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**PROFESSIONAL RELATIONS IN MULTIDISCIPLINARY HEALTHCARE:
A COUNSELLING PSYCHOLOGY PERSPECTIVE**

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Declaration

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RESEARCH ABSTRACT

Primary care professionals work in settings which have traditionally been very hierarchical, and medical practitioners have occupied the dominant places in that hierarchy, possessing structural power through their affiliation with the social institution of medicine, and their control of funding. Counselling in primary care has been described as a fast evolving profession and Counselling Psychologists are filling many of these newly created posts, cautionary notes concerning the impact of the NHS reforms of recent years on the discipline have been raised. This study was designed to raise awareness of some key factors impacting on the process of communication in multidisciplinary working in primary care relevant to counselling psychologists, and to explore multidisciplinary working in health care from a psychological discourse analysis perspective. Three different workshops were run comprised of multidisciplinary groups brought together for the purpose of the study. Each team were trained in the Community Oriented Primary Care (COPC) model and then audio- and videotaped constructing a COPC programme to address depression in older people. Analysis of the group transcripts was carried out exploring power relations, competing agendas and ideological patterns. Conclusions are that 1. COPC may have had limited application due to difficulties implementing the non-hierarchical multidisciplinary working aspect of the model. 2. Counselling Psychology has much to contribute to multidisciplinary working and could foster true innovation in primary care through broadening the clinical perspective. 3. Counselling Psychologists need to be aware of the power of medical discourse in the environments in which they work, and the resistance of primary care to change which can emerge through the promotion of the medical agenda and the language used in multidisciplinary working in medical settings.

(Reproduced in thesis overview under research study)

ABBREVIATIONS

COPC: Community Oriented Primary Care

PCG: Primary Care Groups

PCT: Primary Care Trust

Transcript Excerpts

CP: Counselling Psychologist

ClinP: Clinical Psychologist

CN: Community Nurse

GP: General Practitioner

PC: Practice Counsellor

PN: Practice Nurse

WA: Welfare Adviser

OVERVIEW

This thesis is comprised of 3 main sections (in addition to the overview):

1. An extended case study which illustrates how the genogram can be used as an assessment and intervention tool in a single couple counselling session.

The genogram has been used as a tool in primary care to gather information that can be used in the exploration of the development and maintenance of, and the diagnosis of physical and psychological problems. It has been used by different professionals in general practice including family therapists, social workers and medical practitioners.

The administration, content and interpretation of the tool depends on the practitioner involved and the purpose of the interview. This case was located in a social work agency setting rather than general practice, but the author was employed as a medical counselling psychologist whose remit covered families living with chronic illness and disability. The specifics of the medical conditions, and other personal details, impacting on the family have been omitted for reasons of confidentiality, but the case could have equally taken place in other settings, such as primary care. The case study shows how useful information can be gathered, and therapeutic change effected in a limited amount of time, at one consultation. It is also significant because it demonstrates how a systemic approach can be used with individuals or couples without needing to engage the whole family. The author uses a systemic approach as the overall framework for practice as a Counselling Psychologist into which other approaches can be integrated as appropriate. This case study conveys some of her

therapeutic approach and style of questioning. In the course of completing the doctorate in counselling psychology, as a result of carrying out the research and the literature review, the author's therapeutic style has developed, and she now incorporates social constructionist and personal construct perspectives into her main therapeutic systemic orientation.

This case study was originally published as an abbreviated case example in:

*Stanion P., Bor R. & Papadopoulos L. (1997) "Genograms in counselling practice part 2: constructing a genogram" Counselling Psychology Quarterly Vol.10, No 1:17-28. and has been cited in other publications. *author's maiden name.

2. The critical literature review – Discourse analysis in multidisciplinary health care.

The literature review is of the discourse analysis literature which specifically deals with health care, with a focus on mental health care. It is of particular relevance to Counselling Psychology because it throws a critical perspective on clinical practice from a theoretical viewpoint which highlights the means by which "truth" is produced, and explores how discourse produces, maintains and reinforces power relations, and allows particular agendas to emerge whilst marginalizing others in inter-professional relationships, and professional – client or patient relationships. This area of psychology can inform our practice both as therapeutic practitioners and as colleagues within multidisciplinary teams. This chapter explains what discourse analysis is and highlights the relevance of Foucault's writings for mental health care and counselling psychologists. Research which has applied a Foucauldian perspective in health care settings is critically reviewed, and there is a discussion of the

recommendations in the literature on carrying out a discourse analysis of textual or verbal material. The benefits and disadvantages of traditional qualitative and quantitative research methodologies are compared with the discourse analysis approach. The main focus of the review is on how a discourse analysis perspective can contribute towards developing our understanding as counselling psychologists of multidisciplinary working and mental health provision in medical settings, but also how other health care professionals might benefit from the ideas of Foucault, and the findings in the discourse analysis literature.

Material from this review whilst in progress was presented at the following conferences:

Lenihan P & Legg C.R. Multidisciplinary working in primary care: a discourse analysis perspective. The North Central Thames Primary Care Research Network NoCTen conference, 8 March 2001, London.

Lenihan P, Legg C.R. & Iliffe S. Professional and ethical issues for counselling psychologists in primary care today British Psychological Society Division of Counselling Psychology Annual Conference, 19-21 May 2000, Liverpool.

3. The research study – Professional relations in multidisciplinary health care: a counselling psychology perspective.

Counselling psychology is generally taught from an individualistic perspective and focuses on the contract between the psychologist and identifiable individuals, couples and families. The author became interested in the possibilities that emerge if this individual perspective is integrated into a public health perspective so counselling

psychologists instead of limiting their interventions in primary care services to individuals extended their remit to the local community. A public health perspective would enable counselling psychologists to identify prevalent mental health conditions in the local area and develop intervention programmes with colleagues to reduce the prevalence of those conditions, to intervene at a population level. Community Oriented Primary Care (COPC) was one model of primary care which integrates primary care and public health perspectives which has attracted attention in the UK as changes in primary care have increasingly reflected the theoretical underpinnings of the model. Primary Care Groups were just emerging on the primary care scene when this research was started and the transition into Primary care Trusts has reinforced the rationale on which the selection of COPC is based. Primary care professionals work in settings which have traditionally been very hierarchical, and medical practitioners have occupied the dominant places in that hierarchy, possessing structural power through their affiliation with the social institution of medicine, and their control of funding. Counselling in primary care has been described as a fast evolving profession and Counselling Psychologists are filling many of these newly created posts, cautionary notes concerning the impact of the NHS reforms of recent years on the discipline have been raised. This study was designed to raise awareness of some key factors impacting on the process of communication in multidisciplinary working in primary care relevant to counselling psychologists, and to explore multidisciplinary working in health care from a psychological discourse analysis perspective. Three different workshops were run comprised of multidisciplinary groups brought together for the purpose of the study. Each team were trained in the Community Oriented Primary Care (COPC) model and then audio- and videotaped constructing a COPC programme to address depression in older people. Analysis of the group transcripts

was carried out exploring power relations, competing agendas and ideological patterns. Conclusions are that 1. COPC may have had limited application due to difficulties implementing the non-hierarchical multidisciplinary working aspect of the model. 2. Counselling Psychology has much to contribute to multidisciplinary working and could foster true innovation in primary care through broadening the clinical perspective. 3. Counselling Psychologists need to be aware of the power of medical discourse in the environments in which they work, and the resistance of primary care to change which can emerge through the promotion of the medical agenda and the language used in multi-disciplinary working in medical settings. The study aimed to increase knowledge in this area in order to facilitate counselling psychologists in developing the capacity to effectively participate in collective decision-making in medical settings, and to better meet their professional responsibilities to their discipline and their clients when communicating in multidisciplinary groups.

Material from the introduction to the research study has been published in a number of papers, the most relevant are listed below:

Lenihan P. & Iliffe S (2001) "COPC": a multidisciplinary approach to primary care" Journal of Community and Applied Social Psychology Vol.11: 11-18

Lenihan P. & Iliffe S. (2000) "Counselling the community: the contribution of counselling psychologists to the development of primary care" Counselling Psychology Quarterly Vol 13(4):329-343

Lenihan P., Iliffe S., Drennan V., Wallace P., Blanchard M. (2000) " Designing services for older people: lessons for practitioners" Community Practitioner Vol. 73, No 8: August

Lenihan P. (2000) "Community oriented primary care: the community approach to developing innovative primary care for older people" in Kagen C (ed) Collective Action and Social Change IOD Research Group

CHAPTER 1 THE GENOGRAM AS ASSESSMENT AND INTERVENTION IN BRIEF COUPLE THERAPY

“ In regard to any change there must be some fixed point to which the change can be referred...and this makes possible a system of co-ordinates into which everything else can be fitted. Theoretically any point of reference is possible but...at the dawn of consciousness one stands already enclosed within definite prepotent systems of relationships” (The I Ching or Book of Changes: 281).

Introduction

The genogram has been described as an information-gathering assessment tool with diagnostic qualities relevant to the development and maintenance of physical illness and psychological problems (Zander 1977; Like, Rogers & McGoldrick 1988; Shore, Wilkie & Croughan-Minhane 1994.). It can be a useful tool for gathering family history and information pertinent to the onset, maintenance, and future development of a presenting problem and associated symptoms, representing family structure alongside interactional patterns, family myths and beliefs, relationships, transitional developmental points, significant life experiences and other personal family data. Genograms represent symbolically a complex representation of family context, which can be added to over time, and developed in specific directions according to the nature of the prevailing presenting problem. The underlying framework of the practitioner will direct the nature of the interpretation, discussion and the emphases in the collection of the genogram information (Rohrbaugh, Rogers & McGoldrick 1992). The practitioner

may be from a medical, psychological or social discipline, their background will determine the nature, purpose and therapeutic content of the genogram interview. The genogram in this case context is being discussed as an instrument of therapeutic assessment and intervention.

Systemic counselling conceptualises presenting problems within the context of the relevant interlocking social systems. These systems may include family, friends, community groups, health and work amongst others. In defining a family as a system a decision has to be made where to draw the boundary and who is to be included in the system, a decision which will be directed by the purpose of the decision-maker, and the context within which “the family” is being viewed. The conceptualisation of the family as a system constituted a move from the Aristotelian linear cause-effect logic of traditional therapeutic models towards a non-linear or “cybernetic epistemology” (Keeney 1983). In this case study the context is therapy, the family a 3-generational system, and the therapeutic intervention is introduced through the dyadic sub-system expressing the presenting problems.

The systemic perspective regards crucial stages of problem evolution as occurring in the context of the systems of which they are a part, and as being most likely to arise at times of developmental life transitions. These transitional stages require increased adaptivity and can result in transition related stress. Successful negotiation of these key developmental points in the life of an individual and family will ideally lead to the associated stress being reduced and the family being re-stabilised. According to

Andolfi et al (1980) psychological problems often arise when the family have prematurely re-stabilised without addressing the challenges and changes thrown up by the life stage in question. Successful negotiation of transitional points takes place when the forces favouring change exceed those directed towards homeostasis. Premature re-stabilisation of the family can lead to psychological problems being assimilated into the family system, and it's communication pattern, trapping family members in rigid roles sometimes spanning several or more generations.

The presenting "problem" in systemic therapy is conceptualised as neither residing in the client or their environment but as arising from the interaction between these linked systems (Pincus & Minahan 1973). It is this interchange between people and the different aspects of their environment which results in them both changing and being changed by the social environments in which they live. Re-framing the meaning of problem behaviour through the therapeutic discourse redefines the situation in a more constructive way such that it is more amenable to behavioural and/or emotional change (Watzlawick, Weakland & Fisch 1974; Burnham 1986). Circular and reflective questioning are used to indicate less confrontational interest, define relationships, address differences and challenge unconstructive beliefs, expectations and roles as well as create new meanings and connections within the system (Penn 1985).

Central to a systemic way of working is filtering the counselling process through a biopsychosocial lens and including the family (any individuals defined as such) in the assessment and intervention. Collaboration with other professionals relevant to the case is also considered important. Using these sources of assessment information the systemic practitioner investigates the way the family have organised around the

presenting problem, issues around change and loss, relationship issues and future concerns. The emphasis is on facilitating communication between all the relevant parties. Insight into the evolution of , maintenance of , and hence possible solutions to the problem is gained by extrapolating the relevant belief systems of the family, how meaning has been created around the problem and the pertinent individual and family life stages accompanying the history of the problem.

It is still possible to work in a systemic way with an individual (or couple) without convening the entire family, a topic discussed at length by Jenkins and Asen (1992). Their argument is that systemic therapy refers to the theoretical framework being used not the number of people in the consulting room. The family can be indirectly “brought” in the consulting room through the use of family oriented, and sometimes hypothetical questions, for example: “What would your father say if he were here?”. Formulating therapeutic hypotheses and using multiple means of checking them out are one of the creative aspects of a systemic way of working. These hypotheses act as a guiding map during the counselling sessions and reflection on life cycle issues is recommended (Weber, McKeever and McDaniel 1985; Burnham 1986).

The life cycle perspective may be the starting point of hypothesising why the family has sought help now. There have been various breakdowns of the family life cycle identifying key developmental transition points and modelling two, three, four or more generational systems (Carter & McGoldrick 1989; Solomon 1977; Duvall 1977). The Carter & McGoldrick (1989) life cycle model provided the point of reference for this case example. McGoldrick and Gerson (1985) apply their life cycle theory to the

interpretation of the genogram suggesting six interpretative categories from a family life cycle perspective:

1. Family structure
2. Family life cycle
3. Pattern repetition
4. Life experiences
5. Family relational patterns
6. Family balance and in balance

This structural framework for the interpretation of genograms in this case discussion is accompanied by a focus on the importance of the process-oriented practitioner stance emphasised by (Beck 1987). Some of these benefits of attention to process in constructing a genogram are strengthening the therapeutic alliance, client participation in the formulative phase of treatment and an overall enhancement of this phase of family work. Tomson (1985) advises that the counsellor adopt a manner which presents as sincere, open-minded, interested and non-judgemental when carrying out a genogram interview. Starting with straightforward factual questions facilitates putting the family at their ease as well as enabling the counsellor to build up the genogram in a systematic way. The process of constructing and discussing the genogram is a powerful way to engage a family and enables the family to adopt a more objective perspective as well freeing them to discuss more concealed areas of family life. The patterns in the family's development can frequently be observed by the family in the genogram, and the process of discussing the genogram is very much an interactive process between the practitioner and the family. The genogram can be viewed as a therapeutic intervention and part of the process of counselling (Papadopoulos 1997).

Charting the evolution of a problem whilst discussing the genogram invites the family to relate the family narrative and to participate in the domain of story telling. The practitioner adopts a neutral and respectful stance demonstrating a keen interest in the unfolding of the story. It is important to be sensitive to the reaction of family members to questions and to bear in mind their emotional and physical condition. Moving too quickly may be confusing and stressful, so timing the interview to respect the family's own speed of thinking and discussion is vital. Constructing and exploring a genogram can be a very emotional experience for a family and may reveal issues which may need to be addressed in a further session or through referral, attention to process is vital if the genogram interview is to be more than an information gathering exercise.

This case example illustrates the use of the genogram in couple counselling as an assessment and therapeutic instrument from a systemic perspective. This paper is an analysis of a genogram session with a couple using the McGoldrick & Gerson (1985) categories as a structural framework and systemic family therapy as the therapeutic framework guiding the session aims and process (Bor et al 1992; Carter & McGoldrick 1989; Like, Rogers & McGoldrick (1988; Burnham 1986). The theoretical basis of the application of the genogram as a therapeutic assessment and intervention as illustrated in this case example is drawn from the following models of family therapy: Bowen Theory, Milan Systemic Therapy and Strategic Therapy (Hansen & Keeney 1983).

Integrating family therapy models in genogram construction facilitates avoidance of "the tendency to construct genograms in an affective vacuum" described by Beck (1987; 343). Introducing a genogram into this one-off couple counselling session had a

powerful therapeutic impact revealing how much can be accomplished in short-term systemic couple counselling using this tool. The genogram is very effective at quickly putting the individual, or couple's concerns into a wider family context without the other presence of other family members. This case study describes the counselling process from referral, to assessment and goal setting through to closure and the role of supervision. The focus is on the questioning and process of discussion of the genogram, and the interpretation of the final genogram as it took place in the session.

Case Summary

Clients: "James and Clare"

Number of Sessions: 1

Presenting Problems: Clare's increasing depression and communication difficulties in the couple relationship in late pregnancy

Related Difficulties: Anxiety about the birth and feeling increasingly "distant" from each other.

Counselling Setting: Family Service Unit

Therapeutic Framework: Systemic

Intervention: Genogram interview

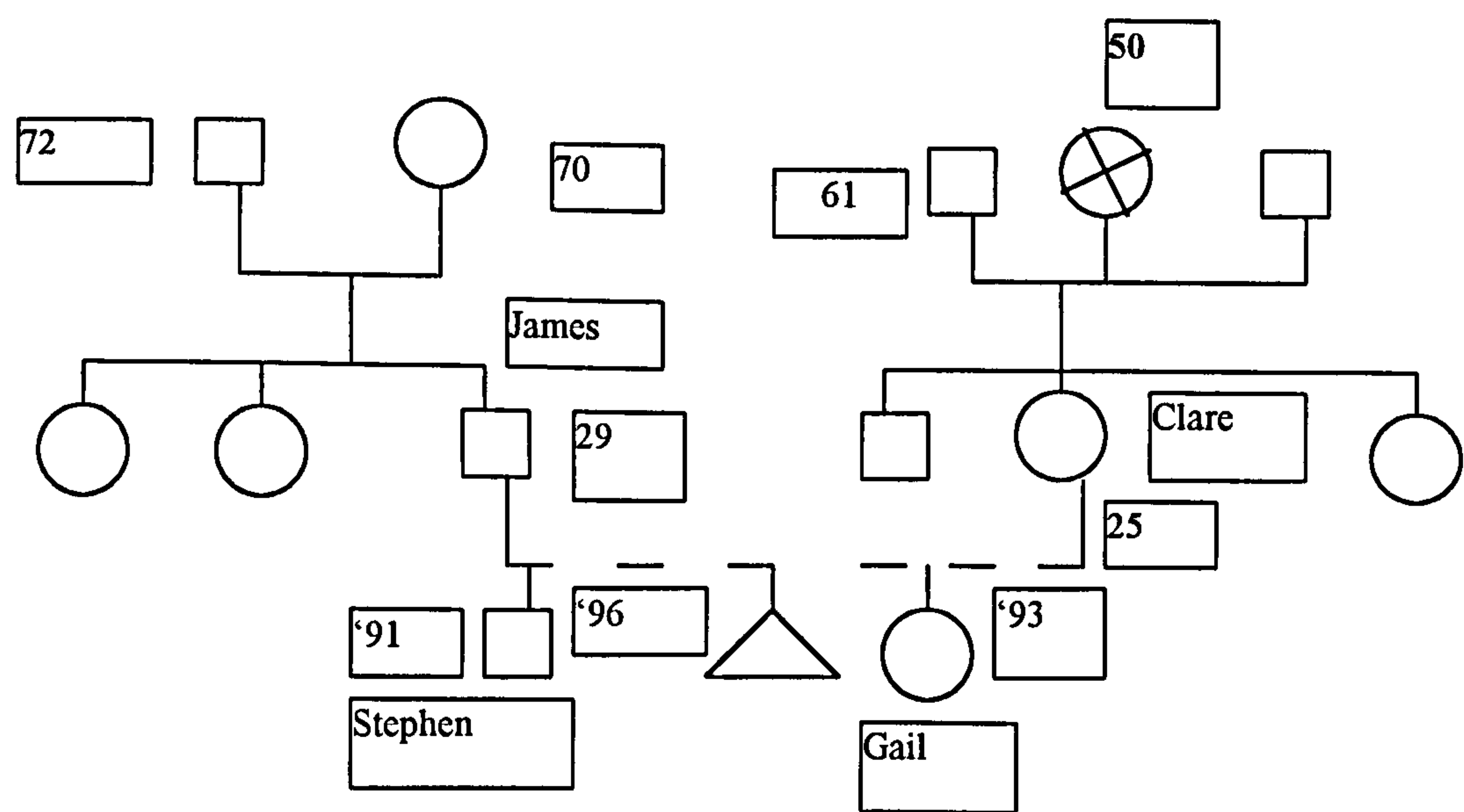
Assessment: Psychosocial issues impacting on couple relationship and pregnancy related to latent grief, current chronic illness in the family and significant loss of social support.

Outcome: Clients opted to take the genogram home with them and continue the discussion at home having identified a few possible courses of action to address the

issues identified in the genogram discussion as significantly contributing to their presenting problems.

Relevance of Case Example: This paper presents the case example as an illustration of how systemic couple therapy can be effective in a single session using a structured process-oriented genogram interview. The couple are able to take responsibility for their own continued development following the session, working together to address the presenting problems, and move away from localising their concerns in the individual partner, with the accompanying alienation reported, towards a renewed sense of togetherness. Therapists can usefully utilise the therapeutic resources located in the couple relationship through tools such as the genogram, reducing therapeutic dependency and reinforcing the couple as a unit for growth.

Figure 1: Skeletal Case Genogram



Biographical Information

The clients, "James" and "Clare" (names have been changed in the interests of confidentiality) were a young couple living together, aged 29 years and 25 years

respectively, with 2 young children Stephen (5) and Gail (3) and a baby in utero (8 months). James was an engineer and Clare cared for the children and managed the house. Stephen had just started nursery school part-time, Gail was described as "a real handful" as she required a lot of individual attention from Clare. The pregnancy was proceeding satisfactorily but had not been planned.

Referral

The couple referred themselves to the counsellor for counselling at a Family Service Unit by telephone. James made the call stating that Clare had become increasingly depressed and distant from him during the previous 2 months and this concerned them in view of the impending birth. They had approached their general practitioner and she had advised them that mood changes are common in pregnancy and not to worry. James and Clare had not been reassured however as they felt that the previous pregnancies had gone generally smoothly and brought them "closer together". The counsellor confirmed with Clare that she also wanted an appointment, and then a time and date was agreed. Ensuring that both members of the couple motivated to enter counselling when arranging the session was considered important by the counselling psychologist if potential "snares" (Palazzoli & Prata 1982) were to be avoided.

The couple agreed on meeting with the counsellor that a short note from the Unit to their general practitioner informing her that they had been booked in for counselling would be acceptable. Palazzoli et al (1980) emphasised the importance of the referring person and whilst the general practitioner had not referred the couple, her involvement in the case indicated a carefully worded note which validated her assessment and informed her of the counsellor's involvement, was warranted. The general

practitioners' diagnosis was included in the assessment of the presenting problem, and the summarising of the session with the couple, the physiological and psychological effects of pregnancy was very likely contributing to the presenting problem and post-session outcome. Maintaining a good relationship with Clare's general practitioner was also considered to be important for the couple, particularly at this time, and professionally advisable for the counselling psychologist..

Assessment

The couple arrived punctually for their appointment, the children did not attend as the couple felt they would only be able to have a one-off session and they wanted to be able to talk freely during that time without being interrupted by the children who were both very young. The session was able to move more quickly and encourage more open communication because it was not assumed that the whole family had to be present (Jenkins & Asen 1992). Systemic questioning could be used to include the rest of the family. Clare presented as tired and somewhat withdrawn, movement was clearly difficult for her. James appeared very solicitous as to her well being but expressed frustration at being unable to make her comfortable. This practical frustration seemed indicative of an underlying dissatisfaction at not having a clearer role to play in the pregnancy. Role responsibilities in relation to mothers are still more clearly defined by health, social and psychological professionals, fathers can end up being allocated a peripheral supportive role (Carter & McGoldrick 1989), with no clear idea of what that support involves.

The session began with the counsellor asking the couple generally what had brought them to counselling. James answered giving the information provided in the referral with little input from Clare. Clare was then asked what she felt James would like from the session and James was then asked the same question regarding Clare. Clare said she thought James would like her to be "the way she was before", James responded that he didn't know what Clare wanted. A short discussion between them led to agreement that they wanted to understand why Clare was so "depressed" and to feel less stuck. This was re-framed by the counsellor in such a way that Clare was less defined as "the problem" through relational exploration of how this "depression" expressed itself and the responses of different family members, including the absent children. Reflexive questioning was used at this stage; reflexivity focuses on the mutual interactional impact different relationships have on each other (Burnham 1986).

The counsellor suggested to the couple that they write down a family history together in diagrammatic form because in view of the forthcoming new addition to the family, this might be a good place to start exploring the reasons why they had come to counselling. She explained that the information provided for the family history would assist her in gaining a better understanding of the family and that the exercise would take around 30 minutes. The Collins' seemed enthusiastic about the idea and it was agreed that the remainder of the 50-minute session would be used for this purpose. James seemed to like the idea of a specific task, having expressed anxiety around "having to talk about what we feel for 50 minutes), and Clare appeared to view the exercise as an opportunity to explore where her current depressive feelings "might have come from".

The construction of a genogram was being used to further define the couple's concerns, create meaning around them, place the problem in the family context and to open up discussion in order that solutions could begin to be generated. The genogram was also an appropriate intervention to check out the general practitioner's hypothesis further. It is a quick efficient means of carrying out a medical, psychological, genetic and social assessment (Troncale 1983). It is particularly appropriate for brief therapy in that a genogram interview has been shown to gather four times as much information in the same time as a less structured interview (Rogers & Durkin 1984). Clare and James had described themselves as feeling "stuck" and the overall goal of this session was to assist them in "moving forward". This is not to say that the counselling psychologist viewed the couple as being "stuck" in a linear way, as the session unfolded the hypotheses were linked more to family life cycle stages, including grieving and adjusting to the death and illness of key family members. A linear rather than a cycle stage approach can frame developmental problems as failures rather than acknowledging that families can evolve in different ways and at different speeds (Penn 1982).

The counsellor informed the couple that although all parties had agreed that this would be a single session at that time, they would be welcome to come back at a later date to re-negotiate more sessions if they felt it necessary. The demands of James' employment, which often involved working late, Clare being in the late stages of pregnancy, and child care responsibilities meant that ongoing counselling was not a feasible option at this stage. The couple seemed to be more looking for "a point in the right direction" than the solution to all their problems. The counselling psychologist did not attempt to engage them in a longer course of counselling and accepted their

reasons for requesting a one-off session, whilst leaving it open for them to reapply for therapy in the future at a more appropriate time, if it seemed warranted.

The Counselling Process

The counsellor spread out a sheet of A3 and placed it so that everyone could easily see the genogram as she drew it up. Coloured pens were also set out so that the genogram could be more easily read as it became more complicated. The Collins were given the choice where to start and began with their parents. The initial genogram showed family members, the gender of each person and ages and relationships to each other. This information was obtained through the use of linear questioning. Factual questions were employed initially in order to set the couple at their ease and so that the genogram could be built up in a systematic way (see genogram). The counsellor's discussion of the genogram with James and Clare was informed by McGoldrick and Gerson's (1985) six interpretative categories for genograms (family structure, family life cycle, pattern repetition, life experiences, family relational patterns, and family balance and in-balance) which facilitate focused use of questioning and hypothesising without being overwhelmed by information. The couple appeared relaxed and began to embellish their answers with information about the people and the relationships depicted. The counsellor facilitated the process through the use of circular and reflective questioning. The categories found to be particularly relevant in this case were family life cycle, family relational patterns and life experiences.

The nature of the relationships in the genogram was illustrated through adding lines of affinity, and additional information that came up that was relevant to the genogram,

such as Clare's sister having had a recent divorce and James' father having had a stroke 6 months before. Divorce scores high (2) on the Holmes and Rahe Scale (1967) of stressful life events and the impact of divorce on the nuclear family has been well discussed (for example Carter & McGoldrick 1989). Less attention has been paid to the impact of divorce on the extended family. Clare's sister's divorce had thrown Clare's relationship with James into sharp relief, leaving them feeling their marriage was in an vague way threatened.

It was apparent from the genogram that James and Clare had experienced a number of relatively recent transitional life events and stresses relating to extended family. It had been a difficult time for the family when James' father had his stroke and Clare said that she had started thinking more about her own mother around this time. Clare's mother was deceased and had died in 1993 soon after Gail was born. Clare had been very close to her mother and had relied on her a lot for support. She had been occupied predominantly with Gail at the time of her mother's death and had therefore not been able to grieve as she would have liked. In fact Clare said she had been surprised at how little she felt at the time. The association of the mother's death with the birth of Gail may have created a reaction in Clare similar to that described by Like et al (1988) in relation to "depressive-anniversary reaction". The impending birth of the new baby may have served as a trigger for grief and depression, in the same way an anniversary of a death can. The genogram allowed a rapid targeting of a precipitating event linked to Clare's depression.

The discussion opened up considerably after this and the psychosocial importance of this death in relation to the imminent birth 3 years later assumed greater significance.

The presenting problems were beginning to be redefined into a family context which linked the problems now, with problems in the past, the onset of the problem and changing family relationships (Penn 1982). Clare and James were firmly immersed in Carter And McGoldrick's (1989) third family life cycle stage of being a family with young children. They were however being confronted with death and illness when they looked at realigning relationships with the extended family to incorporate their parents' developing roles as grandparents. Clare was still adjusting to the loss of a major supportive relationship at a time when she might have expected to have developed a closer adult support relations with her mother, and similarly James was worrying about his father's health rather than engaging him as a grandparent and fellow parent. James' father was manifesting frailty (McGoldrick & Gerson (1989) life cycle stage 5) whilst the children were still very young, rather than during the more flexible period (for James and Clare) of increasing adolescent independence.

The couple had not mentioned the loss of Clare's mother until it came up in the genogram. Clare said that her feelings of loss regarding her mother had increased as her pregnancy developed and she mourned the fact that her mother would never see her new grandchild. The loss had been particularly noticeable because of the lack of other close female relatives to seek support from. She had not discussed these feelings with James because she did not want to burden him when he was so concerned about his own father's health. James' parents were having marital difficulties and this alongside Clare's sister's divorce had made the couple particularly sensitive to conflicts and changes in their own relationship. James surprised Clare when he said that he too had been thinking about her mother. It had been difficult for the whole family when Clare's mother died so close to Gail's birth and he was afraid that it might happen again with

the birth of the new baby. He said that such thoughts were obviously "silly" but his father's health troubled him the more the pregnancy progressed. James and Clare were now having an animated interchange with an outpouring of feelings and thoughts such that the counsellor did not intervene for several minutes at which time she summed up and reflected back to them what they had been saying.

The counsellor questioned the couple further about the crises highlighted in the discussion in order to build up a picture of the family history of coping with crises in general. McGoldrick and Carter (1989) argue that the family history of coping with moderate-severe ongoing stressors is a good predictor of adjustment to acute-onset and chronic illnesses. It was hypothesised here that the reverse might also be true and that the family's experience of unresolved loss and recent separations and illness may be contributing to the increased sense of despair and reduced intimacy the couple were complaining of. The new pregnancy and James' father's stroke may have triggered unresolved feelings of loss regarding Clare's mother's death. The biological influences on mood changes in pregnancy referred to by the couple's general practitioner and associated effects on relationships also needed to be included in any new construction of the problem.

Counselling Outcome

The Collins were booked in for a single session and further sessions were not possible. The session had validated their view that Clare's depression, and their concern about their relationship was not due solely to the biological effects of pregnancy or anxieties about the forthcoming baby. Discussion had been opened up about areas they both

found difficult to talk about but which had been significantly affecting the family. They opted to take the genogram home with them and undertook to continue the discussion at home having already come up with a few possible ways forward in relation to their concerns. Clare said that she would start exploring other sources of support to fill the gap left by her mother's death and she planned to visit her mother's grave to tell her how much she missed her and about the new baby. Jenkins and Asen (1992) describe their use of the unsent letter writing technique as empowering clients, helping them feel more in control of their problems, the latter action may have such a therapeutic effect on Clare. James and Clare also decided to spend regular time with each other away from the children so they could share their thoughts and feelings more and maintain the increased closeness they reported feeling at the end of the session. James seemed to be developing a more emotional supportive role for himself in relation to Clare's pregnancy, now they had some common ground for discussion. The process of constructing a genogram in a therapeutic setting appeared to have increased the bonding of the couple (Beck 1987) reducing the increasing sense of alienation from each other they had been experiencing.

Discussion

A one-off session can adopt a structured step-by-step (Weber et al 1985) goal-oriented approach in order to make efficient use of therapeutic time. This case illustrates how a more neutral approach with the goal of enabling the family to change, what Tomm (1984:p.263) called the therapist's goal of "metachange, that is, a change in the family's ability to change" can be equally efficient in time limited couple therapy. Tomm also identifies specific dyads as appropriate for systemic intervention and a

therapeutic “metagoal” of facilitating the family in self-healing and generating their own solutions. A lengthy course of therapy may not be necessary if the genogram is introduced early on in counselling, and intervening at the dyadic couple level can be sufficient to have a significant impact on the wider family system and address the presenting problems.

Gilbert & Schmukler (1996:13) described the strength of brief couple therapy as lying “principally in the short, sharp focused work aimed at very specific goals which can open the relationship up sufficiently for people to proceed in that vein”. The goals in this case of “addressing the depression” and “feelings of stuckness” being experienced by the couple could not be described as very specific, but the latter goal fits with “opening the relationship up” in such a way to facilitate therapeutic development outside the counselling session. Structured problem exploration, prioritising, planning course of action etceteras may reduce the therapeutic impact that a more process-oriented discussion can have in a brief therapy context, and not allow the therapist to demonstrate trust in the couple’s ability to resolve their own problems. Genograms can be seen as a tool for a therapeutic relationship which lasts over at least 3 or more sessions, whereas brief therapy is a problem-solving intervention (Haley 1990), but this does not have to be the case, if the therapist focuses on reinforcing the clients solution generating process and empowers them through the therapeutic intervention to move forward with their lives with an increased sense of control.

The genogram interview is highly structured in that the therapist can quickly build up a record of family structure and overlay this with family relationships, highlighted transitional points and a myriad of other information relevant to the therapeutic

context. It is the genogram as a basis for discussion, rather than systematic interpretation, which is most effective in brief couple therapy. The most skilfully structured genogram will not have a fraction of the potential therapeutic impact if the couple do not remain in therapy and insufficient time has been allocated to discussion in sessions during the construction. Like many therapeutic tools, the carrying out of the intervention is as (if not more) important as the interpreted outcome. Much of the information generated in this case was not used in discussion, but what was discussed was directly relevant to the presenting problems and therapeutic goals. The genogram interview is particularly appropriate to brief couple therapy as it is specifically a process and task oriented intervention, as well as being an established form of therapeutic assessment. Long-term therapy would have been able to exploit James and Clare's genogram more fully with potentially significant positive benefits for the couple, but brief therapy means developing the discussion with the couple along lines relevant to immediate concerns to make most effective use of the time.

Supervision

The counselling psychologist used supervision to critically analyse the session with the inclusion of a second external perspective. This process was greatly facilitated by having a copy of the genogram, and accompanying notes available. A genogram interview does have the advantage that written notes can be made unobtrusively with the family which can serve as the basis for in-session and post-session discussion. In the absence of a family therapy team, supervision can be used for pre- and post-session review along the lines described by Tomm (1984) in reference to the Milan five-part session approach.

Constructing a genogram had been invaluable in using the session time effectively. A number of issues had come up during the session and the counsellor had not been able to utilise all the information in the genogram but it was agreed that some important areas had been covered in the time available in a comprehensible and focused way. The intervention had appeared to have a significant therapeutic impact on the couple system, an impact further demonstrated by the couple beginning to generate their own solutions. A genogram model which would have been relevant to this couple is “the time-line genogram” (Friedman et al 1988). This would have highlighted the temporal connections between the significant life events and presenting symptoms and should be considered as an alternative to the standard genogram when working with appropriate couples, or as a tool for continuing genogram work at home.

Limitations

In addition to the limitations already described it should be noted that the session was not audio-taped. The material taken to supervision and used as the basis for discussion in this case study is therefore based on case notes taken in the session and counsellor recall. This counsellor’s sessions are not normally recorded, because of particular concerns regarding client confidentiality and sensitivity to un-solicited disclosure due to the nature of her specialisms. The subjectivity of the observations and interpretations of process and content must therefore be taken into account.

It would have been useful to follow-up the couple to assess the long-term outcome of the intervention but this was not done as this was a clinical rather than a research case, and large caseloads mean that follow-up with non-registered clients is not possible in

this kind of work setting. How the couple used the genogram at home is therefore unclear, but they took away their own genogram diagram with the intention of continuing a discussion of the material identified and recorded during the discussion. (The genogram skeleton provided in the case study is just an example based on the starting point of the couple's genogram at the beginning of the session.) Other agencies were working with the couple and the letter to the general practitioner following the session indicated possible future areas of concern relating to risk of post-natal depression and bereavement issues.

The case study is also discussed in the context of the current literature on genograms and systemic therapy at the time of writing. The clinical and academic literature in these areas is constantly being developed and the time taken to write and produce a thesis inevitably means that even with later updating recent literature may not be included.

Conclusion

Effective couple therapy in one session appears feasible using a structured process-oriented genogram interview within an integrated systemic framework. Long-term couple counselling will always be appropriate in some cases, but a briefer intervention, which strengthens the couple's capacity for therapeutic change outside the counselling context, should always be considered. More research is needed on the effectiveness of the genogram not just as a tool to be self-administered for interpretation with a therapist or general practitioner (Rogers et al 1985) but as a therapeutic intervention introduced in counselling, then developed and discussed by couples in a home setting.

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CHAPTER 3: PROFESSIONAL RELATIONS IN MULTIDISCIPLINARY HEALTHCARE: A COUNSELLING PSYCHOLOGY PERSPECTIVE

INTRODUCTION

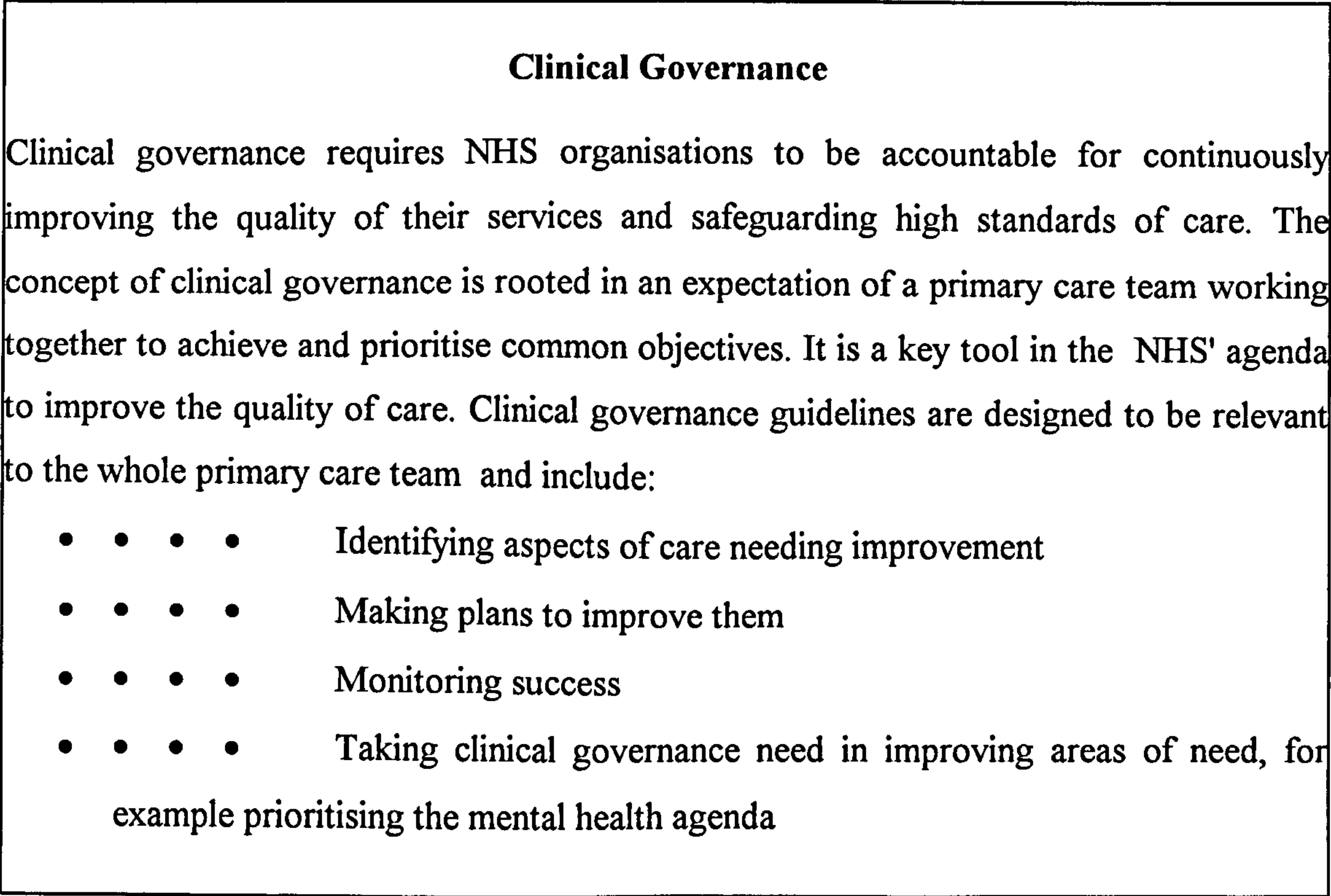
The Changing Face of Primary Care

The Primary Care Groups (PCGs) newly introduced to the National Health Service in the late nineties asked of general practitioners and primary care teams that they improve the health of their communities through addressing the health needs of their practice populations, promoting the health of those populations and working with other organisations to deliver effective and appropriate care (HSC1998/228). This combination of traditionally isolated, small-scale clinical practice with both a public health perspective, and a networking approach to collaboration between disciplines and across service boundaries, was always likely to test the adaptability of general practice, and was introduced with detailed guidance but limited practical support (Iliffe 2000). It did however provide new opportunities for collaboration and funding through the Primary Care Group (PCG) service commissioning responsibilities. Developing more of a local public health focus, and involving local communities in Great Britain in health care decision-making, were key aspects of the PCG agenda, extending health care decision-making beyond the medical service providers. There were 4 levels of PCGs outlined by the government and now PCGs have made the transition into Primary Care Trusts, they are commissioning health, psychological and social services

as well as providing some community services for local populations (Roland & Baker 1999).

Clinical governance was another key development in primary care, this placed requirements on all primary care practitioners to show cost-effectiveness, provide audit data, demonstrate competencies and develop evidence based practice. Figure 2 outlines the principles of clinical governance” which is a core component of NHS guidelines for all NHS organisations including general practices.

Figure 2: “Clinical Governance”



The expectation in clinical governance was that the whole multidisciplinary primary care team would be engaged in service improvement and raising standards of care. Non-medical primary care practitioners were advised against seeing clinical governance as the preserve of their medical colleagues (Roland & Baker 1999). It was

emphasised that the success of clinical governance relied heavily on effective multidisciplinary collaboration and team working. Counselling psychology as a growing discipline in primary care has had to confront the challenges of clinical governance and the development of Primary Care Groups and Trusts along with other disciplines in the envisaged multi-disciplinary primary care service, with general practices and other service providers being linked through Primary Care Trusts (PCTs), the growth of counselling services in or covering one or more practices, increasingly more of which are recruited through PCTs. The counselling sector has experienced rapid expansion in primary care and the development of primary care counsellor posts was strongly supported by many of the Primary Care Groups. Counselling in primary care has been described as a fast evolving profession (Hudson-Allez 2000) undergoing rapid but haphazard growth (Foster 2000), but cautionary notes concerning the impact of the NHS reforms of recent years on the discipline have been raised (Foster 2000). Counselling psychologists have had to integrate into the diversified culture emerging as a response to these reforms in order to effectively operate as clinical and academic practitioners in primary care today, and to be represented at service development level.

Maintaining high professional standards of care require some equality of collaboration across the disciplines, medical and non-medical, to ensure the objectives of all the different disciplines are implemented. Medical priorities and treatment approaches might otherwise subsume psychological or social priorities and approaches if non-medical practitioners do not have an equal voice in setting funding priorities and group decision-making. The practice team members actively involved in clinical governance, and local health and social service planning, will set the development agenda for the

practice and facilitate access to their local Primary Care Trust (PCT) resources. Mental health services have been identified as one of the areas of national importance by the government. Opportunities for counselling psychologists are continually increasing in primary care as Primary Care Groups have prioritised funds for locum, part-time and full-time counselling services in general practices and commission research to develop the evidence base for particular counselling approaches for specific problems. The stress on multidisciplinary working and primary care team collaboration to meet the new guidelines has not however acknowledged the enormity of the culture change which might be involved, and what this increased involvement in primary care, and the current emphasis on multidisciplinary working might mean for mental health practitioners such as counselling psychologists as service providers, service developers and researchers.

Community Oriented Primary Care

The vision of a multidisciplinary primary care approach with a public health perspective underlined by a systematic evaluation using clinical and epidemiological data is not a new one. Community Oriented Primary Care (COPC) is a multidisciplinary model of primary care which integrates the traditional model of primary care with public health. Development of current primary care and public health interest which dates back over 50 years having been developed by Kark first in South Africa (and later Israel) in the 1940s (Geiger 1993). It has been defined by the US Institute of Medicine as:

“An approach to health care delivery that undertakes responsibility for the health of a defined population which is practised by combining epidemiological study and social intervention with the clinical care of individual patients, so that the primary care practice itself becomes a community medicine programme. Both the individual patient

and the community or population are the foci of diagnosis treatment and ongoing surveillance” (Nevin & Gohel 1996).

And by Klevens et al (1992):

“more than a philosophy and an orientation: for the `COPC practitioner, it is an investment in the community and in a practice that restores the social contract between medicine and society” (p64).”

COPC is over 50 years old but has in recent years seen a rise in popularity in the UK as an innovative model of primary care development. It has been historically been applied most in developing or deprived communities, but its integration of public health, primary care and community involvement fits so well with the UK NHS developments such as Primary Care Trusts, Primary Care Groups and Clinical Governance that COPC is now seen as having broader relevance for a wider range of primary care settings and relatively more affluent communities (Koperski & Rodnick 1999). COPC targets prioritised services to a defined population through the integration of public health and primary care, and the explicit application of epidemiological analysis to local clinical practice. The model is a radical social equality based approach to community medicine which reflects the integrated model of public health methodology and primary care clinical practice that is currently sought in the National Health Improvement Programme and emphasises the evaluation criteria outlined in Clinical Governance. The long history of COPC and the research into it's advantages and disadvantages can be used to explore some of the implications and possible challenges of the increasingly integrated primary care-public health perspective in general practice of recent years following the introduction of clinical governance and other primary care reforms.

The original impetus for developing COPC in South Africa was because Stanley Kark decided that in order to effectively meet the health needs of local communities in South

Africa he would have to first identify what those needs were, rather than restrict services to those the health care providers wanted to offer. Researchers and practitioners in the United States have experimented widely with the COPC approach, primarily in deprived areas with under-served populations. The application of COPC to practices in the UK to date however has been limited. This slow development of COPC internationally, particular in more developed countries and less deprived communities has been attributed to the lack of persuasive evidence that it can significantly improve the health of more affluent populations. Examples of COPC being used in the UK include addressing incontinence amongst women in a practice in a small town in Hampshire (Carter & Green 1994), and in inner London (Lenihan & Iliffe 1999) to promote the development of innovative primary care services for older people. It's promotion as a viable model of primary care in the UK is however more supported in theory than practice, particularly where mental health is concerned.

Theoretical analyses of the model and research into the COPC programmes which have been established internationally have not fully addressed the multidisciplinary challenges of the model outside the medical hierarchy. Training multidisciplinary medical teams in COPC which although unfamiliar, contains many familiar concepts, including a cycle reminiscent of a practice audit cycle, should be relatively straightforward, but how well such teams can implement the multidisciplinary aspect of the model which is rooted in egalitarian team working and community consultation, collaboration and engagement is another question. It's applicability to the current climate of primary care, the increasing UK interest in it and the wide remit of COPC as well as it's reliance on multi-disciplinary working, made the COPC model a viable choice for researching multi-disciplinary working in primary care.

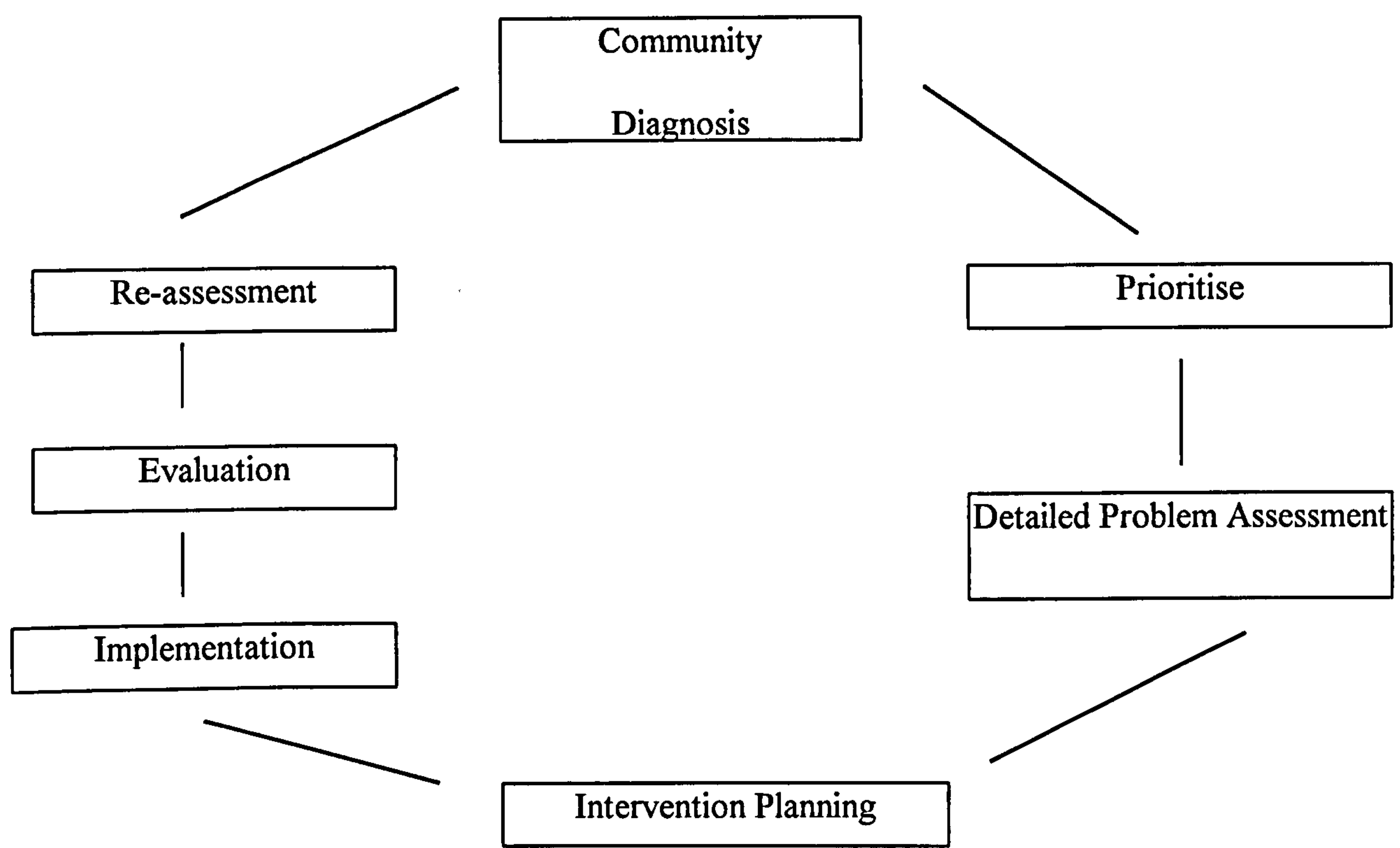
The COPC Model

The core components of the COPC model are (Tollman 1991) (Nutting & Connor 1986):

- A primary care practice which provides care to a specific community.
- A clearly defined community which is served by the practice.
- A systematic process by which the practice addresses the major health problems of the community in alliance with that community.
- The complementary use of epidemiological and clinical skills
- The accessibility of the primary care services

COPC necessitates co-ordination across a range of social and health agencies, an interdisciplinary perspective on health in addition to well-developed communication, advocacy and research skills. The emphasis is on community involvement and the creation of a partnership between the health centre and the community it serves as well as on inter-professional collaboration. It is a model of population-based primary care, where the community is perceived as the primary system for intervention, with events in one part of the system impacting on the other parts of the system. The process of designing, implementing and evaluating a community oriented primary care programme consists of a 7-stage cycle. “Trade-offs” may be necessary in actualising the process and higher levels of each stage must be balanced against relative costs and gains (Nutting 1986). The success of the model relies on the efficient operation of the partnerships and equality of contributions in order to produce the desired public health-primary care programme which is accessible and acceptable to the community for which the practice has responsibility.

Figure 3: The COPC Cycle



Community Diagnosis

The diagnosis of the community (identification of the major health problems impacting on the defined community) takes different forms depending on the level of community-oriented primary care methodology feasible, and appropriate, in the primary care and community setting. This step of the process can use data, which ranges from subjective impressions to a complete current community database. The stages of development possible in the COPC community diagnosis as outlined by Nutting & Connor (1986) are:

Stage I: Subjective impressions of the primary care team or community

Stage II: Use of secondary data sources

Stage III: Enumerated and characterised by ad hoc database specific to the community

Stage IV: Enumerated and characterised from a current and complete database of the community

The community's needs or problems are diagnosed using available and accessible data. Social factors may be identified as greater health risks than disease-causing agents. The necessary multi-factor community perspective is best achieved through the active involvement of a multi-disciplinary team. The data used must ideally fit the aim of the COPC intervention, it is not a question of the more complex the better, but making efficient use of the available data and collecting data which is necessary to develop and evaluate the specific COPC intervention. The focus is on cost-effective service development which is nevertheless based on relevant data and can be subjected to appropriate high quality evaluation.

The community diagnosed can range from the registered practice patients to a specific geographical area for which the primary care team have health care responsibility. The use of practice data is common and collaboration with other practices can be useful in community diagnosis although this does raise issues of confidentiality. The registered practice population and practice data is not necessarily representative of the wider community and has in fact been shown to differ significantly from community data (Gillanders 1991). Practice data can again be a more appropriate choice than a wider community database in certain circumstances, taking into account costs and benefits⁷.

Identifying Community Health Problems and Detailed Problem Assessment

The team and the community identify the major community health problems and their causes in the next stage of the cycle and define the group within the community with the identified health problem. The identification of the community health problems can be based on COPC development stage I subjective impressions through to the use of stage IV systematic measures identifying and establishing priorities from a selection of problems. The impact of the health problem on the target group's health is assessed. The selection of the group and its assessment may be in response to nation-wide or organisation initiatives (stage I), a use of particular resources (stage II), a response to the clearly identified health needs of the community (stage III) right up to (stage IV) targeting of high risk groups and individuals. The community and problem assessment also includes the existing primary care service's impact as well as the community's health problems (Mullan 1984). The community becomes the patient and it is the community's health status in relation to the problem, which needs to be assessed.

Intervention Planning and Implementation

Intervention planning addresses the following questions (Kings Fund 1994):

- What needs to be done?
- When does it need to be done?
- Who needs to do it?
- What resources are needed?
- How will it be evaluated?

The expectation is that the combining of the traditional primary care services with a population-based perspective will give rise to innovative interventions aimed at improving the health outcome of a specified community (Nevin & Gohel 1996). The COPC intervention is implemented by the multi-disciplinary team and continuously monitored. The programme can involve specifically trained community workers and the use of community role models has been found to be useful. A clear timetable of each stage of the intervention and associated evaluation should have been drawn up by this stage.

Evaluation and Re-assessment

The evaluation and monitoring of the COPC programme objectives is a key part of the community-oriented primary care model. COPC is ultimately an integration of social science and epidemiology^{and} this is reflected in the nature of the evaluation. It employs both quantitative and qualitative methodologies. Evaluation usually also includes short- and long-term indicators. The length of time needed to measure the impact of COPC programmes can be variable, and changes in socio-economic variables can also have long-term effects on health status, which need to be taken into account. The evaluation stage of the COPC programme assesses not only the outcomes of the interventions generated but also evaluates the COPC process itself. The evaluation of the process addresses the following research questions (Nutting 1990), amongst others:

- How and why is a particular problem prioritised?
- What other equally important problems might have been addressed?
- How and why is a treatment strategy selected?
- What might have been the impact of similar resources being directed towards other equally important problems in the community?

- What is the effect of refining the strategy in accordance with the COPC feedback loop?

The outcome of the evaluation is fed back into the COPC cycle and forms the basis of the next community diagnosis. The practice decides whether to continue with the original objectives, whether to modify them or whether to start with a new list of priorities. The COPC approach will generate new priorities and interventions, as the model becomes more central to the ways in which the practice delivers its services, and as the relationships between the professionals, and those between the primary health care team and their community evolve. The model integrates public health and primary care and its overall aim is to identify and address the health care needs most relevant to the primary care practice and the specific community which the practice serves. The needs in socially and medically deprived areas are often glaring and encounter little disagreement between the professionals and the community. The model has yet to be tested sufficiently in more affluent and less medically underserved communities to really establish how needs are prioritised by the multidisciplinary team and community in such areas, and how conflicts might be resolved.

The majority of COPC programmes have been developed in the United States and Israel. United States studies have more commonly focused on the application of COPC in deprived areas with limited access to adequate health care. Many studies have reported however that the application of COPC has been effective in achieving the planned COPC outcomes in the targeted community (Haber 1996; Orpaz 1994; Deutschle 1982; Gold & Franks 1990; Connor et al 1990; Cassell 1955; Gordis 1973) Parkland Memorial Hospital, Dallas, used the community-oriented primary care model to decentralise the primary care services and shift the focus from curative interventions

towards prevention and continuity of care (Boumbalian et al 1991). The City Council of Dallas now uses the COPC model as an overall framework for the delivery of public and primary health services. The service providers are rewarded with an incentive pay system linked to the achievement of the COPC objectives. Research support and career development opportunities are also provided.

COPC has been promoted as being potentially useful for the specific development of mental health services in primary care (Freeman et al 1997), but the research evidence for this is sparse. Intervening at a community level may increase the overall effectiveness of such services, and promote collaborative working with other members of the primary health care team. The whole team can be involved in identifying and prioritising the aims of the mental health services. Exposure to risk is the first stage of COPC assessment; prevention is a key component of the model. The initial assessment identifies the factors which contribute to exposure to risk. Risk factors will include associated factors, determinant factors and modifiable risk factors (Kings Fund 1994). The identified processes leading to manifestation of the diseases could be ideally presumed to undergo some variation according to the disciplinary perspective, if each discipline is represented in the discussion and outcome of the multidisciplinary team planning. Subsequent levels of prevention aim to prevent pathology (primary prevention), prevent symptomology (secondary) and prevent further deterioration (tertiary). Mental health services have been identified as one of the areas of national importance by the government (NHS Executive N Thames 1998). COPC is promoted as an approach that is applicable to community mental health problems but the implications for mental health provision in primary care are unknown, like many of the

recent developments in primary care which have shifted it towards a more local public health focus.

Benefits and Disadvantages of COPC

COPC has been in existence for over five decades and despite the lack of rigour evident in many COPC studies, much has been learned about the benefits and disadvantages of a multidisciplinary, local, community oriented networked primary care system from the perspective of service providers and patients. The promoted benefits of COPC are that a community-oriented practice will ideally work together as a multi-disciplinary team; acknowledging and valuing individual expertise, but collaborating to achieve commonly agreed goals in relation to the mental and physical health of the community they serve. Goal similar to those striven for in the new Primary Care Trusts. The COPC approach according to Nutting et al 1991:

- Broadens practitioner's clinical perspective
- Incorporates community medicine into family practice
- Promotes interdisciplinary collaboration and preventative work
- Develops cost-effective focused interventions
- Addresses questions which are specific to the practice and the community which it serves

The main obstacles to COPC reported in the literature though are financial constraints, and a lack of resources; COPC specific skills; feasible evaluation techniques and appropriate quantitative techniques (Connor 1989; Nutting & Connor 1986; Williams et al 1985; Nutting et al 1985; Deutsche 1982). The financial disincentive is particularly relevant in the United States context where physicians can find it difficult

to be reimbursed for COPC activities. Competing priorities of service, teaching and research lead to tensions when obtaining resources for COPC training activities (Strelnick & Shonubi 1986). Few physicians have received any COPC training (Connor 1989). Lack of agreement on the community-physician relationship is a major barrier to COPC. A COPC physician has to decide where and when to intervene in the community and gain satisfaction from statistical change but the role of the general practitioner as an agent of change in the community is devalued and rarely taught (Scwenk & Woolley 1986). Case studies indicate COPC activities have been more driven by general practitioners than community. One general practitioner with an unusual commitment to COPC appears more important to COPC success than community involvement (Nutting & Connor 1986). Is it the commitment of the general practitioner that makes the difference, or do they take a hierarchical leading role in the team? This question is not answered in the literature. Do examples of successful COPC programmes actually succeed because the multidisciplinary team is being instructed by the general practitioner, and what happens when the service being developed falls more within the specialisms of other team members? Again this has yet to be explored.

Resources to implement the epidemiological basis of the model are not always available (Sapir 1994) and organisational barriers can be formidable (Connor 1989). Williams et al (1995) found in developing an IT programme to assess the community's health status encountered problems around confidentiality and barriers to obtaining hospital data. The tool developed was however thought to be able to provide clinically useful tables and the information necessary to target high-risk groups, and this is one of the relatively few COPC studies which calculated costs. Other difficulties which

have confronted COPC include: accessing appropriate management skills, balancing the professional health provider mix and staff support, and dealing with possible breaches of confidentiality/privacy that can arise during extensive engagement of the community (Deutschle 1982). Communities can be resistant to being defined as “research subjects:” and other practitioners being resistant to their patients being included in another practice’s COPC programme (Connor 1989). Linking the COPC practice with other local health care providers is a recurrent problem, as are the long-term sustainability of established COPC organisations and their vulnerability to socio-economic changes. Many of the barriers to COPC outlined above have multidisciplinary and hierarchical relevance such as COPC skills, community involvement and the significance of having one committed general practitioner (committed to or taking control of the process?) in developing a COPC programme.

Prioritising

Selecting one stage of the cycle "Prioritising", a more specific examination of the issues raised by COPC can be made, particularly those relevant to counselling and community psychology. The mental health problems which are prioritised reflect the profile of the community for which the practice team has health care responsibility. Examples of psychological concerns relevant to the primary care setting which can be addressed using a collaborative community-oriented approach include weight control, smoking cessation, sexual health, drug and alcohol abuse, exercise, domestic violence, child care issues, management of pregnancy and the initial postnatal period, depression and suicide. Patient groups with the highest level of psychological need may not be accessing practice psychological services because of being perceived as a low priority

for those services. Older people commonly report bereavement and relationship concerns, but are rarely engaged by the existing counselling services. Functional disability and health problems become more prevalent as the patient reaches their mid 70's, so older patients are high users of practice services, but make up few counselling referrals, despite the high level of clinical depression reported in this patient group. A systematic prioritisation process can increase service access for minority groups, a key component of the COPC philosophy. The expectation is that the combining of traditional primary care with a population-based perspective will give rise to innovative evidence-based services that will demonstrably improve the mental and/or physical health status of the community (Nevin & Gohel 1996). The emphasis is on selecting from evidence-based options to address a prevalent problem in the practice population and designing a targeted intervention ideally incorporating primary secondary and tertiary levels of prevention. Minority groups in the population may be particularly at risk due to problems accessing medical primary care services and as a result the primary care mental health services.

Prioritisation involving the community in COPC is a move towards a more radical democratic model of health and social care, in which communities are involved in defining what services are needed, and how these services should be provided, and away from a consumerist model. The consumerist model of health and social care offers patients options from a previously drawn up package of health care, the options being service provider rather than patient-led. The patient has a choice, but that choice is confined within tightly pre-ordained parameters, which may not reflect the health and social priorities of the community. Advocates of consumerism argue for the freedom of choice exercised by consumers in what is essentially a needs-led service,

and for the effectiveness of the consumer approach in giving the consumers what they want, but consumer choice can be controlled by restricted resources and socio-political factors (Young 1991). The consumerist approach however does offer choice. A practitioner led COPC approach may offer none if the community's priorities are sidelined or not even solicited, since the practitioners would determine priorities on the basis of epidemiologically determined need, and allocate resources accordingly.

The social equality foundation underlying COPC is an aspect of the model, which has not always been promoted, and organisational barriers to doing so have been found to be formidable. There have been problems around confidentiality and sharing of data. This is a problem familiar to many professionals who work across disciplinary boundaries. Most COPC community health centres have targeted individuals in communities rather than whole communities. Competing service agendas, both professional and lay, can lead to programmes, which reflect the concerns of the priority setters rather than the defined community. Interdisciplinary marginalisation of services and priorities is also a risk if the relevant professionals do not take an active role in the COPC process. Similarly it is vital that mental health takes a key position in the PCG agenda and that service development is informed by the professionals in the field to avoid mental health becoming more marginalised (N Thames NHS Executive 1998). Health authorities need the support of mental health professionals, such as counselling and clinical psychologists, in developing appropriate agendas so to ensure the continuing development of cost-effective therapeutic non-pharmacological services. Community trusts running therapeutic services, may be marginalised, or overlooked, through not being known to primary care and not promoted adequately and prioritised. The involvement of mental health professionals in multidisciplinary primary care teams

legitimises and gives added credence to the mental health interventions developed. Is COPC in practice however really a multidisciplinary model and do primary care teams work in a multidisciplinary way? Should counselling psychologists be more aware of the discussion process when sitting down with their primary care colleagues?

Multidisciplinary Working in Primary Care

Multidisciplinary co-operation and non-hierarchical collaboration are the foundation stones of COPC. Co-ordination is required across social, health and voluntary sectors, whilst being accountable to the community. There has been little discussion of the multidisciplinary aspect of the approach in the literature, apart from the disincentive of the lower status of the community specific generalist role of the COPC practitioner when compared to more nationally and internationally relevant specialist research and practice (Scwenk & Woolley 1986). It cannot be assumed that multidisciplinary working in the traditionally hierarchical field of primary care does not have a major impact on the design, implementation and outcome of COPC programmes, as well as the development and dissemination of the model itself. Many of the barriers to COPC identified in the literature (Connor 1989; Nutting & Connor 1986; Williams et al 1985; Nutting et al 1985; Deutschle 1982) have multidisciplinary and hierarchical relevance such as COPC skills, community involvement and the significance of having one committed general practitioner (committed to or taking control of the process?) in developing a COPC programme.

Multidisciplinary teams cannot be assumed to work in a multidisciplinary way, or to produce multidisciplinary outcomes. Working closely with colleagues, involving the

relevant professionals and a “team approach” may obscure hierarchical realities, competing professional agendas, contradictory assumptions and ethical differences which make multidisciplinary collaboration a more complex task in practice. Multidisciplinary teams who share the care of a patient also share moral responsibility, and interaction and power differentials within the group will impact on professional decision-making as a team. In a multidisciplinary team in primary care, to what extent do the different individuals contribute to the collective decision-making and take moral responsibility for the outcome? The credibility of multidisciplinary teams rests on the assumption that multi-disciplinary working is desirable because the separate disciplines are represented in planning and decision-making. This does not address the realities of the professional constructs being employed possibly differing radically and the morality of collective decision-making. Abramson (1984; 42-43) says of inter-professional co-operation:

“they bring different value systems, principles, frames of reference, moral language and definitions of what makes good practice the tensions between the moral commitments of the individual and the group ethic remains.”

Genuine collaboration reflects the objectives of all the professions involved, empowering the whole team rather than providing an acceptable forum for the dominance of one professional agenda over another. Developing a common understanding of one another's culture, language, professional values and key boundaries such as confidentiality fosters a firmer foundation for constructive respectful interdisciplinary work. Multidisciplinary primary care working is clearly a complex process when the hierarchical realities, competing professional agendas, ethical differences and contradictory models are confronted in practice. The new agenda for primary care widens access to resources and opportunities for involvement

in service development for primary care mental health professionals and their medical and social care colleagues. There is evidence from randomised controlled trials that where primary care physicians and mental health care providers collaborate in managing patients with major depression, outcomes are better than for those patients who receive usual care, but treatment of depression in the community has been shown to be less collaborative and interactive than that shown to be effective in the randomised controlled trials (Valenstein et al 1999).

The emphasis in the COPC literature on working closely with colleagues, on involving the relevant professionals and on a “team approach” may obscure the hierarchical realities, conflicting professional agendas and contradictory assumptions, which make multidisciplinary collaboration within primary care, teams a more complex task in practice. Pellegrino (1982) and Abramson (1984) highlighted 3 important questions to ask about collective decision-making and team-working:

1. How is moral agency and responsibility allocated?
2. How is individual moral agency exerted and to what extent is the individual responsible in doing so when agreeing or disagreeing with the group?
3. To whom is moral obligation primarily due: the patient or client, fellow team members, personal morals and beliefs or the professional ethics and standards of a team member's own discipline?

The collective decisions of a team cannot be assumed to be the sum total of the individuals' decisions. The legal and moral responsibility, as well as professional accountability of collective decision-making of team on the other hand is likely to rest

with individuals within a team Collective responsibility in health care roughly falls within the frameworks of (Abramson 1984):

- The Identification model which holds the collective responsible for the actions of individuals
- The Participatory model which holds the individual responsible for the actions or failure to act on the part of the collective
- The Authorisation model attributes responsibility to the individual of particular professional responsibilities, ethics and obligations through a single act of contracting into membership of the collective

The process by which team hierarchy impacts on the process of collective decision-making is clearly important in health care in that the responsibility will in reality lie with the team member who is considered able to make the final choice or provide the expert input on that issue. In a model such as COPC which advocates non-hierarchical collaborative decision-making how are decisions made? In health care teams a basic familiarity of each other's terminology is desirable, but developing a moral consensus around key ethical concepts is important, as is further study of the process of decision-making in interdisciplinary teams (Abramson 1984; Thomasma 1981). McElmurray et al (1999) point out that attempts to engage community stakeholders in primary care has not been particularly successful to date and presents a framework for nurse participation in multidisciplinary working in order to maintain the community focus such as "respect for others, sensitivity to the differences between cultural, racial, ethnic and socio-economic groups and creating outcomes that reflect civic consensus about health for the community"(p.246). These authors refer to the ethical underpinnings of nursing particularly ethical relativism, utilitarianism , Kantian ethics

and moral justice. What is relatively unknown is how professional discourse is constructed in the process of multi-disciplinary working and the effect it has on team outcomes, particularly in contexts such as primary care, where physical medicine has traditionally been the dominant discipline. To what extent does the contribution of nurses to primary care multidisciplinary working discourse reflect the social issues associated with or the particular ethical perspective framing nursing? How are different professional discourses expressed, integrated and reconstructed in the process of multi-disciplinary working?

Definitions of COPC (US Institute of Medicine 1984) highlight one possible concern from a mental health perspective regarding the shift of the COPC focus from physical to mental health - the language used is that of medical, rather than sociological or psychological discourse. The Kings Fund (1994) describe COPC secondary prevention as involving “measures for the early detection and prompt effective intervention to correct departures from good health” (p.12) and interventions are introduced to change the behaviour of the *whole* population. Does this description however really convey the implications of addressing the psychological risk factors and behavioural manifestations of a whole population when “good health” refers to psychological well being? The concept of community is central to the Community Oriented Primary Care model, and involving local communities and patient groups is high on the Primary Care Groups’ agenda. What do we mean by community? Is there really a common understanding across disciplines within the different professional discourses and how are interdisciplinary differences regarding the function of communities in respect to professional assessment and intervention negotiated? How do the discourses of medicine, psychology, nursing and social work interact to produce the concept of

community employed in multidisciplinary communication in planning a COPC programme. Does a new discourse emerge when a multidisciplinary group works together as equals or do one or more discourses become dominant by disallowing others?

The "community" in COPC is the geographical area for which the practice has health care responsibility, a group of people linked by their geographical location (similar to the boundaries of Primary Care Groups), and divisible by the groups defined as at risk for particular prioritised health problems, a primarily medical definition perhaps linked to the responsibilities of medical providers. "Community" as discussed by Drevdahl (1998) is a place of oppression and resistance in her study into perspectives on power and the language of community and her discussion of Foucault's perspective (1977;1978;1980) on power in relation to her study of a free health clinic in the United States, has implications for the process of COPC, and the transition of the model from very deprived to relatively affluent localities which include underserved and impoverished minorities.

Language contributes to and reflects power relations and dominant ideologies in society; the same ideologies which set the agenda for public health. The increasing movement of public health into primary care medicine makes the ideas of discourse analysis of even more relevance, particularly as has been argued by Lupton (1992) discourse analysis is particularly pertinent to the concerns of public health, yet has to date been underemployed in this area. It offers a deeper linguistic perspective to public health promoting "an understanding of the relationship between language and ideology, exploring the way in which theories of reality and relations of power are encoded in such aspects as the syntax, style and rhetorical devices used in texts" and a

“new methodology for understanding the ideologies of health and illness “ (Lupton 1992; p. 145).

COPC shifts the object under observation, what Foucault referred to as “le regard” explicitly from the individual to the population or the community. The community is asked to diagnose itself with the professionals. Individuals are not just responsible for their own health status, the community is responsible in conjunction with the primary care team in *making a significant change to the health status of the community*. The community is established through the prioritisation of community issues and restricted through the geographical boundaries served by the practice. “Le regard” in COPC has shifted beyond the individual to the promotion of health and reduction of risk factors within a population, and even beyond that to bringing the environmental, psychological and social explicitly within the primary care branch of medicine. If illness in the late 20th century signifies not taking care of oneself and following the advice of health promotion with insufficient attention to structural factors (Peerson 1995), then COPC and the NHS now makes the community and primary health care providers responsible for addressing the structural factors in order to promote health and reduce the morbidity and mortality for which patients and now communities seem to be increasingly perceived as responsible. The focusing of multidisciplinary primary care teams on the mental health status of communities arguably places particular responsibilities on counselling psychologists and other mental health practitioners to be effective members of those teams. The criteria applied to physical health are extended applied to mental health in the COPC model and through the multidisciplinary public health focus of primary care groups. Quality of life becomes interchangeable with living a “healthy lifestyle” and possessing the attributes associated with good health.

The community is monitored for its statistical relationship to normative epidemiological illness data justifying intervention at a local level by the health care providers who are expected to put the interests of the patient first in the absence of mitigating factors such as notifiable diseases and criminal behaviour.

In Drevdahl's (1998) clinic study the clinic staff invested a significant amount of time screening clinic users to ensure they were appropriate for free and subsidised services, thus avoiding competition with the other medical service providers in the locality and normalising the clinic's expectations regarding the behaviour and access of the clinic users. The prioritisation stage of COPC similarly legitimises appropriate behaviour and access of potential target groups whilst not prioritising the needs or validating the rights of access of others. COPC links intervention planning with available community resources potentially devolving power to more funders and agencies outside the practice. The development and increasing empowerment of Primary Care Trusts may be devolving power upwards and outwards away from the individual patient and communities based on geographical boundaries, and those based on affinity with others. COPC target groups are identified through being defined as "other" in relation to the community as interventions are devised to statistically shift the prevalence of the attributes under intervention towards the norms of the community - established by not being included in the construction of the target group.

Studies of power relations in medical discourse (Waitzkin 1990; Fischer & Groce 1990; Davis 1988; Silverman 1987; Frankel 1979) and the negotiation of power between the physician and the patient (Gwn & Elwyn 1999; Ainsworth-Vaughn 1995) have not addressed the exercise of professional power within multidisciplinary teams working in medical settings. Discourse analysis provides a powerful methodology for

counselling psychologists to reflect on their practice and to use in identifying the influence of powerful agendas from other disciplines on their clinical practice work and research. Psychosocial issues are becoming increasingly defined and the private subsumed into the public (Peerson 1995) multidisciplinary working is extending the social control power of medicine, and it is not clear how counselling psychology's traditional emphasis on the autonomy and personal development of the individual integrates into the multidisciplinary community oriented face of primary care.

The COPC approach fits well with the direction primary care is moving, offering considerable opportunities for psychologists to be at the cutting edge of developing innovative population-based mental health care services. The emphasis of the model on evidence-based practice, epidemiologically informed community diagnosis and systematic multi-dimensional evaluation of services puts psychologists in a good position to demonstrate the value and cost effectiveness of their work, whilst further developing their role in primary care settings. The COPC model reflects the current framework of primary care, and as such is a useful model for reflection regarding the implications of the current primary care developments for psychologists. Critical reflection when applying the model to mental health in primary care is advisable, given the bias towards a medical rather than a psychological model. There is also the question of why if community oriented primary care is an effective model of primary care development, why in view of its long history has it not been more widely applied internationally?

Assessing the way multidisciplinary primary care teams apply a primary care model of such current relevance and interest as Community Oriented Primary Care is a useful

means of evaluating professional communication within such teams. It is feasible to give teams a basic grounding in the model in a time period short enough to tackle a team task. The challenges of implementing the model are similar to those thrown up by recent reforms in primary care, but are incorporated into a framework which can be taught and practised in a "real world" workshop. The objective of the study was to explore the implications for counselling psychology practitioners of multidisciplinary team working in primary care and extend understanding of this area beyond more structural analyses of team working. The focus of the study was on analysing how power relations, ethics and professional identity are enforced through multidisciplinary discourse and influence outcome, and on applying a Foucauldian analysis of location of power, the objectives of power, the means of enforcing power relations, the forms of institutionalisation and the degrees of rationalisation employed (Tilah 1996) to multidisciplinary discourse on mental health. The present study evaluated multidisciplinary collaboration in mental health in primary care as it developed within the discourse of the different professionals participating in COPC training from the perspective of counselling psychology. A problem had to be identified for a multidisciplinary team to work on which would be appropriate for all the practitioners to discuss, but have particular relevance for the mental health care providers in order to examine more closely how different professional discourses would emerge and be expressed in the team, and in particular what the implications might be for mental health practitioners working in a primary care setting. The groups were asked to design a COPC programme to address depression in older people.

Depression in Older People

"Late life depression is perhaps the best example of the limitations of the biomedical model of health and illness, and of the weakness of the idea of evidence-based practice, but it also reveals the scope for innovation in the community" (Iliffe & Drennan 2000; 175).

There seems to be broad clinical agreement across mental health on what constitutes depression, but different perspectives are held on aetiology, assessment, maintenance factors, prognosis and intervention. The clinical diagnostic criteria for depression (ICD-10, World Health Organisation 1992) includes (Hughes 1997):

- An unusually (for the person) depressed mood not directly attributable to the immediate circumstances
- Loss of interest and enjoyment in usual activities which have previously been a source of pleasure
- Reduced energy, sustained fatigue and greatly reduced activity
- Reduced concentration
- Reduced self-esteem and self-confidence
- Guilt ideation and ideas of self-blame and unworthiness
- Pessimistic view of the future
- Suicidal or self-harming ideation
- Sleep disturbance
- Reduced appetite

Depression is a major concern for most primary health care teams. Studies have shown that between 9 and 20 per cent of Westerners will experience significant depression at some time in their lives, and that clinical depression is twice as likely in women as in men (MacLachlan 1997). The Kings Fund (Freeman et al 1997) has outlined how the

COPC model can be applied to addressing depression in the primary care setting. Interventions for depression within a COPC framework suggested include primary prevention monitoring of at-risk groups such as post-natal mothers, more focused targeting of vulnerable patients approaching transitional developmental points, social support interventions and mental health promotion. Secondary and tertiary prevention strategies include psychological interventions such as cognitive-behavioural or family therapy, social interventions such as social learning therapy and therapeutic group work. Psychiatric input and medication are also likely to be important components of a depression management and prevention programme in primary care. Depression in older people is particular considered to be a significant issue for primary care teams, and is mainly addressed in the primary care setting by general practitioners.

Depression amongst older patients in primary care has been shown to have a high prevalence and complexity of presentation, as well as the presence of co-morbid medical conditions which can contribute to depression physiologically, psychologically or through the side-effects of prescribed medication (US. Department of Health and Human Services 1993). Depression severe enough to merit clinical intervention has been estimated as affecting approximately between 10 and 15% of over 65s with an incidence rate of 2-3% per year (Hughes 1997) to as high as one in five older people (Iliffe et al 2000), mainly as a disability related "demoralisation syndrome". Iliffe et al (see Figure 3) attribute the relatively low recognition of depression in older people in general practice partly to general practitioners reluctance to diagnose that which they cannot treat. The small minority who have clinical depression amenable to effective treatment by antidepressants are far outweighed by the majority whose depression is more diverse in presentation sometimes linked with areas such as disability, social

factors, role changes and issues of identity. The conclusion of a 14-year literature review of the Dutch literature of the prevalence of depression in the elderly (Van Marwijk et al 1995) was that depression was a sizeable, and increasing problem for which there were clear therapeutic options. In the Van Marwijk et al study of depressive symptoms and depressive disorder in 384 general practice patients over 65, they found a high prevalence of depressive symptoms and depressive disorder. Prevalence ranged from 11 to 29% of patients depending on the measurement instrument and scoring cut-off point. Interviewing found 17% warranting a diagnosis of depressive disorder.

Cross-cultural comparison challenges the perspective of older people experiencing a particularly high level of clinical depression and highlights the variability in prevalence of depression in this population in different cultures and settings, and the majority of older people in Europe have been found to be mentally well (Copeland et al 1999). Depression is far from being an inevitable component of ageing. We are also reminded by Hughes (1997) that most older people do not experience depression in later life and that old age should not be perceived as characterised by sadness and depression. The ideal focus group for intervention is older people who experience depression which is significantly affecting their everyday life (who may not meet the criteria for clinical depression) and those presenting with symptoms characteristic of clinical depression. A review of epidemiological studies of depression across the life cycle showing a lower prevalence of depression in older people (Wittchen et al 1994) was cited as possible evidence (Henderson 1994) supporting “psychological immunisation theory” (Henderson et al 1972) which posits an increased psychological resistance to stress as a result of repeated exposure to stressors over time.

Figure 4:Depression in elderly people (reproduced from Iliffe et al 2000)

Depression in elderly people is

Underestimated because:

- Depressed people over the age of 65 are four times more likely to commit suicide than younger people
- Depression in later life is associated with high use of medical and social services
- Depression particularly affects those older people caring for others

Under diagnosed because:

- Community studies show under documenting of depression in medical records when compared with prevalence of depression

Under treated because:

- Not all of those who are diagnosed with severe depression are treated
- Depressed older people are more likely to be treated for anxiety (or symptoms like pain) rather than with antidepressants or psychological treatments-even though the commonest drugs used for suicide by self-poisoning among older people are painkillers and sleeping tablets or tranquillisers.

Assessment of Depression in Older People

Assessing depression correctly in general practice does not always lead to referral for treatment (Macdonald 1986), but a range of screening instruments for depression in older people used by different disciplines in primary care have been developed. The main standardised tools include:

- The Geriatric Depression Scale (GDS) and the short GDS (Van Marwijk et al 1995)
- The Becks Depression Inventory (BDI) (Wells J et al 1993)
- Selfcare (D) (Banerjee et al 1998)
- The Brief Assessment Schedule Depression Cards (BASDEC) (Adshead et al)

Older people and by extension ageing has been characterised as a complex problem in medicine requiring multidisciplinary collaboration (Clark 1994; Savery 1986). :“The multiple and complex needs of the elderly require interdisciplinary collaboration amongst many different professionals to provide comprehensive care” (Deveau et al 1997, p707). Older people have been construed in interdisciplinary (nurses, social workers, psychiatrists, lawyers, doctors, occupational therapists, pharmacists, volunteers, chiropodists, ethicists, family/client member, educators etcetera) panel discussions primarily in terms of risk to themselves, isolation and ageing as leading to death. Older people and depression as stated earlier is seen as a significant issue in primary care and ageing characterised as a time of risk and the development and illness and disability. Deveau tabulates (1997:p.715) examples of interdisciplinary panel discussions regarding older people at the Interdisciplinary Summer Institute on Gerontology. This includes panel topics such as:

- “Communicating with the lonely, isolated and depressed: institutional concerns”
- “Approaches to risk assessment”
- “The professional’s role with the dying person”
- “How various professionals assess for risk in the community elderly”
- “Assessing for competency”

- “Untapped resources for assessing risk”

What might be the factors which make people more vulnerable to depression in later life? Knowing the predisposing and precipitating factors to depression in this age group obviously greatly facilitates a primary preventative approach. The development of depression in later life has been associated with a complex interplaying of social, physical and psychological factors which include gender (female), past history of depression, family history of depression, widow(er)hood, poverty, living in an institution, chronic illness and disability, lack of social support, personality and brain changes, major life events, retirement, major social difficulties and medication (Hughes1997). An alternative question to start with is what factors contribute to ageing without encountering significant psychological and social problems?

A rather selective review of the literature in this area by Koon (1996) relating to Asian and Oceanic older people, in particular Koreans led to conclusions which seem equally relevant to the Western context. He recommends that:

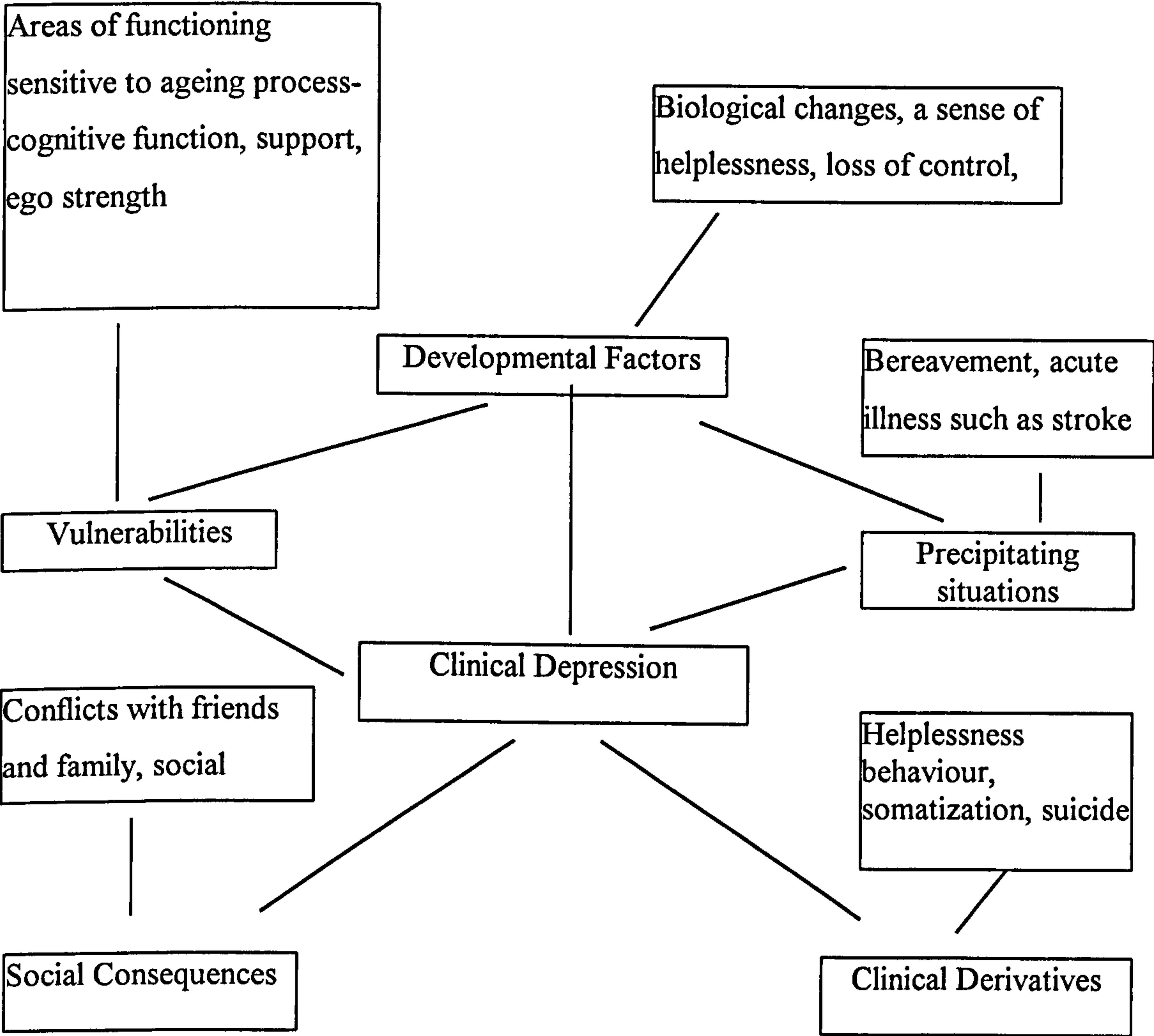
- The retirement age be reduced to enable older adults to develop their own appropriate life spans and points to there being no scientific support for the current retirement age in most Asian countries of 58-60.
- To develop and strengthen family policies and to provide more financial support for low income families so that they can better care for their elderly
- To expand the health and social care systems particular in the areas of diabetes, dementia, hypertension, chronic illness and disabilities
- To maintain the income of older people such that they can select their own living arrangements and life styles

Psychologists have helped to promote ageism through cross-sectional research comparing different age groups on personality and cognitive tests of which conclusions concerning age-related attributions disadvantaging older people have been challenged by recent research (Lawton 1976). Many age related differences disappear when factors such as educational background are controlled for. Ageing can be construed by younger people in such a way that depression ends up being normalised as a response to undesirable physiological, psychological and social changes. Conversations between younger and older people have been shown to construct a negative fragile identity for older people whereas the identity constructed in conversation between two older people is more one of social engagement (Coupland, Coupland & Grainger 1991). Self-esteem is linked to social status and Wood & Kroger's (1993) study of samples of address showed how health professionals and their receptionists can disempower older people through use of their first name without enabling the older person to employ a similar form of address for them. Grainger (1993) similarly showed how older people could be infantilised in discourse using an analysis of the conversation of 2 nurses giving an elderly person a bath (Wood & Kroger 1995).

A biopsychosocial model of depression demonstrates how complex the presentation of depression in later life can be, the circularity of the feedback process, and the points of opportunity of therapeutic intervention. Older people living independently are generally thought to be underserved in relation to health and social care services, but the mental health of older people living in residential homes is often neglected and their specific psychological needs under researched. Entering a care home can be accompanied by

losses such as losing their own home and feelings of anger and bereavement relating to the perceived loss of familial relationships (Cadby 1996).

Figure 5: Antecedents, maintenance of and consequences of depression in later life (adapted from Iliffe & Drennan 2000; 181).



Treatments for Depression in Later Life

Later life depression is not as amenable to treatment by medication as is depression in younger populations. Up to 60% of patients living with moderate to severe depression show significant improvement when prescribed antidepressants (Hughes 1997) but there is a lower prevalence of endogenous depression in older people, and the pharmacological treatments can also have more detrimental side-effects in this age group (Iliffe & Drennan 2000). Counselling is another option for treating depression in older people. Therapeutic counselling at its most basic has been defined as aiming :

"to involve individuals in a process whereby they can be helped to reflect on, and become more aware of, their current situation and the complexity of their own needs. It seeks to allow them to express their own feelings about their lives, without any attempt to impose our own ideas and views. Thereafter it seeks to enable them to initiate and develop new and appropriate responses to their situation." (Scrutton 1997,p.271).

Psychological problems often arise at times of transition, and dealing with loss and change is particularly relevant in later years following retirement, loss of peers and bereavement, changes in social status and role, changes in mobility and health, and the changes in parental relationship. These psychological and social challenges are common across the age span but may be perceived in older people as role as ed along by older people as an inevitable aspect of ageing leading to a disinclination to engage creatively with this client group. A study by Woolfe & Biggs (1997) found that out of a sample of 42 postgraduate students on counselling course, only 19 responded to a questionnaire about counselling older people. On follow-up the main reason given was that students thought the questionnaire irrelevant to them as they hadn't much experience in working with older people. There appeared to be a relative age bias and

reluctance to work with older people in the sample, and therapists' counter transference is identified as an issue.

Dynamic psychotherapy generally has favoured younger age groups in its development, been slow to adapt to the needs of older age groups and geriatric psychotherapy and psychiatry has focused disproportionately on the most physically and cognitively impaired section of the older population (Kahana 1979). The growing number of reports of successful treatment of older people using dynamic psychotherapy (Kahana 1979; Kaufman 1937). The life span development model (Erikson 1963) has been expanded in its final stage (Peck 1968) to include 3 specific conflicts to be addressed (Stuart-Hamilton 1994):

- Ego differentiation versus work-role preoccupation
- Body transcendence versus body preoccupation
- Ego transcendence versus ego preoccupation

Psychodynamic counselling aims to make conscious the unconscious internal conflicts which underlay the presenting problem and the client is enabled to reintegrate and own the projected parts of self. The unconscious conflict is expressed within the counselling relationship through transference and thus can be isolated and rendered explicit. Terry (1997) along with other psychodynamic and psychoanalytic practitioners (McKenzie-Smith 1992;Hildebrand 1982) has challenged Freud's earlier stand that psychoanalytical psychotherapy is not appropriate for older people (Kahana 1979) and he particularly highlights conscious and unconscious fears of death as a recurring theme. In fact older people are described as being more time-focused and better able to make effective use of therapeutic sessions than younger clients. It is

therapists who often encounter more problems working with the older client such as their own fear of dying, counter-transference of parental relationships, fear of ageing and the future and fear of dependency. Client issues outlined by Terry (1997) which are particularly associated with later life and are common themes to psychoanalytical psychotherapy and psychodynamic counselling are:

- Changes in identity and losses associated with work, children leaving home and sexual potency
- Loss of independence and fears of dependence
- Difficulties in intimate relationships coming to the fore with the life and generational changes
- Changes in gender role
- Sexuality

The function of sexuality in older age is usefully acknowledged in psychoanalytical psychotherapy as it can sometimes be marginalised and rendered invisible by younger adults as either not important or as distasteful, particularly in the earlier years of sexual maturity where sexuality can be strongly associated with social physiological attractiveness. Ageing is not just about loss but also about taking on new challenges and experiences. Freud may have considered older people to be insufficiently “elastic” in their mental processes to benefit from psychotherapy (Terry 1987; Cohen 1981) but it has been proposed that some older people become motivated in later life to reconstruct the future and integrate past experiences in a way that might actually make them more likely to benefit from psychotherapy (Cohen 1981).

Cognitive therapy can assist older people in identifying, challenging and changing those thoughts which are contributing to and maintaining the depression, and address ageist beliefs at an individual level. This directive approach enables the counselling psychologist to identify the habitual negative thoughts improve their objective rational thinking and coping strategies. A summarised cognitive assessment and a cognitive model of depression for a case example is reproduced below:

Figure 6: Mrs Turner's vicious cycle of helplessness and hopelessness (Wells & Wells 1997; p. 343)

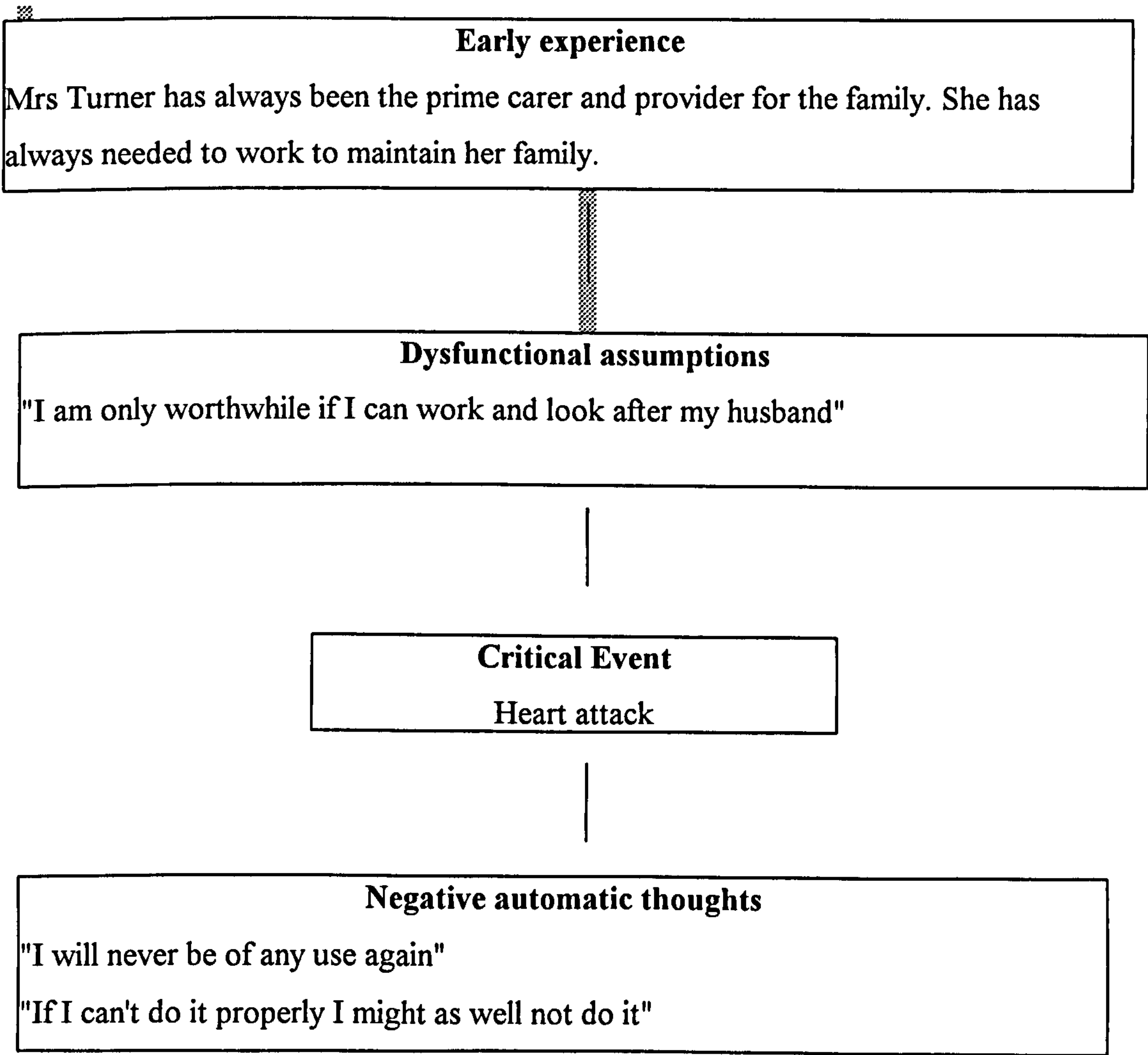
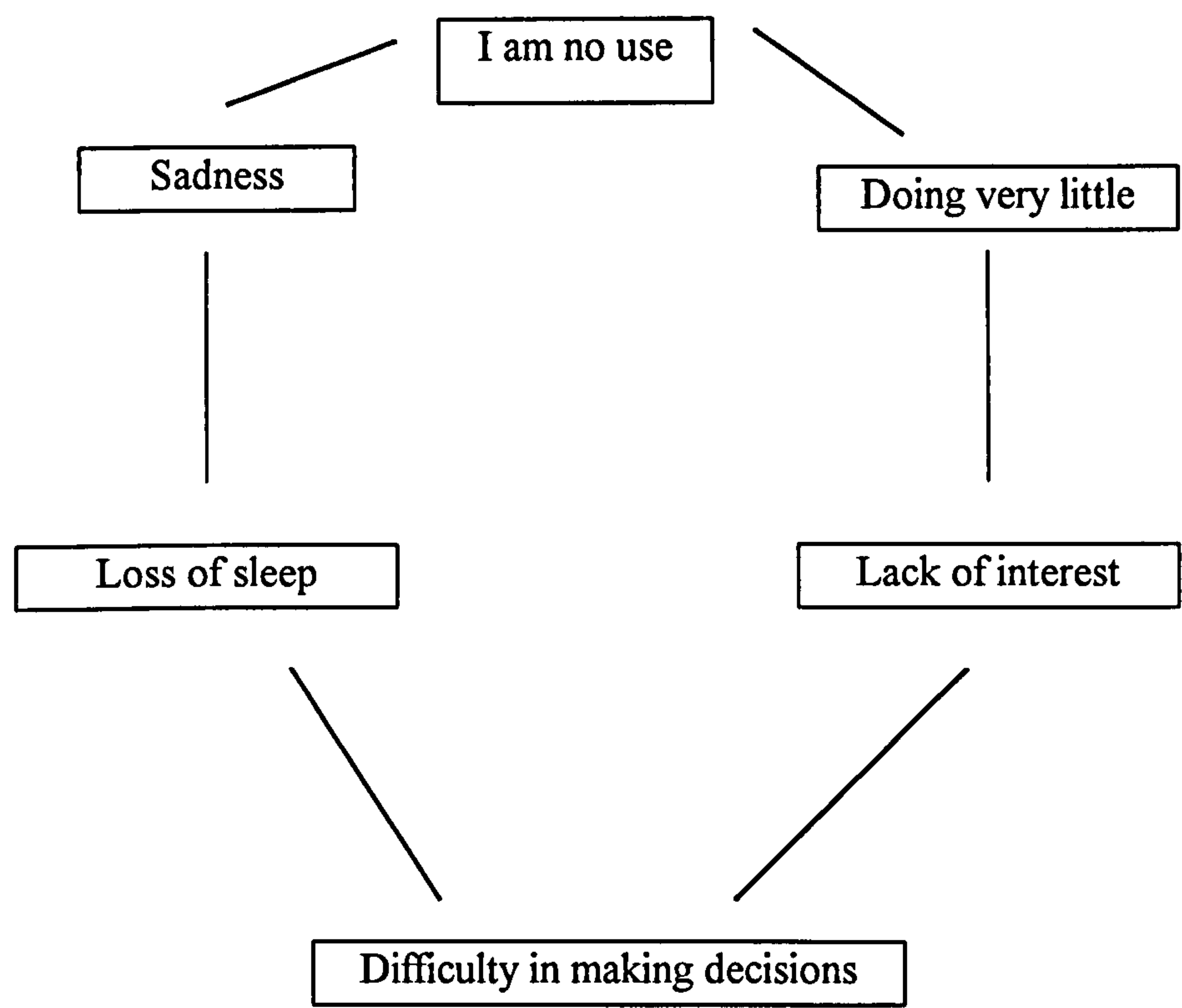


Figure 7: A cognitive model of depression for Mrs Turner (Wells & Wells 1997; p. 343)



Cognitive behavioural therapy integrates behavioural and cognitive therapy. It is widely seen as an effective treatment for depression although not one primarily identified by general practitioners as appropriate for the treatment of older people with depression unless they have psychiatric experience. Counselling was favoured by 60% of general practitioners as opposed to 21% who chose cognitive behavioural therapy as the treatment of choice for older people with depression in one study investigating referral by general practitioners of older patients with depression (Collins et al 1997). The authors argue for increasing general practitioners referral for cognitive behavioural therapy which they define as psychological therapy as opposed to counselling.

Narrative and Group Interventions

Group psychotherapy has been described as becoming increasingly prevalent as an intervention with older people with clear economic advantages (Finkel 1990) and early documented support for its effectiveness with this age group (Linden 1953; Silver 1950). Finkel (1990;1189) views group psychotherapy as benefiting older people in a number of ways:

- In establishing a sense of personal and social identity
- A nurturing source of support
- Increasing insight and coping mechanisms
- Enhancing self-esteem
- Facilitating resolution of conflict

Storytelling has been reported therapeutically beneficial with older people across the range of physical and mental abilities, including those living with dementia (Crimmens 1998), the evidence is based however more on case study reports than research evidence. Crimmens uses the technique extensively in her work with older people as a drama therapist as a creative way of enabling the group to express themselves as well as act out different roles and relationships. The source of the stories used are often from mythology from different cultures which can introduce new stories, archetypes, and variations on themes relating to old age, challenging those which might contribute to depression and fixed role identities. The groups act out the stories and actual physical objects are handled and incorporated in the stories which can both prompt memories and bring them into a current context. These acted out narratives can contain very powerful psychodynamic themes, and challenge as well as reinforce strong cultural beliefs and stereotypes as well as reflecting the universality of human

experience. Stories can be used with older people by therapists of different orientations as means of exploring, actualising and changing powerful feelings, thoughts, beliefs, current relationship configurations and personal life narratives. One example of a Chinese story that Crimmens (1998) uses which is very similar to “Beauty and the Beast” but with some significant variations.

Storytelling has also been used in gestalt reminiscence therapy (Leary & Nieuwstraten 1999) where reminiscence therapy is integrated with the gestalt goals of completing unfinished business, identifying and expressing feelings and assuming mature responsibility for personal actions and experiences. Like systemic therapy an arc is made between the past, present and future. A weekly counselling intervention within an existential story-telling framework was investigated by Cadby (1996) with a very small selected sample of older people(4) in a residential care home and found to have some benefits. Leary & Nieuwstraten (1999) report on the discourse analysis excerpts from a transcript of a gestalt reminiscence session with a small sample of five over 65s in a nursing home. The size of the sample and the absence of a comparative group limits the conclusions which can be made relating to the age of the participants. The group was also predominantly female with only 1 male, so a gender bias may be present. The main finding was that older adults can express unfinished business in impersonal language and that a key role of the therapist was to enable the personalisation of the expression and the exploration and completion of the unfinished business. The peer group were able to introduce different perspectives on the stories being told.

The relationship between depression and marital quality in mature couples has been explored (Sandberg & Harper 1999) using marketing survey data in the US. The sample included 10,000 married couples between the ages of 55 and 75 and was randomised across all states (did not include Alaska). The study found that depression in mature marriages is negatively associated with marital quality and support for the existence of “hardiness” as a mitigating factor. Marital distress and depression were found to be highly related and wives scored substantially higher on depression and marital distress than the husbands. The study did include people experiencing predominantly good health so was not representative of those with functional impairments, general ill health and disabilities. The couples were also pre-retirement rather than people who may be more generally classed as older people in the UK, the over 75s.

Only just over a 10th of the population of people with mental health problems will be seen by mental health professionals. Giel et al (1989) conclude that most general practitioners do not identify mental health issues associated with life events or social support, patients which may benefit from seeing a counselling psychologist. Counselling psychologists working in primary care will only see the patients who have passed through 3 filters unless patients have direct access, which may not be feasible in many busy general practices. Community members can be made more aware of when it is advisable to consult in relation to mental health concerns and the behaviour which might contribute to this decision. General practitioners can be supported in developing their skills in detecting significant mental health problems and in making appropriate referrals. Interventions can be introduced into a community to address the high level of community morbidity found, such as mental health promotion, social support networks

and professionally supported peer led mental health advocacy, advisory and friendship groups

Treatment of depression in the community using a COPC approach appears to be non-existent but interventions into depression within a COPC framework outlined by the Kings Fund included (ref):

- Primary prevention monitoring of at-risk groups
- Focused targeting of vulnerable patients approaching developmental points of transition
- Social support interventions
- Mental health promotion
- Secondary and tertiary prevention strategies such as cognitive-behavioural or family therapy, social interventions such as social learning therapy and therapeutic group work
- Psychiatric medication and intervention

Providing a comprehensive package of COPC depression (or other mental health problem) management to a community would require extensive collaboration between a range of primary care health professionals, psychologists, psychiatrists and social services.

Community oriented primary care has been specifically promoted by the Kings Fund as a feasible model for addressing depression and anxiety in primary care. The application of the model to these areas has not really been tested in practice however for the COPC approach has generally been applied in practice to physical and social problems. There appears to be little, if any, research or published clinical evidence to

support the application of the model to mental health problems, including depression and anxiety. A literature review carried out of published studies in COPC of the last 20 years (Iliffe & Lenihan 2000; Lenihan & Iliffe 2000), found none, which had targeted specific psychological or psychiatric problems. An intervention aimed at raising self-efficacy in an elderly day centre (Haber 1996) was the closest attempt to apply the COPC model in a mental health context in any study which involved¹⁸ addressing of “passivity” amongst older people attending a day centre, resulting in the initiation of a health promotion group and a chess club by the older participants. Specific COPC community diagnosis questions relating to the needs of older people have however been outlined (Kvale et al 1990):

- What are the prevalent types of dysfunction amongst older people in the targeted community?
- Are they higher or lower than expected?
- What is the quality of the primary care services available to this community, which groups have problems in accessing the care and what barriers to care exist?
- What community medical needs are being met, which are not met, and what are the at risk groups?

In summary depression in older people is of sufficient prevalence to be of concern in general practice and an overview of a range of possible treatments ranging from the conventional pharmacological, cognitive behavioural, psychodynamic, group to the narrative type interventions has been outlined, followed by a look at the applicability of the COPC model to addressing depression in older people. The multidisciplinary primary care groups in the study can be assumed to be aware of many of these clinical options, as well as the frequency of presentation of depression in older people. The

group's brief training in community oriented primary care methodology is intended to equip them with a model which they could feasibly use to design a programme which will address this problem as an equal multidisciplinary COPC team.

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CHAPTER 4: AIMS AND METHODOLOGY

Research Objective

To make recommendations regarding effective participation in collective decision-making and team working for psychologists, particularly counselling psychologists, working in primary care. To raise awareness of the process of communication in multidisciplinary working and its impact on allowing a counselling psychology agenda to emerge.

Research Questions

1. To investigate the process of multidisciplinary working in the primary care sector, in relation to a specific mental health issue – depression in older people.
2. To explore the significance of the non-hierarchical multidisciplinary assumptions on which the COPC model is based, for the implementation and development of the model and for the practitioners involved.
3. To identify the professional implications of (1) and (2) for mental health practitioners working in primary care particularly in respect to power, involvement in collective decision-making and the interaction of different professional discourses.

Sample

A half-day training workshop in community oriented primary care was designed using the Kings Fund material for facilitating a COPC workshop programme in primary care. (The workshop booklet is reproduced in Appendix 1). This required condensing and summarising material from the 8 session Kings Fund COPC workshop programme ((Kings Fund 1994) into one 3 hour session.

3 one-day COPC training workshops were set up for primary care practitioners including psychiatrists, clinical/counselling psychologists, general practitioners, social workers, welfare advisers and district/practice nurses. The workshop framework consisted of training in the theory of the COPC approach followed by the participants being asked to design a COPC programme to address depression in a general practice population, a task for which they were given an hour. The workshops were co-facilitated by a Chartered Counselling Psychologist (researcher) and a General Practitioner/Reader in Primary Care. The groups were left alone to complete the group task (see Appendix 1 for the workshop task).

Mailings were sent out to all Camden, Islington and Barnet general practices, Camden and Islington social services, North and South Camden Primary Care Groups, Islington and Barnet Primary Care Groups, selected Departments of Psychology, Departments of Psychiatry and specialist clinics in Camden & Islington. A copy of the information leaflet is in Appendix 2. The mailing included a reply slip and interested participants either registered by post, telephone or fax. Participants were not

individually directly targeted and generally registered by leaving contact details on an answerphone. A maximum of 8-10 places were allocated to each workshop and participants were distributed across the workshops to ensure as far as possible a multidisciplinary group in each workshop, subject to the availability of the participants. Places to each discipline were allocated on a first come first served basis, subject to ensuring the range of disciplines within each workshop. Locum cover was offered where needed but none of the participants applied for this.

Workshop 1 consisted of 2 general practitioners, a welfare adviser/social worker, a clinical psychologist and a practice nurse. Workshop 2 included 2 general practitioners, a counselling psychologist, a health psychologist, a welfare adviser/social worker, a practice counsellor, and 2 practice nurses. Workshop 3 consisted of 2 general practitioners, a community nurse, a welfare adviser/social worker and a practice nurse. The counselling psychologist booked into workshop 3 had to cancel due to ill health.

Workshops

The workshops were audiotaped for the whole 3 hours using 3 multidirectional microphones, 2 tape recorders, and a digital video recorder during the group task. The general practitioner facilitator presented the COPC model and approach, whilst the Counselling Psychologist facilitated the discussion and introduced the group task. The GP facilitator summarised the feedback after the group task in the last half hour of the workshop. The group were left alone to complete the group task in the middle hour of the workshop. Designing a COPC programme to address depression in older people

was the task given to the multidisciplinary group of primary care practitioners in the research and training workshops.

Depression in older people is an issue which is encountered by all the disciplines in primary care and has a wide range of definitions across professional primary care disciplines and in lay settings. It was intended that the knowledge-power imbalance between the disciplines would be limited by selecting this in the study setting, as it was anticipated that all the participant practitioners would have the clinical experience and professional terminology to describe depression and associated interventions. It was also selected as an issue for intervention in the research and training COPC workshops because of its perceived importance by all disciplines in primary care.

Collection of Records and Documents

A systematic literature review of Community Oriented Primary Care (COPC) was carried out which included theoretical papers and empirical studies published over a 20-year period. Literature reviews on multidisciplinary working, social constructionist approaches to mental health, and discourse analysis in mental health and primary care were carried out from January 1980 until January 2001. A coding and discourse analysis methodological framework for analysing the group transcripts was constructed based on the literature.

Transcription

The transcription was taken from the audio- and videotapes of the groups working by themselves on the assigned group task (1 hour). This resulted in 3 hours of transcribed group conversation. Basic transcription notation was used. In some parts of the transcript exact words are difficult to identify and this has been marked with dashes, dots were used to indicate pauses. The participants were identified according to the following abbreviations:

GP-General Practitioner

WA-Welfare Adviser/Social Worker

ClinP-Clinical Psychologist

PN-Practice Nurse

CP-Counselling Psychologist

PC-Practice Counsellor

HP-Health Psychologist

CN-Community Nurse

Each contribution in the transcript has been numbered according to the order it occurred, the speaker has been identified in the transcripts using the discipline code. The speaker codes are numbered where more than 1 professional of the same discipline is present in the workshop, for example “GP1” and “GP2”. The full workshop transcripts are in Appendix 3. The coded sequences were retained in the overall transcripts when analysed to maintain the context and sequence in which they occurred. The transcript data from all 3 workshops was coded independently twice, by

the researcher and an assistant, all coded turns and sequences were then included in the analysis of the research questions.

Analysis

The area of enquiry was spoken interaction focusing on power relations and professional discourse constructions within a multidisciplinary team applying the COPC model without the direct intervention of an interviewer. Preliminary coding categories for pragmatic organisation of the data were constructed related to the research questions foci. These were:

- Professional identity
- “Good” practice
- Ethics, morality & values
- Hierarchy, power differentials and delegation relating to hierarchical status
- Team working, multi-disciplinary and delegation according to professional specialisms
- Community
- Prioritisation and resource allocation
- External observing gaze, outside policing of group activities
- Depression
- Older people and ageing

The analysis of discourse focused on professional discourses and ideologies, and adopted a contextual (relating structural descriptions to the context) rather than a

textual (dimensions accounting for the structures of discourse – the micro linguistic components of discourse such as grammar, syntax etcetera) (Lupton 1992). Data analysis was applied to the transcripts of the verbal interaction in the groups during the hour group task. Existing research studies were reviewed to identify appropriate methods of analysis. The text was analysed for evidence to support or refute hypotheses concerning the intention and consequences (effects) of talk (Wood & Kroger 1995). Extensive samples of the material under analysis was included in the results in order to allow alternative hypotheses to emerge in line with the discourse analysis practice of rejecting objectivity and making explicit the researcher perspective. The reflexivity of language was acknowledged and the discourse of the discourse analysis itself is addressed in the discussion (Cowan 1994).

The broad components of the critical discourse analysis of the transcript text (Fairclough (1989) looked at the experiential value of the words employed, how the speaker's natural and social world was represented in relation to context, knowledge and belief and what classification schemes were drawn on? Examples of rewording were searched for, and ideologically significant meaning relations (synonymy, hyponymy and autonomy), particularly where the rewording counteracted dominant ideological wording. Relational values were explored through the identification of euphemistic expressions and formal as well as informal words and phrases. Ideological metaphors were also looked out for, particularly where the context was atypical, and ideological markers influencing the direction of discourse or marking the speakers ideological position. Some data analysis at a grammatical level was also carried out, in particular the clarity of agency conveyed in the sentences and to what extent processes were what they seemed. The use of nominalizations and the

active/passive and positive/negative nature of sentences and their impact on the meaning and function of the sentence in context were also noted. The relational values of grammatical features, the modes (declarative, question, imperative) were identified as important features in exploring relational modality. The use of pronouns in different contexts and their effects on the discourse were included in the analysis. The means for referring inside and outside the group were also of specific interest. Turn-taking and the use of discourse to control the contributions and turns of the other participants and the interactional conventions employed were used were also of interest.

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CHAPTER 5: RESULTS AND ANALYSIS 1

Workshop A

The discussion begins, [A2] with the Welfare Adviser/Social Worker [WA] and one of the General Practitioners [GP] suggesting that notes are taken, ostensibly so that they 'don't drift', but also so that there is a record of what transpires. The note-taker can occupy a hierarchically lower position in a meeting, but the power they possess by virtue of being the record keeper can also make it an attractive position for an individual who can use the note-taking to facilitate and direct the discussion. In this case a clear agreement on who is the note-taker is not reached. The clinical psychologist disqualifies herself on grounds of being dyslexic. She then starts a definition of clinical depression, but then adopts a less expert role by throwing open a question to the group on how many symptoms of depression are needed to diagnose depression. This serves a relational function in that it is inviting the others to share their knowledge through taking a one down position.

A.5.ClinP: Yes I think that's quite right, definition of -----if somebody else could-----I would actually prefer it if-----first because I'm dyslexic (laughing) because it crops up now and then, so if somebody wants to take notes. I think definition is important, you know and what that is. Five percent have major depression clinically defined as well, clinically defined. (pause 5 seconds) So do symptoms of depression, so that they have to have a certain number of symptoms don't they?

The Community Oriented Primary Care model offers a range of options for defining the context of a programme. It can be totally community based, it can involve the community services, the practice and/or secondary care. The context to some extent depends on the aim of the COPC programme and the other stakeholders which are

engaged, and will serve to make it effective. The first 14 contributions are mainly from the GPs, with the practice nurse occasionally interspersing an “mmm”, and the above contribution from the clinical psychologist (A.5). GP1 defines the context of the planned programme as being the general practice and GP 2 extends the options to secondary care interventions through a reference to a previous project carried out at the Royal Free Hospital.

The Clinical Psychologist [ClinP], Practice Nurse [PN] and two General Practitioners [GP1] and [GP2] debate the idea of sending out a questionnaire as a means of finding the level of depression in the target community. The medical model for depression dominates from the start of the group with the focus being on diagnosis of depression and a Royal Free study which used psychiatrists providing community based interventions as a reference in the discussion. GP2 is concerned with identifying a questionnaire for this diagnosis which is supplied by the ClinP first as a statement that this is what will be used, then she steps back from this fixed position to ask the group if it's “ok” and starting to provide a background explanation to rationalise her choice. GP2 interrupts this rationalisation, takes the floor as the speaker and finishes the ClinP's sentence relating to how many questions the Becks has, thereby claiming knowledge in this area. GP1 then asserts the necessity of medical care in this programme though saying that blood pressure checks have to be done. A hierarchical boundary is drawn up by the ClinP when she reinforces her own expert position through indicating the lack of expertise of another health professional in assessing depression.

A22. ClinP: Well a nurse practitioner can even do a Becks. It's not difficult-----

A common understanding starts to be constructed here whereby medical care is the essential intervention framework into which other interventions are inserted which are seen as potentially useful. The conversation remains dominated by the medical and psychological practitioners. The PN has still only been indicating general agreement through “mmm” (A6, A9, A13, A18, A20) by this point in the group discussion. The welfare adviser has not spoken since first asking who was going to take notes (A2). As the discussion revolves around which method will yield the best results [A5 onwards], the issue of patient consent is first raised though by the WA [A25.], who states the importance of involving the patient in the study. Patient involvement is then defined by the Clinical P’s response as “to have permission”; a definition which is accepted by GP2, although the use of the word “imposing” by the WA indicates the WA is operating from within a different ideological framework at this point. The PN shifts the discussion away from consent back to general methodology.

A25.WA: -----don’t we need to involve the person. Aren’t we jumping a little bit? Don’t we need to actually involve the patient, the person in this? To say we are actually going to do this-----?.....

A26.Several: Oh yes

A27.ClinP: Oh yes, we have to have permission.

A28.WA: cos in a sense we are imposing something aren’t we?

A29.GP2: Yes. Oh you’d have to ask them whether they wanted to answer all these questions wouldn’t we, for a start?

(pause 5 seconds)

A30.PN: Are we going back to the idea that ummmm due to work load and what have you, that, you know, the ideas for a postal questionnaire ----- we could look at that point. Mmmm

Everybody agrees that the patients must agree to be involved, but the nature of patient involvement is defined by the clinical psychologist as obtaining permission [A26-30]. The task given to the workshops is to ‘find a way to evaluate depression in older people and a viable method to address it in the community’. The group is now

confronting a key task in multidisciplinary groups which is to reach consensus on definitions of the task in hand which integrates the different perspectives. The flow of the discussion seems to be towards smooth progression of the programme both in the group discussion and in the outside world. Ideas seems to be gaining root as options without much negotiation and it is the ClinP who raises the lack of clarity in defining depression so far. GP2 recontextualises defining those with depression as identifying patients already diagnosed and being treated by a GP or hospital for depression. This shift in focus is challenged with the ClinP response regarding them already receiving treatment but the discussion has now shifted firmly towards identifying a group to be accessed through GP lists. Mailing everyone over 65 years is becoming the preferred option. GP2 seems to be dominant in this part of the discussion and advocates the use of district nurses as well as the mail shots and phone calls. The next challenge comes from GP1 who raises the issue of patient consent again and then introduces the patient perspective through identifying herself with the patient. GP2's response functions to position the group as non-coercive and respecting civil liberties, but does not pick up on the active engagement of the patient beyond consent as an issue. Patients may be able to assert power through not answering these questions but the power in-balance in the clinical encounter, which maybe reproduced in a telephone call, may mean that the patient feels under obligation to answer the questions if they are asked by a health care provider (Coupland, Robinson & Coupland 1994).

A45. GP1: Well, that might be difficult though might it. But if you like.....if people ring up and ask you if you want to do a questionnaire, with me I'm never all that sure I want to answer the questions.

A46.GP2: Umm. It's a free society, you can't make them.

The welfare adviser tries to broaden the discussion regarding options for communicating with the target group and raises the question of stereotypes. As GP2 has just expressed the opinion that elderly people are suspicious when someone comes to their doorstep she responds personally in the following exchange and seems to take it as a direct comment on her previous contribution. The personalising of the comment weakens its impact and the conversation is shifted and reframed by the ClinP into a discussion on targeting.

A52. WA: I think-----people are whatever the age-----assumption because---- a woman of 59 is 59. A woman of 60 is suddenly geriatric or -----

A.53:GP2: I'm not saying that! (laughs)

A.54.WA: No I know, I know-----so strongly no I think there is a danger about internalising stereotypes

A55.ClinP: Already, we've gone into a problem on how we are going to reach this group.

The Welfare adviser raises the issue of different discipline's having different perspectives and orientations following the ClinP contribution (A57) that the group would hopefully be working with "social workers and psychologists and community nurses and CPNs and geriatricians" which the ClinP responds to as (A59) "my clinical diagnosis of depression would be very different than say from a social worker's point of view". She separates herself out very definitely here from the social worker and the use of the term clinical implies a perspective allied with medicine. It maybe a different clinical perspective to her medical colleagues, a clinical psychologist's one, but it can be clearly differentiated from others outside medicine through being clinical. There is also a question of who is excluded from the list of multidisciplinary professionals who ideally will be worked with, and the hierarchical implications of them being "called in" to meet with us.

A57.ClinP: ----- that's our first trouble, how do we reach them, and again multidisciplinary... hopefully we are working with social workers and psychologists and (knocking sounds) community nurses (knocking sounds) and CPNs and geriatricians, and so perhaps we need to call them into meeting us ----- providing ---- particular area. Ask people to bring along their idea of what statistics might be, umm and then redefine what major (knocking sounds) depression would be within that group. Cos there is a difference between, as you say, brief reaction and depression.

The clinical view here is not only highlighted and the expert clinical stance of the ClinP as opposed to the social worker, but the latter is described as only having a point of view. The WA challenges the concept of there being one super-ordinate clinical definition and argues for a broader multidisciplinary definition of depression. Statistics and evaluation are linked with “narrowly focused responses” but it is unclear whether the WA means that certain kinds of evaluation are narrowly focused in themselves, whether evaluation itself might default to being too narrowly focused in a multidisciplinary group, or both.

A68.WA: -----suggesting maybe one should include all ingredients, rather than narrowly focus on one particular definition, so wouldn't all ingredients be valid? If we are coming from different orientations, should that not all be thrown into-----That's the difficulty of multidisciplinary teams in a sense.-----if it's too narrowly focused, umm you will get narrowly focused responses, that's statistics and evaluation too.

GP2 responds to this by shifting back into a medical framework refocusing on how “major depression” responds to treatment by antidepressants, and the issue of medically defined conditions being likely to respond to medical interventions whereas broader definitions might give rise to wider interventions designed to address those specific definitions is not addressed. GP2 has claimed Aesculapian power through reference to an external medical fact presented as objective. The medical position is then strongly supported by the ClinP who differentiates between different intervention

groups as possibly requiring short or long-term medication, which she later qualifies (A77) as “for the major depression, but not necessarily for the other depressions”.

A69.GP2: But....the problem is A) what the question is, and B) also, I mean major depression responds to antidepressants, whereas other sort of depressions....

A70.WA:Hmmm

The WA issues the most challenging response yet (A78) which he qualifies as “not wanting to push it again” indicating he is aware of the earlier shift in the conversation away from the topic he introduced, and that he is now claiming the floor again. He is implying that the topic has to be “pushed” to be heard. The reactivity of the interventions being discussed is an issue for him and indeed the preventative component of the COPC model is not being reflected much in the discussion.

A78.WA: What happens if somebody ummmm, I appreciate what you are saying and I’m not wishing to push it again, but what happens if somebody’s very worried about finances and they-----very distressed, depressed for 6 months? Do you treat that with what you are saying? Is it a simplistic reactive thing?-----let’s put them on a regime of medication.

A79.ClinP: Well no, I would already have a definition, as I say clinically.....

The ClinP defends her position through reference to the clinical definition assumed by it, much as her medical colleague did earlier. The practice nurse who has been so quiet up until now supports the WA adviser position and suggests some older people might be depressed for financial reasons or because of mobility, isolation or disability related problems. She provides a statistic of 15% to support her case, but as she offers no evidence for this, her claim must be evaluated from her credibility as a professional nurse, the claim is not directly challenged but the ClinP does alter the figure soon after in the discussion, again without evidence being proffered. The ClinP now lists sources of loss which might contribute to depression as well as other pertinent

psychosocial factors and ends up claiming this territory as her own whilst reinforcing the intransigence of the previous allied medical and clinical psychology position.

The PN describes depression as being “an overused word” in A85 and talks about “these people” as being “low in mood”. These people are those described by her as the 15% above but the challenge to the core concept being employed in the task is picked up by the ClinP as an opportunity to define the factors again which might contribute to depression. The alternate discourse of low mood perhaps being inappropriately addressed as depression does not emerge. The focus of the group’s attention is on defining and reaching the target intervention group, not on excluding those from intervention who do not fit diagnoses of depression. There has been no attempts to engage the community in the planned development of this COPC programme.

A90.ClinP:...so-----surely other people can. They all require to umm have to assess across the board to see certain things are being....

A89.PN:Mmm

A92.ClinP:(pause 2 secs)looked at.(pause 5 secs) I mean there is just a clinical depression which is called “free floating” anxiety which just, you’re not sure what the real causes are nor does the person. Now to define that.....I presume that’s the 5%. So that.....I would agree would be treated with antidepressants, which it’s not sort of negotiable. But the other 20%, hopefully these other factors I’ve just mentioned could be discussed.

A93.PN:Mmm

The group now concentrates totally on benefits, financial needs and agencies who could meet them such as the Citizens’ Advice Bureau and Welfare Advisers. The impetus seems to be more towards finding existing problems and matching them with existing solutions rather than developing anything innovative in line with the Community Oriented Care Cycle they have been asked to follow. The WA makes a

lot more contributions in this portion of the transcript, the other 2 main speakers being GP2 and the ClinP. The ClinP talks (A94) at the beginning of this debate around finances (A94-A127) of how “the community can begin to....to speak about their perceived idea of what depression might be to them”. This is referring presumably to the community diagnosis and prioritisation stage of the COPC cycle but rather than prioritising the factors underlying depression, the factors which are not defined as clinical are being redefined by the group as depression in lay terms. Are the community being asked about their perception so of clinical definition as clinically constituted, or as seems intimated something broader? The implications of equating poverty with depression are that the target group by extension has to be low income (wealthier people are assumed not to be depressed within the group framework) for the COPC programme. The point of the group task as defined by the ClinP (A127) prioritises individual professional validation and making some difference to the target group in terms of resources received rather than reducing the level of depression in the target group or another population based COPC goal.

A127.ClinP: ..and that, in that sense you can have some peace of mind as a professional that you’ve at least reached some validation umm and I think that’s the whole, for me, that’s the whole point of the exercise to least get the minimal umm and make sure the people are getting at least something umm and they are not being denied (pause 3 secs).

The WA soon raises the issue of user involvement again where he asks for clarity in this area regarding how the programme would be implemented. The response from GP2 regarding what has to be done is posited as an answer on behalf of the group highlighting the necessity of a medical options menu, this response is supported by the practice nurse and the discussion begins to focus on what can be offered by nurses and general practitioners. The patient’s GP in any event has to be notified according

to GP2 because of their privileged medical and patient knowledge which cannot be ignored.

A142.WA: I think we'd have to be clear, would it be us imposing or suggesting or creating a menu or would it be user led, or would it be a mix of that? So what stance would we as a group take? How much would the user be involved? (pause 5 secs)

A143.GP2: I think people who have been identified as suffering from major depression they've got to be offered some sort of medical intervention.

A144.PN: Mmmm. Yeah.

A145.GP2: Umm...whether that's, you know, a district nurse visiting them or offering them an appointment if their ---- their GP or they've got to be offered something. I think the GP has to be notified as well. I mean, in our practice we are involved in a lot of sort of projects and If you know someone whose got very high cholesterol or whatever, you can't just ignore that information....

A146.PN: Mmmm Mmmm

A147.GP2: sort of.. medically.

The discourse has become very medical in nature and other discourses are being defined as peripheral in that the priority is to meet the medical needs which may be identified during the programme intervention. The ClinP is notably making less contributions to the group at this point in the discussion (none between A139 and A170 inclusive), with the WA taking a facilitative role in relation to GP2. There seems to be a move towards equating being older with being depressed at this stage of the discussion which is exploring options such as exercise.

A163.GP2: Now what we've got to offer some of our elderly patients are exercise classes. So even without talking about depression or whatever, it's something for them to come out.....

The emphasis becomes from this point on how older patients can be brought into existing services and benefit from the expertise of each of the multidisciplinary professionals rather than the design of a multidisciplinary COPC programme. The WA wants to know whether the group will adopt 1 style or a number of styles (A176)

and the ClinP affirmation that a number of styles are needed is followed by an interesting summary of how she perceives the different disciplines might contribute to the care of a particular patient, particularly as her role description reinforces most a specialist knowledge contribution appropriate for patient care generally whereas the other team members are attributed situation specific more generalised tasks. The Authorisation model (Abramson 1984) of collective responsibility seems to be the primary model through which the ClinP is defining her position as a team member.

A176.WA: I'm drawing us back to ----- the task of what, what we will do as a group, what would be our style of.... what would be our style? Or would it be a number of styles.

A177.ClinP: A number of styles because we need to be coming in at a different point. You'd be coming in with, for example, at a financial point. I might be coming in cos somebody is coming presenting specifically with a mental health issue, generally speaking. You might be coming in because umm the repeat prescription, for example, you might be coming because the daughter has telephoned you.

A178.PN: Mmmmm

A179.ClinP: You may be coming in because you've seen somebody at home who is presenting with symptoms

A180.PN: Mmmmm

A181.ClinP: that are there for another reason....

There is still no attempt to draw on community resources outside general practice or the group member's services or to engage the community in the design of the programme. The programme is being designed within the menu option introduced by GP2. The ClinP states the diagnosis has already been made so the patient is in fact being offered "a menu of choice" (A187). She reinforces the idea of the programme as offering a menu of choice in A349 and A351, the WA also uses this term later (A340) to describe what the group is offering, and talks bout upgrading it. The language of consumerism is explicitly emerging here, but consumerism within professionally pre-defined options. The PN has been murmuring again in response to the discussion from A140-A191 but suddenly introduces the concept of patient

defined depression which she supports by referencing a “well-known...psychiatrist”. She does not complete her contribution as the ClinP asserts professional expertise by validating what the nurse has said, referring to her own experience as support and the role of training being able to recognise depression. The effect on the practice nurse is for her to go back to murmuring what can be assumed to be assent. GP2 challenges the ClinP statement regarding how depression can be identified by well trained professionals through external observation pointing out how much is missed in general practice. The ClinP response effectively sidesteps the issue and shifts responsibility onto the patient for the under-diagnosing of depression – they are covering it up – thus more subtle techniques maybe needed.

A192.PN: No no, I was going to say that people umm quite often won't tell you how they are feeling if you don't ask them how they are feeling, and so by the nature of saying “how are you feeling”, I don't know what I'm trying to say, you know but, umm ----- , quite a well known ----- psychiatrist said the best way of finding out someone is depressed is just to say “are you depressed?” (laughing) He reckons they will say “Yes” if they are and “no” if they are not. It's a little bit generalised obviously.....

A193.ClinP: But you know I use that a lot and its true..

A194.PN: Mmmm

A195.ClinP: and and aaaa, I occasionally get “I don't know”. (laughs) But one way you can tell, cos you've been well trained you know, the way they are dressed when you arrive if you go there, you know, if they are aware of sort of general hygiene, you know I mean we've all been----- to see them.

A196.PN: Mmmmmm

A197.ClinP: ...you know, what -----say, you know, “Did you not feel like shaving today? Are you unwell?”

A198.PN: Mmmm

A199.GP2: But in general practice or in medical work generally, half of depression in missed.

A200.PN: Mmmmmm

A201.ClinP: People are good at covering it.

A202.PN: Mmmmmm

A203.ClinP: So. That's why I may have sounded very clinical when I said the Becks, because Becks is very subtle.

A204.PN: Mmmmmm

The group have not been closely following the COPC cycle in planning their programme and the practice nurse indicates some resistance to organising around it, in fact suggesting that the programme could be formulated around the health model. Interestingly the task is now being redefined in the group by GP2 as fitting the programme to the cycle. GP1 is notable in having made very few contributions to the discussion so whilst GP2 may be seen to be reflecting the medical perspective, is there in fact an alternative medical view which is being held by GP1 and not being expressed?

A215.PN: I mean, shall we look at this overhead that talks about planning your objectives and review where we are now....formulate our objectives da di da.... Or do we want to formulate it around the health model? Or do we want to formulate it around ----- cycle? To pull it all together.

(Pause 8 secs)

A216.GP2: I think the way it's questioned it fits more in to this cycle.

A217.PN: Mmmmm

A218.WA: Hmmmm

The following exchange which attempts to refine the programme to fit with the cycle is suddenly personalised by the ClinP who does not seem to be thinking along the lines of a wider community programme but the service she provides. The practice nurse throws open to group discussion which sub-group already discussed should be prioritised and the ClinP invokes both her personal practice- what she would do- and legal rules of practice.

A223.PN: I was thinking as well, you know, it says we've already decided that umm it's a priority, for an intervention. But within prioritising, would, would we prioritise between these two slightly different groups?

A224.GP1: ----- tend to think---

A225.PN: or whether we want to look at the 25%.

(pause 6 secs)

A226.ClinP: I would certainly prioritise the 5%.

A227.Several: Yes...

A228.ClinP: again, I am legally bound to... -----I don't think that's even an option to be honest.

The choice of the important interventions has to be made by the ClinP and the GP prescribing medication seems to be the implications at this stage of the transcript (A225-A237), but the group is offered the choice of deciding about exercise. Other options for the menu identified later (A319-A324) by the ClinP and GP2 are welfare rights, dieticians, volunteer home visitors, but the options seem to be prescribed by what is already on offer rather than the group developing any new options.

A237.ClinP: I would not make any too many different recommendations for the 5 or the 20%, I think at a certain point. Once ----- percent is in they would be treated just as the 20% from my perspective.

A238.PN: Mmmm

A239.ClinP: It would be up to the group to see if we offered exercise, it would be offered you know, depends..... the -----.

GP1 starts contributing more now the programme is beginning to take a more tangible form, mainly to raise possible problems and to reinforce patient choice something she has done in her relatively few earlier contributions. . The PN later sets the surgery as the space where over 65 patients can be proactively reached when they next come in (A254) thus the practice is again reinforced as the context for the programme. The group is grappling with how to engage the patients in the programme from the specific perspective of asking questions from A269-A301. The depression priority has not been broken down into sub-priorities which might already be important to the community, and the discussion starts to look at how the group can be defined as having a research type function in the eyes of the community which involves collecting data on depression to help people cope with it better. Earlier in the group discussion the WA asks the group whether they as a group should be “proactive and

gently reach them” (A166) which elicits the responses from GP2: “In an ideal world yes” (A167) and A169 stating that he is “not sitting in surgery twiddling my thumbs”. The WA has said the group should be proactive, but gently implies that proactivity might be perceived as intrusive. The responses of GP2 indicate a resistance to any more work, and imply the WA is not as rooted in the “real” as opposed to the “ideal” world as he is. The WA who first suggests the need to take notes again raises the issue of keeping track of a multi-disciplinary discussion and how difficult it is to reflect on the intentions within the short time span (A261). He is in the process of expanding this talking about the need for “a common denominator where we feel united...” when the ClinP takes the floor and redirects the group from reflecting on process to agreeing as a group what she extends in A265 as 5 or 6 questions. The shift to engaging people outside the group more actively comes when the ClinP raises the problem of resources. Other projects in the community can be used “to help us out”, thus community engagement is being resource led and the importance of ownership of the programme within the group is emphasised.

A303.ClinP: we have to look at our resources...

A304.PN: ..well, I know

A305.ClinP: So. Do we have resources to actually go out there and find them. If the answer is yes, terrific (laughs)

A306.ClinP: If the answer is no, how can we use other people like vulnerable older persons other projects that already exist. So how do we use

A307.PN: Yes

A308.ClinP: ...existing projects in the community to help us out?

A309.PN: Mmmm

A310.ClinP: Age Concern.....MIND or the rest of it, just for example.
Mmmm

A311.ClinP: so can they help us out? This is our specific interest -----

A312.PN: Hmm Hmmm

A313.ClinP: not just by referrals, but again can we include them in, you know, in a meeting on a quarterly basis even, can you go that far?

A314.PN: Mmmmmm

A315.ClinP: do we have the time to do that? Do we have 45 minutes to devote to a community meeting in the practice? Meaning, we draw in MIND, Age Concern umm whatever.

A316.PN: Yes

A317.ClinP: the Royal Free (laughs) whatever.

A318.PN: So once we've identified our people, how are we going to intervene?
(pause 5 secs)

The programme has taken form but outside resources are needed to implement it who won't intrude on their interests. The older patients are even referred to as "our people" by the PN. The group address who might be best placed to form a relationship with the target group and offer the "menu of choice" in A349-A362. Gp2 (A44) early on in the discussion describes the involvement of district nurses because they are in contact with those at greatest risk, in terms of how the group can "use district nurses". The ClinP drawing again on her own professional experience as validation suggests the GP and positively frames the power held by GPs as useful in influencing the patients. She in fact reinforces how desirable it is that patients not only listen to their GPs but can reproduce it word for word. She anticipates the focus on the GP-patient power in-balance might be received as challenging and quickly expresses she sees it as "good".

A359.ClinP: GPs are well placed to, to to offer that because in in in my experience people look to their GPs for advice as well as medical interventions, so ...they listen, at least my experience is that they listen to GPs very.....they repeat what GPs say verbatim to me....

A360.GP2: Really! (laughs)

A361.ClinP: which is very good.
(laughs)

A362.ClinP: its very good because it ----- what I say verbatim, forget it! In one ear out the other...so, in that sense....knowing the...your power, you know, or knowing how your relationship works with that particular patient or client is important.

A363.PN: Mmmmm

A364.ClinP: happy to offer ----- and menus of choice.

A365.GP2: The GP is in a position to offer a lot of different things, to to the patient, umm but some of these patients will need more active... interventions than being told, you know, there's this that and the other. Umm.....

GP2 accepts the positive approbation but GP1 keeps quiet. These types of contributions from the ClinP function to strengthen an alliance with GP2 as well as promote a medical perspective. GP2 accepts what the ClinP says but points out “more active...interventions than being told” (A365) may be necessary and the group starts to look outside again to see who can actually carry out the work. The GP is then gradually defined by the ClinP who dominates most of this part of the discussion as being in the role of introducing the depressed patient. Practice counsellors are proposed by her as being possible resources but then the ClinP quickly defines their function as “advice and information” which is “practically based not medically based” (A380), the nature of being practically based is not expanded on, but it is defined as complementary to the medical advice. Notably in A370 the ClinP says either the counsellor or nurse practitioner in the practice could be offered by the GP for a discussion “in depth”. Counsellors are both defined as a professional resource that “can tease out the difference between bereavement and clinical depression” (A382) and as being “a wonderful resource” (A386) which does this in the course of “a normal conversation as it becomes apparent without putting anyone on the spot...” (A384). The implication when practice counselling is being described as a “wonderful resource” is that it is complementary but not absolutely necessary, or as important as other practice services. Within this clinical alliance (medicine and clinical psychology) discourse nurses and general practitioners cannot be described as wonderful resources, they are the practice, not the resources for the practice.

The task of follow-up comes up at this point (A388) The practice nurse introduces the topic of evaluation and Gp1’s suggestion of re-administering a questionnaire is seen as having a low return rate, although the figure posited by the ClinP of 5 out of a

100 falls far below the usual anticipated around 50-70%, GP 1 is in agreement with there being unlikely to be many returns. The suggestion by the ClinP is to send it along with a social worker. The group starts to move far beyond the original COPC task of addressing depression in older people after A400 to looking at what other health problems such as hearing and vision impairment might need addressing, and whether home visits are necessary to see if physiotherapy input is required. This is rationalised as important for effective communication purposes and the ClinP describes herself as responsible for meeting these needs (A417). The ClinP more than the other group members personalises her contributions. The WA tends to frame contributions more from a group perspective whereas GP2 will objectify his contributions more from a common general practice perspective. Ongoing assessment and monitoring is raised as an important issue by the ClinP, one which she owns through implying that she is going to have to “go on about” it. The implication is that it is important and that she is responsible for ensuring it is given enough attention by the team.

A432.ClinP: The thing that I want to go on about is on-going monitoring and on-going assessment----- so that again.....what we talked about earlier.....the fluidity of it, so its about that... every time they come in for something, whether it be a repeat prescription or whatever it is, there is some level of assessment going on. So that there are some basic questions that are still being asked mmm...that is recorded, because reassessment is essential. ----- cos if we do it once....and think oh well, next year I'll do it again! -----you have to have a sense ----- relationship ----- -one patient may need every 3 months to be reassessed.....

The PN contributes more at this stage regarding how patients could be monitored on an ongoing basis perhaps because of her familiarity with the over 75 check, it is still the ClinP who is leading the discussion however and taking responsibility for what is in fact a health related issue. Earlier the PN (A302) has broadly summarised without

challenge the identification of the target group as “using any member of the primary care team who is next in touch with anybody who is aged over 65 to ask them these questions”. The use of computer technology is promoted by the group as a means of keeping monitoring the older population through having an age trigger programmed in alerting the practice when a particular birthday is reached. The development and evaluation of a targeted programme addressing depression has now moved into a discussion of how all patients can be monitored through the computer system once they reach a certain age. The WA suddenly challenges the flow of this line of development when he states his reservations about these developments from a personal point of view.

A456.WA: Some things you mentioned ----- I wouldn't be happy setting this up....

A457.GP2: We don't have to now.

A458.ClinP: No, we don't have to now -----

A459.WA: No. I think one has teased out a few things, but one hasn't umm..... got to a solid common line out of this ----- very nice heading -----
(pause 30 secs)

A460.GP2: I think what we've mentioned ----- can be explored ----- time to see what is practical and what isn't practical....

A461.PN: Mmmm

A462.GP2: and then.....and now we ----- throw some ideas -----

A463.PN: Mmmm

A464.ClinP: One way of working with this we have a head of a practice or head of a ----- an enthusiastic practitioner or somebody who ----- is going to take some responsibility....

A465.PN: Mmm

A466.ClinP: so from there, that practitioner may say well we have a multidisciplinary meeting here, should we do it by, lets say, making formal referrals to each other, by formal letter, to develop a relationship, you go that way, that's one way you smile at me, what would you suggest?....as opposed to.....

A467.WA: I think that's valid.

This challenge from the WA is dealt with by the other group members by reframing it as a time and practical issue, any ethical component is excluded from the subsequent

discourse. The ClinP is proposing a GP, possibly a head of practice, to take in-practice responsibility for the programme which fits with the more traditional medical hierarchical responsibilities rather than the non-hierarchical approach advocated by the COPC model. The involvement of an enthusiastic General Practitioner has been found in the literature to be a key factor in the more successfully implemented COPC programmes, so the ClinP may in fact be expressing a realistic understanding of general practice culture. Finally the ClinP expresses what seems to be very much an in-group mentality at the end of the hour task (A470). The predefined objective for the group was not to generate more work for themselves, or to set up a confidential referral system, but by defining themselves as “the specialists” the group is perhaps reducing those outside as resources to serve the group interests as discussed earlier.

A468.ClinP: Yeah. That's one way that may be -----I'm not sure I want to refer this person ----- group, so you have to find that out.....so if everybody ...we knew each other.....

A469.PN: Mm

A470.ClinP:-----you know, we're the specialists -----
I'm not the psychologist, I'm not sure about this, but they haven't mentioned this, I would like to make a formal referral and see where we go, and there would be feedback, and again, there would have to be feedback on the 'need to know' basis because as you rightly said, confidentiality is a key component and so all of this has to ----- So again, we don't want to ----- it but we also don't want to make it too therapeutic, we want a balance between the two. What else, for example what else would you-----
 (pause 30 secs)

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CHAPTER 7: RESULTS AND ANALYSIS 3

Workshop C

This workshop consisted of the smallest group and the transcript is much shorter than the other two workshops. The group was made up of two GPs (Gp1 and GP2), a Welfare Adviser (WA), a Practice Nurse (PN) and a Community Nurse (CN). GP1 starts the discussion by summarising the purpose of the task, and he appears to be taking a leading role at the outset of the group. The first 17 contributions are mainly made by GP1 and GP2, with the CN contributing a “No” (C6) to a general question and agreement through a “Mmm” (C13). The GPs identify that the team has to go through the COPC cycle, depression needs to be defined and so does the population. GP1 has already started defining depression however whilst posing the question to the team (C9).

C9.GP1: We have to define what the health problem is. We have to define depression, and then define sort of the population, don't we?. (pause 3 secs)
C10.GP2: So how do you define depression? How do you identify the depressed?

Depression is being defined here in the question as a health problem and GP2 takes this further and conceptualises a group of people who may have depression as being “the depressed”. Depression becomes both the problem and the people, a conceptualisation GP1 also continues with. In workshop 3 the target group are not referred to as patients from the beginning, GP1 in his statement acknowledges that the condition which is personified by the people can be referred to as patients, people or clients. This does have an impact on the discourse in that the group continues to call them people rather than refer to them by a term which reflects one profession's

relationship with them more than another. The use of the term “our agencies” also implies that all the team members are similar in that they are all “agencies” rather than any one discipline being dominant at this point.

C14.GP1: Yes, 'cos your depression could be defined as people or clients or.....because it's some sort of community thing isn't it, so there'll be patients, clients or whatever each of our agencies call these people.

It is the WA which introduces more medical terminology in referring to “symptoms” (C17) following a more general description of the target population by GP1. The WA changes this to “behaviours” which GP2 picks up on from a medical perspective as the terms have distinctly different meanings.

C16.GP1: People with the following characteristics.

C17.WA: Set of symptoms.

C18.GP2: Yeah. Symptoms or things that point

C19.WA: Behaviours.

C20.GP2: Yeah, behaviours. Yeah. Um yeah. Symptoms are not necessarily the same because the patient may not necessarily present and say “I'm depressed”.

The team then have debate around whether the depressed person would present themselves to the GP. The WA says they wouldn't whereas GP1 challenges this and says actually a lot do. The agreement reached by the group is that they possibly see different types of referrals, although GP1 sees the WA's agency as receiving organisational rather than self-referrals which he challenges. The alternative to professional referrals is described by GP1 as “trawling through the streets” whereas the WA emphasises the number of self-referrals. Patients seeing the GP are under their care because they are on the patient lists, so are not seen as self-referrals, as they do not need to be referred, the notion of referrals is quite significant in multidisciplinary working because it is one means by which the different professions

may vary considerably. In general practice patients have to be referred to the practice counsellor, they are not on the counsellor's list. Only the GP has patient lists in that each patient is registered with a particular GP not any other professional in the practice. The CN defines the issue here as where are they looking at depression which brings the team back to defining the task. The meaning of "community" becomes another concept to be defined by the group.

C23.WA: Presumably ----- they wouldn't present themselves to a GP.

C24.GP2: Mmm

C25.WA: Am I right? So that makes that a lot easier (laughs)

C26.GP1: Well I don't know, a lot of them do present to us.

C27.CN: Not necessarily.

C28.GP1: But a lot of them, by the nature of their depression, don't.

C29.GP2: Yeah yeah. Whether they present to us with other symptoms.

C30.WA: Yeah.

C31.GP1: And I think the people that present to you are probably those that don't present to us, because if they are new referrals directed to you, they are probably going to you but by definition they don't come to us. They are either sent to you because some other agency has found they are a problem, a relative or something like that.

C32.WA: Do you mean Age Concern?

C33.GP1: Yes.

C34.WA: ----- agency. Right OK.

C35.GP1: 'Cos you don't trawl through the streets saying to people.....

C36.WA: No no.

C37.GP1: You know, "Are you depressed?" You don't sort of write to people and

C38.WA: We get quite a lot of self-referral actually. It does come from different agencies, but surprisingly quite a lot of self-referrals. Not necessarily depressed older people who self refer but erm....

C39.CN: From what basis are we starting off looking at depression, from the community point of view?

GP1 defines the community as the practice community using the workshop task as a means of legitimising this task and COPC. He correctly says that the COPC community lives within a particular geographical area, it has however been outlined in the training that this is not necessarily the practice community. A COPC programme targets people living within a particular local area, not those registered

with a particular practice. A choice has been made here which left unchallenged by the rest of the team shifts the programme into a specific general practice of which the GP will be the lead. The means of identifying the older people is then described as easy by GP2 because most practices have a medical database system, although the WA reminds the group of a socio-psychological perspective when he queries whether the system can provide ethnic monitoring information.

C63.GP1: Everybody living within a certain supposing geographical..... I mean they've defined that for us have they? Practice community...so it's a practice based community.

(pause 7 secs)

C64.GP1: I suppose sociable geographical area.

C65.GP2: ----- population.

(pause 10 secs)

C66.GP2: So that's easy to identify because most practices have a ----- system ----- over 65 year olds.

C67.WA: Does it umm provide any further information in terms, for example, ethnic group or?

C68.GP2: Ummm it is really vague on that.

The PN's first contribution comes at C83 when she describes the target group as patients, now the programme is located in the general practice it is assumed they are "patients" and she suggests a more general targeting of patients who haven't had a consultation in the last 12 months. Her use of "Would you...." at the beginning of her question rather than "Would we" functions to place her outside the group still perhaps in the observer's role she has taken so far. She does say that the patients might see a GP, practice nurse or counsellor but the focus in the following exchange is very much on seeing the GP.

C83.PN: Would you want to be sort of targeting patients that hadn't had a consultation in the last 12 months? Would they be more of a priority to the ones that

have been in the last year? To see a GP a practice nurse or counsellor within the practice?

C84.GP2: -----

C85.CN: So are we saying these aren't already known?

C86.GP1: Well that's just it. We've got to decide who our target....you know... we are looking at depressed people.

C87.GP2: We can't say ----- depressed over 65s until we actually try it.

C88.CN:OK the depressed....we're looking at the fact that they've seen a GP-----

C89.GP1: Or is he?

C90.CN: Are the ones we're looking at, are they already diagnosed as being depressed or ?

C91.GP2: Not necessarily, I think we've got to pick out people in that group and it's up to us to find them, whether they present on that.

C92.GP1: So you are on 'patients presenting', 'cos a lot of our patients present with depression to GPs, and they can present...I mean

The PN does become more engaged with the group though and starts to own the intervention demonstrated by her starting to use “we” rather than “you” in her contributions. She refers to specialist nursing knowledge (C95) in saying “It’s clinically that...” when she asserts that all those seen by a clinician in the last 2 years will not be in the target group, it is those patients not seen by the practices which may be depressed. GP1 actually says the opposite in that he defines the target group as those who have been diagnosed by the GP.

C95.PN: It's clinically that, that's what I'm saying, if they've been in the last year or 18 months or 2 years, then they've actually, we've got those. It's the other people that aren't coming.

C96.GP2: Other people that have presented with depression?

C97.PN: No presented with, you know, well you know someone comes into your surgery, hopefully as a clinician you'll be able to pick that up. I mean if you think of all the different...

C98.GP2: Not necessarily, 'cos they might have presented for wax in the ear or something you know. You certainly don't pick up that they're depressed.

C99.GP1: What you'd have to do, to actually find the patients you'd have to have a set of patients who actually present with a diagnosis of depression either made by the GP from their mental health symptoms, or through a multitude of, you know, somatic physical symptoms.

C100.GP2: Mmmm

GP2 has acknowledged that GPs might not identify depressed people. She restates more or less what the PN has said earlier as her own view.

C109.GP2: My feeling is that we should be attacking the people who haven't presented or are not being treated. 'Cos people who haven't presented at surgery for depression, they've got treatment, they've been identified, they've got the resources, they know they are in the system already. We should be looking for people that haven't presented or haven't.....

C110.PN: So how long a time would you want to be looking at if they hadn't been for a consultation? You think 12 months is too soon to be drawing these patients in.

C111.GP2: Umm Yeah well I think we could.... In some you'd modify it, I think you could say "lets look at people that haven't been for lets say 2 years and then see what sort of numbers that throws up". If that's not very many, then I think probably 2 years is reasonable.

Earlier in the discussion GP1 refers to "other workers like practice nurses" (C103) in the practice and the PN states they do have more time. The PN states that they would not code patients for depression but refer on to GPs and counsellors for a clinical diagnosis. It was also the PN in her first contribution (C83) who included practice counsellors in the grouping of appropriate practitioners to see depressed patients. The CN has made relatively few contributions to the discussion (9/111 so far). The WA asks GP1 a question regarding whether the intervention would be drug based soon after this. The question is answered by GP2 indicating that it is a general medical question, something the WA validates when he takes a "one down" position by claiming not to be medically trained without outlining what else he can offer. The medical discourse has become dominant in this group very quickly, despite the agenda at the beginning being more multidisciplinary than the other groups. The non-medical practitioners have contributed much less to the discussion than the two GPs so far, and have not challenged the locating of the programme in the general practice, the defining of the community as the practice list or the strong focus on the identification of the target population by the GPs. The terminology to describe the target population

has become medical (patients) despite the acknowledgement at the beginning that they are referred to as clients by non-medical agencies, and the initial usage of the term “people” by the group.

C123.WA: Would intervention be drug based in the main? If I were to present to you as a depressed person.

C124.GP2: I think we’re going down the line here, we’re talking about----- identify a group first, then talk about how they are going to get treatment.

C125.WA: Right. Yeah.

C126.WA: It’s just that, it’s different for me because I’m not medically trained at all so....

C127.GP1: A lot of depressed patients you preferably treat with social intervention. Or support, that would be the objective of the exercise. In a way you want to treat as few elderly people with medication as possible because usually..... you look at well, why is this person depressed, and they’re going to be depressed unless you sort out why they are depressed. If it’s found to be because of bereavement you’ve got to sort out some support because a spouse has died, or if they’re ill you should sort out a physical problem then their depression gets better..... Medication is there only like a plaster cast. It’s a chemical support until they can feel better.

C128.WA: Right

C129.GP1: That’s the best way to think about it.

C130.WA: That makes sense. Right

C131.GP1: There are some people who are on antidepressant tablets for life.

C132.WA: Yeah. Mmmm

C133.GP2: How are we going to identify these people erm....

C134.PN: So we’re going to target all the over 65s who haven’t had a consultation in the last year.

C135.GP1: I think we’ve got to target this group

C136.PN: OK. So that’s the group we’re targeting.

C137.GP2: Well, I think it’s your whole practice population.

C138.PN: Mmm. Yep. OK.

GP1 and GP2 are leading the discussion and seem to be accepted as the discipline to identify the target population and to deliver the initial intervention of seeing the patients, the CN notes what has been said so far on this and acknowledges their central role asking them as if they also hold key responsibility for designing the intervention.

C142.CN: I'll just jot it down. You are saying hypothetically, say it's the practice size is round about 300 of which 65+ is about 105, the age group of those 65+ -----not seen about the past two years ----- medical intervention, of those that you have not seen in the past two years that are male and female of that age range. Umm. How would you be, from that point of view, what questions or what way would you invite these people if you haven't seen them in the past two years, to come along to the surgery. Or are you going out to them?

C143.GP2: Well that's what we're getting down to, how are we going to identify these people. So we've said that errr that anyone that's over 65 we see every two years. What we're going to do with them erm we could either invite them in or we could send them a questionnaire. Erm if we invited people to the surgery you're not going to have that big a response ----- over 75 year checks you send them out invitations, but only a small percentage of them will come in

There is further discussion around the value of sending out a questionnaire and GP1 continues with suggesting how "you" could identify the patients who have a diagnosis of depression on "your computer" and send them a standardised depression test. The GPs start to discuss what questions might be on the questionnaire to which the CN makes one contribution (C160).

C150.GP1: I was surprised the number that actually replied. So you could.....what you could do is erm to define what the health problem is, I suppose what you could do is, you could do your computer search to see err on your computer all those patients who got a diagnosis of depression, 'cos they are the people you're seeing. Of all the patients you're not seeing, you could send all of them erm...there are standardised scoring systems. You could send some of these things and score them when they come back in, so you can therefore define the population that way can't you?

C151.GP2: ----- Do we have to design the questionnaire?

C152.GP1: Do we have to design the questionnaire as well?

C153.GP2: ----- how are you going to define the questions? Erm ----- The sorts of question "So you feel low?" -----something to assess their mood.

C154.GP1: Are you eating? You know. Weight gain, weight loss, sleeping properly. (pause 5 secs)

C155.GP1: Hepatitis. There are questions about "how do you feel your general health is?"

C156.GP2: Yeah. General health.

C157.GP1: Level of ... Could you ask people how happy they are?

C158.CN: Yes.

C159.GP1: Erm level of happiness. I don't know how you define it.

C160.CN: You could ask people "Do you ever feel depressed and to what level?"

C161.PN: Feelings of isolation.

C162.GP 1: "Do you feel lonely?" "Are you suicidal?"

C163.GP1: "Do you think you would be better alive or dead? To what extent?"

The last workshop was held soon after the Harold Shipman case and the nurse makes a joke about Shipman which is ignored by the group. The WA does raises an ethical issue though of whether the questionnaires might be “damaging” to the target population, which GP1 counters with a view that the questionnaires might actually be beneficial. The WA directly disagrees with this.

C167.WA: Sorry, these questions are going on written questionnaires sent to a potentially depressed person are..... Might I be so bold as to add but, but it could be extremely damaging to that person to receive those kind of questions in the post. If they were a depressed person.

C168.CN: It depends on how depressed. If they are just beginning or at the end.

C169.GP1: I think there are ways of it could be damaging but at the end of the day, what you're aiming to do is you're aiming in a way to A) get these questionnaires back, but also you might in a way give a lot of people who feel down.....they could think “hang on a second, I feel really lousy, I feel depressed or whatever, I'm here all alone, and I've just received this from the practice or whatever, whatever, there is somebody out there who actually.... And at the bottom of the letter or at the beginning you could say “please fill this in and if you feel that there is something arising out of filling in this questionnaire you wish to come and speak to us about, please feel free”. And they might actually feel “Oh thank God for that. I thought I was here without any hope” or whatever, you're actually giving them some hope.

C170.WA: I don't totally agree with that.

C171.GP1: It might, it might be positive.

C172.WA: For the main percentage of potential clients that might be the case, but then a lot of depressed older people or depressed people in general, there isn't necessarily a motivation to do very much of anything, let alone.....

C173.GP1: We've had a lot of forms returned to us saying “I feel lousy”.

C174.WA: What's the percentage, do you know, have you been told that figure yet or?

C175.GP1: I've got a big box that high (laughs)

C176.CN: What age group?

C177.GP1: Over 75s.

C178.CN: That's good.

The group do not at this point reach a decision on this and the discussion diverges into the characteristics of the patients aged over 75 years who might be isolated. The WA raises another ethical issue – sharing of data between agencies. His speech turn is

interrupted and sharing of data becomes reframed by GP1 as whether the other agencies “would be able” to give the relevant information. He starts to develop the programme hypothetically as this is an area the GPs are not sure on, and the other team member are not contributing anything in this area which might better inform the discussion. The importance of focusing on the community is referenced by GP1 to an external observer, the workshop programme, a reference he used at the beginning of the workshop in identifying the task as going around the COPC cycle. Unlike then though there is ambivalence being communicated in his statement over involving community resources (C189). Involving the community becomes an action that is driven by outside pressure to do it, and it appears to be other to the rest of the intervention in that it is defined at its start as a hypothetical possibility as it relies on information not available through general practice.

C184.WA: I would say perhaps one of the big issues is erm sharing data between agencies. I mean just as a general issue in terms of a subject like depression. It could be that say Social Services may have information about your patients that.....

C185.GP1: Well, if they know who our patients are you see. We can, we can ask District Nurses to say “Well look, you know who our patients are, because you’ve got a list of which patients you see and come from our practice, could you let us also have a list of patients you think are depressed”.

C186.WA: Yeah.

C187.GP1: But if we went to somebody like Age Concern or you went to Home Help Services, I don’t know if they’d be able from their databases to give us that information. It might be a possibility so we could, we could.....I mean this is completely hypothetical, so we could take that idea on board for this purpose for identifying our population.

C188.WA: Mmmm

C189.GP1: Because we are supposed to be doing a community thing so it would be...those people as being identified by Home Help Services, Social Services, local Age Concern, Citizens Advice Bureau...

The extension of the intervention suggested by the CN (C196) soon after extends the monitoring of the older people to gathering information on what classes or groups they may attend in the community organisations listed. This is not developed in the

group and the next contribution is from GP1 who lists some of the symptoms of depression to be ticked off in a questionnaire (C197). GP1 suggests the group commissions someone to draw up the questionnaire for the group.

C196.CN: We could find out are they on the erm agency listing, if so which one goes in the art therapy -----

(pause 5 secs)

C197.GP2: Yeah I mean if we have a questionnaire which says erm ticking those that apply to you and saying something like "Sleep problems, poor appetite, concerns regarding general health erm, feeling depressed, feeling lonely" I don't think they are too sort of.....

C198.CN: I think that's quite clear...

C199.GP1: I think what one would do is erm you'd commission somebody from the Department of Psychogeriatrics or the Department of Clinical ----- to draw up your questionnaire for you.

The debate moves onto what depression can mean for different people and agencies.

GP1 makes a long contribution here which GP2 agrees with. GP1 equates depression with a range of what she describes as common behaviours in older depressed people including paranoia, confusion, repeated ringing of the health and police services, shop-lifting and suicidal tendencies. The CN says from her experience of home visits it is deterioration of domestic tidiness and cleanliness which she notices as early signs of depression. GP1 sees Social Services as a resource which can provide "cleaning squads" the focus is on treating the symptoms.

C212.GP1: If you've done a proper assessment. Umm the extent of our problem, I mean....I mean you're going to get all this huge sort of array of numbers of people, but how are we going to in a way be aware of the extent of the health problem, you've got to sort of try and find out what, what does that diagnosis mean to all these people, I suppose. 'Cos you're not...you're not just treating the fact that somebody feels depressed, you've got to think about what being depressed means to the patient in terms of ...a lot of elderly people who are depressed get confused and therefore...you know wander or act in a paranoid state, or you get a lot of elderly people who don't even drink and therefore get malnourished and get dehydrated... and then the ----- or do they go and shop lift or do they go and worry their neighbours or do they keep ringing the health services or do they keep ringing the police or ----- do they

attempt to commit suicide. So that....I don't know how you'd try measure the extent of that problem.

(pause 10 secs)

C213.GP2: It's a big problem.

And

C217.CN: As a Community Nurse, going to people's homes, there are certain sides of depression where about say.....at the beginning it's quite nice, clean and tidy -----
-----you notice that ----- signs of depression so in that sense you could say that's how it affects ----- try and find out why they are depressed and you'd want to do some kind of intervention straight away.

C218.GP1: Yeah, the extent of their health problem is that they need care from Social Services. They might need one of these erm cleaning squads because their house is in such squalor that it's become a health hazard both to the person and to their neighbours.

C219.GP2: Yeah. So you're going to have to start talking to Social Services and see erm how much resources they can make available once you've identified them.

One of the strongest examples of medical discourse that comes through in this workshop is when GP1 talks of patient compliance and how lack of it in relation to certain chronic conditions "impinges" on nursing staff. This follows a statement where he attributes a lot of the hospital admissions to prescribed medication, which he concludes must be due to patient confusion due to depression or taking too many tablets rather than suicidal tendencies.

C234.CN: I've never thought of that. How many older people do attempt suicide in that sense? From depression?

C235.GP1: It's, it's a fair risk. And I often wonder how.....

C236.CN: Is it purposely or is it accidentally?

C237.GP1: Oh that's the question you see because you'd have depressed people that get confused and therefore take too many tablets. A lot of hospital admissions are due to the medication that we prescribe, therefore one thinks is it simply because they are confused because they are depressed?

C238.WA: Yes.

C239.GP1: Or are they taking too many tablets?

The group moves onto a preventative agenda after the CN asks why the patients might be depressed (C248). The WA says it could be a multitude of factors after which GP1 redefines what he initially calls the precipitating factors as problems, after the CN has called them “triggers”. Through doing this the agenda moves from looking at risk factors triggering depression to looking 6 problems of which depression is one.

C256.GP1: No this is the....the problem is depression.

C257.CN: The problem is depression, but if we were to define saying erm six triggers.

C258.GP1: Ah is that the erm....

C259.CN: That’s what I’m wondering. Is that what we are referring to if we look at it from that point of view. If we looked at say only six areas of triggers for all depression.....

C260.GP1: Ummm. I think that’s problems.

C261.CN: Problems.

C262.GP1: Yes, six problems.

C263.PN: Of which depression is one.

C264.CN: Yeah.

The group refers back to the written task a number of times in this workshop. GP1 summarises the outcome of the further defining of the target population and the underlying causes of depression and in so doing juxtaposes a number of problems which the group has depicted as accompanying depression in older people.

C280.CN: Which bit have we answered now.

C281.GP1: We’ve done the ‘what’ haven’t we? Who...you know what’s our population, who are our depressed people, and the extent is. The ‘why’ is because they are lonely, they are poor, housing, translocation....umm physical ill health. Premorbid personalities. I mean just the fact that they are getting old and just getting fed up.

C282.CN: And their body is breaking down and they can’t do all the activities that they would like to do.

C283.GP1: I mean changes in society, as you said, you know, feeling of worthlessness. Just the fact that society changes, and they suddenly feel.....

C284.WA: They are no longer part of it.

C285.GP1: Yes.

C286.CN: -----

(pause 8 secs)

C287.CN: (Reads out) We are to design a community orientated primary care programme to address the depression.

C288.GP1: From the 'what' you can have your list of people can't you? And from your list of people I suppose you can assign all these causes, you can computerise the whole thing. You can recode it, and you can have your list of people, you could have all their precipitating factors, you know, loneliness, including morbidities. That's housing problems.....'cos I think the important thing is data collection and records, and if the whole thing is computerised and recoded..... It's a formidable task.

The programme as being developed is not dissimilar to those of the other 2 groups and the CN is explicit that the new over 65 patients will be assessed by a nurse and referred onto a GP (C296). She also suggests employing someone from a nursing or community background to tie the research skills in with the assessment skills. The referral is to the GP who will initiate a medical or social intervention as appropriate. The assessment is to refer to the GP who will take the necessary action.

C303.CN: And that's where... your expertise....if we're not going to do medical intervention, we want to do the social intervention if possible....

C304.GP1: It could be everything.

C305.CN: Everything.

C306.GP1: Yes. This is community wide. A lot of what we do is "I'm not going to give you any tablets. This is what you need". You know we all pick somebody up when they are depressed. You all make some suggestions to them or erm... we'll have somebody who's got a housing problem or they live alone, they'll come to you, you'll have whatever it is that you say ----- It's a bit sort of you know, you've got sort "how are you going to sort of manage this patient" Are you going to manage them physically, are you going to manage them socially or psychologically, you know, that sort of standard thing.

C307.WA: Yeah. Sure.

The CN raises the question of what the patient wants which GP1 picks up as being about the patient agenda versus the professional agenda. The WA has been quiet for some time but challenges GP1's statement that the GP can "just take over" if the patient wants them to. The GP laughs, the WA does not follow up his objection and as

the PN redirects the conversation to questionnaires being returned after this the objection is not expanded on.

C310.CN: Ultimately though, once you've found out who the people that are depressed, you'd have to ask them what is it that they want. Where do they see their

.....

C311.GP1: This is, this is ...what's our agenda and what's their agenda.

C312.CN: Yes, what's their priority?

C313.GP1: Yeah.

C314.CN: And what we think -----

C315.GP1: Exactly. But in a way, we won't be able to meet their expectations if we don't know what we think their problems are. Because in a way, by knowing there are housing problems out there, and by knowing there are loneliness problems, at least we can set up systems to cope with those individual problems. And it's only by knowing ----- you can then come back to the client and say, "OK, tell me what you think you want?" And some of those people will say "I know what I want doctor, I need a new bath, or I need somebody who could help me bath". Or it's erm "I don't know what I need doctor because I'm so depressed, you're the doctor you tell me what to do". In which case you can say "Ah fine, wonderful, I'll just take over". -----

C316.WA: No, no no.

C317.(GP1 laughs)

The intervention programme being developed by this team is again focused on identifying individual patients within the practice rather than a community oriented programme to bring down the overall level of depression.

C340.GP1: We are sort of in the 'why' bit. What we think we've done, the 'why's', we're saying well why are these people depressed, it's obviously about housing, lost sense of belonging, loneliness, financial problems erm physical health problems, just the fact that they are getting older, societal problems. Erm.... I put something down and I can't erm -----

C341.GP2: Family problems.

C342.GP1: Oh continuing poverty yes. Yes I think it's dislocated families ----- those things. Because as they say here, you know once you've, you know, know the causes, you can then plan.....or what are you going to do. It's the questions, you know sort of, erm.... What are we going to do? I think what we.....the only way from our list of "What" and "How" we can put all that information on computer. We can put all these names, and next to each name you can put all these re-coded precipitating factors and morbidities. So you can then get this huge morbidity register, you can get all your depressed patients up on the screen, and under each patient's name, you can have this subset of precipitating factors, if it's possible to do

so. But I think in resource terms, how do you do that in your own practices, what we need is a dedicated person....a funded person to actually do that.

C343.WA: Yeah.

C344.CN: ----- to incorporate that, can't you? It's expensive but effective

The use of the term "customers" in the following extract conveys that the group are aware of the strong consumerist ethos to their COPC programme, and can reflect on it with a touch of humour.

C348.GP1: What you're going to do with the patients doesn't it? With the clients or whatever.

C349.GP2: What ----- make a plan?

C350.GP1: Yeah. What's our plan?

C351.GP2: What's your plan. How you're going to.....

C352.GP1: We've got all these depressed people and what are we going to do with them.

C353.GP1: Well what we're going to do with them, what are we going to provide!

C354.GP2: Yeah.

C355.GP1: And how are we going to provide it, and how we're going to entice the customers into us, to have done to them what we think we ought to have done to them.

(laughter)

C356.GP2: With all those problems you've listed, are they broken down into causes?

C357.GP1: Yeah.

C358.GP2: ----- causes.

C359.GP1: Yes. And I think a lot of that is....you in a way have to decide well erm.....

C360.GP2: Things like neglect I suppose you'd...would be one of the things....one of the things you'd pick up as a sign of their depression. So the one that's got 'neglect' on it, you could perhaps get someone from Social Services to go in and see if they need anything. Erm....

Finally the group reflect on the similarity between the programme they have devised and the services which already exist and have existed in the past with seeming nostalgia, so are they in fact consciously recreating that which they have experienced themselves, or heard that was effective in the past.

C394.GP1: Intervention planning means getting, I mean, is looking at all your responses to see well “hang on a second. What is the real....what is the perceived need?” Implementation means us responding to patients when they come into us, and you’re calling the patients to say “well look can we come and see you?”

C395.CN: That’s part of it.

C396.GP1: That’s part of the implementation really isn’t it? It’s only out of the implementation.....yes sorry.....yes what do we do with all this list? We’d have to have a person who’s putting the people on the list doing some sort of co-ordination job dieting...you know people doing the work and us doing the implementing ----- practice nurses do the implementing. They can use all the referring agencies, so we’d have to have...we have to know what Social Services can offer us, or physiotherapy can offer us, what people like Age Concern can offer us, or there are other people like Crossroads and ----- nurses and all these other ----- You’d have to have your sort of erm your primary care team, extended primary care team, or.....

C397.PN: It’d be like having a co-ordinator like with the cardiac nurses that are employed in the community for Camden & Islington. Someone kind of be able to work within the ----- or different agencies and surgeries and people involved to try and co-ordinate it.

C398.GP1: You’d have to have your, in a way, care of the elderly co-ordinator. You used to have these called ----- yeah they used to exist.

(laughter)

C399.GP1: When I was young they used to exist.

C400.WA: We’ve had....we’ve heard so many times how great they were and ..yeah.

C401.GP2:-----

C402.GP1: Because they were ----- of information. They knew exactly the sort of job we’re talking about now. The implementation would be mustering things, you doing something, everybody doing their little bit.

C403.WA: Their bit.

CHAPTER 8: DISCUSSION

The discussion in each workshop is firmly rooted in the medical model despite the prior training in Community Oriented Primary Care (COPC) whether the team includes mental health practitioners (Workshops A and B) or not (Workshop C). In fact it is only in Workshop C that the language used to describe the target population extends beyond the medical model usage of “patients” to include other possible labels such as “clients” or people, this seems to be an acknowledgement of the Welfare Advisers’ presence indicating that perhaps a minority presence can have as much, or more impact, on language in multidisciplinary teams than the presence of a more balanced range of disciplines. The usage of the term patients is key in maintaining the dominance of the medical agenda, once the developing COPC programme is located in individual practice settings. Each workshop located the COPC programme in a general practice, and the employment of the term patients can function to reinforce the dominance of the GPs position in relation to the programme, as once the location was established, the patients by extension become “his/her patients” on his/her practice lists.

Workshop C did appear to have limited discursive resources available to them in that it was entirely comprised of GPs and Nurses, apart from the Welfare Adviser who did not provide alternative language in which to discuss the target population even when the opportunities arose at the outset of the workshop to label them “clients”. The group did refer to them as “people” until the intervention was firmly located in a specific general practice. In Workshops A and B the psychologists and counsellors do not challenge the medical usage of “patients” which does have the effect of promoting

the medical model.. In Workshop 3 it is unlikely that if the Welfare Adviser had used the term “clients” or “service users” that this would have greatly impacted on the emergence of the dominant medical agenda once the intervention was located in general practice, and the term patient would have seemed more correct within the prevailing general practice discourse. The resources of the multidisciplinary team seem to be employed in extending the range of components of the intervention beyond the core medical activities rather than using the broad-ranging specialist expertise and language to target and refine the definitions and programmes. Multidisciplinary working in these workshops appears to be more about contributing an assortment of ingredients” (A68; A177; A179) except some agendas such as counselling or counselling psychology do not emerge. Marginalisation occurs to some extent because although all ingredients may seem hypothetically possible, only some ingredients, medical, (A147) are seen as essential.

General Practitioner 1 controls the discussion in Workshop C. He speaks the majority of time, and makes the longest contributions to the discussion, as well as frequently summarising on behalf of the group what needs to be done. The Nurses and Welfare Adviser defer to his medical expertise without highlighting their own professional skills. In Workshop A the Clinical Psychologist contributes frequently to the discussion and asserts her clinical expertise and specialist knowledge on a number of occasions which appears to function in the workshop to form a clinical alliance with the General Practitioners, which is not apparent in the same way between the Health Psychologist, Counselling Psychologist or Counsellor and the General Practitioners in Workshop B. In fact the Counselling Psychologist does assert her specialist knowledge using some of the same information, like suggesting the Becks Depression

Inventory (BDI) for assessment purposes, but is challenged on this later by her psychological colleague, who implies she is the more critical psychologist. The Clinical Psychologist in Workshop A is the only mental health practitioner and may be in a better position to wield professional power and promote a psychological agenda than in the team where although there are more mental health practitioners, differences in recommendations serve to undermine their contributions. There is a textual relatedness between the two clinical positions of the Clinical Psychologist and the General Practitioners, they hold similar positions in the dialogue about depression. There are observable symptoms which correspond to those included in a commonly accepted clinical diagnosis and the condition diagnosed is treated using specialist professional expertise not available to the non-clinician. Again minority influence maybe more powerful in a setting where the team has been instructed to function in a multi-disciplinary way and the person representing a mental discipline can carve out a unique role that does not conflict with the role of other team members, as long as the individual takes the opportunity, which the Welfare Adviser does not seem to in Workshop C. His role is seen as taking referrals from other agencies and relatives by the General Practitioners which he challenges pointing out that his organisation actually receives a lot of self referrals (C23-C31). The significance of this is that what is being questioned is who presents with depression in General Practice as opposed to the Welfare Officer's organisation, as the General Practitioners in Workshop C are stating that they see a lot of patients with depression who will be different, and present with different symptoms to those the Welfare Adviser sees. The ownership of patients as in whose patients are being seen emerges in the discourse in many different forms during these workshops when discussing who can have access to

them, who must see them, who is qualified to see them and who the patient group feels comfortable with and “knows”.

Each workshop consisted of two General Practitioners, but conflicts in medical opinion did not take place, and their roles were constantly being reinforced through the discussion of each intervention programme which focused in each workshop, for a great deal of the time, on what general practitioners would do in relation to the intervention. In fact common to each workshop was that General Practitioners were centralised in the intervention with the discussions mainly focusing on who else would be employed to provide additional services within the practice (B342). A professional agenda dominated each workshop and community involvement was reframed as community compliance, or the right not to comply, a concept rooted very much in a traditional medical discourse – treatment compliance and non-compliance. The community had the right not to comply, or to choose from an offered list of options, or to reject the options, but not to generate it's own options. In Workshop A, GP2's conceptualisation of “a free society” (A42) is the right to resist intervention. The overriding health care model in each workshop appeared to be more a professionally driven consumerist model of health care (C353-C355) than the multidisciplinary social equality model which underlies COPC (A142-A143). It seems that not to offer the intervention within this multidisciplinary discourse is to “deny” the population, professional validation is linked with giving the patient the options, giving them “something” (A127), the converse of this that patients are not receiving entitled health care may be the underlying belief which fuels the drive in the groups to produce such broad-ranging assessments and comprehensive health based interventions.

The discourse around consent, compliance, patient rights and choice is complex in these workshops. Patients as stated above are depicted as having a right to choose options, and consent to intervention, yet resistance to assessment, and depression being missed (A199) is constructed as “covering up” (A201), patients’ power to resist professional intervention is both supported and challenged. Patients’ may not know why they are depressed (B473) until they are assessed. Patient empowerment is supported as being the consumer’s choice within a free market, but challenged as being subversive if it conflicts with the norms of social control, such as the norm which encourages people with depression to seek and be in receipt of treatment. The older patients living with depression must be sought out wherever they may appear (C90-C92; C95), those that might see secondary care as meeting the needs of those individuals who require such proactive identification “do not know what it is like out there” (B934-B942).

In each team the COPC programme developed consisted of very similar components, a general health assessment of the older practice population with a special focus on depression carried out by a practice nurse, or someone employed by the practice specifically for the programme who was described as needing research skills and relevant but unspecified qualifications if they fell outside of nursing, followed by referral to the General Practitioner of patients living with a significant level of depression demonstrated by some clinical symptoms. The General Practitioner would then be able to provide appropriate medical care and refer out to other agencies as relevant if there were co-existing problems such as social isolation, poverty etcetera and use the person employed for the project to co-ordinate referrals, provide follow-

up and generally manage a caseload of older patients taking on what is similar to a social worker role. Other agencies in the community are valued in the discussion for the resources they can provide to the group rather than the contribution they could make to the development of the programme (A306; A308; A311). There is an issue of trust here in cross-sector working, in that there is concern over who would be the individuals referred to (A468) and ensuring anyone outside the workshop group was “appropriately” trained (B284). The Counselling Psychologist in Workshop B reminds one General Practitioner that they can refer severely depressed people on (B945) as referrals to outside agencies are not being adequately considered as an option. The Practice Counsellor’s attempt to put counselling on the agenda (B1033) is not acknowledged by the Workshop B group and is unsuccessful, referral options across the groups seem to be limited to the General Practitioners and Nurses within the practices, a specifically employed project worker, and outside voluntary and statutory agencies who might be useful to the groups (C396). Working with psychologists and social workers is raised in Workshop A (A57), but specific routes of referral or roles in the intervention programmes by mental health practitioners are not covered in the discussions.

The discourse surrounding ageing in the workshops is generally pathological in nature and highlights factors social isolation, poverty, bereavement, chronic health problems, disability, decreasing social worth and increasing feelings of worthlessness. Constructing older people as vulnerable (B279) rationalises other assumptions about them needing a particularly sensitive approach (B282; B289) which are then open to challenge through claims that is not about sensitivity, but about the patient needing to feel safe and comfortable with people they know (B292). The opposite pole to this

assumption is that older people feel threatened by strangers (B538), if they are not threatened on account of the person being unknown or younger (B292) then “the dementia creeping in” makes them vulnerable (B543). The vulnerability of the older person becomes accepted by the group. Foremost on the list of people elicited that the older people know best are carers (excluded because they do not have the specialist training for the role of assessment all the groups agree is needed), and practitioners in General Practice such as Practice Nurses and General Practitioners (B295). Older people are constructed as having social identities which are composed of problems (C212) seen as co-existing with as well as being causal factors of depression, many of these are predominantly social or physical in nature (C281 – C285) and perceived within this discourse as outside their control. Attempts to challenge stereotypes within the groups by individual team members although acknowledged by the other team members did not result in the emergence of any other more positive or patient-centred discourse (A52-A55; B860). The drawing of attention to the older people who do not fit the descriptions of the older target populations constructed in the group is generally reframed as a consent issue, in that these would be the people who would not want or need the intervention options, rather than it impacting on the identity constructed by the teams for the group targeted for intervention. The risk factors for depression identified result in older people living with depression being further pathologised in each group.

The changing use of the pronouns used by speakers in the groups when using action phrases indicate the points in the workshops when different disciplines are perceived to have ownership of the developing intervention, and when the speaker is claiming responsibility for and rights over the intervention. The second person pronoun “you”

is most frequently used when the Nurses or other team members are addressing the General Practitioners, whereas the third person pronoun “we” is frequently used by the General Practitioners in summarising the team planning and decision-making, thus legitimising their version of the events as being multidisciplinary. The first person pronoun “I” is used by all the Psychologists to assert what they would use with their clients as practitioners, they tend not refer to common professional practice, this more subjective means of claiming expertise results in their claims having less impact within medical discourse which favours the language of professional objectivity. The General Practitioners do however refer to “my practice” which is received within the group as a more general observation on what happens in general practice and also asserts their dominant place in the team when discussing the COPC programmes which would all be taking place in practices similar to theirs.

An ideological position common to all the workshops is that older people living with depression warranting a clinical diagnosis should be identified by the team and referred to the General Practitioner. Older patients can exercise their right to choose (A25-A29; A45-A46), but they are not seen as having a right not to be identified, and the dominant ideological pattern across the workshops is that depression should be treated. Workshop C differs in that the language used by the General Practitioners is more aggressive in promoting this agenda, for example GP2 talks of how the team “should be attacking” people who do not present at the surgery with their depression, or who are not being treated for it (C109) and GP1 (C315) advocates “taking over” for the patients. The humour which is implied by the laughter which accompanies the more directive statements which acknowledge the degree of social control being exercised in Workshop C does function to lessen the potential for disagreement, but

does not change the nature of what is being agreed. There is a conflict here for the General Practitioners in the Workshops in that they are trying to develop a population based public health strategy whilst meeting the requirements of care as they see it for their individual patients. This individualistic focus is common to the discourse of all the practitioners in the groups, it may be the ideology of individualism underlying the discourses which promotes the development of the same “assessment- diagnosis- patient intervention- individual case management” programmes in each group.

The Psychologists and Counsellors could not claim the “patients “ as theirs in the way the General Practitioners can, but equally there is no evidence that they have integrated a public health perspective into their thinking for this task any more than their General Practitioner counterparts. Another reoccurring ideological position within this ideological pattern is that the team should not miss any patients who should be assessed for depression (B827) and would consent to and benefit to intervention. This is in opposition to the ideological position from a public health perspective which promotes changes in population statistics and does not give an equal value to individual benefits which are not reflected in the population profile. The Welfare Advisers are the members in each team which use an ethical framework to legitimise this position, raising ethical objections is a role they all took on (A25; A28; A456; B839; C167; C316).

Ideological content which is also repeated across the Workshops and which emerges from the dominant medical discourse is that physical health problems should be treated alongside or prior to any mental health problems. This is justified by the General Practitioners and Nurses through the argument that the physical health

problems might be causal factors for the depression, and better management of them is necessary to treat the depression effectively. The effect of the promotion of this integrated model of the body and the mind, where the body is given priority, is that the treatment of the mind through medication is rationalised. It is also claimed through this ideological position that the consequences of not treating physical ailments is less desirable than not treating the depression, which itself is frequently constructed as the outcome of the physical and social ailments. Ageing is perceived as resulting in identified physical and social problems which both lead to and are accompanied by depression, and the primary intervention is to assess people for depression and these accompanying/causal problems, which are then to be addressed by referral to the appropriate agencies. A broad-ranging assessment is presented as a requirement (A90). Older people have to be engaged and brought into practices so this assessment can be carried out (A167; B404), the target group are not a population known to be depressed, but a population whose depression and physical ailments will be identified as apart of the COPC programme, but are assumed to be there prior to assessment.

The Welfare Adviser in Workshop A highlights the social control agenda prevalent in each workshop when he asks the Clinical Psychologist if she will be using medication to treat somebody who is depressed because of social factors (A78). Social control has been defined as statements that promote people's adherence to the norm, which in medical discourse includes a doctor prescribing medication to treat a situation caused by psychological, social or interpersonal factors (Waitzkin 1990). The Clinical Psychologist refers to the clinical specialist knowledge which enables her to make decisions which can discriminate between those with whom social factors should be

discussed, and those whose “free-floating” anxiety is appropriately treated with anti-depressants (A79; A92) because as the cause of their depression is unclear, treatment with anti-depressants is not negotiable. The depression must be managed “clinically” and medication is not open to discussion with non-clinicians is the implication, in fact the Clinical Psychologist’s right to make a unilateral decision on this is stated as a legal requirement (A228). Another message of social control emerges in the statements around personal care falling below the norm expected of the non-depressed leading to interventions to assess why (A195; A197; C217-C219), this is not explicitly presented as a social control agenda in the workshops, but as a product of professional expertise informing observations. In Workshop 3 when the Welfare Adviser introduces medication as an option it is a General Practitioner who presents the case for other interventions (C127) but these are social in nature, such as support for bereavement, and he advocates the addressing of physical health problems which might underlie depression. None of the Workshops produce a programme which includes referrals to a psychological or counselling service, but here depression is being defined clearly as a problem resulting from situational or health events for which extra support is required, or as in the other Workshops some patients can be treated with anti-depressants in the absence of a clear causal problem which can be solved (C131).

The power the General Practitioner can exercise in the General Practitioner-patient relationship results in the General Practitioner being constructed as a resource within the intervention as well as a central agency in delivering the programme (A359; A362; A365). The General Practitioner is being used as a resource of socially legitimated power and influence by the group and presenting him/her as just

controlling the group discourse through a medical agenda would be simplistic. The General Practitioner holds access to a valued resource highlighted in each workshop as a basis for intervention – patient lists. The groups are also employing other social control actions through him/her in utilising the statutory health check system (B753; B755), in this case the until recently statutory over 75 check. All patients over 75 had to be offered an over 75 check, there was no option not to be offered the check and it is through this means the groups all chose to legitimately contact and engage patients in relation to the COPC intervention. The patients can be “drawn in” if they have opted not to take up an annual check (C109) and other agencies can be used to gather information on patients (C189). The degree of patient observation in-built into these observations, the “intrusion of the external gaze” is high (A432; C186), in workshop A the Clinical Psychologist advocates assessment every time the patient comes in, and perhaps every 3 months for some patients, because “they may need it”. The evaluation agenda is used to legitimise on-going assessment and monitoring in addition to evaluating the impact of the programme intervention which gets relatively little attention in the workshop discussions. The Practice Nurse in Workshop B explicitly raises this focus on assessment rather than prevention as a problem (B398). The analysis so far might suggest that it is the dominance of the medical discourse which enables the General Practitioner agenda to dominate every workshop, an alternative perspective might be that the multidisciplinary discourse emerges as predominantly medical, and the General Practitioner is centralised, because this serves another function of empowering the multidisciplinary group in their access to Aesculapian power, knowledge and structural power (A464; A466; C315). The General Practitioner in the workshops whilst actively developing the programmes challenge

the degree of the extra work which they would have to adopt (B155-B158; B169; B296) and their perceived ability to offer everything (A365; C303-C307).

The language of depression is predominantly drawn from medical discourse and this has its roots in the use of a diagnostic model of depression to identify presenting symptoms in each workshop (A5; B8; B151; B229; C16-C19). The discourse within which depression is defined and the language used to discuss depression is key to how older people are constructed within the workshops. Defining older people is prescribed within the boundaries of medical discourse by the language used to initiate the defining process, for example the question on how “geriatric” should be defined at the outset of Workshop B (B7), a label which has just been introduced by the Practice Nurse in her statement that “a quick geriatric assessment scale” (B6) would be run. Depression is defined in the context of a health problem in Workshop C from the outset (C9-C10). In Workshop B the Counselling Psychologist’s attempt to weaken the link between depression and older people (B29) is successfully counteracted by a General Practitioner (B30) and as a result she makes a discrimination between older people aged over 65 years and “adults” (B37).

There is resistance to any change to the COPC programmes which would constitute a significant change in traditional general practice activities. Suggested interventions such as group work for depressed older people made by the Practice Counsellor in Workshop B (B885) were firmly opposed by the Practice Nurse (B886-B894) and one of the General Practitioners expressed reservations saying “there is a definite problem about them” (B887), the idea is not developed. The programme interventions which were developed in the workshops were generally based on what already exists

or has existed in primary care (A163; B346-B348; C398-C402). This study obviously cannot provide the answers to all aspects of how multidisciplinary teams function in primary care or how they might operate differently. It was designed to explore the process from a mental health perspective and increase or awareness of the complexity of multidisciplinary working at a time when it is promoted as an ideal without the problems perhaps being fully recognised when non-medical practitioners are required to integrate into a traditionally hierarchical environment such as primary care. In order to address more specific questions more detailed analyses would need to be done on specific areas of the transcripts relevant to each area of enquiry.

This study investigated a much larger area of analysis than is common in discourse analysis studies in exploring transcripts from three workshop tasks each lasting an hour. The resulting analysis both gives a temporal analysis of each individual workshop and an overview which enables the reader as well as the researcher to form an informed impression of the data and the themes emerging across the workshops. The discourse excerpts therefore were not randomly selected but selected according to coding criteria and difference within workshops, as well as replication and difference across workshops. The costs of this was the sheer value of data to be analysed, and the transcription was relatively basic, the benefits that the final excerpts were not subjectively selected to fit pre-existing theories but can be followed in temporal context. The transcription of all the data using video and audio-recordings means that not only do other observers have access to all the recorded data, but each interpretation can also be linked to an excerpt in the analysis/results section, and the excerpts can be compared to the complete transcripts. The study also aimed to investigate the utility of applying a discourse analysis framework to exploring team

working in primary care and as such has demonstrated that such a methodology can increase our understanding of the processes involved, and has value for raising the awareness of minority disciplines such as Psychology and Counselling of how their professional discourses can be subsumed into the dominant discourse of medicine. The Counselling Psychologist dropping out of Workshop C due to ill health was not seen as particularly detrimental to the study in that it meant that the two workshops involving Psychologists and Counsellors (Workshop a & B) could be compared to one that didn't (Workshop C), and that all the workshops had been set up in the same way with the same preparation and COPC training delivered.

The importance of language and context are two areas highlighted in the workshops in impacting on multidisciplinary primary care team members working on an equal level, and how medical terminology and centralising General Practice in community oriented interventions reinforces the dominance of the medical agenda and General Practitioners. It also seemed that the primary care practitioners in the Workshops found it difficult to apply a public health perspective, even with the limited training they received in COPC immediately prior to the Workshop task. Professional discourses other than medicine were very marginalized in the multidisciplinary groups, and psychological and counselling agendas were not equally reflected in the ongoing discussion, decision-making or group outcome, regardless of whether a Psychologist or Counsellor was present. The most influential psychological practitioner was a Clinical Psychologist but the psychological perspective which was allowed to emerge in the multidisciplinary discourse had much in common with the medical perspective with the emphasis on a clinical diagnostic perspective.

Limitations of the Study and Future Research

In order to more accurately assess the impact of the multidisciplinary team working on the process of COPC programme construction and outcome, it would be useful to compare the results of the multidisciplinary groups with single discipline groups given the same training and tasks. This would enable us to see whether the different disciplines produced similar discourses and outcomes when isolated from their medical, psychological, nursing and social work colleagues. This study was carried out in an academic medical department which whilst reproducing the medical bias in a primary care setting does not allow us to see how the results would have differed if the workshops had been carried out in settings where non-medical practitioners might have felt more empowered. The study findings indicate that the “multidisciplinary working” component of the COPC model is more of a challenge than hitherto acknowledged or investigated in the literature, and COPC may have had limited application due to its’ model of non-hierarchical multidisciplinary working. More research is needed to further explore this aspect of COPC as a barrier to its implementation in less deprived and medically underserved areas.

The author is currently involved in a study to investigate the relevance of COPC at PCT level and to provide appropriate training to selected practices. This will enable more investigation into the limitations of the training offered in the workshops in the current study. Thirty minutes covering the whole model may have been insufficient training for the workshop task or the participants could have been actively resisting the public health component of the model and the expectations of non-hierarchical working. This follow-on study will include additional emphasis on these two aspects of the model in order to ascertain whether participants are more able to apply the

learning. The time allocation of 30 minutes to the initial training and 1 hour to the group task followed by group discussion and feedback was directed more by a training than a research agenda. The participants although they had consented to research participation had come for training and the construction of the workshop had to best meet those needs in the time available. It was likely to have been difficult for groups to adjust individualistic perspectives and hierarchical roles so quickly

The participants agreed to be audio-and video-taped for the production of the transcripts with the understanding that they would not be identified in the research. In the interests of anonymity all identifying characteristics such as gender, race, age, length of professional experience, specific qualifications have been omitted from the analysis. This must be taken into account when interpreting the results as these are all characteristics which can have a powerful impact on group process and emerging discourses. The findings of this study indicate there is value in continuing the exploration of the research questions in this study, and further investigations could usefully include the impact of the characteristics above in the analyses, which may mean research participants coming from a far wider geographical area than in this study or discussing with participants the risks of compromising anonymity through these additional identifiers prior to obtaining consent. It is also hoped that more discourse analysis and other qualitative research will be carried out on the full workshop transcripts made available in this thesis (subject to appropriate acknowledgements and the special conditions outlined in the acknowledgments section).

The workshops analyses were based on coding of the categories being explored by two independent coders as relevant discourse appeared in the transcripts as it was assumed that the multidisciplinary discourse emerges throughout the workshop and random sampling might miss key stages in the development or suppression of particular perspectives. Random selection of discourse excerpts would be an interesting follow-up study to compare the findings and test this assumption as well as whether alternative hypotheses not identified in this study emerge. The quantity of data was much higher than in many discourse analyses because the sample was recordings of groups in progress rather than group interviews or participant observation so this limited the analysis to key areas relevant to the main study questions for pragmatic reasons. The data could act as a useful basis for other discourse analysis studies relevant to this study sample, with different exploratory questions and alternative means of analysis. The compilation of the transcripts was very time-consuming and difficult, due to the complications of transcribing group discourse where turn-taking is not established by particular questions and the process is not being managed by a facilitator. The transcripts are now available as a resource for academic researchers and it would be interesting to see what others who make different choices to those outlined in this study might find.

Conclusion

Counselling Psychology has much to contribute to multidisciplinary working and could foster true innovation in primary care through broadening the clinical perspective, but Counselling Psychologists need to be aware of the power of medical discourse in the environments in which they work, and the resistance of primary care

to change which can emerge through the medical agenda and the adoption of medical terms in multi-disciplinary working . The perception of other agencies as potential resources for one's own work and agenda may be something that is common to medical, psychological and social practitioners in primary care, and there may be a need for a shift in this perspective to seeing other practitioners as equal collaborators with a view to sharing power, rather than channelling power through General Practitioners, in order for primary care to become truly multidisciplinary in its' functioning as well as structural composition.

Appendix 1: COPC Workshop Letter and Promotional Material

Dear

I am enclosing details of a series of Community Oriented Primary Care Training Workshops to be run within the Primary Care For Older People Programme at The Department of Primary Care & Population Sciences, Royal Free/University College Medical School. The training is currently being offered free of charge, and as a high demand for places is expected, early registering of interest in the workshops is strongly advised.

Please could you pass these details onto practices and appropriate colleagues in primary care.

Yours sincerely

Penny Lenihan

TRAINING WORKSHOPS IN COMMUNITY ORIENTED PRIMARY CARE

The primary care groups (PCGs) newly introduced to the National Health Service require general practitioners and primary care teams to improve the health of their communities by addressing the health needs of their population, promoting the health of that population and working with other organisations to deliver effective and appropriate care (HSC1998/228¹). This combination of clinical practice with both a public health perspective and a networking approach to collaboration between disciplines and across service boundaries is likely to test the adaptability of general practice, and prove challenging to medical, mental health and social care practitioners, and PCGs alike.

Community oriented primary care (COPC) is an internationally tested approach to primary care which meets the requirements of the PCG agenda in its multidisciplinary synthesis of primary care and public health perspectives. It offers the integration of public health methods and primary care clinical practice, currently sought in Primary Care Groups and the Health Improvement Programme and delivers targeted prioritised services to a defined population. The model has the potential to

assist general practice teams, mental health care practitioners, social care agencies and PCGs in meeting the requirements of the modern and dependable NHS through developing their clinical skills and promoting healthier communities.

A series of free one day workshops on community oriented primary care will be running in October, November and December 2000. These workshops are designed to enable participants to familiarise themselves with:

- The principles of COPC
- The application of the principles of epidemiology to primary health care
- The skills of community diagnosis
- The skills of detailed problem assessment
- The skills of intervention planning
- The skills of evaluation planning

Each workshop will include a practice session which will be audio-taped for evaluation and with the approval of participants excerpts will be transcribed (anonymously) for research purposes.

These workshops are designed for primary care practitioners such as general practitioners, practice/district nurses and health visitors, psychiatrists, clinical/counselling psychologists and social workers. Places will be allocated so as to ensure a multidisciplinary participant make-up to each workshop, and early application is recommended.

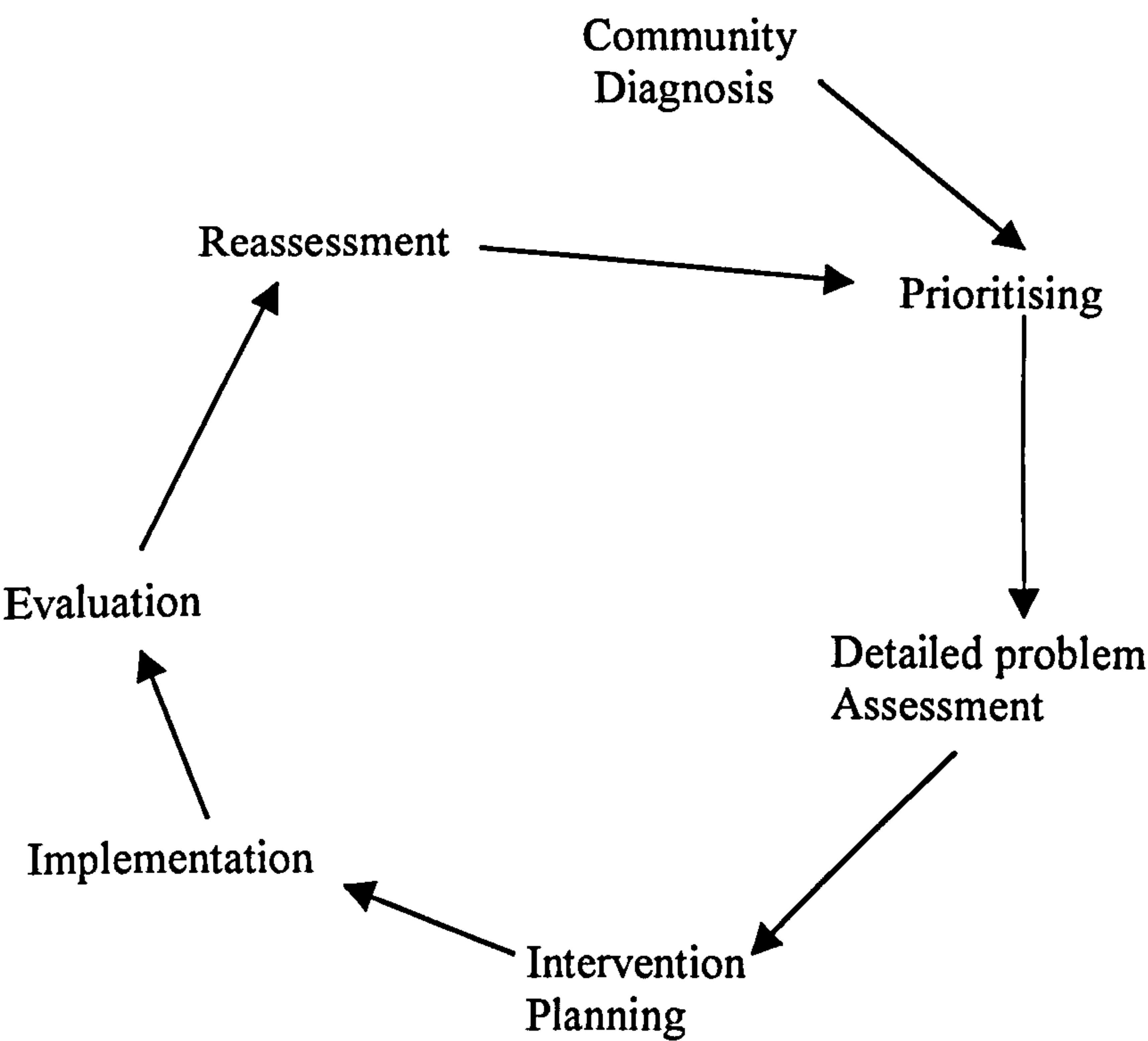
If you would like to register for one of these workshops (subject to availability) or to obtain further details please contact Penny Lenihan C Psychol or Dr Steve Iliffe on 0207 830 2393; email p.lenihan@rfhsm.ac.uk or write to us at The Department of Primary Care, RFUCL Medical School, RF Campus, Rowland Hill St, London, NW3 2PF

APPENDIX 2: COPC WORKSHOP BOOKLET/OVERHEADS

Overhead 1: Community-orientated primary care [COPC] – Definition

COPC is a *continuous process* by which *PHC* is provided to a *defined community* on the basis of its *assessed health needs* by the planned *integration of public health* with PC practice.

Overhead 2: The COPC cycle



Overhead 3: COPC features

- Works with a defined group.
- Provides primary clinical care.
- Has defined programmes.
- Interests itself in *all* factors that affect health.
- Is concerned with the total natural history of a disease and all levels of prevention.
- Involves a multi-disciplinary team.
- Involves the community
- Uses epidemiological methods
- Is an integral part of PHC work

Overhead 4: Why a community diagnosis?

- To know your practice.
- To identify all major health problems
- As the basis for selecting your COPC priority
- To ensure that you do not overlook potential resources
- To ensure that you take a *population-based* view.
- To ensure that you do not inadvertently plump for an ‘obvious’ project.

Overhead 5: The community diagnosis checklist

- General description of environment.
- Community characteristics.
- Health service system:
 - outside the practice
 - within the practice.
- State of health:
 - morbidity
 - mortality
 - behaviour
 -
- Health problem list – maximum of 6.

Overhead 6: Detailed problem assessment

What

- A description of where your group is now:
 - what the health problem is
 - who is in the group
 - the extent of the health problem.

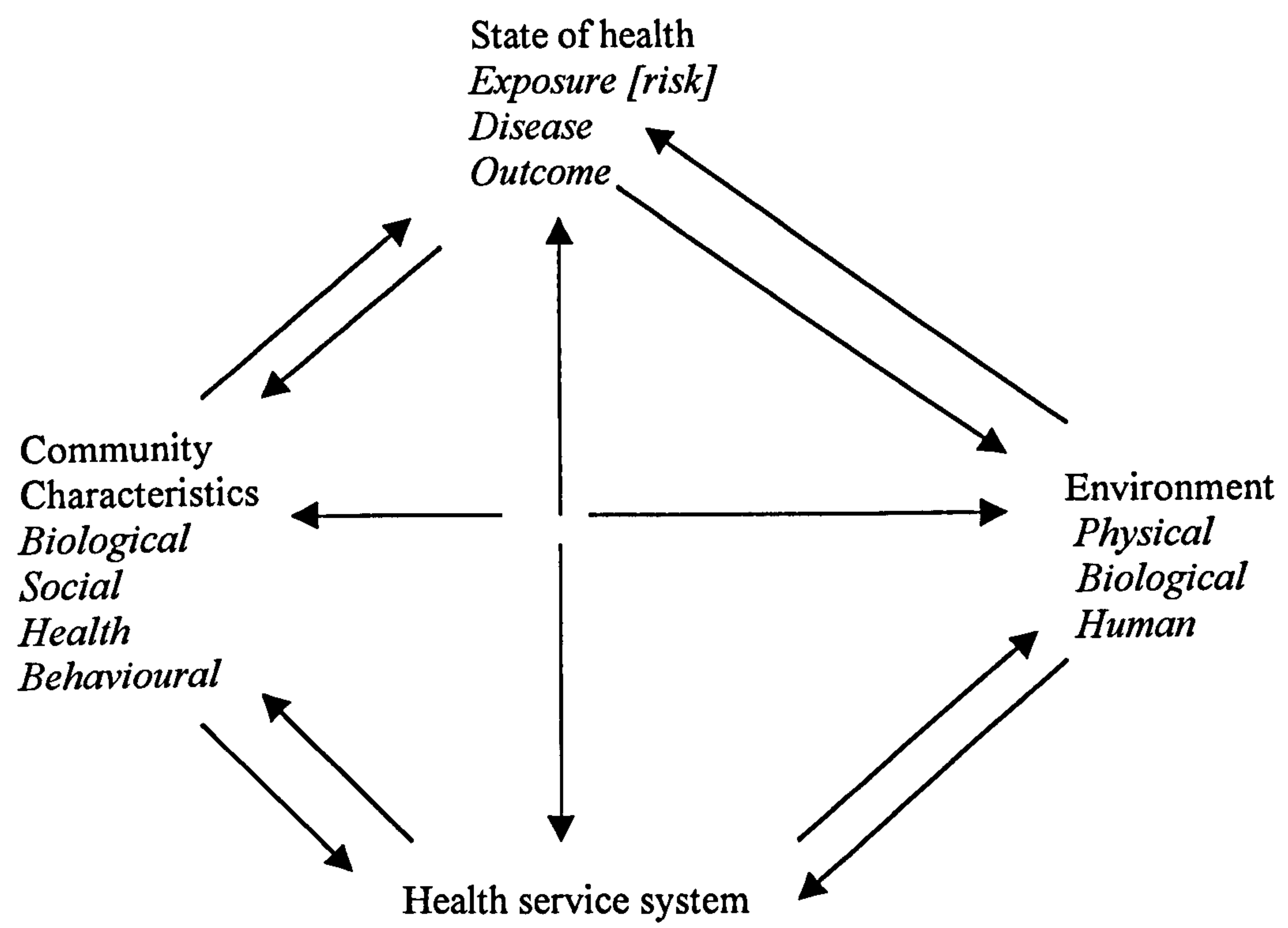
Why

- As a base from which to:
 - Plan
 - Implement
 - evaluate your COPC programme.

Overhead 7: Detailed problem assessment – content

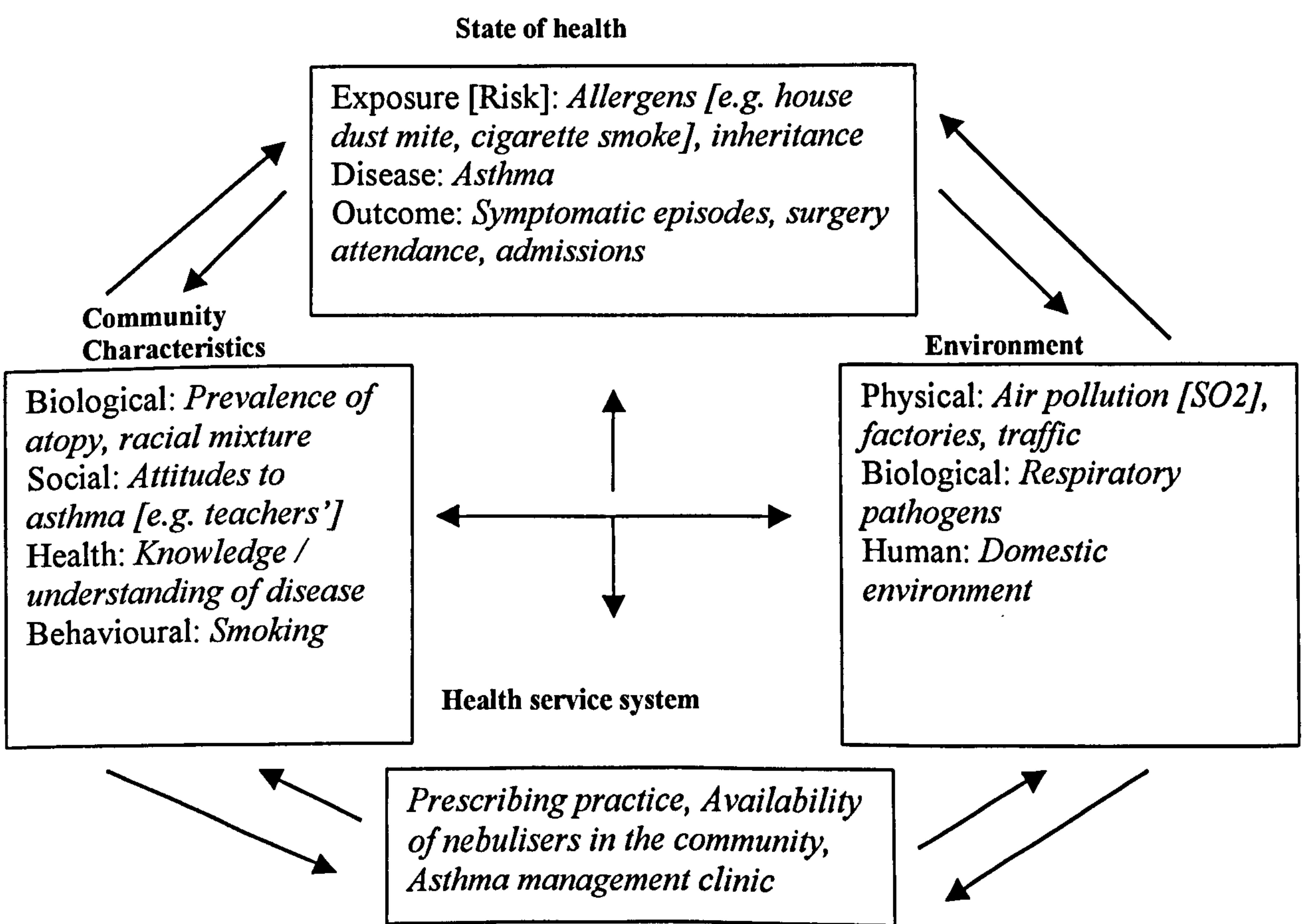
- Definition of the group.
- Characteristics to be measured.
- Definition of the measures.
- Methods of data collection.
- Records.

Overhead 8 The health model



Overhead 9: Health model example

Health problem: Asthma in childhood – cough/wheeze/shortness of breath



Practice Scenario

The process of group diagnosis and priority setting in your practice community has led to depression in older people being identified as the priority for intervention.

Group Task

The whole group is asked to design a community oriented primary care programme to address depression in older people and an evaluation framework for the programme. It is up to the group to decide the specifics of the target group and the content of the intervention. The final programme is to be outlined on the paper provided, for feedback and group discussion.

Time

One Hour