Mental Health in Family Medicine 2008;5:237–45

Article

Low-intensity workers: lessons learned from supervising primary care mental health workers and dilemmas associated with such roles

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ABSTRACT

The UK government's latest primary care mental health initiative, Improving Access to Psychological Therapies (IAPT), seeks to achieve its aims partly through the extensive use of low-intensity workers (LIWs). As clinical supervisors to teams of primary care mental health workers (PCMHWs) already offering brief, evidence-based interventions in primary care mental health services, we draw on the growing body of literature and our own experience to discuss dilemmas associated with the roles of such workers. These concern clinical governance, training, supervision and integration into existing services. We discuss how IAPT service characteristics may provide solutions to some of these dilemmas. We argue that it is unlikely they will be completely resolved and that IAPT services, in addressing future challenges, could benefit from lessons learned from the PCMHW role.

Keywords: IAPT, low-intensity workers, primary care mental health

Introduction

The demand for wider access to psychological therapy far exceeds the resources available. This increasingly places pressure on mental health services to generate innovative models of provision that can deliver both effective and economically viable interventions.

In 2000, the government's *NHS Plan* introduced the notion of primary care mental health workers (PCMHWs), 'trained in brief therapy techniques of proven effectiveness' and aimed at increasing the accessibility of psychological interventions.[1] PCMHWs would deliver brief interventions to large numbers of people with common mental health problems and be employed by primary care trusts (PCTs) to clearly locate them in primary care. Their role would involve direct work with clients, as well as supporting general practitioners (GPs) in their mental health work, by improving knowledge about the network of community resources for people with mental health problems and undertaking practice teamwork such as audit.[2]

In 2006, the UK government launched the Improving Access to Psychological Therapies (IAPT) programme. This also seeks to broaden access to a range of effective and appropriate psychological therapy options but is restricted to anxiety and depression using a stepped care model whereby low-intensity, low-cost treatments are often delivered as a first option, prior to referral to higher-intensity, high-cost care.[2] IAPT capitalises on large numbers of low-intensity workers (LIWs).

The LIW role has similarities to that of the PCMHW role: LIWs have comparable levels of training

to PCMHWs and carry out low-intensity interventions similar to those offered by PCMHWs.[3] This paper seeks to raise awareness about dilemmas presented by the relatively new role of PCMHW. These are pertinent not only to services currently provided by PCMHWs but also to the proposed development of IAPT services employing LIWs.

We discuss our experiences as clinical supervisors for teams of PCMHWs offering low-intensity interventions in two inner London boroughs and explore some of the clinical, professional and clinical governance issues that we have wrestled with in relation to the PCMHW role. It is important to emphasise that this paper is not intended to be a critique of the work of our PCMHW colleagues. They have developed and provide an innovative, valuable tier of mental health services despite the challenges they have had to face. We hope that IAPT will provide solutions to some of these challenges.

The role of the PCMHW

PCMHWs are required to be educated to degree level but this degree need not be mental health related. They complete a part-time post-graduate certificate in primary care mental health in their first year of employment. The content and assessment methods have varied between training courses with some placing greater emphasis on developing and directly assessing clinical skills, e.g. requiring PCMHWs to demonstrate competencies in role-plays or videotaped sessions with clients. Locally, the initial cohort received 30 days' core training, with 10 days focused on clinical issues: the two other modules covered 'policy and context', and 'audit and evaluation'. The course took up approximately one day per week and PCMHWs spent the rest of the time in their work setting. The second cohort's training had a greater emphasis on clinical issues and, in particular, cognitive-behaviourally based interventions for mild–moderate anxiety disorders and depression.

Nationally, the role has varied according to local needs. Strain *et al* describe three models:[4]

- 'precision skill', where PCMHWs interact with clients within strictly limited boundaries, such as facilitating computerised cognitive-behavioural therapy (cCBT)
- 'knowledge co-ordination', where the key commitment is signposting to other service providers, rather than the PCMHWs adopting a clinical role themselves
- 'limited clinician', where a range of different therapeutic interventions are regarded as feasible for delivery by the PCMHWs.

In our services, the PCMHWs have primarily adopted the latter model, though the interventions offered include cCBT and signposting. Direct client work has tended to predominate in response to local pressures from the referrers and the PCTs. Furthermore, the PCMHWs get most satisfaction from and are particularly motivated to develop this aspect of their role. It is the PCMHWs' clinical work that generates most of the dilemmas described below.

Dilemmas

Qualified para-professional or novice practitioner?

White expressed concern that, despite the fact that graduates are placed in positions of responsibility, fulfilling semi-professional duties, they are not given the most basic practitioner training that colleagues in other health and social care professions take for granted.[5] Warne and McAndrew have questioned the reality of delivering the vast amount of content required in a curriculum spanning one year.[6] Our experience has been that PCMHWs have needed considerable, ongoing on-the-job training in addition to that received from their initial year's course.

Despite this limited training, PCMHWs are expected to fulfil relatively complex assessment, referral routing and psychological intervention roles. PCMHWs are also generally expected to work clinically from the time they start in post, whilst still in training. We would argue that although they may be qualified para-professionals after the year's certificate course, PCMHWs should be regarded as relatively novice practitioners for a significant post-qualification period while they consolidate and develop their skills.

Mismatch between training/competencies and expectations

There has been a huge mismatch between the training and experience of the PCMHWs and the expectations placed on them. The ambitious aims of policy documents (suggesting that PCMHWs work across age and client groups, including with clients with complex problems), may have added to confusion about the role and misunderstandings resulting in inappropriate referrals.[7,8] Warne and McAndrew argue that what can be asked of novice and inexperienced practitioners may have been overestimated.[6] They believe the assumption, that PCMHWs would be the solution to the difficulties of providing services to people with common mental health problems, to

be naïve because of the hidden complexity of mental health problems encountered in primary care. Warne and McAndrew emphasise that complex problems should be recognised and addressed by those most able to do so and that a rigorous assessment process is necessary to ensure that clients receive an appropriate and sensitive intervention.[6] As Foster points out, PCMHWs are not qualified to assess clients.[9] It is therefore debatable whether they should take direct referrals (without prior screening or assessment). A national survey of the first cohort of PCMHWs showed that half of clients referred to PCMHWs had been previously reviewed by an experienced mental health professional to determine their suitability for the PCMHW to manage.[10] This strategy has been understandably criticised on the grounds of cost, for restricting access, and for limiting the potential benefits of the low-intensity intervention (Kenright M. *Ealing Pathfinder Site: outcomes and user preferences behind the service model*. Presentation at Law Society, London, 2007).[10] However, when PCMHWs are the first point of contact, clinical governance issues frequently arise: they may see clients who are unsuitable for low-intensity interventions, with severe and complex presentations, e.g. personality problems and high levels of risk. Screening for appropriateness requires complex skills, frequently based on past experience and access to those with past experience. PCMHWs, often working alone, are expected to be able to do this and make decisions regarding referral onwards (albeit under supervision), despite their extremely limited training in assessment and risk management.[11–13] Our experience has been that PCMHWs are routinely faced with clinical demands which would be challenging to an experienced primary care psychologist or counsellor. PCMHWs in our services encounter clients presenting with risk of self-harm more frequently than primary care psychologists and counsellors. This may be because they take referrals directly from primary healthcare teams, have an unfamiliar and ambiguous role and often work in isolation from other mental health professionals.

Referrers find it difficult to identify those clients with anxiety and depression who might be likely to benefit from a very brief self-help intervention, and pressurise PCMHWs to take on clinical work for which they do not have the necessary skills. Data from one of our services suggest that the rate of inappropriate referral is between 30% and 40% of total referrals.[13] Despite strenuous efforts to explain that low-intensity interventions are not counselling or therapy and that cCBT is not the same as CBT, referrers frequently refer clients to the PCMHWs, expecting them to offer counselling or CBT. In our other service, GPs book clients in to see the PCMHW, so they can be faced with clients with a wide range of difficulties, with little or no opportunity to screen referrals to determine their appropriateness for a low-intensity intervention, prior to the first meeting. There is a danger that PCMHWs are pressured to work beyond their level of competence, particularly if the PCMHW is expected to compensate for the absence of other mental health services in primary care and 'fill the gap'. Pressure to take on unsuitable cases has happened even when the PCMHW has explicitly stated that they are not the most appropriate worker to see the client. The PCMHWs have found these situations stressful and difficult to manage given their limited experience and relatively low status in the power hierarchy. Farrand *et al*, in a qualitative study involving interviews with stakeholders, reported that several GPs specifically highlighted that they referred clients to the PCMHW in the full knowledge that their difficulties were too severe for the interventions they were in a position to offer.[14] These issues are compounded if the PCMHWs take direct referrals from multiple GP practices rather than working as part of an existing primary care mental health service or at a centralised base.

The roles of PCMHWs are unfamiliar, varied and multifarious, depending on the local context (e.g. client demographics, pressures from referrers, political situation, configuration of supplementary services). Roles vary considerably across regions and even between workers in the same service. Ambiguity about what the role should encompass and how it relates to the roles of other primary care mental health staff have been highlighted as crucial issues to address if services offered by PCMHWs are to be implemented effectively.[15] Locally, the same mental health trust provides the clinical supervision to PCMHWs in three boroughs, yet the PCMHWs have different employers, vastly differing roles and referral/treatment protocols and even differing titles. This can cause confusion amongst fellow professionals about the nature and scope of the role. It is not surprising, therefore, that referrers may find making an appropriate referral somewhat challenging and may hold inappropriate expectations. There is widespread misunderstanding among primary care professionals about PCMHWs' levels of competence and training. O'Connor comments that the identity of PCMHWs is being negotiated by the relationships between them and the stakeholders involved and that it will take time, possibly years, for their role to become established.[16]

Dilemmas arising from organisational context

The idea of PCTs rather than mental health services employing PCMHWs confers potential benefits such as reducing stigma associated with mental health

services and a chance to re-orientate culture within the PCT to include a mental, as well as physical, health focus. Unfortunately, there can be significant disadvantages to using relatively unsupported and inexperienced novices as agents of change in the NHS,[8] and these potential benefits have not materialised so far, at least locally. The services offered by PCMHWs were not 'owned' and developed by their employer or referrers until after considerable input from the PCMHWs and their supervisors over a period of years. They were hampered by the lack of formal structures to facilitate the interface between services offered by PCMHWs and other local mental health services, and a split between line and professional management, which has implications for clinical responsibility.

The PCMHWs, being employed by PCTs which had few or no other mental health staff, are isolated and at risk of being cut off from vital peer contact, opportunities for informal clinical discussion and continuing professional development (CPD) opportunities. They are located outside an environment that focuses on provision of high-quality mental health services. PCT in-house training courses rarely meet their needs and many mental health trust in-house training events are closed to them, given their employment by the PCT. Their PCT line managers are unlikely to have experience of providing mental health services and may even be unfamiliar with the issues involved. A PCMHW is often the only mental health worker in their GP practice.

PCMHWs are at risk of operating a stand-alone service, yet services offering low-intensity interventions are most likely to be successful if deployed in collaboration with, and complementing those, offered by other members of the primary care mental health teams. A fundamental feature of stepped care is that it is self-correcting and that systematic monitoring allows for interventions which are not achieving significant health gain to be 'stepped up' to increased intensity.[17] This necessitates links between the PCMHWs and primary care counsellors, psychologists and secondary care mental health services. Foster expresses concern that little strategic thinking has taken place as to how PCMHWs link in with existing primary care counselling services and that there has been confusion about who should most appropriately be seeing whom.[9]

Locating PCMHWs within PCTs means that although managerial responsibility is held within the PCT, clinical supervision must usually be bought in. This potentially places clinical supervisors in the position of holding clinical responsibility for the work of their PCMHW supervisees without having control over their clinical workload, and, in particular, the cases taken on and whether these fall within the limits of clinical competence.

There may be little understanding within a PCT managerial context about the needs of mental health workers and what should be expected of them. Local PCT policies regarding issues such as clinical risk and record keeping, for example, are not tailored to mental health services, yet, where experience and training is limited, such protocols are particularly important.

Due to the demands of the role and external pressures, PCMHWs have been required to operate with a high level of autonomy and frequently to work at the very edge of their capabilities. It is often their enthusiasm and eagerness to develop and expand their knowledge that allows them to fulfil these relatively unsupported roles so well. Yet, clinical supervisors may have to rely on PCMHWs recognising the limits of their competence and this can become a source of contention over which clinical supervisors have limited influence. If a clinical supervisor deems a case to be too complex, there can be uncertainty about whether they are in a position to make only recommendations regarding the appropriate course of action or to ensure that their advice is heeded. For example, in situations where child protection concerns arise, it is unclear whether the clinical judgement of the supervisor or the PCT child protection lead's advice should take precedence.

Difficulties with supervision, support and professional identity

Mental health staff with professional status in primary care, such as psychologists, counsellors and CBT therapists, are comparatively far better equipped and supported than PCMHWs, by virtue of their training, role clarity and often also by their organisational context. In their lengthier training, they usually take on small caseloads of carefully selected clients deemed to present difficulties appropriate to their level of competence. They usually work as part of a team so that more experienced colleagues are at hand for both support and referral allocation. Qualified therapists are expected to receive ongoing supervision and the amount is recommended by professional bodies. Their role is explicit and senior colleagues offer models for career development. Many mental health professionals are employed by mental health trusts and this offers several advantages.

PCMHWs are in a very different position. They usually carry much larger caseloads than trainees or junior professional practitioners, despite the fact that they are likely to have far less training or experience. There are no formal requirements for supervision and the frequency and quality of supervision provided for these inexperienced workers has been

cause for concern.[8] In some areas, professionals such as GPs have been providing supervision and, PCMHWs themselves have been determining the amount of supervision they receive. As supervisors, we may regularly be asked to provide our PCMHW colleagues with supervision for over ten cases in one hour, due to their large caseloads and high turnover, which leaves minimal time for discussion and reflection. As far as we are aware, the training course content has not covered the reflective skills required to recognise the need for supervision or the limits of one's competence. The PCMHWs are not affiliated to any professional body and have no relevant code of practice to guide them in ethical issues, so in this area, they are reliant on the guidance of the clinical supervisor. PCMHWs often have little access to informal professional support as described above, and few opportunities for career progression.

Supervision of PCMHWs may frequently have to compensate for the problematic context described above. We have found that the PCMHWs can be skilled at matching intervention type to presenting problem, and in supporting clients to use cCBT or written self-help material etc once the assessment is completed. However, they experience far more difficulty in determining whether a low-intensity intervention is appropriate in the first place. A large proportion of supervision time may be used in screening out the high proportion of referrals unlikely to benefit from a low-intensity intervention and to make decisions about where to divert unsuitable cases. This reduces time to focus on appropriate referrals. GP notes are extremely useful for this screening process, although reviewing these has been time consuming for the PCMHWs. They have struggled with balancing the clinical and administrative demands of managing their caseload and have required a lot of support to ensure that communication with clients and referrers is appropriate and timely. The workers may also need high levels of support to cope with the stress of the role.

Local attempts to address the dilemmas

Locally, we have taken steps to try to address some of these dilemmas. In one service, the workers are now called 'primary care self-help facilitators'. Although an equally cumbersome title, it is hoped that it conveys more accurately the nature of the interventions they offer. The supervisor's title has been changed to 'clinical supervisor and professional manager' to underline the far broader remit of her role. Referral criteria were disseminated at an early stage and self-referrals halted because of a very high rate of inappropriate referrals. Policies covering issues such as clinical risk and notes and record keeping were written in collaboration with the PCMHWs and endorsed by the PCT clinical governance committee. Meetings between the PCMHWs, their referrers, line manager and supervisor/professional manager were set up at GP practices, to clarify roles and agree procedures including those for managing risk. The locality model initially adopted by the PCT, which led to each worker covering 10–15 practices, is being reviewed in the light of service evaluation data, since it militates against the development of relationships with referrers: it is hoped that close links can be fostered with a few practices whilst some services can be provided across localities. The PCMHWs and primary care psychologists and counsellors have been encouraged to develop links with each other, leading to fruitful collaborative relationships. Some psychologists/counsellors carry out joint assessments with the PCMHWs and offer informal supervision and support. Cross referrals are made in both directions. A representative of the PCMHWs attends the monthly business meeting of the primary care psychology and counselling service. Seminars tailored to the PCMHWs' needs have been provided by the supervisor and we have persuaded the mental health trust to permit them to attend in-house training events.

In the other service, we have concentrated on increasing the links between PCMHWs and local primary care psychology services and fostering the working relationships between the local mental health trust (which offers clinical supervision) and the PCT, which provides line management and access to financial resources etc. Policy documents, modelled on those in operation in the first service, have been developed, and a strategic approach to training, incorporating external courses funded by the PCT and in-house training seminars (within the mental health trust) will be initiated, to facilitate clinical skills development. Discussions have begun regarding possibilities for career development. In addition, the rapidly evolving nature of the current working environment has resulted in changes within the PCT and mental health trust, which have, in turn, enabled a number of issues raised here, to be addressed.

The supervisors and managers of the PCMHWs, in our and neighbouring boroughs, have developed links. We have organised meetings for the PCMHWs, both separate from and including their supervisors and managers, to share experience and good practice, and for mutual support. The local training course modified its curriculum on the basis of feedback from supervisors and trainees in our and other boroughs.

Our supervisory style and focus have inevitably been adapted to the needs of the PCMHWs who are offering a very different service to their clients than we do as therapists. Case discussion is practical, task-oriented and inevitably brief. Without minimising the complexity of cases, we have found it essential to encourage the PCMHWs to limit their focus, to not get drawn into detail but to identify key intervention points and individual factors that could maximise change. We highlight similarities between cases so that they can develop key core skills to apply more generally. Overall, treatment plans tend to be much more protocol based and less idiosyncratic. Managing a large caseload is often difficult and in the first service, the line manager introduced 'case logs' with the dual aim of helping the PCMHWs to monitor their caseloads and allowing the supervisor to have an overview, review all cases prior to discharge and ask about cases not brought to supervision.

Although the above have been valuable developments, the dilemmas remain, since their resolution depends on the co-ordinated action of all stakeholders at local and national levels. As supervisors, rather than line managers, our influence is unfortunately limited. The situation may change with the need for PCTs to focus on commissioning rather than providing services. Decisions will need to be made regarding who employs PCMHWs and how their work may be linked with that of IAPT teams.

Lessons learned from the PCMHW role

The initiative to introduce PCMHWs was implemented with little planning at a national level with regard to their training, role and integration into existing mental health services. Many, perhaps most, PCMHWs are expected to assess and treat direct referrals from GPs and work independently in primary care. Our experience suggests that training offered to PCMHWs may not equip them to assess clients, to manage cases of the complexity often presented, or to work at the level of autonomy expected of them in their work settings. This has sometimes resulted in clients being seen by PCMHWs unqualified to help them, motivated PCMHWs suffering high levels of stress and isolation, and referrers confused about how to make the best use of the valuable services PCMHWs can offer. This raises questions about whether clients are receiving a service appropriate to their needs and whether PCMHWs are getting a fair deal. For a number of reasons, this situation is not conducive to safe and effective practice or staff support and development, and has implications for the role of LIWs.

Warne and McAndrew comment that there is a place for practitioners such as PCMHWs in primary care, but only if their role reflects their limited training and they are employed in collaboration with and complementary to other primary care mental health professionals.[6] Indeed, Foster reports that graduate workers flourish when they have clear direction, clear management and are integrated into the wider primary care mental health team.[9] Lavender has stressed that unless these roles fit in with clear career frameworks, and are coherent with local service design/developments, they will be unsustainable.[18]

We believe that PCMHWs and LIWs are a welcome addition to the primary care workforce, but should only be deployed where a supportive organisational and professional infrastructure exists. It is our hope that the IAPT initiative will make use of the lessons learned from the PCMHW role and that the stepped care systems in which LIWs are intended to operate will address some of the issues outlined above.

Does IAPT provide any solutions to the dilemmas?

Training

An IAPT low-intensity training curriculum has been developed which should both increase consistency across courses and ensure LIWs meet required levels in the competencies expected of them.[19,20] In our view, training for low-intensity interventions should include a particular emphasis on assessment, risk management and caseload management, given the challenges of high throughput and large caseloads: these issues are indeed prioritised in the curriculum. Trainees will have to practically demonstrate clinical competencies. We believe training should also include socialising to the supervision process: it should not be assumed that LIWs can make good use of supervision simply because it is provided. They should be encouraged to use it to reflect on their skills and to be aware of the limits to their competence.

Given the experience with new PCMHWs, LIWs should be gradually introduced into their role by measures such as starting with small caseloads, seeing carefully selected cases, and opportunities to observe experienced PCMHWs or LIWs and other mental health staff. LIWs should also be offered specific support in managing the transition from novice to

more experienced practitioner and be considered as novice practitioners for a significant period. They need opportunities for career development and progression.

Supervision

Guidance regarding supervision has been provided.[21] We welcome the fact that recommendations have been made about minimum supervision standards and training for IAPT supervisors. The guidance clarifies that the specific nature of low-intensity interventions necessitates supervision that is qualitatively different from supervision for high-intensity interventions, i.e. case management supervision integrated with monitoring of outcomes and supported by case management systems to ensure that all cases are reviewed at appropriate intervals. It also highlights how supervisors need to be clear about governance arrangements around autonomy and scope of practice, including the extent to which assessment and risk issues are overseen by a more experienced practitioner.

With regard to sources of clinical supervision, Richards and Suckling have suggested that professionals operating from a low-volume, high-intensity clinical paradigm (for example most clinical psychologists) may not be the best equipped to deliver high-volume case management clinical supervision.[22] John and Vetere, on the other hand, point out that such therapists can adapt, as demonstrated by psychologists like ourselves currently supervising PCMHWs.[23] In their view, experienced clinicians will be necessary for the sustainability and quality of service offered by low-intensity workers, who may face stress and burnout. We would agree that supervision offered to PCMHWs and LIWs should be tailored to their needs, but therapists experienced in mental health services, and primary care in particular, can adapt to these challenges. We are conscious of the range of roles we have had to play in relation to the PCMHWs, extending far beyond those necessary when supervising therapists. We believe that our experience working as clinical psychologists in primary care and in other tiers of mental health services, places us in an excellent position to contribute to current service developments.

Integration into teams

LIWs will be integrated into teams working alongside high-intensity workers and experienced therapists. Referrals will be received centrally rather than to each worker according to the idiosyncratic arrangements of where they are deployed. Outcomes will be closely monitored and referrals will be stepped up and down as required. These differences should address some of the issues we have identified regarding clinical governance, worker isolation and referral routing. If LIWs are employed by PCTs with supervision 'bought in', clarity of roles and responsibilities and close liaison between clinical supervisor and line manager are essential to ensure appropriate expectations and address the dilemmas outlined above.

Role

The role of LIWs is likely to be more homogenous and less ambiguous than that of PCMHWs. It will probably become more familiar to referrers than that of PCMHWs due to the greater numbers of LIWs. Hopefully, the stepped care context will reduce conflict with roles of more highly trained mental health professionals in primary care.

All these changes should mark a significant improvement in comparison to the way PCMHWs were introduced and their services implemented, but it is unclear at this stage whether IAPT services will address all the issues of concern we have identified.

Ongoing dilemmas

As with training for PCMHWs, the training for LIWs is limited to one day per week training for a year. It remains to be seen if LIWs will also need considerable on-the-job training during and after qualification as did PCMHWs. Anecdotally, services already employing LIWs confirm that this is indeed necessary.

Furthermore, although the quality and frequency of supervision may be improved under IAPT, we note that the recommendations are that high-intensity workers should get more additional supervision than LIWs (1.5 hours/week versus 1 hour/fortnight, respectively). If LIWs are to have caseloads of up to 45 active cases and complete treatment of between 175 to 250 clients per year,[19] the challenges for supervision will continue to be intense. It is difficult to see how the minimum supervision requirements of one hour per week plus one hour a fortnight can be sufficient. In our opinion, LIWs require more supervision and support than that offered to their high-intensity counterparts given their paraprofessional status, comparatively more limited training and experience and their much higher caseloads. In addition, as mentioned above, some LIWs may need support to make appropriate use of

supervision. Many IAPT services are using more junior staff to supervise LIWs than high-intensity workers, whereas we believe it important to use experienced clinicians as supervisors of LIWs given the challenges such supervision presents.

LIWs will receive direct referrals of clients who may not have been assessed (although they may have been screened). In many IAPT services, all clients (unless clearly unsuitable) will initially be offered an LI intervention ('pure' stepped care). Even IAPT services that triage referrals to high- and low-intensity workers ('stratified' stepped care) will base their decisions on very limited information rather than a full assessment. The introduction of self-referrals and referrals to a central point of access, rather than direct to workers based on-site in GP practices with close proximity to referrers and client notes, means that less information may be available at the point of referral than in existing services. This means that LIWs will still be expected to carry out an important assessment role and may potentially see a relatively high proportion of inappropriate cases. The increased 'distance' from referrers – either due to working off-site or due to the central referral point – may make it more difficult for LIWs and other IAPT staff to liaise closely with referrers. Opportunities to form close relationships with a GP practice, to clarify roles and expectations, and improve the suitability of referrals will be reduced. Stringent efforts on the part of the service to liaise and educate at every possible opportunity will be required.

We are not suggesting that LIW referrals should always be assessed by a more experienced therapist, but that referrals should be screened by senior staff for suitability prior to allocation. Although there are many advantages in terms of access when PCMHWs and LIWs take direct referrals, there are significant clinical governance implications. Despite screening, PCMHWs and LIWs are still likely to encounter a significant proportion of clients unsuitable for a low-intensity intervention, placing pressure on supervisors to manage the implications: for example, the supervisees' capacity to address risk issues, assess appropriateness and manage the stepping up process sensitively etc. Factors that make clients unsuitable for a step 2 intervention, may also make it more complicated to transfer them to another worker for a step 3 treatment.

Finally, although the role of LIWs in IAPT services should be clearer compared with that of PCMHWs, which created potential for role ambiguity and role conflict, we believe that LIWs are likely to encounter similar organisational dilemmas to those we have outlined above. Even if LIWs are integrated into teams, they may well see clients in settings such as GP practices, and voluntary sector and community organisations, where they will be working alone, with a high degree of autonomy. They may be confronted, like PCMHWs have been, with issues that are challenging for an experienced professional. Local GPs frequently express their belief that they can manage people with mild to moderate anxiety and depression, and it is the complex cases they wish to refer to mental health services. Therefore, the risk remains that referrer expectations will lead to a high proportion of inappropriate referrals which LIWs will have to assess if they take direct referrals.

Conclusion

Given the plans to recruit large numbers of LIWs whose roles will be similar to PCMHWs', it is imperative that lessons should be learnt from the PCMHW initiative. PCMHWs have experienced particular difficulties with assessing the appropriateness of referrals, managing large caseloads, using supervision and relating to referrers. LIWs and their supervisors are likely to find these issues challenging despite the changes IAPT will bring to LIW training, supervision, monitoring and the organisational context in which LIWs work. IAPT is a major step forward in supporting the work of staff offering low-intensity interventions but we believe dilemmas remain, which have implications for the LIWs themselves, their supervisors and, most importantly, their clients.

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CONFLICTS OF INTEREST

None.

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Accepted 3 July 2009