

International research

Primary care mental health workers: a narrative of the search for identity

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SUMMARY

In this paper I explore, via the use of reflective narrative, the struggle for identity of graduate primary care mental health workers. In my role as director of a primary care mental health workers' programme it has become clear to me that the key issue facing those who have taken up this new role relates to the search for identity. The task facing this group is not an easy one as they compete with other well-established groups of professionals to establish a legitimate place for themselves. The grading of this post within Agenda for Change, the title of 'graduate', and the lack of professional affiliation have exacerbated the struggle for recognition. Taking a social and relational perspective on identity, I draw on the work of Norbert Elias and Ralph Stacey to make sense of this struggle. I emphasise that the identity of this new group of workers arises and is sustained in

the relationships among all the key stakeholders. This group, although new, conforms to established norms and habits of other related professionals. I suggest that with any new role it cannot come into existence 'fully formed'. It is in the lived experience of all the stakeholders that the identity of primary care mental health workers is established. Like any new role, it will take time, even years, to establish a recognisable identity. With proper funding and support, this role could in time come to fill the niche in primary care that was initially intended. I conclude that primary care mental health workers have already made a significant contribution to primary care services, and I make a number of suggestions of what I believe needs to happen to give this group the chance to establish a recognisable identity.

Background

This paper is a reflective narrative based on my experience of running the postgraduate certificate in primary care mental health at Salomons, Canterbury Christ Church University. The opinions I express in this piece are based on conversations with participants on the programme and on my experience of being a trainer in postgraduate education at Salomons for the past eight years. In September 2005, I moved from working on Salomons' doctoral programme in clinical psychology to take over as director of the primary care programme.

The graduate primary care mental health worker (GPCMHW) was introduced in *The NHS Plan* (2000) and is a new role in the NHS workforce.¹

One thousand new Graduate Primary Care Mental Health Workers, trained in brief therapy techniques of proven effectiveness, will be employed in Primary Care Trusts to help manage and treat common mental health problems in all age groups including children.¹

This postgraduate certificate programme was designed in line with the training requirements set out by the Department of Health.² The three modules of the programme are well linked with the specifications for the role in primary care trusts (PCTs), namely:

- practice-based team work
- direct work with clients
- work in the wider community.

Central to the delivery of the year-long programme at Salomons are placement visits, to ensure that participants are given appropriate opportunities for engaging with each of the three aspects of the role in their work bases.

A conversation with the group of participants on the first day of the programme highlights the crux of the issue that faces this group of workers, and illustrates their ongoing struggle for recognition and identity.

What's in a name?

On day one of the two-week induction I met with the group to introduce them to the programme and to explain what was involved in the three modules, and how this linked with their work in PCTs. Having read the guidance written about the role of 'graduate mental health worker', the title used in Department of Health documentation, I was conscious that this might not be a title that the workers themselves would use. In my experience, the word graduate does not convey a sense of the breadth of life experience that many people feel they have acquired since graduating from university. Aware of this sensitivity I decided to ask the group how they wanted to be referred to while on the programme. I invited the group to have a discussion with the person sitting next to them and come up with some suggestions.

Among the suggestions were, 'primary care mental health advisor', 'primary care practitioner', 'mental health practitioner', 'mental health worker' and 'primary care clinician'. We conversed about the reasons for and against adopting each of these titles. After some time we settled on the title of 'primary care mental health worker'. Although the name clashes with other professionals working in primary care, we agreed to stay with this title in the absence of any agreed national guidance on this issue.

After the session, I was aware of feeling that settling on a title that both the group and I felt happy with was an important marker of the identity we were attempting to co-create. As programme director, a significant part of my role involves continually negotiating with participants, supervisors, managers and commissioners about what this title means in practice. For me this is a legitimate and crucial aspect of my role. My visits to the work base of participants have involved a wide range of conversations about who primary care mental health workers are, and what work they should be doing. These conversations have often felt fraught with tension as I find my way negotiating within a web of confusion about a role that many appear to believe was poorly conceived and not well thought through prior to implementation.

Areas of confusion

In my opinion, it is not surprising that there is confusion about a role that has no clear career structure after completion of the postgraduate certificate. There is no professional affiliation at present for this group, and most importantly the Agenda for Change (AFC) pay banding varies from one PCT to the next. Salary is surely an important reflection of status and professional identity. Add to this the fact that workers frequently find themselves allocated to PCTs where some of the other therapy staff feel threatened, because many of them feel they themselves have fared badly as a result of Agenda for Change.

One of the key issues that both supervisors and participants struggle with is negotiating when the workers can begin seeing clients and what kind of direct work with clients they can be allowed to do. Again this is not easy territory. Some supervisors are reluctant for the primary care workers to do any direct work and would prefer them to signpost clients to the voluntary sector. The workers themselves are eager to pursue clinical work, and indeed most have taken up the role so that they can work directly with clients.

I am now going to look at the phenomenon of 'gossip', drawing on the work of sociologist Norbert Elias to explore how gossip is used to sustain and undermine identity.³

The importance of 'gossip' in sustaining and undermining identity

In Elias and Scotson's (1994) sociological study of a small community in Leicester the authors found that, when a new group of residents joined an old-established group, the old group closed ranks and stigmatised the newcomers, using gossip.³ The effect of this gossip was that it affected the self-image of the newcomers to the extent that they came to believe they were inferior to the more established group. What was interesting was that the two groups were not distinguishable in colour or social class. The key difference between the groups was that one group had more potential for social cohesion because they had lived in the neighbourhood for two or three generations. Gossip played a significant part in establishing and maintaining the binary distinctions between the 'them' and 'us' groups. This concept is pertinent to the struggle for identity among the primary care mental health workers.

The latest gossip undermining the search for identity of these workers is the probability that the programme I run at Salomons may not be viable even for a third cohort in September 2006. The PCTs who commission the programme have huge over-spends and will struggle to increase the number of primary care mental health workers. There is also talk that funding for primary care mental health workers is not one of the performance targets for most PCTs for 2006/2007, hence making funding very unlikely. Like many HEI leads, I am dependent on this funding to secure a cohort.

Further evidence of such gossip took place in February 2006, during the NHS Quality Assurance Agency (QAA) review of programmes at Salomons. In my opinion the following anecdote illustrates how identity is sustained by gossip. During the visit when the QAA reviewing team were talking to clinical psychology doctoral trainees and primary care mental health workers, apparently one of the trainees said to one of the participants, 'your role is going to be disbanded next year'. This comment highlights how gossip helps sustain the identity of primary care mental health workers. In this example it is also possible to see how gossip sustained the binary distinction of 'them', the group that 'is going to be disbanded next year', and the 'us' group of trainees who feel secure in their chosen career. Gossip is playing a key role influencing the identity of this new group of workers. In this example, the clinical psychology trainees belong to a cohesive group with over 50 years' history of establishing a secure identity. I will now examine what other writers have to say about identity.

A relational view of identity

I understand identity to mean the ever-moving yet continuous and recognisable sense of self. I believe identity is created and sustained relationally. What I mean is that identity is not a set of finite characteristics that are fixed and unchanging, but one's sense of self, while stable, also changes as one relates with others.

My view of identity is influenced by the complex responses processes perspective of relating proposed by Stacey.^{4,5} Three essential aspects of Stacey's process perspective of relating include: first, the view proposed by Stacey that the individual is social to the core.⁴ Second, and related to this, is the capacity we have as individuals to take the attitude of others towards ourselves. The third aspect is the part played by history and memory in the experience of relating. I will briefly explore each.

According to Stacey, identity is entirely socially constructed. He proposes that the individual is 'social through and through', going on to suggest that individual mind is logically the same process as social relating, that there is no separate level of individual and social.⁴ I understand Stacey to be saying that we are not individuals first and social beings second. Rather, we are social to the core. Our psyche is socially constructed.

Second, an essential aspect of this social process is Mead's concept of the capacity we have to take the attitude of others towards ourselves.⁶ Another way of expressing this is that mind or thinking is a process of 'internalised conversation'. We develop the capacity over time to have conversations with others in our heads, and our thoughts and actions are influenced by these 'silent conversations'. This means that we can anticipate the responses of others towards us, and this in turn influences both our private, silent conversations and our actions. In turn, our sense of self is influenced by this capacity to respond towards ourselves as we anticipate how others might respond to us. This perspective clearly gives primacy to the social. It emphasises for me the importance of how identity arises and is sustained socially, and in one's silent conversations, which are also social.

The third key aspect of Stacey's thinking is the part played by history and memory. I define history as how we make sense of our past. This view of history differs from a view of history as a set of events with fixed characteristics. History and memory play an important part, as new experiences are filtered through previous experiences which provide a sense of continuity to the sense of self. History and memory are also changed in the light of these new experiences. Therefore in this process perspective of relating, history and memory give a sense of continuity to the sense of self, while at the same time the sense of self is also changing.

To summarise, I understand that identity is not a reified notion, nor is it a set of static and fixed characteristics. I understand identity to have continuity, while at the same time the sense of self shifts and changes in conversation (including silent conversation). In addition, I understand that as we are formed by the groups we belong to, so too are we forming these groups at the same time. As Stacey suggests, 'we form the experience of each other as we relate'. I now want to extend the understanding of the struggle for identity of primary care mental health workers by drawing on further writing by Norbert Elias.

In *The Civilising Process* (1939), Elias proposes that identity is shaped by the norms, culture and values of the groups one is part of and also the image of the nation one belongs to.⁷ These values are experienced

by the individual as part of their own self-worth and self-esteem. To examine how some of Stacey, Mead and Elias' understanding of identity relates to the current struggle for identity of primary care mental health workers, I return to the narrative, in particular the conversations I have had with supervisors, participants and line managers on my regular visits to the work base of participants.

The significance of working with clients

The new role of primary care mental health worker introduced by the government into the workforce in 2003 has met with plenty of opposition, as all the stakeholders have preconceived ideas of what the role means in practice. The following brief narrative explores some of these differing ideas. It also illustrates how the identity of these workers is being negotiated through conversation.

I arrived at the practice base to meet with the line manager, supervisor and participant. I soon found myself defending the decision I had taken to include six days of training in basic cognitive-behavioural therapy techniques (CBT) in the training programme. The supervisor and manager were of the view that there should be no training in therapy techniques and the workers should confine themselves to signposting clients to voluntary services in the community. Both the line manager and supervisor therefore found the change that I introduced to the programme suspect, and suggested that:

'If you wanted to train therapists, the role should have been set up like this in the first place. It takes years to train as a therapist, therefore we do not believe that these graduate workers are anywhere near ready to see clients, let alone do therapy with them.'

Thinking quickly on my feet, I realised that I could not afford to alienate the supervisor and manager by criticising their viewpoint, which I had some sympathy with. I also found myself wanting to represent the views of the participant, who was delighted at the prospect of getting six days of training in CBT techniques because, after all, she, like most other participants, is primarily interested in direct work with clients.

I responded by saying something along the following lines:

'These workers like the rest of us have come into this role to enjoy the satisfaction of working

directly with others. If we do not recognise that they want to work with clients, they will not stay in post. I agree that we need to prevent them being overloaded with client work, and in order to sustain them in their roles we need to ensure that there is a balance between the different aspects of the role.'

On reflection I can see that I was encouraging the supervisor and manager to empathise with the participant's wish to 'help' others. It felt crucial to point out that most participants cannot be expected to remain in post without some fulfilment of the wish to work directly with clients. By the end of the conversation each of us had shifted our positions to accommodate each other's opinions. The programme participant was free to express how much she was looking forward to direct client work. She also pointed out how important she saw the other two aspects of the role: audit and signposting. The supervisor said she was willing to let the participant sit in and observe her working, and they would then think about getting suitable clients. The manager had shifted too saying that she still did not know how patients would be able to distinguish between trained CBT therapists and primary care mental health workers with six days' training in CBT, but she was willing to find a general practitioner (GP) surgery that would take on the worker on a trial basis. All of us changed our thinking in the course of the conversation, making it likely that shifts occurred in our sense of self.

Returning to my view of identity arising and being sustained socially, I suggest this is evident for each of us in this conversation. It is possible to see how the identity of the participant was shifting in the conversation as she was able more freely to acknowledge her wish to do therapy. It also seems that the manager and supervisor were re-adjusting their view of the work the participant could legitimately engage in. For me, this is one example from a range of similar conversations that has resulted in shifts in how I understand my role as programme director. I appreciate more fully that in these conversations I am influencing the identity of these workers by expressing what I believe is legitimate work for them to undertake. I too am influenced by the caution that the experienced clinicians express, particularly in relation to the participants working beyond their competence and the associated risks of overload. I have also noticed that, in the writing process itself for this paper, my own understanding and sense of identity has shifted. My conversations have changed as I have reflected more on what it means to take up a new role, and in turn this has influenced how I talk to others about the role.

The new and not-so-new role of primary care mental health workers

In this conversation it is possible to get a sense of what Elias describes as the norms and values of the group that one subscribes to. What I am suggesting is that despite the fact that the role of the primary care mental health worker is a new one in the NHS, it is nonetheless a role that has an existing set of values and a shared understanding of what it means in practice to see clients. Let us see where this is happening in the conversation.

Each of us contributing to the conversation had a shared understanding of what it is to do clinical work. The participant was eager to get the chance to sit in a room with another person called a patient or client, and to speak to the client in such a way that she could get a sense of what was troubling the person. The caution expressed by the manager and supervisor comes from their experience that in primary care the therapist often has no idea what is really troubling the client, and indeed it is a highly skilled task to formulate what the problem is within a brief therapy model of up to three sessions. I also suggest that the role was set up by government advisors in a way that implicitly acknowledges this shared understanding of what it means here in the UK to undertake 'direct client work'. What does all of this mean?

I suggest that the identity of primary care mental health workers arises in interaction between all of the stakeholders involved. This includes the influence of government policy and PCT commissioners in their willingness to commission places on university programmes. It includes the participants themselves, GPs and other staff in primary care, supervisors, managers and university staff. Over time, the service users will also influence the identity of the role as people come to have a view of what to expect from primary care mental health workers that is different from all of the other professionals who work in the NHS.

To conclude

In this paper I am suggesting that the identity of primary care mental health workers is negotiated relationally and is being formed by the interaction of all of the key stakeholders involved. I am also saying that there are existing norms, customs and values that are shared for the most part and help to

define the identity of these workers. The values, habits, customs and roles are still in the early stages of being negotiated.

I have explained that the role of primary care mental health workers was introduced as a new one in the NHS in 2003. At the time of writing, there are approximately 700 primary care mental health workers in England, and it looks as if the government is not committed to hitting its target of '1000 graduate mental health workers' in England. Many people believe that the role was poorly conceived by central government. The lack of a satisfactory job title, pay banding, career structure, professional affiliation, etc can all be perceived as reflecting poor planning and implementation of this new role.

Now, however, I am suggesting that this is not the whole story. Rather, it is my view that no new role can come into existence 'fully formed'. Indeed it is only in interaction that identity arises, even though this process is influenced by existing values and norms and by past interaction. I am also suggesting that it is not solely the job of any single stakeholder to define the identity of these workers. For example, it is not just up to the government, the participants or the supervisors/managers or HEI leads. In my view, the identity of primary care mental health workers is formed in the experience of all of the stakeholders.

We don't know at the moment which route the role will take. If the role does disband over the next few years the experience of the stakeholders will not have been lost. The workers have already made a significant contribution to primary care services, and this valuable experience will be a real asset to them within other roles in the NHS. Other stakeholders who are involved in developing and planning other roles and programmes have learned a great deal from the experience. Many, like myself, are taking this learning forward to develop other programmes.

If the role continues, there are a number of things that need to happen in order for primary care mental health workers to be given the time necessary to establish an ongoing sense of continuity in their roles. I therefore suggest urgent consideration is given to the following:

- the implications of not funding the training of additional cohorts of primary care mental health workers. The postgraduate certificate programmes are contributing a great deal to the development of a coherent sense of identity for these workers
- professional affiliation for this group needs to be addressed urgently
- the Agenda for Change banding needs addressing at a national level, so that there is a sense of career progression upon completion of the

postgraduate certificate that is equitable across the country

- The word 'graduate' needs to be reconsidered and an appropriate title agreed for workers who have completed the postgraduate certificate programme.

Finally, I conclude that, as with any new role, it will take time (even years) to establish a recognisable identity for primary care mental health workers. It is never possible to think through any new role 100%. A good example of this is the profession of clinical psychology, which has been defining and redefining its identity in the UK since the late 1940s. The title of 'doctor' has been a crowning achievement for the profession, and this was only achieved in the 1990s. It took 50 years. Therefore, I conclude that, with proper funding and support, the role of primary care mental health worker could in time come to fill the niche in primary care that was initially intended.

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CONFLICTS OF INTEREST

None.

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