

Research papers

Graduate primary care mental health workers providing safe and effective client work: what is realistic?

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ABSTRACT

The role and training of graduate primary care mental health workers (GMHWs) are being developed to enable them to contribute effectively to the provision of primary care mental health services. An important role for GMHWs is to provide direct, safe and effective evidence-based interventions. Concern has been expressed about the level and type of client work possible for these newly qualified graduates with no previous training and no professional group to ensure regulation. This paper describes a framework for safe and effective client work, provided by GMHWs during their training, for clients with

anxiety and depression. The approach of facilitated self-help using the cognitive behavioural therapy model, is illustrated with four case studies. The client work was provided as part of a training programme, which enabled the development of generic therapeutic skills and skills specific to facilitated self-help. This equipped the GMHWs with the skills to provide more accessible primary care interventions in the future.

Keywords: CBT, graduate mental health workers, graduate primary care mental health workers, mental health, primary care, self-help

Introduction

The introduction of 1000 graduate primary care mental health workers (GMHWs) from 2003–2004 was announced in *The NHS Plan*.¹ This was intended to support the aims of *National Service Framework for Mental Health* to increase the capacity of primary

care to deal with mental health problems.² This is important when one considers that up to 90% of those with mental health problems are managed in primary care, a quarter of all GP consultations are for people with mental health problems, and depression is the third most common reason for consultation in general practice in the UK.^{3–5} The roles for the new GMHWs were proposed to be

within three areas: direct client work; practice team work; and wider network skills.⁶ The client work role is the most contentious, and concerns have been expressed about the type of effective brief therapy GMHWs could carry out.⁷ *The NHS Plan* (p. 119) states that GMHWs should be, '... trained in brief therapy techniques of proven effectiveness ...'. There was some acknowledgement of the difficulties of GMHWs being involved in providing direct therapy in the subsequent *Mental Health Policy Implementation Guide*, which included a more conservative statement regarding the client work role.⁶ It stated they would 'support delivery of brief, evidence-based effective interventions and self-help for people with common mental disorders, including children' (p. 67).⁶ Clarifying the appropriate level of client work for GMHWs is therefore one of the biggest challenges in this development. They are likely to be recent graduates with relatively little experience, no therapy training and with no professional group to provide and enforce standards and regulation. There are particular dangers in the first training year where the emphasis should be on their training needs rather than service provision. Key issues to be addressed are how to train GMHWs to provide safe, effective and evidence-based client work that meets the needs of primary care services and the appropriate framework and service contexts for such work.

This paper addresses these issues by describing a facilitated self-help intervention for patients with anxiety and/or depression, provided by GMHWs as part of a training course.⁸ The training programme was a validated postgraduate certificate in primary care mental health which began in November 2002. It was part of a pilot development in West Yorkshire and therefore preceded and informed the national roll out of GMHW posts and training programmes. Initially five GMHWs were on the programme but one left their NHS post early on so could not continue with the training. Implementing the pilot training programme involved clarification of the appropriate level and type of client work for GMHWs and a framework within which this could be provided safely, so this paper helps clarify these issues.

The training

Training in providing a facilitated self-help (FSH) intervention using the cognitive behaviour therapy (CBT) model was one of three modules on the one-year postgraduate certificate and provided half

the credits. Other modules covered understanding mental health problems, issues and policies, mental health and primary care services, mental health assessment and a practice-based project work module. The module, led by ML, provided students with theoretical knowledge and clinical practice skills to enable them to understand the nature, development and assessment of anxiety and depression in primary care settings. They also learnt to facilitate clients' use of self-help material for anxiety and depression. Some skills developed and assessed were generic therapeutic skills appropriate to all client work, and others were specific to facilitated self-help and working with clients within the CBT model. Assessment was via essay, case report and assessment of practice skills via direct observation and audiotape. The capabilities were specified and assessed in practice by supervisors and some required direct observation, which included taped sessions.

Why facilitated self-help?

Facilitated, or supported, self-help has been increasingly advocated in recent years as a potentially effective and cost-effective intervention for a range of problems, particularly anxiety and depression that are the most prevalent common mental health problems.⁹⁻¹¹ Most self-help material is based on CBT, which has good evidence of efficacy with anxiety and depression.^{12,13} Areas covered by self-help material often include understanding the cognitive model, understanding the nature of the anxiety and depression and the relationships of thoughts, feelings, physiology and behaviour, self-monitoring, cognitive and behavioural strategies and relapse prevention. Self-help interventions can be provided in a range of settings, with different amounts of professional support to the client, and with different amounts of information, ranging from relatively brief booklets to more comprehensive workbooks.¹⁴⁻¹⁶ It has been suggested that self-help interventions can be used as part of a stepped care approach in which relatively low-intensity interventions are provided initially, and more intensive, costly interventions provided only if required.¹⁷ Self-help, or self-management, approaches are important in that they increase self-efficacy and self-reliance and provide a range of options that can be accessed more easily. This is important in view of the lack of availability of therapists and the consequential long waiting times.

The facilitated self-help intervention

Facilitated self-help can be provided as a 'Type A' intervention following assessment from an experienced mental health practitioner, defined as 'supervised psychological interventions as a component of mental healthcare'.¹⁸ It was decided to use this as a framework during the training so the facilitated self-help intervention followed a mental health assessment (in fact often the GMHW took part in a joint initial assessment). This is important when GMHWs are relatively inexperienced and increases the chances of appropriate clients being identified for the intervention. It is hoped that after training the GMHWs, given appropriate protocols, would have the skills to provide interventions without the need for an initial assessment from a mental health practitioner.

The facilitated self-help work carried out by the GMHWs on the training programme involved a minimum of five face-to-face sessions of 30 to 60 minutes over a period of several weeks. This included one session to set up the work with the client and negotiate realistic goals, at least three sessions to support the clients' understanding of their problems (the formulation) and to facilitate their use of self-help approaches, and one follow-up session to review longer-term progress and discuss future aims and relapse prevention. The programme required a minimum of two clients to be seen by each GMHW and the four case studies described in this paper were taken from these training cases. The type of intervention was made clear to clients at the outset with the emphasis on the GMHWs supporting the clients' self-help and self-management strategies. The GMHWs received some group supervision on the training course and regular clinical supervision in their workplace. The workplace client work supervision was provided for three of the GMHWs by clinical psychologists with CBT training and for the other by a cognitive behaviour therapist with a mental health nursing background.

Formulations were developed using the five-systems cognitive model, based on Beck's cognitive model,^{19,20} This allows a shared understanding of clients' problems in terms of relationships between environment (stresses, triggers, situations), thoughts, feelings, physiology and behaviour (see Figure 1). In some cases formulations were developed that also included experiences that led to underlying beliefs and critical incidents that triggered the emotional problems. Figure 2 shows a representation of

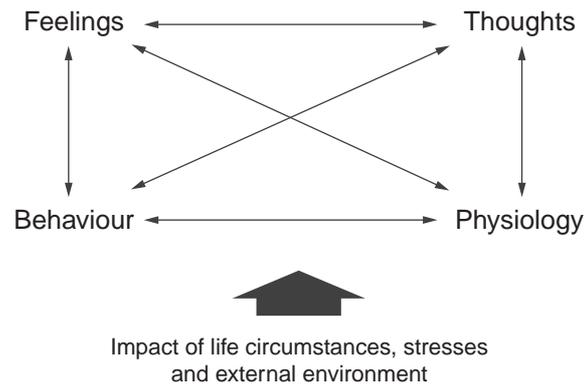


Figure 1 Five-systems cognitive model

this. Both Figures 1 and 2 are well-established frameworks for developing formulations based on the cognitive model and allow clients to understand their problems and identify areas to work on. The GMHWs supported the clients' understanding of their problems (the formulation) in a validating and supportive way. This enabled clients to understand the reasons for their problems rather than suggesting the clients had somehow 'gone wrong' in their behaviour or 'got it wrong' in their thinking.

The GMHWs were encouraged to use standardised measures to track clients' progress throughout therapy. The measures recommended were the CORE-OM, Hospital Anxiety and Depression Scale (HADS) and Beck Depression Inventory (BDI).²¹⁻²³

Using the CBT model as a framework, clients were supported in identifying main problems and goals, understanding their problems (the formulation) and possible solutions, and in trying out a range of strategies. These included self-monitoring, various relaxation and stress reduction strategies, behavioural strategies such as goal setting, behavioural experiments and graded exposure, and cognitive strategies such as identifying and evaluating negative thoughts and beliefs. A range of self-help material was used by clients, all based on the CBT framework. They were encouraged to be creative, particularly with clients who may have reading problems and where English is not their first language. The four case studies below illustrate the approach and are taken from the four more comprehensive case studies provided by the GMHWs as a course requirement. Each case is described with the initial presentation, formulation, goals, progress and outcome. In the actual work, the formulations were drawn diagrammatically for clients using the models shown in Figures 1 and 2. All outcome measures completed by the four clients are reported.

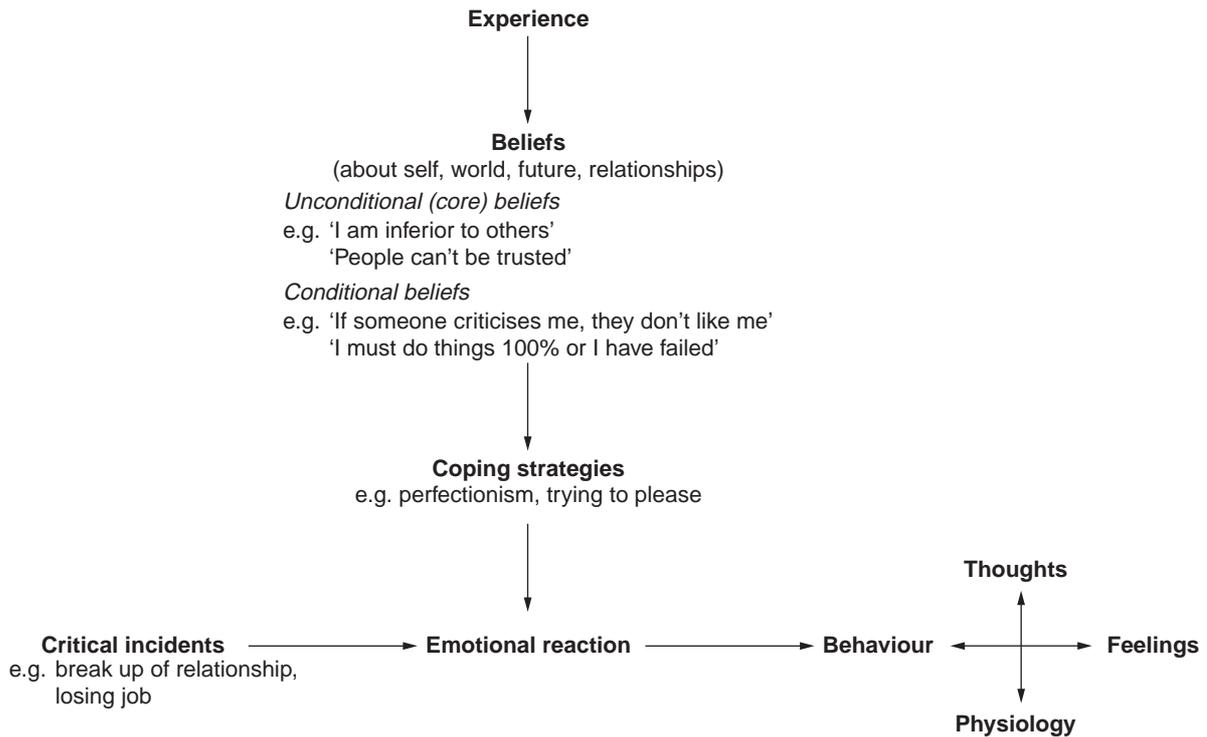


Figure 2 Cognitive model incorporating experience and beliefs

The graduate primary care mental health workers

All four GMHWs (RO, AS, CH and BH) who completed the training provided one each of the case studies in this paper. Their average age when training commenced was 25 years (range 24 to 26 years), with an average of 2.75 years (range 2 to 4 years) since completing their degrees. Two had masters degrees and none had received a professional training or formal therapy training. All were psychology graduates, although graduates with social sciences and health and social care-related degrees were also considered for these NHS posts. Three of the four were on one-year NHS contracts due to the posts being part of a one-year pilot for the employment and training of GMHWs.

Case studies

Client 1

Initial presentation and history

CL, a 27-year-old female secondary school teacher was referred by her general practitioner (GP). At the

initial assessment she described symptoms of anxiety, low mood and tearfulness over the previous six months. She was a newly qualified teacher and her symptoms appeared to be stress related. She found her job stressful and unrewarding, doubted her capability as a competent teacher and she felt she had little support in the workplace. Although CL had a stable relationship and a good social support network, she reported frequently feeling lonely and insecure in her relationship. CL felt that she had had problems sporadically for about 10 years. Pre-treatment measures on the HADS were anxiety, 10 and depression, 7 (cut offs for clinically significant depression and anxiety are 7). Mean total CORE-OM score was 1.46 (cut-off score for clinically significant population is 1.29).

Formulation

The following formulation was developed with CL in relation to her depressed mood. CL became aware that experiences in her childhood and the relationship with her parents affected the way she felt about herself. She was very self-critical and often talked about being a failure. She felt her partner would often dismiss her feelings, reinforcing her negative view of herself. She felt insecure in the relationship and thought her partner would end the relationship because of her current state of mind. She said her mother was very critical of her and she felt pressurised

to succeed as a teacher. She had unrealistically high expectations of herself (perfectionist belief) and experienced her difficulties as a teacher as failure.

Goals

CL's goals were: coping better with work stresses and job dissatisfaction; improving the relationships with her boyfriend and mother; improving her self-esteem and confidence.

Progress and outcome

CL was seen for eight sessions for facilitated self-help over 19 weeks. The following areas were tackled:

- helping her to understand depression and stress, to acknowledge the reality of her stresses and normalise her problems
- monitoring negative thoughts with a diary and challenging negative thoughts about her low self-esteem in her relationship and as a teacher
- exploring ways in which she could relax and organise herself better. This included the use of a relaxation tape and regular yoga classes, aromatherapy massage, Reiki and meditation
- organising her time to do work at home and ease the workload at school.

She also spoke to her family and friends about her work stress and they were all very supportive, particularly (and surprisingly to her) her father.

At the end of the intervention, CL felt she was able to use techniques to manage her symptoms on a daily basis. She became aware of the problems caused by her perfectionist beliefs and felt she required more in-depth therapy to address deeper issues and underlying problems stemming from her childhood. She was therefore referred on for longer-term psychotherapy.

Post-treatment measures on the HADS were anxiety, 4 and depression, 1 (both below the clinically significant cut-off level of 7). Mean total CORE score was 0.26 (reduced from 1.46 pre-treatment and below the clinically significant cut-off).

Client 2

Initial presentation and history

RB was a 50-year-old married woman; the referral indicated a long history of anxiety problems, but she had recently suffered a severe episode of anxiety and depression, culminating in her taking time off work. Despite having improved and no longer being low in mood, her anxiety problems had persisted. In the past she had attended an anxiety management

group, and she was taking medication for anxiety and receiving primary care counselling for bereavement issues concerning the death of her mother. Pre-treatment measures on the HADS were anxiety, 16 (above the cut-off) and depression, 6 (below the cut-off).

Formulation

The following formulation was developed with RB in relation to her anxious mood. RB's anxiety focused predominantly on her concerns over work, notably that it was unpredictable and stressful. She had frequent negative thoughts about not being able to cope at work and engaged in various safety behaviours to avoid an anticipated problem. For example, she tended to avoid work when it was busy, assuming she would be unable to cope. When the intervention began she was off work and also tended to avoid crowded places such as supermarkets and enclosed spaces. She avoided worries by filling her day with activities and found it difficult to spend time alone. This meant she was having little relaxing time for herself.

Goals

RB identified the following three goals as priorities: to feel comfortable about staying in the house alone; to no longer work the day away; to be able to go back to work.

Progress and outcome

RB was seen for eight sessions and a follow up over a period of 21 weeks. The work targeted the following areas:

- increasing RB's understanding of anxiety and developing techniques to manage her anxiety
- challenging negative and unhelpful thinking. This enabled RB to gain a more balanced view of situations and helped her to manage her anxious thinking.

RB successfully began engaging in more relaxing, enjoyable activities at home. She successfully performed a number of behavioural experiments, whereby she set out to challenge some assumptions about the consequences of her anxiety; in all cases the outcome was a positive learning experience, which she utilised well. For example, she went to work on a day when it was busy and found she coped well, thus undermining her assumption that she would be unable to cope on such occasions.

An important outcome was that RB was able to return to work. During the time of the intervention,

RB's rating of anxiety (HADS) reduced from 16 to 13 at the last session and to 9 at follow up. She felt she had developed skills in challenging her negative and anxious thinking and felt she had developed distraction techniques that helped her to manage her symptoms. In the follow-up session, which was three months after the previous session, RB had taken more time off from work but had clearly been continuing to use the techniques she had developed. Post-treatment measures on the HADS were anxiety, 9 and depression, 3.

Client 3

Initial presentation and history

JH, a 51-year-old married female, working as a shop manager, was referred by her GP. At the initial assessment she described symptoms of low mood and tearfulness along with a feeling of being 'unable to cope' if things went wrong. She had experienced these symptoms sporadically over the past six years but they had become particularly difficult when she had tried to reduce her medication on three separate occasions during this time. She was not comfortable with taking medication and had concerns about relying on it long term. Pre-treatment measures on the HADS were anxiety, 2 and depression, 0. Although her depression score was zero it is worth noting that in the past when she had reduced her medication she had become more depressed which reinforced her belief that she could not cope. Therefore, although the antidepressants may have been successfully controlling the depression, a significant goal for JH was to stop taking the medication without a relapse.

Formulation

The following formulation was developed with JH in relation to her depressed mood: JH felt that her symptoms stemmed from when, six years ago, she was experiencing a difficult time supporting her ill, elderly parents-in-law who were in separate nursing homes. Although her husband was very supportive, the stress of this time, combined with work pressures and caring for relatives, contributed to her feeling very low and she was prescribed medication by her GP. Having been prescribed medication, JH began to doubt her own ability to cope with life events. These doubts were reinforced by her experience of coming off medication on three occasions, where she immediately experienced symptoms of low mood again and her GP re-prescribed medication immediately. These circumstances, coupled with JH's self-doubt about her ability to cope, and a belief that she had no real, justified reason to feel as she

did, combined and contributed to JH's low mood and to a deeper belief that she must have a fundamental psychological weakness. Additionally, her high expectations of herself and others reinforced her beliefs about not coping and led her to perceive others as letting her down in some way.

Goals

JH's goals were: to understand generally what depression is, and how it affects her; to learn strategies to cope with symptoms of low mood; to come off her antidepressant medication.

Progress and outcome

JH was seen for eight sessions of facilitated self-help over 16 weeks, and then one follow-up session four weeks after the end of the process. The following areas were worked on:

- understanding depression, in general and how it was affecting her
- self-monitoring of difficult situations and unhelpful thoughts using a diary. She realised that work was significantly contributing to her low mood and related to her unhelpful thoughts about herself
- relaxation, including aromatherapy baths, progressive muscle relaxation and guided imagery
- evaluation of her negative thoughts about needing to do things perfectly; being let down by people; not being able to cope
- discussion of her beliefs of a weakness in herself and being an 'inadequate person'.

JH also planned to take a different perspective at work, to be aware of how her high standards of herself and others were contributing to her negative thoughts. She started asking for help when she needed it, especially at work, and took a more relaxed view of the behaviour of others when it did not fit with what she expected. She also tested out being more assertive with her managers.

At the end of the sessions, JH felt she had a better understanding of depression and how it affected her. She was able to manage her symptoms of low mood better and by the follow-up session she had stopped taking her medication and felt confident in being able to cope with future stress without medication. She felt that the stress at work was fundamental to her managerial role and made the decision to leave that job for a new one. By follow up she was happy in a new job and coping confidently with life issues that came her way. Post-treatment measures on the HADS were anxiety, 0 and depression, 0.

Client 4

Initial presentation and history

RF had moved from abroad to England to be with her husband and was referred for psychological therapy by her GP. At the initial assessment she reported panic attacks that had started four months previously following a traumatic reaction to morphine when in hospital. A fear of dying was prominent in her anxiety attacks. Although the anxiety symptoms had decreased since the incident, she was still reporting having low motivation and feeling worried, unable to relax and tired. RF also experienced physical symptoms of anxiety such as headaches and irritable bowel syndrome and she had suffered from long-standing recurrent depression since her teens. Although RF was in a secure marriage with support from friends, she felt lonely because she missed her family greatly. She also felt inferior to others, which was compounded by being unable to work in this country. Pre-treatment score on the BDI was 41, in the severely depressed range.

Formulation

A formulation was developed initially in relation to her anxiety and panic attacks. Later a formulation was developed to explain the severe and long-standing depression. With regard to the depression, RF identified that her father's high expectations of her as a child had led to feelings of inferiority in later life. She felt that she had become a perfectionist, which led to frustration with those around her when they did not live up to her expectations. She identified a key belief, 'If I am not perfect, I am a failure'. The separation from her family also contributed to her depression. She also felt a burden to her friends. RF was happy in her marriage but identified her high regard for her father as a problem in the relationship because she often expected her husband to behave as her father would have done.

Goals

RF's main area of concern was reducing the effect of her perfectionist tendencies on her relationships and her view of herself, which were seen as leaving her prone to depression. Her other goals were coping with panic attacks, dealing with unhelpful thoughts, learning to control her breathing and to have more realistic expectations of her husband.

Progress and outcome

RF was seen for eight sessions over a period of 13 weeks, with an additional review six weeks after the last meeting. The following areas were tackled:

- RF identified feelings of inadequacy when surrounded by her friends so negative thinking related to this was monitored and evaluated
- negative thoughts were found to be associated with anxiety, e.g. 'I'm not as good as them' and panic attacks, e.g. 'I'm going to die'
- provision of information and discussion helped RF to understand her anxiety. The formulation helped clarify the physical symptoms of anxiety and how cognitions and behaviours were maintaining the anxiety
- relaxation and breathing were taught in sessions and RF identified relaxing activities that she could incorporate into her life
- diary planning was used to increase activity levels. Pleasurable activities such as card making and reading were introduced and were planned for the time of day when she felt least motivated, in order to reduce the low mood that resulted from her lack of activity
- RF's cognitions related to the depressed mood were identified and evaluated using 'thought challenging worksheets'. RF decided that her perfectionist tendencies led to thoughts of self-dislike and self-criticism (both of which scored highly on her baseline BDI)
- talking to family at home alleviated feelings of loneliness and anger. Her relationship with her father changed positively. RF became more able to see things from other perspectives including those of her husband and her father. This helped her goal of separating her father from her husband and enabled her to see how her high expectations of others can lead to frustration and disappointment.

Objective and subjective measures were used to track progress and outcomes. RF's BDI score fell consistently during the intervention, with individual BDI item scores for self-dislike and self-criticism falling from 3 to 1 on the four-point scale. RF reported feeling more motivated and active at follow up. Issues of self-affirmation were still a problem at follow up and she felt she had more to learn in coping with panic attacks. She was referred to a clinical psychologist for further work on these areas. Post-treatment score on the BDI at follow up was 15, in the mildly depressed range.

Discussion

The clients described in the four case studies are typical of clients seen in primary care with anxiety and/or depression. They varied in the duration of the problems, ranging from a few months to many years. There were also big differences in severity with client RF in the severe depressed range on the BDI and client JH scoring in the normal range but wanting to stop taking her antidepressant medication. In all cases a formulation was developed with the client, based on the five-systems CBT model, which led to self-help strategies.²⁰ In three cases (clients 1, 3 and 4), beliefs were also identified that were maintaining the problems. For example, in one case a client was able to identify their own perfectionist beliefs, which led to unrealistic and excessive expectations on themselves and consequent stress, anxiety, a sense of failure and depression. Although clinical outcome was not systematically measured, all clients made significant progress towards achieving their stated goals such as returning to work and coming off medication, and there were reductions on standardised measures. Client 3 (JH) initially had very low, normal scores of anxiety and depression on the HADS but made significant progress in that she was able to achieve goals and come off antidepressants without adverse effects. Previous attempts had failed, reinforcing her belief that she could not cope.

It is important to emphasise that GMHWs carried out these interventions in their first training year, despite having little previous experience in psychological interventions. It therefore supports the contention that GMHWs, who have no previous therapeutic training, can carry out evidence-based interventions with the appropriate training, support and supervision and within the appropriate, safe service framework, although further systematic research into this is clearly needed. The facilitated self-help intervention was provided following an assessment from an experienced mental health practitioner (Type A intervention). Where possible, this practitioner should be working in primary care but there will be concerns that this could constitute a secondary care intervention and will not therefore improve access. There is a tension between the safe and effective practice on the one hand and more accessible, efficient and innovative approaches on the other. In the first training year at least, a framework such as that described in this paper is necessary because of concerns that some GMHWs will be required to work with clients whose problems are beyond their capabilities, and will be working without adequate support and supervision. However, as their skills develop they will be

equipped to work in more innovative ways that may improve access and efficiency. For example, with clear protocols, GMHWs could take referrals direct from primary care practitioners for self-help interventions and this has been the case for at least one of the GMHWs in the year following their training.

The GMHWs developed generic therapeutic skills such as beginning, structuring and ending sessions and establishing and maintaining therapeutic relationships and skills specific to facilitating self-help and the use of the CBT model. This gave them a solid foundation in skills applicable to any further client work.

It is apparent from the cases described in this paper that the distinction between facilitating clients' use of self-help material and providing more traditional one-to-one psychological therapy is not clear cut. The GMHWs saw their clients for up to eight sessions and, although the focus was on self-help, a therapeutic relationship was established and this probably played a significant part in the success of the interventions. Clinical supervision helped the GMHWs stay within the 'facilitated self-help' approach, work at an appropriate level with clients' problems and not become involved in more intensive psychological therapy. The approach, taken in the client work described in this paper, is at the more intensive end of the continuum of supported self-help. Sessions tended to be up to 50 minutes in length so an eight-session intervention involved up to six to seven hours of face-to-face contact. As they become more skilled and confident, GMHWs will be well suited to less intensive interventions, with less client contact and including telephone contact, as long as clients are appropriately selected.

The issue of supervision is a very important part of the development and training of GMHWs. Each of the four GMHWs in the pilot received supervision from therapists with CBT training but we do not consider this to be necessary. It would be unrealistic to expect this level of training for all supervisors in future training programmes. We suggest supervisors should be experienced mental health practitioners, including primary care practitioners with mental health training, and the training programmes should provide supervisor training and ongoing support. The minimum supervision required for the minimum client work on the programme was one hour every two weeks. Where the GMHW's role involves more client work, this should be increased with weekly supervision if required. Small group supervision should also be considered. Two of the GMHWs were supervised together by the same supervisor and this worked well.

This paper supports the notion that GMHWs, recent graduates with little previous experience and no

professional or therapeutic training, can provide safe, acceptable and effective interventions as part of a supervised clinical service. It describes just one such approach, using the CBT model. Hopefully, other approaches will also be developed as long as this is within the framework of safe and effective practice. The role of GMHWs lends itself to innovative approaches such as self-help but such service innovations should be balanced against the need to ensure safe and effective practice. Clearly, further more systematic research into the client work of GMHWs is required, particularly regarding impact on service users and cost-effectiveness. Some consistency in the outcome measures used would be desirable and we would recommend the CORE-OM and HADS scales.^{21,22} The advantage of using the CORE-OM is that it has been widely adopted by counsellors in primary care. Such research could be linked to research on the effectiveness of self-help interventions.¹¹

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CONFLICTS OF INTEREST

None.

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