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A graduate primary care mental health worker pilot study: facilitating access to voluntary and community sector services. A description of the 'Community Link Service'

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ABSTRACT

Background *The NHS Plan* proposed that 1000 graduate primary care mental health workers (GPCMHWs) be employed by 2004. Recruitment of GPCMHWs and their enrolment on university training courses has begun; however, the specific roles to be carried out by GPCMHWs are still in the process of being defined, and there is a limited evidence base to underpin this.

Aims The current paper discusses a pilot study of GPCMHWs facilitating access to voluntary and community services, via a 'Community Link Service'. The rationale behind the facilitator role and its application to primary care are provided, and vignettes are employed to help clarify and illustrate the service within the context of primary care.

Results People supported by the GPCMHW service were most likely to have experienced

depression, anxiety, isolation or difficulties around relationships and work, and tended to fall within typical ranges of clinically affected populations (as measured on the General Health Questionnaire-12, Clinical Outcomes in Routine Evaluation, and Work and Social Adjustment Scale). Perceptions of primary care staff about the project were generally favourable.

Conclusions It is feasible for GPCMHWs, with relevant training and support, to set up and run a primary care-based service facilitating access for patients to voluntary and community sector organisations.

Keywords: graduate primary care mental health workers (GPCMHWs), primary care, voluntary sector

Introduction

There have been a number of documents, such as the *National Service Framework for Mental Health*, the *NHS Plan*, and the *Priorities and Planning Framework*, which have reflected the government's move to redress the balance of resources within the NHS, particularly with regard to the relative under-resourcing of mental health services in primary care.¹⁻³ The latter document (in addition to the Department of Health's (DoH's) best practice guidance) specifically declared the government's intention to employ at least 1000 new graduate primary care mental health workers (GPCMHWs).⁴ The purpose of these new professionals is to support the provision of mental health services in primary care.

The available data on the prevalence of mental health problems in primary care reflects the need for more resources at this level. Mental health problems are indicated as constituting part or all of one in four primary care consultations, and psychosocial problems have been identified in up to 75% of patients attending a GP consultation.^{5,6} While it is estimated that 90% of people with mental health problems in the UK are supported entirely within primary care, only 10% of the NHS budget is spent on mental health in primary care.⁷ The GPCMHWs are one of the proposals set out by the government to expand mental health resources within the primary care arena.

Since the publication of the *Priorities and Planning Framework* there has been considerable discussion within the DoH and the NHS about GPCMHWs, such as the specific roles they will carry out, and their training needs.^{3,8,9} Three main areas have been identified in which it is felt that GPCMHWs can be effectively utilised: a clinical role involving direct patient contact (e.g. guided self-help); practice team work such as audit, data entry, analysis and report writing; and work within the wider community, such as 'mapping' local voluntary sector services.⁴ It is likely that most GPCMHWs will be provided with generic training that enables them to carry out duties from more than one of these areas.

The current pilot study is an example of the third area of suggested work, actively linking primary care with the voluntary and community sectors. The 'Community Link Service' provided patients with information about, and support in, accessing services within the voluntary and community sectors. Information on identified resources was subsequently used to update a web-based database of local mental health services provided by the voluntary, community, private and statutory sectors.¹⁰

The importance of increased communication and co-operation between primary care and the voluntary

sector has been raised in a number of government papers.^{2,11} The voluntary sector offers a range of services that are potentially able to address some of the mental health problems presenting in primary care, and it is argued that the voluntary sector has the opportunity to be more innovative, thus providing some services that primary care is unable to offer.¹² While referrals between these two sectors do take place, there is evidence that the potential of this relationship is not fully utilised.^{13,14} This is probably partly fuelled by misconceptions about the voluntary sector, in that primary care practitioners questioned have been found to be uncertain of the value, accountability and standards of interventions provided by voluntary sector services.¹⁵ It can also be difficult for primary care teams to help people to access voluntary sector resources appropriately, due to a lack of knowledge about what is currently locally available.¹⁶ The particular services available locally may change quite rapidly, and primary care practitioners have limited time to keep up to date and facilitate such access.¹⁵

There is some evidence that having a specific worker to help link people with appropriate voluntary and community resources can improve mental health outcomes in primary care. A qualitative evaluation of a social prescribing scheme in Penge and Anerley (South London), where GPs could refer patients to a community worker with extensive knowledge of the voluntary sector, found a perceived reduction in patients' isolation and an increase in their self-esteem.¹⁷ In addition, GPs reported that they felt the project resulted in their patient care being more holistic. A similar pattern of change has been reported in a comparable London-based service.¹⁸

There is further supportive evidence from a randomised control trial of the Amalthea project, in Bristol.¹⁹ The Amalthea project was similar in its organisation to the services mentioned above, but differed in that it consisted of 'referral facilitators' who worked across a number of practices. Patients referred to a referral facilitator by their GP were most likely to have experienced anxiety/stress, interpersonal/relationship difficulties or depression, as well as a range of other psychosocial problems. Patients were assessed within seven days of referral and were then followed up to encourage attendance at recommended voluntary organisations. Comparing the Amalthea project to GP treatment as usual, patients who accessed the project were found to have significantly greater improvements in anxiety, other emotional problems, feelings about their general health, and in their ability to perform daily functions (as assessed by standardised questionnaires).

The current study has built on the ideas and methodologies used in these services, and uses a

GPCMHW to provide a link between the local voluntary and community sectors and inner-city primary healthcare staff across a number of practices.¹⁷⁻¹⁹ Our study aimed to evaluate the feasibility and acceptability of such a community link role being undertaken by a GPCMHW with no, or limited, previous training in mental health, and no prior knowledge of local community resources. The specific aims of this paper are to explain how the Community Link Service works; to provide data on the patients who accessed the service; to illustrate the service within the context of primary care with representative vignettes, and to discuss primary care personnels' perceptions of the service. (Outcome data for the service can be found in a paper by Grayer *et al* (in preparation).²⁰

Methods

Preliminary work

The Community Link Service was set up by two inner-city London primary care trusts (PCTs) in Camden and Islington, in collaboration with the Centre for Outcomes Research and Effectiveness (CORE), University College London. Two assistant psychologists were recruited to work on the service (one in each PCT), with the aim of supporting the initial development of the service, piloting the role of the GPCMHW, and aiding in the evaluation of the service. Each of the assistant psychologists had an undergraduate degree in psychology and some experience of research and clinical work. Once in post the workers received ongoing, in-house training from two clinical psychologists for approximately one session every six weeks. Training involved a variety of seminars and workshops (including opportunities for role-playing). Topics covered included primary care and the NHS; clinical skills (including structured interview skills, and motivational interviewing); recognising personality disorder; and welfare rights. The workers also attended a three-day guided self-help course. In addition, the workers made contact with a wide variety of voluntary and community sector resources.

General practices across both Camden and Islington PCTs were contacted by letter and email about the project, and meetings were subsequently held with those who expressed interest in taking part. In Islington PCT a 'hub and spoke' model was adopted, in that the GPCMHW was based at four practices, but accepted referrals from an additional two local surgeries, which enabled practices without the necessary space to utilise the service. In Camden

PCT the service was based at seven individual general practices. The two full-time assistant psychologists each spent approximately five sessions per week at these general practices. Their remaining time was spent on service-related tasks such as investigating appropriate services for patients and administration of the project, as well as the evaluation of the service, and continuing professional development.

Procedures

The decision about which members of the primary care team could refer to the service was made by individual practices. In some practices it was decided that only GPs were able to refer, while at others all clinicians could refer, and at some practices non-clinical staff such as the practice manager made indirect referrals by making suggestions to clinical staff (see Box 1). The eligibility criteria for the service were designed to be as inclusive as possible in order to increase accessibility (see Box 1). The service was developed to fit into a stepped-care model, i.e. initial low levels of support and increasing as necessary. It was envisaged that patients would not usually be under the care of another mental health service. However, when other mental health services were involved with the patient, the GPCMHW ensured that they liaised with them about the case (employing a collaborative care model, in that care for the patient was not provided by isolated individuals).

Once a member of the primary care team had made what appeared to be a suitable referral, the GPCMHW contacted the patient, preferably by telephone, to (i) explain the service (particularly to emphasise that it was not a counselling service), (ii) clarify that eligibility criteria had been adhered to, and (iii) arrange an appointment if deemed appropriate. The first appointment tended to last for approximately 50 minutes; however not all assessments required this amount of time. This appointment included an explanation of the service, and a semi-structured interview (available from the authors on request) to assess the current psychosocial situation as well as the patient's needs. This enabled the patient to indicate the type(s) of support they felt would be beneficial for them.

Patients also completed three standardised questionnaires: the General Health Questionnaire-12 (GHQ-12), Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM), and Work and Social Adjustment Scale (WSAS).²¹⁻²³ The GHQ-12 measures mental or emotional distress. The CORE-OM is a measure of global distress and includes a risk (of harm to self or others) subscale, which was the

Box 1 Source of referrals to, eligibility and risk criteria for, the Community Link Service

Referrals (*n*) to the service were made by the following practice staff:

• GP	226
• nurse	11
• practice manager	9
• psychologist	4
• counsellor	3
• healthcare practitioner	2

The *inclusion* criteria were:

- age 18 years and above
- a psychosocial problem that the referrer judged could potentially benefit from contact with a voluntary sector or community service.

The *exclusion* criteria were:

- a current episode of acute psychosis or in crisis
- being housebound
- people who are, or who should be, under the care of other services, e.g. community mental health team (CMHT) or social services
- active suicidal ideation, assessed as follows:
 - if the patient scored three or over on items 6, 9, 22, 24 or 34 or scored one or over on item 16 of the CORE – Outcome Measure questionnaire (CORE-OM), then the GPCMHW asked the patient about suicidal intent. If clear intent was present, then the patient would be informed by the GPCMHW that they would have to break confidentiality and inform the GP. If the risk posed was judged by the GPCMHW to be immediate, then the patient would be asked to wait while the GPCMHW discussed this with the GP.

primary tool in the study risk protocol (see Box 1). The WSAS measures the impact of the patient's problems on work, social activities and relationships.

The GPCMHW researched the potential resources available for patients either during the initial session or thereafter, through a combination of paper and electronic directories (e.g. www.cimh.info¹⁰), telephone enquiries, peer guidance, and supervision from a locally based clinical psychologist. Discussion about the identified resources took place at this or subsequent appointments with the patient. Further contacts if indicated (face to face or by telephone, and usually lasting not more than 20 minutes) enabled the GPCMHW to (i) support and encourage the patient's attendance at recommended organisations (in collaboration with voluntary sector staff as appropriate), or (ii) discuss alternatives if initial plans had been unsuccessful. In addition, the GPCMHW could accompany the patient when attending a suggested organisation on the first occasion, thus giving additional support and helping to reduce the gap between primary care and the voluntary/community sectors.

To aid continuity of care and communication with GPs and other primary care staff, there was routine documentation of sessions at the general practice (e.g. using EMIS, an electronic patient notes system), and also feedback to the referrer and/or GP by letter at discharge – this information allowed primary care staff to refer patients on to other appropriate support where necessary. At the end of the evaluation period, a study-specific questionnaire was posted to participating practices asking primary care staff about their perceptions of the Community Link Service. (The questionnaire was scored on a Likert scale with anchors of 'strongly agree' (1) and 'strongly disagree' (5), thus a lower score indicates agreement with the statement.)

Results

There were 255 referrals to the service over approximately a one-year period, of which 234 were eligible. Figure 1 shows the movement of patients through the service. Fourteen per cent of appropriate

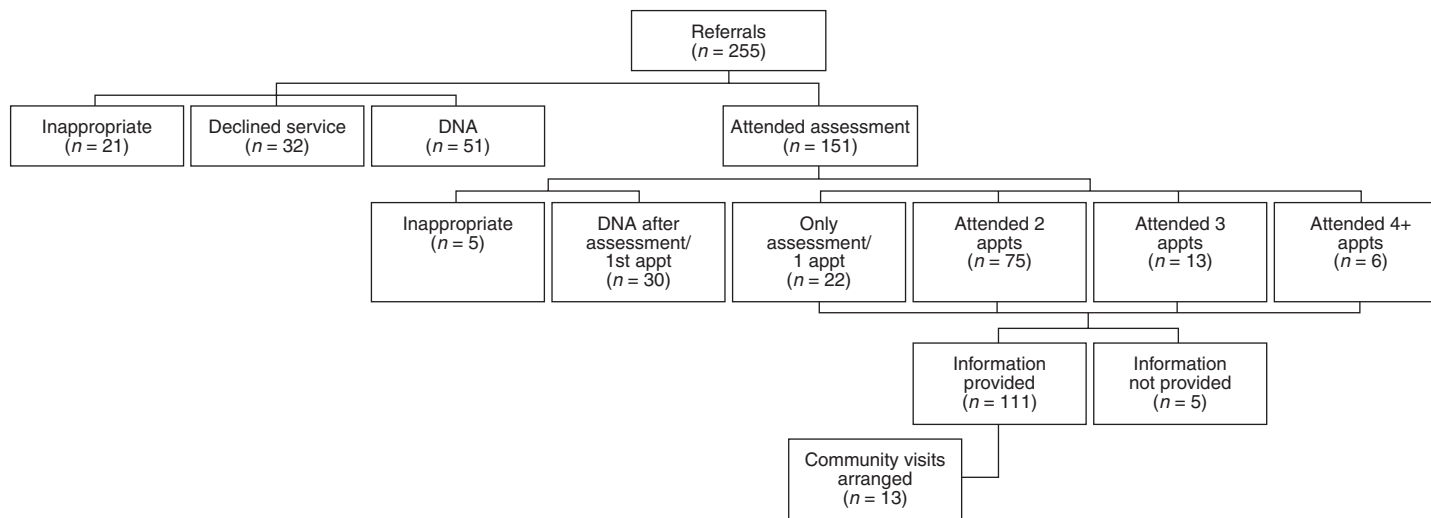


Figure 1 Movement of patients through the Community Link Service

patients declined the service, while 22% did not attend the assessment appointment. Five patients were not taken on by the service after the initial assessment, because of a high level of risk elicited, and it was therefore decided in discussion with their GP that the service could not adequately provide for the patients' needs. The further data presented in this paper are therefore from those patients who attended the initial assessment with the GPCMHW and were at that point considered appropriate ($n = 146$).

Demographic and clinical characteristics

Demographic and clinical information is detailed in Table 1. Approximately two-thirds of the patients were female, and the mean age was 43.8 years (standard deviation (SD) = 15.3 years). Patients were predominately white, and spoke English as their first language. In addition, the majority of patients were unemployed and currently receiving at least one benefit. Individuals were referred for a range of psychosocial problems. In relation to mental health, symptoms of depression were cited most frequently, while the most common 'social' problem identified on referral forms was isolation.

Table 2 gives data from the three standardised questionnaires administered. Patient scores on the GHQ-12, and on the CORE-OM indicate that the majority of patients had significant levels of distress.

Scores on the WSAS, indicate that the majority of patients experienced a significant disruption to their daily lives as a result of their problem(s).

Interventions and information provided to patients

Patients were most frequently referred to the service by GPs (see Box 1).

One-third of patients were only seen for the assessment appointment; half were seen for one further appointment, and small numbers were seen more than this (see Figure 1).

Information on a wide range of organisations was given to patients, as categorised in Table 3. The nature of the service meant that information provided tended to be about non-statutory services; however information on local government organisations such as housing bodies was also provided. In total, 95% of patients were provided with information, most frequently concerning mental health-related organisations.

Fictitious examples of the interventions and information provided by the GPCMHW are detailed in

Box 2 to give an example of the types of patients seen and the input provided.

Perceptions of primary care staff

The response rate for non-GP staff on the study specific questionnaire was low and therefore the data have not been included here. The response rate for GPs was 65% ($n = 33$). GPs perceived the service as useful for patients (mean = 1.65, SD = 0.84) however, there was some ambivalence as to whether patients were seen for long enough by the GPCMHW (mean = 2.21, SD = 0.9). GPs endorsed the idea of the service being implemented more fully across the two PCTs (mean = 1.65, SD = 0.71).

Discussion

Main findings

This pilot study showed that it is feasible to set up and run a primary care-based Community Link Service to connect people with relevant resources in the voluntary and community sectors, using GPCMHWs with no previous experience of such work. Patients who were appropriate referrals to the service had experienced a range of psychosocial problems, most commonly depression, anxiety, isolation, and difficulties around relationships and work.

How does this study compare with others in the literature?

While previously described services have tended to employ workers who had prior knowledge of the local voluntary and community sectors, this study demonstrated that with the appropriate resources and support it is possible for someone new to the area to assimilate the necessary information relatively quickly.^{17,19} While continuing to learn about the local sectors in an ongoing, 'on-the-job' process, the GPCMHWs were competent to deliver the service within three months of being employed. Furthermore, the current workers were recent psychology graduates with limited clinical and research experience, indicating that, with appropriate and relevant training, this group can become skilled enough to support people with psychosocial problems in primary care. It is thought that this finding can also be generalised to non-psychology graduates who are

Table 1 Demographics, primary psychosocial problems as recorded on the referral form, and current treatment methods and support

Characteristic	Number (%)
Demographics	
Age (years) (<i>n</i> = 146)	Mean = 43.8 (SD = 15.3)
Sex (<i>n</i> = 146)	
Female	94 (64.4)
Ethnicity (<i>n</i> = 139)	
White (including 'White European')	99 (71.2)
Black African	8 (5.8)
Bengali	7 (5.0)
Language (<i>n</i> = 132)	
English	102 (77.3)
French	7 (5.3)
Bengali	5 (3.8)
Religious (<i>n</i> = 84)	51 (60.7)
Employment	
unemployed (<i>n</i> = 140)	109 (77.9)
receiving benefits (<i>n</i> = 132)	94 (71.2)
Primary problems	
Clinical (symptoms of) (<i>n</i> = 146):	
depression	57 (39.0)
anxiety	25 (17.1)
mixed anxiety and depression	20 (13.7)
other	17 (11.7)
two or more mental health problems ^a	6 (4.1)
none	21 (14.4)
Social (<i>n</i> = 146):	
isolation	46 (31.5)
personal relationships	21 (14.4)
other	18 (12.4)
work	11 (7.5)
welfare	10 (6.8)
two or more social problems	15 (10.3)
none	25 (17.1)
Substance use	
drinking within recommended limits (<i>n</i> = 131)	117 (89.3)
illicit drug use (<i>n</i> = 128)	22 (17.2)
Current treatment methods and support	
medication (<i>n</i> = 142)	72 (50.7)
current psychological treatment (<i>n</i> = 135)	15 (11.1)
	68 (48.9)
	32 (27.2)

^a Not anxiety and depression

Table 2 Mean scores, standard deviations, and percentage of sample above threshold on the GHQ-12,^a CORE-OM^b and WSAS^c

Measure	<i>n</i>	Mean (SD)	% (<i>n</i>) \geq cutoff
GHQ-12	124	6.01 (4.14)	79.8 (99) 2+ 67.7 (84) 4+
CORE-OM	137	1.75 (0.69)	71.5 (98) moderate + 16.8 (23) severe +
WSAS	118	24.34 (11.87)	87.3 (103) moderate + 60.2 (71) severe +

^a General Health Questionnaire-12, a 12-item 4-point bimodal response scale. The GHQ scoring method 0,0,1,1 was adopted, with clinical thresholds of 2+ and 4+

^b Clinical Outcomes in Routine Evaluation – Outcomes Measure, 34-items with a Likert scale ranging from 0 to 4. Clinical thresholds: below threshold (<1.19), moderate (1.19–2.5) and severe (>2.5)

^c Work and Social Adjustment Scale, 6 items with a Likert scale from 0 to 8. Clinical thresholds: subclinical (<10), moderate (10–20) and severe (>20)

Table 3 Percentage (*n*) of patients provided with information about different kinds of organisations

Information category	Examples	% (<i>n</i>)
Mental health	Anxiety support groups, counselling, mental health day centres and telephone helplines	29.9 (69)
Leisure	Complementary therapies, leisure centres, rambling	19.1 (44)
General support	Day centres, drug and alcohol services, family support, LGBT ^a organisations	16.5 (38)
Education/employment	Careers advice, computing classes, ESOL, ^b supported employment projects	16.0 (37)
Welfare	Benefits and housing, legal advice	8.7 (20)
Volunteering	Time banks, volunteer bureaus, website databases	8.2 (19)
Other	Self-defence, transport timetables	1.7 (04)

^a Lesbian, gay, bisexual and transgender

^b English for speakers of other languages

eligible to apply for GPCMHW posts, but this needs to be formally demonstrated.

In the present service, GPCMHWs were available to accompany patients within the community. This offer of support was not often required and, while it might have been problematic if a large number of patients had wanted it, the findings suggest it is feasible to offer this without it having an adverse impact on work load.

The ability of the GPCMHWs to work across a number of practices, for a specified number of sessions per week, supports the finding from the Amalthea project that it is possible to offer this resource on a locality-wide basis and that it need not be limited to a single practice as in earlier studies.^{17–19}

The nature of patients' problems was similar to that reported in other studies.^{17–19} In general,

Box 2 Fictitious examples of the Community Link Service by a GPCMHW**Vignette: 'Michael'**

'Michael' is a 64-year-old man who lost his wife nine months ago, and since her death has been feeling lonely. He has also been experiencing headaches and has had difficulty sleeping, which led to an increase in his attendance at his GP surgery. He felt that he would like some structure to his day and after some discussion the GPCMHW introduced him to St Luke's centre, a day centre for the over 60s. The GPCMHW accompanied Michael on his first visit to the centre, when he met the staff and registered as a lifetime member. It is hoped that the centre will provide Michael with the support and structure that he needs.

Vignette: 'John'

'John' is a 22-year-old man who worked as a labourer until he broke his leg a year ago. Since being out of work he was relying on his parents for money, which was putting a strain on their normally good relationship. His mood became quite low and he became very frustrated at his own lack of motivation, which was resulting in paranoia about his relationships, and some aggression. He felt he wanted to retrain but didn't have the motivation to start. The GPCMHW gave him information about a local careers guidance service, as well as a local project aimed at helping young people to train and gain employment. John felt he needed no further support from the service and was happy to continue without further help from the GPCMHW.

Vignette: 'Mina'

'Mina' is a young woman with refugee status who has been in London for one year. She presented at her local practice with low mood and feelings of isolation, due in part to her difficulty in speaking English, and living in temporary accommodation. The GPCMHW was able to link her into ESOL (English for Speakers of Other Languages) lessons. In addition, the GPCMHW also provided contact details for a local community women's group and went with Mina on the first occasion to help her with public transport and to introduce her to the staff.

patients' baseline scores on the administered questionnaires were within the clinical population range and most reported being on psychotropic medication. However, only a small proportion was currently engaged with psychological services. Thus, the Community Link Service could be viewed as part of a stepped-care approach, in that it provides an accessible, brief intervention, to (i) those patients whose difficulties are not, or are not recognised as, requiring referral for formal psychological therapy, or (ii) those who have been through the mental health system and are now under the routine care of their GP and would benefit from this type of support.

The favourable perceptions of primary care staff suggest that the Community Link Service could be integrated into primary care relatively easily, at least in practices expressing an interest in such a service. As a service, most staff described it as helpful to patients, and one that most primary care practitioners do not offer themselves. Those surveyed recommended its expansion across the two PCTs. This may, however, be a biased sample reflecting the opinions of the types of general practices willing to engage in such projects, and it is uncertain how much can be generalised from their views. It is also important to consider the cost-effectiveness of such

a GPCMHW-led service before its expansion. The Amalthea project found that the short-term costs of the service were greater than treatment as usual.¹⁹ Additional research is needed to clarify whether such interventions are cost-effective in the long term.

It is important to note that the sample was predominantly white, which is not representative of the cultural diversity within the areas that the Community Link Service was located. This finding has implications for the way the service is initially promoted and explained to patients, and the generalisability of the findings.

Local factors affecting this study

One factor that may significantly impinge on the clinical and social effectiveness of a Community Link Service is the size of the local voluntary and community sectors, i.e. are the local resources available and do they have the capacity to accept additional referrals? The London boroughs of Camden and Islington are in some ways in an enviable position, as they have a wide array of voluntary services, many of which have been in existence for a substantial period of time. However, this is also

associated with areas of considerable deprivation and complex social needs in both boroughs. Most patients seen were receiving benefits of some type, which meant they were eligible for 'low-cost schemes'; for those who are not on benefits, finances can be a barrier to accessing services as 'voluntary' is not synonymous with 'free of charge'. In this study we did not canvass the voluntary and community sectors' views about such a Community Link Service.

Conclusion

It appears that a GPCMHW is able to provide a locality-wide Community Link Service, which supports people with a range of psychosocial problems in accessing existing voluntary and community services. The pragmatics of setting up the service have been detailed to enable replication and implementation. This model has been found to be acceptable to the primary care staff coming into contact with the service; however its potential benefits for and acceptability to patients also need to be demonstrated.²⁰

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CONFLICTS OF INTEREST

None.

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