

International research

Community mental health nurses' views of their role in the treatment of people with common mental disorders

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ABSTRACT

Background Tension is apparent between primary and secondary care services with regard to the treatment of people with common mental disorders (CMDs). Studies have consistently shown that general practitioners (GPs) would like direct access to community mental health nurses (CMHNs) for CMDs, despite a lack of evidence of effectiveness for this treatment approach. Policy initiatives direct community mental health nurses to concentrate their efforts on people with severe mental illness (SMI). This is an important issue as GPs take on practice-based commissioning. The views of CMHNs themselves are under-reported. **Aim** To explore community mental health nurses' views concerning the nature of common mental disorders and their role in treatment.

Design Qualitative case study.

Setting Four NHS trusts providing mental health services in southern England.

Methods Six group discussions were undertaken with 37 CMHNs. Data were analysed using thematic content analysis.

Results Unlike GPs, CMHNs did not consider treating people with CMDs to be part of their role. While they had the skills for this work, they felt it would distract from their primary purpose of caring for people with SMI. Having to deal with 'inappropriate' referrals from GPs could be frustrating for nurses. However, they perceived a gap in provision for people with CMDs, and a need to facilitate speedy referral to secondary care for those people who did not respond to treatment in primary care.

Conclusion Notwithstanding the limitations of the methods of this study, the findings suggest that CMHNs are likely to resist any attempts to commission them to provide direct care for people with CMDs in primary care. Developing alternative partnership arrangements between secondary and primary care services may be more appropriate.

Keywords: common mental disorders, community mental health nurses, qualitative methods

Introduction

The term common mental disorder (CMD) is generally reserved for those mental disorders that are anxiety- or depression-related and tend to be seen in primary care.¹ These disorders are recognised as causing considerable social and economic burden in

the UK, with community prevalence estimated at 15–30% and the cost of depression alone estimated as £9 billion per year.^{2–4} Although many occurrences of CMDs spontaneously resolve, a significant proportion of people will experience a slower course

of recovery, co-morbidity of symptoms, and frequent relapses.^{5,6}

In the UK, general practitioners (GPs) have expressed a preference for direct access to community mental health nurses (CMHNs) to provide care and treatment for people with CMDs.⁷⁻¹¹ GPs believe CMHNs are appropriately skilled to offer such services, and members of the wider primary healthcare team have expressed satisfaction with CMHNs being located within primary care.^{8,12-14} However, there is a lack of evidence of clinical effectiveness of CMHN care for CMDs.^{15,16}

The role of CMHNs in relation to primary care has not been strategically planned, and historically has developed in an *ad hoc* way.¹⁷ When it was demonstrated that direct referrals from GPs accounted for more than 50% of referrals to CMHNs, it was suggested that CMHN services were neglecting people with severe mental illness (SMI).¹⁸ The 1994 Mental Health Nursing Review concluded that all mental health nurses should focus their efforts on people with SMI in secondary or tertiary settings.¹⁹ Subsequently GPs identified, and were dissatisfied with, the reduction in CMHN services to primary care.¹² Furthermore, CMHNs have identified and reported the tensions they experienced by opposing demands from their employing NHS trusts and local GPs. Their experience was one of service expansion for people with CMDs in the 1980s that was followed by retrenchment when mental health trusts 'disinvested' in work with patients not described as seriously mentally ill. This left CMHNs making individual compromises with fundholding GPs to maintain good working relationships.²⁰

Recent policy has further confused the situation. The National Service Framework for Mental Health has demanded that people with CMDs should be referred to specialist services for care and treatment when required.²¹ Other policy directives suggest that a substantive majority of community mental health team (CMHT), hence CMHN, clientele should be people with time-limited health problems who will be referred back to their GP after a period of weeks or months (essentially people with CMDs).²²

In contrast to the knowledge about GPs' views, little is known of the CMHN perspective on their role in primary care for the care of people with CMDs. One study interviewed 11 CMHNs about their self-perceived roles, including nurses who were providing a primary care service, and found they included counselling, behavioural treatments, and prevention, as well as giving and supervising medication.²³ These interventions would be suitable for people with CMDs, but the study did not make it clear which patient group the nurses were involved in treating. Furthermore, the study was conducted prior to the Mental Health Nursing Review.

In another more recent study, the views of CMHNs were included along with those of the GPs, practice nurses, psychiatrists and clinical psychologists to ascertain professional views of managing CMDs in primary care.²⁴ This study concluded there was considerable uncertainty about how CMDs should be managed and no clear strategies for their care were evident in either primary or secondary care. With the return of practice-level commissioning, this issue is highly relevant today.²⁵ Given the evidence on GPs' perspectives, they may use their financial leverage to obtain CMHN care for people with CMDs. An in-depth understanding of the CMHN position in relation to the direct care of people with CMDs is required to provide valuable evidence for those involved in the commissioning process.

A randomised controlled trial (RCT) to assess the clinical evidence of CMHN treatment for people with CMDs, and linked qualitative studies of the CMHNs' and patients' experiences of the trial have been conducted.¹⁶ This paper reports on CMHNs' views of their role in the treatment of people with CMDs.

Aim

The aim of this study was to explore community mental health nurses' views concerning the nature of common mental disorders and their role in treatment.

Methods

Design

This paper draws on a case study of CMHN experiences and views conducted alongside the RCT.^{16,26} The first part of this case study studied in-depth the nurses' experiences of practice within the context of the trial, adopting individual interviews as the method of data generation and a dual approach to data analysis. The second part of the case study, although related to the first, was specifically designed to address the aim stated above, and as such it is appropriate to report the two parts of the study separately. This part of the study engaged a wider group of CMHNs in a series of group discussions which were deemed appropriate to explore how and why the nurses thought in a certain way.²⁷ Data were analysed using a method of thematic content analysis suitable for qualitative data.

Context

The setting for the case study spanned four NHS trusts areas across Hampshire and East Dorset (some of these trusts no longer provide mental health services since recent reconfigurations). All four trusts had sectorised generic adult CMHTs which covered a defined geographical area and were linked with specific inpatient units. Within some of the teams specific roles had been developed, for example discharge, homeless, or primary care liaison. Although the universal policy was to discourage referrals of people with CMDs from GPs to the teams, this was operationalised in different ways across the area. Some operated very strict policies where referrals were directed straight back to primary care, other teams sometimes responded more flexibly on an *ad hoc* basis, whereas others had set up specific mechanisms to manage these referrals. These factors suggested group discussions were required to capture the diversity of experience and facilitate discussion between nurses with a range of experiences and views towards the care and treatment of people with CMDs.

Sampling/participants

All the participants were CMHNs in the adult mental health services in the four NHS trusts participating in the RCT. Prospective sampling for the study was underpinned by the principle of maximum variation in relation to the experience of treating people with CMDs.²⁸ The sample included nurses who had participated in the trial, CMHNs who had an explicit role taking referrals directly from primary care (who therefore had recent exposure to treating people with CMDs), and CMHNs from the generic adult

teams who were not usually involved in the direct care of people with CMDs (see Table 1). All CMHNs in the generic adult CMHTs were invited via posters, leaflets and team meetings to take part. In addition snowball sampling was used in that trial CMHNs nominated and invited colleagues not involved with CMDs and those providing a primary care service, to ensure maximum variation.²⁹ The groups were organised by locality, rather than participant type, to maximise attendance and encourage discussion between participants with different types of experience.

The participants were almost three-quarters women (26/37) and had between 2 months' and 20 years' experience (mean 7.5 years; median 7 years) of community mental health nursing. Apart from those nurses specifically sampled for their primary care role, four others had specialist roles with the CMHT (discharge liaison, homeless, screening and assessment (2)). Four others had team leader responsibilities.

Data generation

Data collection was conducted in 2003, with participants commenting on the analysis and interpretation in 2005. The groups were guided by a schedule that aimed to generate discussion around the nurses' experience of treating people with CMDs, their everyday practice, and their perceived role with people with CMDs. Each group was facilitated by the lead author and observed by a colleague. The observer took notes to aid transcription, and picked up any points the facilitator failed to pursue. Group duration was between 75 minutes and 2 hours. All groups were audiorecorded and transcribed, ensuring, where possible, that talk was correctly attributed

Table 1 Participants presented by group discussion and experience type (number participated (number volunteered))

Group number	Trial CMHNs	Non-trial CMHNs	CMHNs with a primary care role	Total
1	4 (6)	1 (4)	0 (0)	5 (10)
2	4 (4)	1 (2)	1 (2)	6 (6)
3	2 (3)	4 (4)	0 (0)	6 (7)
4	1 (3)	1 (1)	2 (3)	4 (7)
5	5 (6)	3 (3)	0 (0)	8 (9)
6	3 (3)	5 (6)	0 (0)	8 (9)
Total	19 (23)	15 (20)	3 (5)	37 (50)

to individual speakers. This ensured the comparison of views between the different types of participant was possible.

Data analysis

Data analysis followed the principles of thematic content analysis.^{30,31} This consisted of three stages. Codes or categories were identified by close readings of the transcripts, which were systematically applied to the data. Following this the categories were refined into broader themes. Attention was paid to uncover any disconfirming cases. The final stage involved synthesis with existing evidence and knowledge. During this stage the analysis was presented to participants, providing the opportunity to comment on the developing interpretation.

Anonymisation

Pseudonyms have been given to all participants. This added trustworthiness to the study as it allowed an audit trail of the decisions taken in the analysis. Furthermore, the pseudonyms are used to identify the quotes presented in the article, indicating the range of the participants represented in the findings.

Results

Even though the study did not set out to achieve consensus, there was remarkable uniformity in the main themes that were identified within and across the group discussions. Little disagreement was found between the nurses despite purposefully sampling participants with a range of experience in relation to CMDs, and stimulating discussion of alternative positions during the group discussions.

The nature of common mental health problems

Most nurses believed that CMDs were explained by a psychosocial model of mental health. The nurses described this type of distress in relation to life events and social problems, for instance, financial, occupational or personal difficulties, rather than characterising CMDs as mental illness. It was noted in all groups that for practitioners in secondary care the term 'common' signified disorders considered severe and enduring, rather than disorders that were

more commonly encountered in the general population:

Angela: 'What about psychosis? Because we see quite a few don't [we]. I mean we get a lot of people with schizophrenia and bipolar ...'

Sheila (trial CMHN): 'yeah that's right ... I see psychosis as something that will come through to [the CMHT] and it will be common to our service but we are talking about common in primary ...'

Angela: [addressing researcher] 'Oh do you mean common in the community?'

Inappropriateness of CMD referrals

Across all the participants in the study, only those who had a specific primary care role were engaged in treating people with CMDs as part of their everyday, routine practice. Most nurses thought that people with CMDs should not be cared for by specialist services as these should be focused on the care and treatment of people with SMI:

'... basically patients who should be in our service are these guys with SMI for a long period of time.' (Jonathon, trial CMHN, group 5)

However, maintaining the focus of the CMHT could be difficult:

'In the team I work in we are being told that we're there for severe and enduring mental health problems and that's our remit, but I don't think that always happens. That's the theory.' (Sonia, trial CMHN, group 1)

The way most nurses experienced contact with people with CMDs was when dealing with what they termed 'inappropriate referrals' to the CMHT. The nurses identified that the nature of mental health problems, which can be hard to categorise, made managing the boundary around their service difficult:

'... the nature of mental health, it is very difficult to draw boundaries. While you have got psychosis, schizophrenia it's very obvious that it's a mental health problem that needs intervention. And then you start going down the list, personality disorders and depression [with] the line becoming more blurred.' (Pete, non-trial CMHN, group 1)

They felt this caused problems for GPs who may have difficulty knowing when and who to refer to specialist services. It was also difficult for mental health services to reject referrals on the basis of a referral letter, even if they thought a referral did not

meet with the definition of SMI. They felt an obligation to at least see the person for assessment even though this diverted them away from providing services for people with SMI.

The nurses' views and experiences of people with CMDs had not changed between taking part in the study and the completion of the analysis. When the nurses commented on the findings, they confirmed the analysis remained relevant to their current practice.

Maintaining the focus on severe mental illness

Across the study area two approaches were being used to manage GP referrals considered 'inappropriate', and to maintain the perceived role of secondary care services. In one locality this problem had been addressed by the introduction of a screening and assessment team with a specific remit to manage referrals to the CMHT. In two other areas, CMHNs had responded to requests from GPs to provide a service for people with CMDs. However, the underpinning rationale for both approaches was similar. Firstly, to 'signpost' (Tina, primary care CMHN) people with CMDs to other services, or refer back to primary care. Participants from the screening and assessment team believed that members of the core CMHT had much less contact with people with CMDs because they had screened them out:

Nancy (screening and assessment team CMHN): ... [addressing Eddie, non-trial CMHN] 'you in your role don't actually get to see [people with CMDs], we see them in screening but we stop them there and send back to GPs. So there are dozens coming presenting with these problems that you never get to see ... I'd say a huge percentage go back don't they?'

Mandy (screening and assessment CMHN): 'yeah an awful lot I mean.'

Nancy: 'eight ninety percent do you think?'

Anna (trial CMHN): 'inappropriate referrals?'

Mandy: 'Yes, about ninety percent go back to the [GP].'

Nancy: 'Because they are not deemed as having severe and enduring mental illness so they are referred back to the GPs saying "we don't have a service we can offer you".'

Secondly, these nurses offered brief structured interventions. These were aimed at providing support strategies at an early stage of a period of distress, in

an attempt to prevent the distress developing further and avoid later referral to the CMHT.

Gap in current service provision

While the CMHNs did not dispute that treatment was required for people with CMDs, many nurses felt that the current service configuration was neglecting them:

Ellen (Trial CMHN): 'But I think there are a lot of people who get nothing.'

Jane (primary care CMHN): 'This is what I mean, there is a gap now.' (group 2)

'... in fact there is this whole group that we exclude and to some extent that surprised me when I went on the trial ... There was this whole band of people who were really very distressed and really quite unwell at times who really wouldn't have got any support, apart from popping along to their GP once every week perhaps or every fortnight or something like that. And who equally were not appropriate for CMHT either and definitely shouldn't be with the CMHT.' (Len, trial CMHN, group 3)

Some nurses had recognised that the gap in service provision for people with CMDs had been exacerbated by the CMHTs deflecting treatment of CMDs to primary care. But at the same time, it was felt that by addressing this gap with alternative, more appropriate, services the CMHTs would be better able to maintain their primary purpose of care and treatment of people with SMI. If service provision for people with CMDs was improved, then there would be no need for GPs to make the number of referrals they currently did to the CMHT. This would free up the time they spent assessing people who they then referred back to the GP as they did not fit the CMHT criteria:

'[you] wouldn't have your time wasted with seeing people who just don't fit the criteria.' (Frances, trial CMHN, Group 6)

Participants thought this would require more meaningful links between primary and secondary care so that if a person subsequently required referral to secondary care it could take place without delay. There was scope for the movement between services to be more 'fluid' (Liz, non-trial CMHN, group 3) and 'flexible and responsive' (June, trial CMHN, Group 3) to allow people to move between different services as their condition indicated. There was recognition that services were currently congested, attributed to insufficient resources, which would be a barrier to this model of working.

Alternative service provision

As described above, the nurses did not contest the notion that people with CMDs required some kind of intervention, but they did not believe that CMHNs in CMHTs should be the professional group or the service to provide this treatment. Underpinning their views was a desire to prevent subsequent episodes or escalation of the distress.

‘... but isn’t there an argument then for stopping these people from getting to that stage [requiring referral to CMHT]? The argument that when people first present with a depression or an anxiety, that they actually do get some kind of short focused treatment that actually helps them see that there is a way of coping with this and it’s [the patient] that copes, not us ... it stops them coming into our system.’ (Jane, primary care CMHN, group 2)

The idea of ‘short and sharp’ (Brenda, trial CMHN, group 1) treatment, which was orientated to promote the patients’ own coping resources, was important. A potential consequence of contact with secondary care services was, the nurses believed, the engendering of dependency, with patients becoming used to and dependent upon services for long-term support. It was further suggested that nurses, with a traditional helping role, were not the best professionals to promote this empowering type of treatment approach:

‘... you’re going against your natural instinct wanting to help someone ... when you try and encourage that person to help themselves but also lend a helping hand as it were as well and try and get the balance right ... the traditional role of a nurse is to be there to help.’ (Pete, non-trial CMHN, group 1)

Pragmatically, the nurses also wanted to make sure adequate skills were retained in secondary care. Threats to the provision of quality services for people with SMI may arise if CMHNs were involved in treating CMDs and developed concurrent roles in primary care. One participant raised this practical concern, borne from experience, that any development of primary care roles with this group of patients could mean less nursing staff available to secondary care services:

‘I think we would be at risk of losing very skilled and valuable members of the CMHT and I think that happens when new initiatives come up.’ (Sheila, trial CMHN, group 6)

Alongside the practical issues of staffing, a range of services with finite numbers of nurses was the belief that the primary focus of secondary mental health services was to provide the support and treatment of people with severe and enduring mental health

problems, and that this underpinning rationale should be upheld. While many nurses thought that CMHNs did have appropriate skills to offer services to people with CMDs, they noted that other groups had these skills, for instance occupational therapists, or support staff, and could provide services without the threat to the primary role of the CMHT. As illustrated in Box 1, the nurses thought that a range of service options were available to provide the necessary support to people with CMDs, including community-level support to reduce the need for recourse to the health services.

Discussion

The nurses in this study did not think they should have a role in the direct care and treatment of people with CMDs in primary care. Rather, they believed their specialist skills were best placed in secondary care, working with people with SMI. Importantly, this view did not appear to have changed among those nurses involved in the trial treating people with CMDs referred by GPs, and despite the acknowledgement that treating people with CMDs could be rewarding and enjoyable. The nurses demonstrated creative thinking in relation to the treatment of people with CMDs (see Box 1), which aimed to improve the organisation of services rather than offer new treatments.

The nurses’ views on their role expressed in this study run counter to the existing evidence on GP views of CMHN role.^{8,9,12,13} Furthermore, the nurses’ concern about the leeching of skills from the generic adult CMHTs in which they worked appears justified. In the recent reconfiguration of services, generic adult teams and inpatient units are reporting the loss of staff to the new specialist community teams, such as home treatment.³²

The finding that CMHNs view their primary function as providing care and treatment to people with SMI is important, because, given the chance, GPs will make direct referrals of people with CMDs to CMHNs.^{1–7} Importantly, the findings from this study, that CMHNs do not want a role in direct care of people with CMDs, are supported by the results of the associated trial. The trial did not demonstrate any significant differences in symptoms, social functioning and days off work between patients randomised to nurse treatment or GP care, leading to the conclusion that brief interventions by CMHNs for people with CMDs confers no additional benefits over usual GP care.³³

Like others, the nurses believed that enhancing the working relationships between primary and secondary care would improve the care of people

Box 1 CMHNs' suggestions for care and treatment of people with CMDs**Community level**

- Liaison with occupational health (groups 2 and 6)
- Parenting classes (group 2)
- Voluntary sector (group 2)
- Family workers (group 2)
- Community outreach, e.g. in community centre/churches etc (group 6)
- Community-level support (group 1)

Primary care

- Primary care mental health team (group 3)
- Graduate workers (group 2)
- Train primary care staff to deliver interventions to CMDs (group 4)
- Use of guidelines and protocols (groups 2 and 6)
- Treatment plans in referral letters (group 6)

Types of intervention

- Time-limited interventions (group 3)
- Focused work (group 3)
- Anxiety management/confidence building (group 5)
- Group work (group 3)

Role of CMHNs

- CMHN triage in primary care settings (groups 3, 5 and 6)
- Education of other primary care professionals, especially GPs (groups 1, 2, 5 and 6)
- CMHNs consultation–liaison to primary care (groups 1 and 3)
- Nurse-led CMHTs (group 3)
- Better links between primary care and secondary care (group 5)
- CMHNs closer to surgeries, like health visitors (group 5)
- Counsellor in practices (groups 1, 4 and 5)
- Crisis slot in surgeries (group 5)
- Alternatives to CMHN (group 5)

with CMDs.³⁴ They conceptualised the CMHN role as one of consultation and liaison, such as a nurse consultant role, which has been identified by others in the field as the required role of the CMHN in primary care.^{35,36} The development of a liaison relationship between secondary and primary care has been associated with greater satisfaction with services, for both mental health services and GPs.^{37,38} Initiatives such as the screening and assessment team seen in this study and the new roles in primary care, such as the 'gateway' and primary care graduate workers, require further investigation to assess the impact on managing referrals of people with CMDs to generic adult CMHTs.³⁹

Strengths and limitations of the study

There are issues relating to the method and the context of the study which require caution in the

interpretation of the findings. Firstly, it is acknowledged that even with the extensive effort expended to achieve maximum variation sampling, the participants were a select group because of their interest in the topic and willingness to take part in this research. Although a high number of the participants had recent exposure to treating people with CMDs, their views on their role with this patient group were in line with those who had not had such extensive and recent exposure. Secondly, it is recognised that the near consensus in CMHNs' views may have come about due to the censoring and confirming processes at play within group settings.^{40,41} In order to minimise these effects, alternative positions were purposefully introduced into the discussion by the facilitator. Thirdly, the CMHNs' experience of frustration with referrals of CMDs may be a result of the study setting, which was an area where the developments towards improving primary mental healthcare provision, specifically the new primary

care graduate mental health workers, have not taken off. At the time of the study no primary care graduate workers had been appointed across the locality, with only three appointed by 2005 when the nurses commented on the interpretation of data. Therefore, the tensions experienced by CMHNs as they dealt with 'inappropriate referrals' identified in this study may have diminished in areas where primary care mental health services are better developed.

Notwithstanding these limitations, this study has provided the much-needed perspective of CMHNs to balance that of GPs, which has been more thoroughly investigated. Transferability of the findings to CMHNs more generally is suggested firstly by the high participation rate of nurses with a range of experiences with regard to treating people with CMDs, and secondly in that the findings accord with other research.^{20,36}

Implications for clinical practice and future research

CMHNs do not want, and would therefore probably resist, a role in the direct care of people with CMDs in primary care. Combining these findings with the results from the trial provides strength to the suggested policy response: GPs should be discouraged from routinely referring people with CMDs to community mental health teams and CMHNs.³³ These findings are timely and should be accounted for by practice-level commissioners. Other models of service delivery where CMHN specialist skills are made available to the primary healthcare team have been shown to improve satisfaction with services. These approaches require further research to assess the effectiveness of such models of care. However, given the significant burden of CMDs and proportion of people who experience chronic ongoing symptoms, targeting resources on those people with most disabling conditions should not be at the expense of those with CMDs. Questions still remain about the care and treatment of people with CMDs who do not respond to initial treatment in primary care. While practitioners may argue for clear definition of roles and remit to operate services effectively, it is also suggested that flexibility is required to respond to individual patients' needs as they become apparent.

ACKNOWLEDGEMENTS

The authors would like to thank all the CMHNs who participated in the study and Clare Gould and Olwyn Johnston for observation and note-taking in the group discussions. We also wish to acknowledge the helpful comments from Catherine Pope and the anonymous reviewers on the draft manuscript.

REFERENCES

- 1 Goldberg D and Huxley P. *Common Mental Disorders*. London: Routledge, 1992.
- 2 Weich S. Prevention of the common mental disorders: a public health perspective. *Psychological Medicine* 1997;27:757–64.
- 3 Singleton N, Bumpstead R, O'Brien M *et al*. *Psychiatric Morbidity Among Adults Living in Private Households, 2000: summary report*. London: Office for National Statistics, 2001.
- 4 Thomas CM and Morris S. Cost of depression among adults in England in 2000. *British Journal of Psychiatry* 2003;183:514–19.
- 5 Tyrer P, King M and Fluxman J. Treatment of common mental disorders in general practice: are current guidelines useless? *British Journal of Psychiatry* 2003;183:78.
- 6 Krueger RF. The structure of common mental disorders. *Archives of General Psychiatry* 1999;56:929–31.
- 7 Stansfeld SA, Leek CA, Travers W *et al*. Attitudes to community psychiatry among urban and rural general practitioners. *British Journal of General Practice* 1992;42:322–5.
- 8 Monkley Poole S. The attitudes of British fundholding general practitioners to community psychiatric nursing services. *Journal of Advanced Nursing* 1995;21:238–47.
- 9 Double DB. What do GPs want from mental health services? *Journal of Mental Health* 1999;8:385–9.
- 10 Warner RW, Gater R, Jackson MG *et al*. Effects of a community mental health service on the practice and attitudes of general practitioners. *British Journal of General Practice* 1993;43:507–11.
- 11 Sheppard G. Commentary: finding a place: a review of mental health services for adults. *Journal of Mental Health* 1995;4:9–16.
- 12 Hannigan B, Stafford A and Laugharne R. General practitioners' views of community mental health services: a survey in one London borough. *Journal of Interprofessional Care* 1997;11:287–93.
- 13 Badger F and Nolan P. General practitioners' perceptions of community psychiatric nurses in primary care. *Journal of Advanced Nursing* 1999;6:453–9.
- 14 Crawford P, Carr J, Knight A *et al*. The value of community mental health nurses based in primary care teams: 'switching the light on in a cellar'. *Journal of Psychiatric and Mental Health Nursing* 2001;8:213–20.
- 15 Gournay K and Brooking J. Community psychiatric nurses in primary health care. *British Journal of Psychiatry* 1994;165:231–8.
- 16 Kendrick T, Simons L, Mynors-Wallis L *et al*. Trial of problem solving by community mental health nurses for anxiety, depression and life difficulties among general practice patients. *Health Technology Assessment* 2005;9(37):1–104.
- 17 Audit Commission. *Finding a Place: a review of mental health services for adults*. London: HMSO, 1994.

- 18 Brooker C and White E. *The 1996 National Community Psychiatric Nursing Survey*. Keele University: Report to the Department of Health, 1997.
- 19 Mental Health Nursing Review Team. *Working in Partnership: a collaborative approach to care*. London: Department of Health, 1994.
- 20 Secke J, Pidd F, Parham A *et al*. Mental health in the community: roles, responsibilities and organisation of primary care and specialist services. *Journal of Interprofessional Care* 2000;14:49–58.
- 21 Department of Health. *National Service Framework for Mental Health*. London: Department of Health, 1999.
- 22 Department of Health. *Mental Health Policy Implementation Guide: community mental health teams*. London: Department of Health, 2002.
- 23 Barratt E. Community psychiatric nurses: their self-perceived roles. *Journal of Advanced Nursing* 1989; 14:42–8.
- 24 Nolan P, Orford J, White A *et al*. Professional views on managing common mental health problems in primary care. *Primary Care Mental Health* 2003;1:27–36.
- 25 Department of Health. *Practice-based Commissioning: achieving universal coverage*. London: Department of Health, 2006.
- 26 Stake RE. Case studies. In: Denzin NK and Lincoln YS (eds) *Handbook of Qualitative Research*. Thousand Oaks: Sage, 2001, pp. 435–54.
- 27 Kitzinger J. Qualitative research: introducing focus groups. *BMJ* 1995;311:299–302.
- 28 Kuzel AJ. Sampling in qualitative inquiry. In: Crabtree BF and Miller WL (eds). *Doing Qualitative Research*. Newbury Park: Sage, 1992, pp. 31–4.
- 29 Patton M. *Qualitative Research and Evaluation Methods*. London: Sage, 2002.
- 30 Coffey A and Atkinson P. *Making Sense of Qualitative Data: complementary research strategies*. Thousand Oaks: Sage, 1996.
- 31 Ryan GW and Bernard HR. Data management and analysis methods. In: Denzin NK and Lincoln YS (eds). *Handbook of Qualitative Research*. Thousand Oaks: Sage, 2000, pp. 769–802.
- 32 The Sainsbury Centre for Mental Health. *Briefing 28: acute care 2004*. London: The Sainsbury Centre for Mental Health, 2005.
- 33 Kendrick T, Simons L, Mynors-Wallis L *et al*. Cost-effectiveness of referral for generic care, or problem-solving treatment, from community mental health nurses, compared with usual general practitioner care for common mental disorders. Randomised controlled trial. *British Journal of Psychiatry* 2006; 89:50–9.
- 34 Whitty P and Gilbody S. NICE, but will they help people with depression? The new National Institute for Clinical Excellence depression guidelines. *British Journal of Psychiatry* 2005;186:177–8.
- 35 Goldberg D and Gournay K. *The general practitioner, the psychiatrist and the burden of mental health care*. London: Institute of Psychiatry, 1997.
- 36 Walker L, Barker P and Pearson P. The required role of the psychiatric-mental health nurse in primary health care: an augmented Delphi study. *Nursing Inquiry* 2000;7:91–102.
- 37 Rajagopal S, Goldberg D and Nikolaou V. The relationship between mental health services and primary care services in the UK: a postal survey. *Primary Care Psychiatry* 2003;8:131–4.
- 38 Brown J, Afuwape SA, Downes-Grainger E *et al*. Organising community mental health teams around GP practices: GPs' responses to the linkworker model. *Primary Care Psychiatry* 2004;9:45–50.
- 39 Department of Health. *The NHS Plan*. London: HMSO, 2000.
- 40 Carey MA. The group effect in focus groups: planning, implementing, and interpreting focus group research. In: Morse JM (ed). *Critical Issues in Qualitative Research*. Thousand Oaks: Sage, 1994, pp. 225–41.
- 41 Kitzinger J. The methodology of focus groups: The importance of interaction between research participants. *Sociology of Health and Illness* 1994;16:103–21.

FUNDING

The case study was funded by a studentship from the Faculty of Medicine, Health and Life Sciences, University of Southampton. The trial to which this study is linked was funded by the NHS R&D Health Technology Assessment Programme (project ref: 97/43/09).

ETHICAL APPROVAL

Obtained from four RECs in Hampshire and Dorset.

CONFLICTS OF INTEREST

None.

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Received

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