they have to cancel appointments. On paper, the client appeared suitable for an assessment with me....The [telephone] message was from the client I had booked to see the following week. He said he was feeling low and would like me to phone back. I phoned back....he was crying, saying that his family did not care for him and that he had

no-one....I was aware that he had been drinking, that he had tried to take his own life on three occasions and that he lived alone. He then said he was going to jump of the ninth floor of his block of flats..... (Participant 1)

Another struggled to cope with a client's rising panic during an assessment session:

The assessment was really difficult to carry out as she was constantly in a state of anxiety and started to have a panic attack during the assessment. All I could do was keep calm and explain to her that the symptoms would eventually go away but this was very difficult for her to hear and she wasn't really listening to what I was saying. I felt that I had not conveyed the treatment rationale to her adequately and this would affect how she would take to treatment in the future. (Participant 2)

Others were unsure of how to help clients who presented with multiple problems, feeling uncertain of how to signpost or where to refer appropriately. One of the group exemplified this with reference to a recent complex assessment:

I struggle more with clients presenting a number of problems, some of which are complex, or that I can associate with. I saw a client recently for an assessment and he presented with feelings of social phobia, depression but also had health problems and feelings of guilt with regards to past relationships. He had had many courses of therapy in the past and therefore it was difficult to know how to refer appropriately. (Participant 4)

All group members seemed acutely aware of, and troubled by, a lack of experience, particularly when handling complex cases or ethical issues. In the following extract, one PCMHW described the difficulty in understanding and handling a boundary issue, something that was attributed, in hindsight, to 'naively' agreeing to a client's request for confidentiality:

A client who was seeking treatment for the effects of child abuse in her youth...had agreed to a referral for psychotherapy....I naively agreed to the client's request not to inform their GP of why the referral had been

made. I later realised that I had been drawn into a struggle between the client and GP that did not concern me (Participant 3)

However, the notion of risk and complexity was also considered within wider systemic issues within the PCT. One PCMHW raised the possibility that complex cases were being referred to them by GPs who were themselves frustrated at having to deal with patients who were not considered suitable for secondary care services. In this extract, it is not entirely clear whether this particular group member felt that 'it's not fair' that GPs are left to struggle to support difficult patients, or that 'it's not fair' that PCMHWs were being left to manage the resulting inappropriate referrals. In any event, a sense that something was wrong within the referral system emerged clearly:

This issue of inappropriate referral is possibly a response by GPs to the negative strategy employed by secondary services in an effort to reduce pressure on their service. By only taking the most acute or chronic patients, or at least those who don't fail to respond to a first contact attempt, they leave the most complex cases to be supported by GPs in the community. It's not fair really. (Participant 3)

'I'm not a counselor!': role confusion

Group members also felt there was a degree of confusion amongst referrers and patients about their role within the service. They pointed to the way that referrers seemed to think PCMHWs were counselors, offering ongoing therapeutic work rather than assessment and signposting. Feelings of irritation and anxiety emerged, particularly where participants felt patients had misconceptions about their professional backgrounds:

... I do feel that professionals outside of the Service do not really understand our role e.g. GPs, GP staff and health visitors who keep telling their patients that we are counsellors, which gives the patient a false expectation when they come to see us. (Participant 5)

Misleading information on the part of referrers resulted in patients either being referred needlessly, and/or not being referred on to more appropriate services. Some participants developed

Primary Health Care Research & Development 2010; 11: 72–86

an informal protocol for explaining the PCMHW role to clients ahead of assessment. Other described feelings of irritation at constantly having to remind patients and referrers of the limits of the PCMHW role, finding this professionally demeaning. Indeed, lack of clarity over their clinical role seems to have resulted in some PCMHWs inevitably adopting a somewhat understandably defensive expectation that they would be questioned about their role and level of professional expertise:

One of the difficulties we face in our role is that some GPs refer to us as counsellors when talking to their patients whom they believe might benefit from our service. Clients may then attend an assessment with us with certain expectations about what they think we do and may then question our professional background. (Participant 4)

Conversely, another group member felt that it was precisely the lack of professional mental health qualifications that was valuable, offering clients a potentially normalizing, more genuinely collaborative assessment interview, unhampered by professional diagnostic concerns:

One advantage ... is that of the PCMHW role not being a qualified mental health profession. For clients that are aware of this, I feel it makes for a less anxious meeting by making client feel less 'labelled'. (Participant 1)

The potential importance of PCMHWs in normalizing psychological distress was highlighted in the same participant's description of a client whose poorly handled referral seems to raise feelings of anger and anxiety at being stigmatized and labeled as someone with 'mental health issues':

I have seen clients who immediately jump to defend their mental health, saying they are not mentally ill...I saw a client who described feeling low due to stressful life events. He had previously been discharged after asking for no further help from the service. He was referred by his GP... When I met him, he insisted that he did not need help as he did not have mental health issues. He did not want me to take notes or finish the assessment. He rejected the option of counselling and did not want treatment. (Participant 1)

'I do not sit comfortably': managing ambivalence about data collection

All participants were surprised at the level of administration and paperwork required of their role. Four of the five PCMHWs were already participating in the IAPT project; these participants all commented on the emphasis on data collection requirements and the use of the computer programme Patient Case Management Information System (PCMIS) as a data collection tool. This seemed to raise ambivalent feelings in the group: there was a tension between recognizing the significance of data collection in a climate of evidence-based practice, whilst simultaneously feeling uncomfortable about asking for – and storing – a great deal of confidential information:

One of the group members felt strongly that high quality data collection was important to the service:

In practice, I think that it is a very good programme, and from personal experience I find the programme easy to use and does not take a great deal of time to enter the data...I feel that it is imperative for us to collect good, meaningful data so that we can analyse and understand how our clients are benefiting from using the service. (Participant 5)

However, others seemed to find the continuous quest for clinical data more onerous. One of the group members described the session-by-session requirements:

... there are certain data collection requirements that are expected of some of us. Whenever we have clinical contact with a client – whether by telephone or face-to-face – we have to record this data on to PCMIS...this means that once a client has agreed to start a course of treatment with us, we need to get measures for these [PHQ-9 and GAD-7] questionnaires during each telephone or face-to-face session and also try to get a minimum set of measures if they do not attend their discharge session or if they drop out of treatment. (Participant 4)

Another participant pointed out that whilst PCMIS is ostensibly intended as a clinical tool, designed to help clinicians and supervisors monitor and map client progress, it seemed to be more frequently used as a data collection tool.

Concerns about the ethical implications of patient consent in the collection of such confidential information emerged in the following extract:

In reality, it [PCMIS] is more a data collection tool with benefits for patient management as a by-product. An example of this bias is the presence of a 'patient consent' button. If this were a patient management tool, then leaving this button unchecked would mean that neither the patient's name nor their data would be added to the central database, but it would remain accessible for the purposes of patient management. I am unsure as to whether this is the case. (Participant 3)

Similarly, another participant voiced serious discomfort at the amount of data being collected on behalf of the PCT:

From a personal point of view, I do not sit comfortably with the amount of personal information being collected and stored about clients and often think how I would feel if an organisation had that much information stored about me, and question how much is actually relevant or needed. (Participant 2)

One of the group felt that asking clients to fill in questionnaires was disruptive, potentially disturbing a carefully built therapeutic alliance established during the assessment session:

Data collection can be difficult in practice. After an hour and a half assessment, a few [clients] are reluctant to fill a set of measures in. Sometimes I have felt awkward doing this, feeling as though I had weakened the rapport we had built in the assessment. (Participant 1)

'A daunting environment': additional resources for sharing, normalizing, and supporting

Given the above demands of the role, it is not surprising that participants referred to a range of supports available to them within the PCT: clinical supervision, clinical practice meetings and the reflective practice group. Many of these support systems were perceived as essential to maintaining communication with the wider team, normalizing feelings, sharing good practice and supporting each other. For instance, the reflective practice group was valued for providing a place where both the client's

and the practitioner's feelings could be discussed, shared and normalized:

In one assessment I felt quite distressed at seeing an elderly client cry, maybe it hit a particular nerve. In this situation discussing the client in reflective practice in a group helped me to normalise the situation as well as my own feelings. (Participant 5)

The reflective practice group was also seen as a relatively informal arena for sharing experiences and learning:

I think in any mental health profession it is always good to have a reflective group like this, where boundaries are clear at the beginning but equally there is not too much structure for it to feel like another meeting. It feels like a place where issues can be discussed openly. (Participant 2)

Clinical supervision raised a number of ambivalent feelings. One participant was disappointed at the style and format of early supervision sessions, which felt somewhat restrictive and limiting to professional development:

In its original guise supervision was simply an opportunity to discuss referrals and as such a useful but actually quite stunting, stifling experience...I had found a dead end in my career development...supervision sessions were simply an opportunity to check I was working through my case load, conveyor belt-like. (Participant 3)

Another participant, whilst finding clinical supervision potentially intimidating, ultimately found it professionally and personally worthwhile:

I have found clinical supervision can be a daunting environment where your work is critically examined, your judgements are questioned and your faults are highlighted. I firmly believe however that any professional and personal development I have acquired in this role can be predominantly attributed to clinical supervision with my supervisor. (Participant 1)

Joint supervision was experienced as particularly helpful and supportive, even where colleagues had differing levels of experience:

My supervision presently is jointly with one of my co-workers, although we are at different

Primary Health Care Research & Development 2010; 11: 72–86

stages of experience of working with clients it is useful to share our experiences at supervision and through our supervisor. (Participant 2)

Domain 3: professional development and career plans

'This may prove to be quite monotonous': wanting more

Whilst all group members felt they were acquiring valuable experience within the PCT, none felt that their current role as PCMHWs was a long-term career option. A common thread running through all accounts was the continuing sense of the position being merely a 'stepping stone' to another profession within the mental health field, as one group member articulates:

I cannot ever see it develop as a career in itself, but more of a helpful stepping-stone into a desired profession. (Participant 2)

Three PCMHWs went on to describe their ambitions to train in clinical psychology, pointing to the advantages and limitations of the PCMHW role in providing relevant experience:

The role has been excellent experience but I would not like to commit myself to it for another two years. I feel that in the future I will need to seek employment elsewhere so that I gain a wide range of experiences to prepare me for training. (Participant 1)

For some, the very brief nature of the contact between PCMHW and client inevitably limited the possibilities for rewarding therapeutic engagement in the context of ongoing clinical work:

The mere characteristics and structure of the role does however limit the involvement of the therapist and perhaps as a long-term career this may prove to be quite monotonous and the need to stay in this particular role may dwindle. (Participant 5)

This last point perhaps links with an earlier theme of developing clinical confidence, and the importance to group members of undertaking satisfying and professionally rewarding clinical work. The wish to engage therapeutically with their clients emerged forcefully in the individual

accounts and perhaps goes some way towards explaining why group members all expressed a need to progress, either in terms of professional training and qualification or in terms of further career changes. Some were interested in the IAPT low-intensity training posts and were already planning to apply. It was clear that these posts too were seen as a further stepping stone on the path to a clinical or counseling psychology training:

Recently there have been opportunities such as the high-intensity/low-intensity courses/posts, which seem a good stepping stone for me to aim for. I could then decide after doing the post for a few years if I wish to continue to progress into psychology. (Participant 2)

Discussion

The role of PCMHW is a relatively new one, and already the recent introduction of IAPT training programmes has resulted in new training and career pathways being established. To date, there is very little literature on how PCMHWs themselves have experienced their roles within the NHS, and how they themselves view their professional futures. This study has attempted to identify some of the concerns and issues that have arisen for a group of PCMHWs within a primary care mental health team. In common with other qualitative studies, the current group is not intended to be a representative sample of the wider population of PCMHWs, but rather has been used to illustrate and elucidate their experiences of training and clinical practice in order to provide a more detailed 'insider perspective'.

Our qualitative analysis has highlighted several areas of concern to PCMHWs. One area relates to the strongly perceived need for a coherent, visible professional career structure. All the PCMHWs in this group had accepted the role as a 'stepping stone' to future mental health work in which working face-to-face with clients was felt to be a primary motivating factor. Several were intending to train as clinical psychologists, and, at the time of writing, others had already applied for posts as low intensity workers under the IAPT programme starting within the Trust. The need for a professional qualification and recognition of their skills and training was highlighted as a source of concern for many in the group.

A more central issue relates to the difficulty of applying academic and skills training to the messy world of real-life clinical practice. PCMHWs highlighted issues of risk management, and the difficulties in dealing with complex cases that stretched beyond the intended remit of their role. In this respect, the issue of support systems were identified as central means of helping the PCMHWs develop their understanding of the clinical issues involved and to maintain clear professional boundaries.

Tomson (2002) originally identified a number of functions appropriate to the role of PCMHW, including assessment and triage, team working and communication, facilitating systems to support care, care planning, co-ordination and review and mental health promotion and prevention, as well as therapeutic interventions. However, results from this study suggest that face-to-face client work was perceived as highly significant for group members, and many were pleased that they were permitted to contact with clients early on in their training. Indeed, O'Connor (2006), in discussing early opposition within the NHS to the role of PCMHW, has pointed out the importance of working with clients: 'most participants cannot be expected to remain in post without some fulfillment of the wish to work directly with clients' (p. 96).

This study shows that all group members had been surprised by the level of clinical complexity they found themselves facing so early in their client work. This raises an important issue related to role definition, as referral guidelines (eg, Department of Health, 2001; Firth *et al.*, 2003) suggest that issues of severity, complexity and risk are potential determinants of clients referred to PCMHWs. Bower *et al.* (2004), in discussing the way in which PCMHWs may be differentiated from other mental health professionals, suggest that in future PCMHWs' client work may be defined less by techniques (eg, self help and signposting) and more by the type of client referred. However, it is clear that the current participants felt that GPs were unsure and ill informed about the role and function of a PCMHWs role, and that this, along with the systemic pressures to keep patients out of secondary care, frequently resulted in cases of greater complexity and risk being inappropriately referred to them.

Primary Health Care Research & Development 2010; **11**: 72–86

This raises serious issues of training, ethics and safety in the context of the rapid national expansion of the IAPT programme and the likely rise in numbers of patients being referred to low-intensity workers or PCMHWs. The Department of Health's (2008) implementation plan for IAPT includes the following statement:

Low-intensity workers are expected to operate in a stepped-care, high-volume environment carrying as many as 45 active cases at any one time, with workers completing treatment of between 175 and 250 patients per year. Workers must be able to manage caseloads, operate safely and to high standards and use supervision to aid their clinical decision making.. (p. 5).

Results from this study suggest there may be good reasons for sounding a note of caution about this extremely high-anticipated workload, and for ensuring that the assessment of patients in primary care remains in the hands of qualified, experienced mental health staff who can then refer individuals as appropriate to low intensity or PCMHWs. In the face of rising numbers, it could be argued that case management supervision for IAPT and PCMHWs may simply be insufficient to identify, support and manage the complex decision making processes highlighted by our participants as necessary in adequately dealing those referred to primary care mental health services. It may also fail to address the emotional needs of practitioners struggling to tolerate and manage their own anxieties when faced with the complex, sometimes intense psychological demands of their clients. The experience of our group members suggests that the referral and management of complex clients is a fairly commonplace occurrence, and reflects a disturbing reality 'on the ground' that may be overlooked in the current push to roll out the IAPT programme across the UK.

The importance of practitioners in mental health services reflecting on and using their feelings in the context of clinical work is commonly raised in the context of psychoanalytic work, where the therapist's counter transference is considered a potential signifier of emotional disturbance in the client's internal world. The significance of attending to practitioners' feelings has also recently been raised in relation to social

Primary Health Care Research & Development 2010; **11**: 72–86

workers managing child protection cases in the aftermath of the 'Baby P' case (Asen *et al.*, 2008). Results from our study suggest that PCMHWs, like social workers, may face high caseload demands where the need to acknowledge and address psychological pressures arising from client work may be crucial to sustaining ongoing empathic therapeutic work, and to prevent professional burnout. However, unlike social workers, the potential risk issues in PCMHWs' caseloads have not to date been acknowledged, as low-intensity work within the IAPT model is presumed to exclude working with high-risk clients. Results from the current albeit very small-scale study shows this not to be the case and that high risk clients are being referred direct to PCMHWs for assessment and referral. Further studies are needed to establish whether this practice is occurring in other localities. Meanwhile, it is clear that current IAPT curricula (Department of Health, 2008) for low-intensity trainees neither address the reality or complexity of referrals such as those highlighted by participants in our study; nor do they address the likely psychological impact of such referrals on inexperienced trainees and practitioners working in the context of high-volume front-line work. We suggest that ensuring adequate levels of training as well as ongoing psychological support/reflective practice opportunities for these inexperienced practitioners may now be a priority for many PCTS, given the rapid expansion of the IAPT programme and the deployment of large numbers of low-intensity workers within the NHS.

Limitations of the study

There are two major issues arising from this study. One is that group members provided a written account of their experiences, rather than the more in-depth opportunity for discussion that would have been provided by face-to-face interviews. As Karchmer (2001) has argued in the context of e-mail interviewing (which we may regard as analogous to the current methodology), some participants may not be as effective writers as they are speakers. However, studies comparing both e-mail and face-to-face interviews (eg, Curasi, 2001; Murray, 2004; Murray and Harrison, 2004) suggest that participants interviewed by email tend to focus more closely on interview questions

and provide more reflectively dense narratives than those interviewed face-to-face. Whilst this study is based on participants' written accounts, it should be remembered that topics and issues had already been generated and discussed within the reflective practice group, providing members with an opportunity for clarifying and elaborating on their thoughts and ideas prior to writing them down. We feel this methodological combination has sponsored a rich and detailed picture of group members' feelings and subjective experiences, which we feel goes some way towards justifying our choice of methodology.

The other concerns the professional context of the study. It could be argued that, in my dual role as group facilitator and main author of the paper, hierarchical issues of role, power and authority may have impacted on the extent to which group members were prepared to fully share and discuss their interests, issues and feelings. It is certainly possible that salient themes may have been omitted by participants in the interests of privacy and confidentiality. Denzin (1989), too, has pointed out that the act of selecting, amplifying, interpreting and discussing participants' accounts is inevitably shaped by the researcher's subjectivity and professional interests. In this case, my own clinical interest in psychoanalytic psychotherapy, and my research interests in practitioner personal development have implicitly been highlighted in the details of the foregoing analysis. However, researcher subjectivity is likely to have been offset significantly by the very full role all group members played in the development and implementation of the study, with each individual offering considerable feedback and criticism on drafts of the paper, with further material provided for inclusion where appropriate. Indeed, it is for this reason that we made a decision for the paper to be jointly co-authored. Whilst acknowledging the inevitable tensions raised by such a strategy, we nonetheless feel any disadvantages are outweighed by the benefits of openly sharing and discussing such a topical, albeit under-researched area within the contemporary mental health field.

Conclusion

This qualitative study has provided an in-depth perspective on the subjective experiences and concerns of PCMHWs within a primary care mental

health team. Issues relating to professional recognition, and the importance of face-to-face client work were raised, as well as concerns about role ambiguity and the reality of managing clients referred with complex psychological needs.

Clearly, larger, more rigorous qualitative studies, exploring low intensity workers' and PCMHWs' experiences of client work in more detail would go some way towards establishing whether the themes documented in this study are representative of practitioners working in other PCTs. Where set alongside the experiences of service users, we suggest such studies may usefully contribute to a more psychologically aware training and education for the large numbers of PCMHWs and low intensity IAPT workers currently entering the mental health field.

References

- Asen, E., Cooklin, A., Lucey, C., Kraemer, S., and Trowell, J. 2008: Social workers need training and support. Retrieved 3 November 2009 from www.timesonline.co.uk/tol/comment/letters/article5288795.ece
- Bower, P. 2002: Primary care mental health workers: models of working and evidence of effectiveness. *British Journal of General Practice* 52, 926–33.
- Bower, P., Jerrim, S. and Gask, L. 2004: Primary care mental health workers: role expectation, conflict and ambiguity. *Health and Social Care in the Community* 12, 336–45.
- Braun, V. and Clarke, V. 2006: Using thematic analysis in psychology. *Qualitative Research in Psychology* 3, 77–101.
- Chambers, R. 2008: Transitioning to IAPT: a graduate worker perspective. *Healthcare Counselling and Psychotherapy Journal* 8, 8–13.
- Charmaz, C. 2002: Qualitative interviewing and grounded theory analysis. In Gubrium, J. and Holstein J., editors, *Handbook of interview research: context and method*. London, UK: Sage.
- Curasi, C.F. 2001: A critical exploration of face-to-face interviewing versus computer-mediated interviewing. *International Journal of Market Research* 43, 361–75.
- Denzin, N. 1989: *Interpretive interactionism*. Newbury Park, CA, USA: Sage.
- Department of Health. 2000: *The NHS plan: a plan for investment, a plan for reform*. London, UK: Department of Health.
- Department of Health. 2001: *Treatment choice in psychological therapies and counseling: evidence based clinical practice guideline*. London, UK: Department of Health.
- Department of Health. 2008: *Improving access to psychological therapies. Implementation plan: curriculum for low-intensity workers*. Care Services Partnership and National Institute for Mental Health in England. www.dh.gov.uk/publications

- Elliott, R., Fischer, C. and Rennie, D.** 1999: Evolving guidelines for the publication of qualitative research in psychology and related fields. *British Journal of Clinical Psychology* 38, 215–29.
- Firth, M., Dyer, M., Marsden, H. and Savage, D.** 2003: Developing a social perspective in mental health services in primary care. *Journal of Interprofessional Care* 17, 251–61.
- Karchmer, R.A.** 2001: The journey ahead: thirteen teachers report how the Internet influences literacy and literacy instruction in their K–12 classrooms. *Reading Research Quarterly* 36, 442–66.
- Murray, C.D.** 2004: An interpretive phenomenological analysis of the embodiment of artificial limbs. *Disability and Rehabilitation* 26, 963–73.
- Murray, C.D. and Harrison, B.** 2004: The meaning and experience of being a stroke survivor: an interpretive phenomenological analysis. *Disability and Rehabilitation* 26, 808–16.
- O'Connor, H.** 2006: Primary care mental health workers: a narrative of the search for identity. *Primary Care Mental Health* 4, 93–98.
- Smith, J.** 2004: Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology* 1, 39–54.
- Stiles, W.** 1993: Quality control in qualitative research. *Clinical Psychology Review* 13, 593–618.
- Tomson, D.** 2002: *Making the Best Possible Use of Primary Care Mental Health Workers*. Newcastle-upon-Tyne, UK: Primary Care Mental Health Education and Development Unit, University of Northumbria.
- Yardley, L.** 2000: Dilemmas in qualitative health research. *Psychology and Health* 15, 215–28.