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Improving primary care mental health: survey evaluation of an innovative workforce development in England

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ABSTRACT

Objectives Primary care provides the bulk of care for common mental health problems, but problems with access to effective treatments exist. Changes to workforce and skill mix are one method of improving services. *The NHS Plan* proposed a new paraprofessional worker, the primary care mental health worker (PCMHW). However, the introduction of this role raised interprofessional tensions and concerns about quality, effectiveness of care and retention. This study aimed to evaluate the effectiveness of the PCMHW policy.
Methods Evaluation of the policy was conducted using a postal questionnaire of the first cohort of workers. Results from the survey were compared with original policy goals and current treatment guidelines.
Results Fewer PCMHWs were employed than initially planned, and 40% reported an intention to seek other work within the NHS. Approximately two-thirds managed patients, but access was often restricted (half of patients were reviewed by a specialist mental health professional). Types of patients seen and interventions provided were generally in line with current guidelines. Integration of PCMHWs into primary care was a significant predictor of important aspects of the role.
Conclusions Although generally successful, some aspects of implementation have faced more barriers than others. The results may have important implications for workforce developments in the NHS and beyond.

Keywords: graduate primary care mental health worker, mental health, primary care, workforce

Introduction

Although primary care is seen as the optimal site for treatment of common mental health problems, access to effective treatment remains problematic.[1] Effective psychological therapies exist, which are increasingly popular with patients; however, limited numbers of specialist mental health staff means that demand usually outweighs supply.[2,3] Overcoming problems with access to care is an international concern, and current policy in the UK has highlighted this issue.[4,5]

Quality improvement in the NHS often involves changes in workforce and 'skill mix', such as modifications to the ratio of junior and senior staff, or the composition of the healthcare team.[6] There has also been interest in improving access through the deployment of *paraprofessionals* (those without postgraduate clinical training), and reviews have suggested paraprofessionals might be capable of achieving equivalent outcomes to more experienced professionals, although those findings are controversial.[7]

Interest in paraprofessionals has coincided with developing evidence about the effectiveness of 'minimal' psychological interventions, delivered with limited professional contact and supported by technologies such as books.[8] The combination of paraprofessionals and minimal interventions has the potential to provide the greatest benefit from available resources.[9]

In line with these developments, *The NHS Plan* proposed the introduction of primary care mental health workers (PCMHWs), 'employed to help [general practitioners] GPs manage and treat common mental health problems'. Key policy aims and objectives are outlined in Box 1.[10]

Box 1 Aims of the PCMHW initiative

The NHS Plan[10]

- One thousand new graduate primary care mental health workers, trained in brief therapy techniques of proven effectiveness, will be employed to help GPs manage and treat common mental health problems in all age groups, including children.
- By 2004, more than 300 000 people will receive extra help from the new primary care mental health workers.

Graduate primary care mental health workers: best practice guidance[11]

- Appoint at least 1000 new graduate primary care workers by 2004.
- [Provide funds] sufficient to employ 2 or 3 new graduate workers in each [primary care trust] PCT according to need, and to retain them.
- Support the delivery of an integrated mental health service, building on the strengths that already exist, to ease pressure on GP services and improve the quality and outcomes for service users.

However, a number of concerns have been highlighted. It is unclear whether workers will adopt evidence-based interventions, and concerns have been raised about the safety of clinical work conducted by staff with limited experience and training.[12]

It was also anticipated many posts would be filled with graduate psychologists, who might seek a career in clinical psychology, and would not be retained within primary care.[13,14]

In addition, pilot studies suggested that PCMHW roles would vary considerably according to local needs and context.[15,16] One factor of particular importance is the 'ownership' of workers in terms of their integration into primary care settings. PCMHWs are ostensibly a resource for primary care, and GPs have traditionally been keen that mental health staff are physically located within primary care settings.[17] This has practical advantages in terms of convenient access and communication, and more fundamental implications in terms of power and control. However, clinical or managerial supervision that inexperienced PCMHWs require might be more appropriately provided by specialist services. Workforce development has been described as an arena for the clash of professional interests, and there are potential tensions between the needs and aspirations of primary care and specialist staff in relation to this role.[15,18]

This study aims to evaluate the workforce policy through a survey of the first PCMHW cohort. The survey examined whether the PCMHW programme (a) met policy goals stated in the *The NHS Plan* and Department of Health guidance (see Box 1) and (b) was in line with current service standards and treatment guidelines (see Box 2).[5,9–11]

Methods

Sampling

We sought to identify all PCMHWs during the first year of implementation and used two sources: individuals on training courses, and PCMHWs already in post (identified via local PCT officers). Each participant was sent a postal questionnaire 3–4 months into the training course or once identified by the PCT, with reminders 2 and 4 weeks later.

Questionnaire

The questionnaire was designed to gather information on a number of facets, but only those relating to the aims described above are detailed.

Recruitment

The main survey gave an estimate of PCMHWs recruited, and individuals provided details of their current employer to allow analysis at PCT level.

Box 2 Effective management of depression in primary care

National Service Framework for Mental Health[5]
Standard 2: any service user who contacts their primary health care team with a common mental health problem should:

- have their mental health needs identified and assessed
- be offered effective treatments, including referral to specialist services for further assessment, treatment and care if they require it.

National Institute for Clinical Excellence (NICE) guidelines for depression treatment in primary care[9]

- *Step 1*: recognition of depression, by the GP or practice nurse, assessment of severity.
- *Step 2*: mild depression, managed by the primary care team or primary care mental health worker, through guided self-help, computerised cognitive–behavioural therapy (CBT), exercise, brief psychological interventions.
- *Step 3*: moderate or severe depression, managed by the primary care team or primary care mental health worker, through medication, psychological interventions, social support.
- The provision of telephone support by appropriately trained members of the primary care team, informed by clear treatment protocols, should be considered for all patients, in particular for the monitoring of antidepressant medication regimens.

Integration in primary care

The physical location of workers was used as a proxy for integration into primary care. Individuals working within general practice were coded as 'fully integrated', those who visited general practice at least once a week were 'partly integrated', while the remainder were 'not integrated'.

Retention

Respondents were asked whether they intended to apply for clinical psychology training.

Clinical role

Respondents were asked whether they currently managed patients and to complete detailed information on the last three patients, including primary presenting problem, type and duration of interventions delivered. More specifically PCMHWs were asked if they provided the following interventions: signposting to other services (i.e. providing patient with information about voluntary groups); guided self-help (helping patient using a self-help manual); ongoing support and advice; stress management/relaxation; psychological therapy (a series of sessions using counselling, CBT or other therapeutic skills); assisting with medication management (providing information and encouraging appropriate use) and other, where PCMHWs were asked to specify the intervention delivered. PCMHWs were also asked about clinical supervision.

Outcomes: access to care

To examine whether PCMHWs improved access to mental health care, they were asked to estimate the total number of new patients managed within the past month, and to indicate the referral source for each patient, and whether referrals were screened for suitability by an experienced mental health professional.

Outcomes: effectiveness of care

Effectiveness of the role was assessed by PCMHW-reported outcomes for the last three patients.

Job satisfaction

Respondents were asked how satisfied or dissatisfied they were with various aspects of their job.[19]

Analysis

Categorical variables are reported as the percentage within each group. Number of new patients managed is reported as the mean and standard deviation (SD) and number of sessions by the median and interquartile range (IQR). Relationships between 'level of integration in primary care' and other categorical outcomes were examined using a chi-square test for trend. Number of new patients managed by level of integration was examined using analysis of variance (ANOVA) and the F statistic. Analysis was conducted at the PCMHW or patient level where appropriate.

No adjustment was made for clustering of patients within PCMHWs, as its effects were likely to be marginal. All analyses used SPSS 11.0.

Results

Survey response rate

The response rate was 82% ($n = 294/358$), and varied according to source of recruitment (84% from training courses, 59% from PCTs). At the time of response PCMHWs had been in post for approximately five months (median = 5.2 months, IQR = 4.5 to 6.1).

The main results of the survey are summarised in Table 1.

Recruitment

A total of 377 workers were identified: 350 from training courses and 27 from PCTs. Fifteen left the post before receiving the questionnaire and four were ineligible. PCMHWs were employed by 109 different PCTs, 19 mental health trusts and one voluntary organisation. Of those trusts that employed PCMHWs, 39% employed one worker, 36% two and 12% three; the remaining 12% employed four or more workers.

Integration into primary care

Thirty-five per cent of PCMHWs were considered to be fully integrated, a further 35% partly integrated and 30% not integrated into primary care.

Retention

The proportion indicating that they intended to apply for clinical psychology was high (40%), with a further 27% undecided. Fifty per cent of those not integrated within primary care indicated their intention to apply for clinical psychology, compared to 38% and 33% of those partly or fully integrated respectively (χ^2 trend = 7.0, $P < 0.01$).

Clinical role

Two-thirds ($n = 184$) of PCMHWs carried out clinical work. Anxiety, depression and psychosocial or life events accounted for 93% of presenting problems. Only a small proportion of patients were children ($n = 6$, 1%). PCMHWs provided a range of interventions (see Table 1). Sixty per cent of patients who had completed the intervention attended three or fewer sessions of a median 50 minutes length (IQR = 40–60 minutes). Of those who managed patients all but three had a clinical supervisor.

PCMHWs who were fully integrated were more likely to manage patients (75%) than those partly integrated (67%) or not integrated (44%) (χ^2 trend = 19.0, $P < 0.01$). Severity of problems did not differ significantly according to level of integration. Only the frequency of one intervention (signposting) differed by level of integration (χ^2 trend = 10.4, $P < 0.01$).

Outcomes: access to care

PCMHWs who reported managing patients saw an average of 5.4 new patients per month (SD = 5.9). Based on the assumption that the full cohort of 1000 workers is employed and they all have a clinical role, the estimated number of new patients seen in any one year by the PCMHW workforce would be approximately 65 000.

The majority of patients were referred from a GP or other primary care clinician (70%). However, half ($n = 232$, 50%) had previously been reviewed by an experienced mental health professional to determine their suitability for the PCMHW to manage.

There was a significant difference in the number of patients managed according to level of integration. Those fully (mean = 6.4, SD = 6.7) or partly integrated (mean = 5.6, SD = 5.6) managed more patients than those not integrated (mean = 2.9, SD = 3.5, $F = 5.0$, $P < 0.01$). There was no difference in the number of sessions offered to patients according to level of integration.

Outcomes: effectiveness of care

Treatment was ongoing for most patients (70%). Of the remainder, 41% had been discharged, 21% were in long-term follow-up, 15% were referred for further mental health treatment, 11% were judged inappropriate and referred back to the referral source or other agency, and other outcomes were reported for 11%. There was no association between level of integration and outcomes.

Job satisfaction

The proportion reporting satisfaction (very satisfied or satisfied) with various aspects of their work are reported in Table 2. Remuneration caused the greatest level of dissatisfaction, with only 16% being very satisfied or satisfied with their salary. Lower levels of

Table 1 Key aspects of the PCMHW role[a,b]

	n	%
Integration in primary care		
Fully integrated	103	35
Partly integrated	102	35
Not integrated	89	30
Intention to apply for clinical psychology training		
Yes	118	40
No	94	32
Don't know	80	27
Clinical role		
Currently managing patients	184	63
Primary problem[c]		
anxiety	168	36
depression	134	29
psychosocial and life events	78	17
multiple common disorder[d]	51	11
severe mental health problems	19	4
other problems	15	3
Types of interventions delivered[c,e]		
guided self-help	289	62
ongoing support and advice	242	52
signposting	184	40
stress management /relaxation	177	38
psychological therapy	159	34
medication management	77	17
other interventions	26	6
Outcomes: access to care		
Referral source:[c]		
primary care staff	327	70
self	6	1
other	132	28
Patient reviewed by mental health professional[c]	232	50

[a] Sample size differs because of a small amount of missing data for each item
[b] Percentages may not add up to 100, due to rounding
[c] Analyses based on the last three patients managed by the PCMHW
[d] Where more than one primary problem is indicated from anxiety, depression and psychosocial and life events
[e] Type of intervention not mutually exclusive

satisfaction were also reported for the opportunities to use one's abilities (47%), physical (51%) and technical resources (53%), and recognition given for good work (53%).

Discussion

Problems with access to effective mental healthcare is not restricted to the UK,[1,20,21] and the deployment of paraprofessionals is one method of improving access to patients. Previous reviews have suggested that interventions provided by paraprofessionals might be as effective as those provided by more experienced professionals,[7,22,23] and although these conclusions have been criticised,[24] interest in the use of paraprofessionals remains. Some of the key issues concerning the development of paraprofessional roles in mental health are: the importance of ring-fenced funding, clear career development, renumeration, clarity of role, management of risk and the potential importance of integration into

Table 2 PCMHW job satisfaction

	n	%
Hours of work	235	80
Support from colleagues and fellow workers	208	72
Freedom to choose own method of working	199	69
Supervision arrangements	187	64
Amount of variety in job	175	60
Amount of responsibility given	170	58
Recognition for good work	155	53
Access to technical resources	155	53
Physical working conditions	148	51
Opportunity to use abilities	135	47
Remuneration	47	16

primary care. The success of the PCMHW programme in the UK may have important implications for healthcare systems elsewhere.

Limitations of the study

Clearly, testing a policy programme through a self-report survey has limitations. Although the response was high, self-report may be an unreliable measure of some factors. In addition, PCMHWs were at an early stage of training and their clinical role is likely to increase as they become more established within the post. We are currently conducting a follow-up survey of the same cohort, to examine changes over time.

Evaluation of the PCMHW policy programme

Implementation of the PCMHW programme can be considered a partial success. The number employed was lower than that envisaged, and retention may be problematic. Limited, though significant, clinical work was undertaken, and types of problems encountered and interventions provided were broadly as specified within current policy and treatment guidelines. However, direct access to PCMHWs was often restricted. Despite this, there was some evidence to suggest a benefit of the role in terms of expanding service capacity in primary care. PCMHWs integrated into primary care played a more substantive role in direct patient care.

In relation to recruitment and retention, new courses and cohorts are being developed, thus the eventual recruitment target may still be met. Although there were sufficient funds to employ and retain 2–3 PCMHWs in each PCT, funds were not specifically ring-fenced, and recruitment may not have been a priority for many PCTs. Recruitment must also be seen in the context of retention. A high proportion of PCMHWs reported an intention to apply for clinical psychology. Even though significant bottlenecks exist in access to such training, it is possible that investment in training individual workers may have long-term benefits for the NHS, but short-term benefits for primary care.

Retention issues do not reflect high levels of job dissatisfaction. However, remuneration was an important source of dissatisfaction. Although pay is not a critical motivator of public sector workers generally, PCMHW remuneration is relatively low.[25]

The intervention most frequently provided by PCMHWs was in line with NICE guidelines (see Box 2), and the 'minimal' interventions model. However, the second most frequent intervention was 'ongoing support and advice', and it is not clear whether this reflects a structured intervention, or a more non-specific role of the intervention.[26] Other evidence-based models, such as supporting GPs through medication management as part of 'collaborative care', were used less frequently.[12]

PCMHWs were designed to improve access to effective treatment in primary care.[5] The majority of referrals were from primary care staff, but PCMHWs were often not the first point of contact, with half of patients having previously been reviewed. Clearly,

this limits the potential impact on access, imposing another rate-limiting step on the process of referral.[27] However, this situation may change as workers become more established.

Our estimate of total patients seen in any one year was markedly lower than that proposed (see Box 1) in *The NHS Plan*,[10] and PCMHW caseloads are predictably lower than comparable caseloads for professionals such as community mental health nurses.[28] Undoubtedly our projection is crude, and as PCMHWs become more experienced, patient throughput is likely to increase. In the current study we asked about the number of new patients managed in the past month, and how this relates to current caseload is unknown. In addition, as previously highlighted, PCMHWs were at an early stage of their training and therefore a limited amount of time was spent in clinical practice.

The self-report data on outcomes are especially limited. Of those that had completed treatment 40% had been discharged and fewer than 15% referred for further mental health treatment. This provides limited evidence that the addition of PCMHWs is increasing capacity in primary care. However, rigorous evidence of clinical and cost-effectiveness is required.

Although our definition of integration into primary care was arbitrary, the physical location of workers is likely to be a key factor. Day-to-day working in a particular setting will familiarise workers with the 'culture' of that setting, through 'surface' artefacts (e.g. medical equipment) and attitudes and behaviours of peers and managers, which will teach more fundamental values and assumptions over time.[29] In addition, colleagues and managers make up the role 'set', and it is the *role expectations* of this set that represent the standards used by the new workers to evaluate their role and performance. These standards are communicated to the individual in order to bring about conformity with those expectations.[30]

Summary

Initial analysis suggests that PCMHWs will help expand primary care mental health provision, but fulfilling the potential of the new role raises a number of challenges. These relate to integration into primary care settings; effective management of the tension between increasing access and managing risk; and development of effective career pathways for these paraprofessionals within primary care settings. The PCMHW programme may provide an interesting model for future workforce developments in primary care, and the success of the programme may have important implications for healthcare systems in other countries.

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CONFLICTS OF INTEREST

None.

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