

## International research

# Primary care graduate mental health workers' experience of using an integrated care pathway for the treatment of depression in primary care

S Gardner BSc(Hons) MSc PGCert  
Primary Care Graduate Mental Health Worker

D Hanson BSc(Hons) PGCert  
Primary Care Graduate Mental Health Worker

South East Sheffield Primary Care NHS Trust, Manor Clinic, Sheffield, UK

S Wakefield MA PGCert Advanced Dip RMN  
Senior Lecturer in Mental Health Nursing at Sheffield Hallam University, Faculty of Health and Wellbeing, Sheffield, UK

### ABSTRACT

In 2004 the Department of Health proposed to recruit 1000 new graduates to assist in the treatment of depression and anxiety in primary care. The National Institute for Health and Clinical Excellence guidelines provide an indication of what is required but no guidance as to how to deliver their proposals. The introduction of primary care graduate mental health workers (PCGMHWs) to fulfil the Department of Health requirements has proved to be a challenge to existing primary care NHS trusts. At present there is great variability in the way that PCGMHWs work. This article aims to introduce a potential vision of working that PCGMHWs in the south east of Sheffield have pioneered. We propose that integrated care pathways (ICPs) can be used to deliver cognitive-behavioural therapy (CBT)-based interventions as part of a stepped care model. The ICP facilitates a collaborative approach to working which involves the PCGMHW, the general prac-

itioner (GP) and the patient. We have designed and implemented an ICP for the assessment and treatment of depression in GP surgeries. Questionnaires were used to gauge practitioners' experience of using the ICP for the treatment of depression and to offer recommendations for improvement, producing positive findings. The ICP is a continually evolving clinical tool, which we have refined as a result of our evaluation. Owing to the success of this innovation, we intend to develop similar ICPs to facilitate the treatment of other common mental health problems in primary care, such as the anxiety disorders.

We intend this article to be a resource to practitioners faced with similar issues who may wish to consider an ICP as a tool to implement change.

**Keywords:** depression, integrated care pathway, primary care graduate mental health workers (PCGMHWs)

## Introduction

It is now widely acknowledged that over 90% of those patients experiencing depression are treated solely in primary care and that primary care practitioners

require knowledge and skills for the effective treatment of depression.<sup>1</sup> Given the new responsibilities of primary care to manage common mental health

problems, and only refer those people with more severe problems to specialist services, there is a need to build capacity in primary care. The arrival of the primary care graduate mental health workers (PCGMHWs) is one of the key ways to both increase capacity and ensure there are workers in primary care skilled in the treatment of mild to moderate mental health problems. Part of the role of the PCGMHW is to support primary care staff in the treatment of depression, and to also administer evidence-based treatments for common mental health problems.<sup>2</sup> How we best make use of the PCGMHW resource is still an area for debate.

The *National Service Framework for Mental Health* (NSF) makes it quite clear that primary care is a significant first point of contact for people with mental health problems, and that the majority of these problems would be best dealt with in primary care.<sup>3,4</sup> The NSF has a vision of sophisticated primary care mental health services providing a holistic service with seamless, well-developed linkages into specialist services. Within this, PCGMHWs might be ideally placed to meet this need.

## Primary care mental health worker: a new breed?

Challenges to the role of PCGMHWs include the possibility of existing professionals such as general practitioners (GPs) and other practice staff in primary care questioning the need for these new workers, along with a possible reluctance by primary and secondary workers to bring the treatment of common mental health problems into primary care. There may be scepticism from professionals about accepting PCGMHWs since they are considered 'non-professionally trained' workers, (i.e. not mental health nurses, clinical psychologists or counsellors), which is a problem that has been encountered by some PCGMHWs. Having said that, a number of PCGMHWs currently in post feel that most GPs and associated workers in primary care have been extremely positive and enthusiastic about the contribution to be made by mental health workers, who are seen as a valuable resource at the front line where most mental health need exists. Any initial scepticism by existing professionals seems to be allayed once PCGMHWs set up in practices and begin to hold clinics and treat patients.

Following on from the initial one-year postgraduate certificate in primary care mental health practice, which PCGMHWs need to complete in their first year, they will require ongoing training and

supervision. Diploma level cognitive behavioural therapy (CBT) training would appear most suitable in line with National Institute for Health and Clinical Excellence (NICE) guidelines,<sup>1</sup> along with, for example, short postgraduate-level courses in systemic psychotherapy and family therapy, since the nature of primary care work means professionals regularly see patients who are members of the same family. Primary care work could be considered ultra-brief-ultra-long therapy, with short bursts of treatment over a long period of time (i.e. the complete lifespan), with no discharge, where patients weave in and out of the surgery throughout their lives. PCGMHWs can work with individual patients with common mental health problems using facilitated self-help, or with specialised groups of people in primary care, for example, asylum seekers, many of whom suffer from post-traumatic stress disorder (PTSD). Hence, trauma-focused CBT and training in, for example, eye movement desensitisation and reprocessing (EMDR) would appear most salient (80–90% of PTSD sufferers also have other problems such as depression and anxiety).<sup>5</sup> Short courses in working with interpreters would seem important for those PCGMHWs that work with individuals who are speakers of other languages, who may have a limited working knowledge of English. Training in cultural awareness would also help in engaging with members of other ethnic groups who are often disadvantaged in accessing help by mental health professionals, and health services in general.<sup>6</sup>

Bearing in mind that PCGMHWs might see large and diverse populations of patients, often with complex needs, (and more often than not in areas of high socio-economic deprivation) clinical supervision by skilled mental health practitioners, with experience of providing clinical supervision, is vitally important.<sup>4</sup>

## The stepped care approach

The recently published NICE depression guidelines offer practitioners clear guidance on the treatment of depression.<sup>1</sup> The 'stepped-care' approach embedded within the guidelines aims to ensure that people receive the level/intensity of care that best meets their needs and only 'progress' to the next tier should the situation require it. This reduces the number of inappropriate referrals to specialist services and ensures treatment interventions are appropriate to the level of severity, i.e. antidepressants are not automatically prescribed for first-episode, mild depression. Therefore, care received and referral pathways should be consistent and resource efficient.

PCGMHWs can be novice mental health practitioners who require clear guidance to ensure they practice in a safe and efficient manner. They must therefore be familiar with the NICE guidelines, especially those interventions to be delivered in steps 2 and 3 (arguably those of most relevance to the PCGMHW).

As part of the 'stepped care' model,<sup>1</sup> PCGMHWs are also ideally placed to be able to 'gatekeep' referrals into secondary and tertiary services. This ensures that increasingly complex interventions are only used after less-intensive interventions are implemented at the early stages of depression. By treating patients early in the onset of common mental health problems, PCGMHWs can screen patients, thereby ensuring more appropriate referrals are made into secondary services, and hence reduce waiting list times.

## Facilitated self-help

The NICE guidelines recommend facilitated (or guided) self-help for the treatment of mild depression.<sup>1</sup> This is to be provided by PCGMHWs and/or the primary care team. It suggests facilitated self-help consist of 'appropriate written materials and limited support over six to nine weeks, including follow-up from a professional who typically introduces the self-help programme and reviews progress and outcome'.<sup>7</sup> Most self-help literature uses basic CBT principles and techniques, along with patient education.<sup>7</sup> This is delivered through written material, such as leaflets, workbooks, self-help books, telephone conversations, computer packages, audiotapes, videotapes and self-help support groups. In primary care mental health services, self-help is most commonly used in the treatment of depression and anxiety disorders, and also used as a health-promotion tool, for example in assertiveness training. One advantage of guided self-help in the first level of the 'stepped care' pyramid is that it provides an accessible mental health service, which educates and empowers clients to use their own coping strategies and build upon these. This approach sees the client/patient as an expert in their own life, and does not require referral on to specialist services, thereby reducing the stigma attached to being seen in specialist psychiatric or secondary services.<sup>8</sup> By being able to 'pop down' to their local GP surgery, this reduces the stigma and normalises the experience of depression and anxiety as everyday problems, just like having physical health problems such as diabetes or high blood pressure.

Self-help has been researched for anxiety disorders and depression.<sup>9-11</sup> Davison<sup>12</sup> and Lovell and Richards<sup>13</sup> suggest the problems of high demand and low availability leading to the build-up of waiting lists can be avoided through 'stepped care'. This would also appear to be the most cost-effective way of dealing with this huge demand. Research by Bower, found significant advantages of self-help as compared to controls in terms of clinical and cost-effectiveness.<sup>14</sup> Most evidence for clinical and cost-effectiveness relates to CBT-based self-help interventions, though the evidence so far is limited.<sup>7</sup> A pilot using psycho-educational approaches to the treatment of common mental health problems in primary care (anxiety disorders, depression, PTSD, the most common problem being mixed anxiety/depression), indicated that low-intensity interventions could be useful as a first step.<sup>15</sup> Thus, within the stepped-care model, PCGMHWs are ideally placed to operate at the frontline to meet this demand.

## Our Experience in south east Sheffield

In accordance with *The NHS Plan's* proposal to recruit 1000 PCGMHWs by 2004,<sup>16</sup> 13 people were recruited and deployed within primary care trusts in Sheffield and Barnsley. All of the new NHS employees were educated to degree level and had a variety of previous work experience, and during the first year of employment, all employees undertook a postgraduate certificate in primary care mental health practice.

Two of the authors (SG, DH) were among those recruited, and in January 2004 took up post within South East Sheffield PCT. One of the aims of recruiting graduate mental health workers was to 'assist GPs manage and treat people with common mental health problems', by supporting the delivery of brief evidence-based effective self-help interventions.<sup>17</sup> The challenge for the South East Sheffield PCT mental health facilitator was to decide within what capacity PCGMHWs could positively contribute to existing local primary care mental health services.

Local health data indicate that the prevalence of depression within south east Sheffield extends to approximately 8% of the total population.<sup>18</sup> Consequently, a decision was made for the new graduates to work collaboratively with GPs to assist in the management and treatment of depressed patients.

The challenge faced by the mental health facilitator in south east Sheffield therefore was to develop

a clear, defined PCGMHW role to complement and supplement that of the GP, while managing and treating depressed patients, in accordance with clinical recommendations and guidelines.

The NSF for mental health standard two explicitly states:<sup>3</sup>

... any service user who contacts their primary care health team should have their needs assessed ... [and] be offered effective treatment ...

Therefore, a decision was made to develop a role for PCGMHWs which involved contributing to both the assessment and treatment of patients.<sup>3</sup> Research in relation to safe clinical practice frequently highlights the potential difficulties associated with non-professional, isolated workers engaging in clinical practice without an established operational protocol. Wakefield and Peet for example suggest that 'professionals with a limited range of approaches should not do first line assessments'.<sup>19</sup> Similarly, a recent evaluation of a PCGMHW pilot programme emphasised the necessity of professional standards and related policy to guide clinical practice in accordance with best-practice guidelines.<sup>2</sup>

Prior to deployment within GP practices therefore, the task of the mental health facilitator in South East Sheffield PCT was to develop an appropriate and innovative model of care not only encompassing clinical recommendations for safe practice, but also facilitating a collaborative care approach involving both GPs and PCGMHWs.

As a consequence, adhering to the south east Sheffield stepped care model, the mental health facilitator engaged the newly recruited PCGMHWs in a task to develop an integrated care pathway (ICP) for primary care patients with depression. The ICP was to serve as a clinical tool for GPs and PCGMHWs to collaboratively assess and treat mild to moderately depressed patients, in accordance with the NICE guidelines for depression.<sup>7</sup>

In addition to clarifying the roles of GPs and PCGMHWs, the aim of the ICP was also to provide a structured approach for assessing and treating depression in a safe manner, working within professional boundaries of competence. Furthermore, in clarifying the role of PCGMHW, it was envisaged that the ICP might assist in facilitating the integration of the new role into existing primary care team, thereby minimising the risk of isolated working, as reported in the PCGMHW pilot programme evaluation.<sup>2</sup> Facilitated self-help is just one of a wide range of activities PCGMHWs can undertake in the treatment of depression and other common mental health problems in primary care.<sup>4</sup> PCGMHWs in south east Sheffield have also, in collaboration with a cognitive-behavioural psychotherapist from Sheffield Care Trust, developed group psycho-education

workshops, based on the work of White's 'Stresspac'.<sup>20,21</sup> These are delivered in an 'evening class' format (informal, normalising experience with a tea break in the middle), with group sizes potentially accommodating up to 60 people. These groups consist of six two-hour sessions, held weekly in non-NHS buildings, and are open to the general public on an opt-in basis. This didactic approach uses the mode of 'the therapist as teacher'.<sup>15,21</sup> The teaching format makes it appropriate for large groups, and again normalises the experience of mental health problems by framing it as 'stress', which is seen as a common, more socially acceptable problem than depression, anxiety, panic disorder etc (e.g. mental 'illnesses').

## Integrated care pathways: the solution to managing depression in primary care?

Throughout this article the challenges facing the treatment of depression in primary care have been presented. These are:

- confusion over role(s) especially when introducing a new type of worker (the PCGMHW)
- wide variation in clinical practice and therefore clinical outcomes
- ensuring evidenced-based techniques are effectively implemented
- problems with communication, both within primary care teams and between primary and secondary care services
- developing the autonomy and clinical expertise of a new breed of worker, the PCGMHW, while ensuring safe practice and clear working boundaries
- making difficult decisions about when to refer on.

It is unhelpful to attempt to address these issues in isolation as they are so closely interlinked. One tool that can be used to address the issues in a systematic way is the ICP. Although ICPs have been utilised widely in medical and surgical settings (e.g. hip replacements), their use is still relatively new in mental health care.<sup>20</sup>

ICPs (sometimes referred to as critical pathways, care pathways or critical care plans) are defined as a tool which:

determines locally agreed, multi-disciplinary practice based on guidelines and evidence, where available, for a specific patient/client group. It forms all or part of the clinical record, documents

the care given and facilitates the evaluation of outcomes for continuous quality improvement.<sup>22</sup>

The ICP is an innovative clinical governance tool. It is different from a clinical guideline because the health professional 'interacts' with the ICP on a daily basis. The worker uses it to plan care, record the care given and also make free-text notes when necessary.

ICPs are flexible tools that can be highly effective in areas such as primary care where turnover is fast and where there are usually clear treatment protocols to follow.<sup>23</sup> This is clearly the case with mild to moderate depression. The NICE depression guidelines outline best practice for the treatment of depression.<sup>7</sup> These guidelines can not only be effectively embedded into an ICP, but the ICP can ensure the guidelines are implemented into daily practice and regularly evaluated, thereby increasing practitioner knowledge and skill. National guidelines, even when widely endorsed and supported by a variety of stakeholders, can be notoriously difficult to put into practice. This is because they often 'sit on a shelf' and never make the progression into a care plan or treatment strategy. Although treatment algorithms go one step further, as they more clearly guide clinical decisions, there is still no easy way of recording (and thereby knowing), whether the protocol has been followed. The ICP is part of the patient record and includes demographic data, assessment information, plan of care and referral information. It is essentially a 'one-stop-shop' whereby the clinical guidelines and record of care are held in one place (see Appendix 1). This greatly increases the likelihood of best practice being implemented on a daily basis. ICPs can also increase the patient's involvement in their care. A copy of the ICP can be shared with the patient, and the worker can then talk through the likely interventions to be used and sequencing of events. This can reduce patient confusion, a common problem for patients when discussing self-help strategies with their GPs, and can increase their sense of ownership and ultimately their engagement in the therapeutic process.<sup>24</sup>

## Our experience of developing and using an ICP

Once we had decided to use the ICP tool, the process of designing and writing it began. The small team spent a number of sessions whereby the patient journey was mapped out, starting with consultation with the GP and subsequent diagnosis of depression, to 'referral' to the PCGMHW through treatment

implementation and discharge. This phase was important as it improved our understanding of our roles, the client group and the treatment strategies to be adopted. This process in itself can have a positive effect on quality of care even without the development of a full ICP.<sup>25</sup>

We also developed a depression workbook which is an integral component of the ICP. The workbook is a clear, self-explanatory, loose-leaf booklet which the patient and PCGMHW work through together. The booklet is based on CBT self-help principles and includes information on depression, medication and sleep hygiene, and offers simple strategies to challenge unhelpful thinking. The ICP refers the worker to the workbook and the two are used in conjunction. The use of the ICP and the workbook should ensure high-quality evidence-based care is delivered while reducing variation between practitioners.

In accordance with Department of Health guidelines, the ICP assessment section recommends that the GP subjectively screens for risk and severity of depression as an indication of whether a self-help approach might be an appropriate firstline treatment for the patient.<sup>26</sup> Following identification of appropriate patients, extending the assessment process, the ICP subsequently recommends that the PCGMHW carries out an objective measure of risk and severity before discussing the main presenting difficulties for the patient during an extended consultation. The ICP then incorporates a number of evidence-based self-help interventions, facilitating patient choice.

In the absence of primary care mental health professionals and associated operational protocols, the introduction of an ICP for depression as a means of facilitating a collaborative approach to care was both innovative and challenging.

Prior to implementing the ICP, GPs were invited to attend an open event aimed at introducing the ICP approach to collaborative care for depression and to facilitate a discussion about the potential usefulness and acceptability of such an approach. The event was well attended, and despite initial scepticism about the PCGMHW role, the majority of attendees displayed interest and enthusiasm about the proposed collaborative approach by the end of the event. Consequently, we began by implementing the ICP in six GP practices, with a view to carrying out an evaluation after the first six months.

Each GP was supplied with ICP documents, which were to be used collaboratively to guide the assessment and treatment of depressed patients, and also as a referral mechanism for engaging the PCGMHW. GPs record details from consultations with patients, such as severity of problem, risk status and nature of any interventions such as antidepressants and/or

provision of information. The ICP is then passed on for use during subsequent PCGMHW consultations. Specifically, the PCGMHW supplements assessment by administering an objective depression scale incorporating risk screening, and in offering an extended consultation systematically checks for factors that might be maintaining depression such as housing, financial or work difficulties, relationship problems, substance abuse and so on. The ICP assessment section also includes reminders about the need for prompt collaboration between GP and PCGMHW when a patient discloses his/her intent to cause harm to themselves or others, or when complex difficulties involving substance abuse are identified. The purpose of collaboration is to determine the appropriate level of care for the patient and how any potential risk should be managed.

Following assessment, the patient and PCGMHW then use the ICP to consider appropriate self-help-based intervention options as a means of planning subsequent care. Any action taken is recorded on the ICP to enable progress to be monitored, and each entry is dated and signed. The ICP details a number of brief firstline self-help-based interventions in accordance with a stepped care model such as medication monitoring, provision of information, signposting, promoting behavioural engagement, problem solving, challenging negative thoughts, and finally relapse prevention. The content of the ICP for depression has been developed around offering patients up to ten PCGMHW sessions; however this number is not absolute.

## Achievements and future developments

After implementing the ICP for depression for six months, an evaluation was carried out to ascertain practitioners' and service users' experiences of the approach. Questionnaires were administered to GPs, PCGMHWs and service-users (see Appendix 2). On the whole, despite the fact that many GPs were not familiar with ICPs, feedback about the effectiveness as a means of facilitating a collaborative approach for depression involving PCGMHWs was favourable. GPs felt that the ICP was particularly useful as a referral and liaison mechanism, and in clarifying the role of PCGMHW it helped to integrate the new role into existing primary care services. Some GPs however did not feel that the ICP improved their assessment and treatment of depression, although they acknowledged that the inclusion of risk screening

and the subsequent need for collaboration was good practice.

PCGMHWs found the ICP to be extremely valuable in terms of role clarification, ensuring safe clinical practice within the boundaries of competence, and in facilitating collaboration between themselves and the GP, especially in relation to managing risk. In terms of practicality, however, following the evaluation, the ICP document was modified and the clinical recording section was substantially condensed given the need for PCGMHWs to record notes in electronic systems. We have discussed developing an electronic ICP which would form part of the patient's electronic notes.

Small-scale service-user feedback of PCGMHWs and the self-help approach has been very positive. Many patients have openly expressed their satisfaction in being able to access mental health care within the GP practice and being able to monitor their progress throughout the course of treatment. Moreover, objective and subjective measures of progress indicate that a self-help approach is associated with positive clinical outcomes.

In view of the apparent success in using an ICP to manage and treat depression in primary care, the south east Sheffield PCGMHWs are currently implementing the approach in more GP practices. Clearly there is a need to continue to carry out evaluations, however the significant progress made so far within South East Sheffield PCT is a testament to the commitment and effort of the mental health facilitator. We acknowledge it is still early days in the implementation of the ICP. Our focus now is to continue to use it while evaluating its usefulness, comprehensibility, user-friendliness, patient satisfaction and impact on clinical outcomes.

## ACKNOWLEDGEMENTS

We would like to acknowledge the following persons: Mark Knowles, Primary Care Mental Health Manager, South East Sheffield Primary Care NHS Trust and Jenny Porritt, Primary Care Graduate Mental Health Worker, South East Sheffield Primary Care NHS Trust.

## REFERENCES

- 1 National Institute for Health and Clinical Excellence. *NICE Management of Depression in Primary and Secondary Care*. Clinical Guideline 23. London: National Institute for Health and Clinical Excellence, 2004,
- 2 Northern Centre for Mental Health. *Graduate Mental Health Workers in Primary Care: evaluation of a pilot programme*. Durham: Northern Centre for Mental Health, 2003.

- 3 Department of Health. *National Service Framework for Mental Health: Modern Standards and Service Models*. London: Department of Health, 1999.
- 4 National Institute for Mental Health in England, North West Development Centre. *Primary Care Graduate Mental Health Workers: a practical guide*. London: National Institute for Mental Health in England, 2004.
- 5 National Institute for Health and Clinical Excellence. *Post-traumatic Stress Disorder (PTSD): the treatment of PTSD in adults and children*. NICE Guideline. London: National Institute for Health and Clinical Excellence, 2005.
- 6 D'Ardenne P and Mahtani A. *Transcultural Counselling in Action (2e)*. London: Sage, 1999.
- 7 Williams C. *Overcoming Depression: a five areas approach*. London: Arnold, 2001.
- 8 National Institute for Mental Health in England. *Self-Help Interventions for Mental Health Problems*. London: National Institute for Mental Health in England, 2003.
- 9 Ghosh A and Marks IM. Self-treatment of agoraphobia by exposure. *Behavior Therapy* 1987;18:3–16.
- 10 Febraro GAR, Clum GA, Roodman AA *et al*. The limits of bibliotherapy: a study of the differential effectiveness of self-administered interventions in individuals with panic attacks. *Behavior Therapy* 1999;30:209–22.
- 11 Marks IM, Mataix-Cols D, Kenwright M. *et al*. Pragmatic evaluation of computer-aided self-help for anxiety and depression. *British Journal of Psychiatry* 2003;183:57–65.
- 12 Davison G. Stepped care: doing more with less? *Journal of Consulting and Clinical Psychology* 2000; 68:580–5.
- 13 Lovell K and Richards, D. Multiple Access Points and Levels of Entry (MAPLE): ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy* 2000;28:379–91.
- 14 Bower P. Primary care mental health workers: models of working and evidence of effectiveness. *British Journal of General Practice* 2001;52:926–33.
- 15 Ricketts T, Curran J and Saxon D (2004) *Psycho-educational approaches for common mental health problems in primary care: evaluating a pilot service*. Sheffield: Sheffield Care Trust and South East Sheffield Primary Care Trust.
- 16 Department of Health. *The National Health Service Plan*. London: Department of Health, 2000.
- 17 Department of Health. *Fast Forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers Best Practice Guidelines*. London: Department of Health, 2003.
- 18 South East Sheffield Primary Care Trust (2004). *Making a Difference*. [www.doh.gov.uk](http://www.doh.gov.uk) (accessed 1 October 2007).
- 19 Wakefield S and Peet M. ICPs in mental health: the need for the human touch. *Journal of Integrated Care Pathways* 2002;6:108–14.
- 20 White J. 'Stresspac'. Three year follow up of a controlled trial of a self-help package for the anxiety disorders. *Behavioural and Cognitive Psychotherapy*, 1998;26:133–41.
- 21 White J. *Treating Anxiety and Stress: a group psycho-educational approach using brief CBT*. Chichester: Wiley, 2000.
- 22 Overill S. A practical guide to integrated care pathways. *Journal of Integrated Care* 1998;2:93–8.
- 23 Chave J, Painter J, Peet, M *et al*. Using an integrated care pathway to deliver a nurse-led clozapine clinic. *Journal of Integrated Care Pathways* 2004;114–118
- 24 Rogers A, Oliver D, Bower P *et al*. People's understanding of a primary-care based mental health self-help clinic. *Patient Education and Counselling*, 2003; 53:41–6.
- 25 de Luc K. Care pathways: an evaluation of their effectiveness. *Journal of Advanced Nursing* 2000;32: 485–96
- 26 Northern Centre for Mental Health in Primary Care. *Evaluation of a Pilot Programme*. 2003.

#### CONFLICTS OF INTEREST

None.

#### ADDRESS FOR CORRESPONDENCE

S Wakefield, Senior Lecturer in Mental Health Nursing, Sheffield Hallam University, Faculty of Health and Wellbeing, 11–15 Broomhall Road, Collegiate Crescent Campus, Sheffield S10 2DN, UK. Tel: +44 (0)114 2255604; email: [s.wakefield@shu.ac.uk](mailto:s.wakefield@shu.ac.uk)







