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Primary care graduate mental health workers: implementation in the north west of England

Janine Fletcher

Primary Care Facilitator, National Institute for Mental Health in England (NIMHE – North West Development Centre), Hyde Hospital, Hyde, UK

Liz Kell

Primary Care Graduate Mental Health Worker, Chorley and South Ribble Primary Care Trust, UK

Jan Robinson

Knowledge Officer

Peter Anderson

Service User Representative

Debbie Nixon

Primary Care Programme Lead

National Institute for Mental Health in England (NIMHE – North West Development Centre), Hyde Hospital, Hyde, UK

This paper has been written to identify some of the issues relating to the implementation of primary care graduate mental health workers (PCGMHWs) in one region of the UK. It highlights some key learning points and raises some examples of good practice which can be shared by other, developing regions.

Background

The *National Service Framework (NSF) for Mental Health* acknowledges that primary care is the first point of contact for most people with mental health problems, and that the majority of such problems are best dealt with in primary care.¹ Two of the seven standards in the NSF focus specifically on primary care mental health, with Standard 2 stating that patients should have access to effective assessment and management of common mental disorders.

In order for primary care to achieve the standards set out in the NSF, *The NHS Plan* identified funding for 1000 new primary care graduate mental health workers (PCGMHWs) nationally by December 2004.² These workers were originally allocated to primary care trusts (PCTs) based on a population size with £25k per PCGMHW allocated in the baseline

budget. The responsibility for recruitment, training and retention was to be managed locally.

PCGMHWs are one of a number of new roles being established in mental healthcare to help tackle the demand and capacity issues which are highlighted by Lovell and Richards.³ The role of the PCGMHWs was outlined in the *Mental Health Policy Implementation Guide* which identifies the following three key elements:⁴

- to support the delivery of brief, evidence-based, effective interventions (including self-help)
- to support the development of practice-based information systems, audit and outcome measurement
- to improve knowledge within practices about the network of community resources

Guidance on the role was written to be flexible enough to enable final decisions to be made at local level in the light of existing service patterns and need. However, the guidance stressed that PCGMHWs should be employed by PCTs and be firmly embedded within primary care by working with a small number of practices with strong links into specialised, secondary services.⁵

Training programmes were commissioned around the country and the north west was one of the leading areas in terms of recruitment and training of the PCGMHWs. A review in the north west of roles which were similar to those proposed for the PCGMHWs was conducted by the National Primary Care Research and Development Centre and used to inform the way the role has been established in the region.⁶

Recruitment of PCGMHWs

The north west of England comprises three strategic health authorities (SHAs): Greater Manchester, Cheshire and Merseyside, and Cumbria and Lancashire. Collectively there are 42 PCTs which have a total PCGMHW allocation of 161. To avoid expensive advertisement costs, the three SHAs joined together in the first recruitment wave and used a central clearing house for all applicants within the north west. However, due to logistical difficulties with this, each SHA took responsibility for their own recruitment process in year two. The most effective method of recruitment was when each SHA, workforce development centre (WDC) and the PCTs worked together to co-ordinate the recruitment process.

Collectively the three SHAs advised PCTs which payscale and salary point trainee PCGMHWs should be placed on. Some PCTs took the advice and others did not which led to disparity in pay and conditions and has subsequently led to 'poaching' of PCGMHWs in some areas.

Implementation in the north west

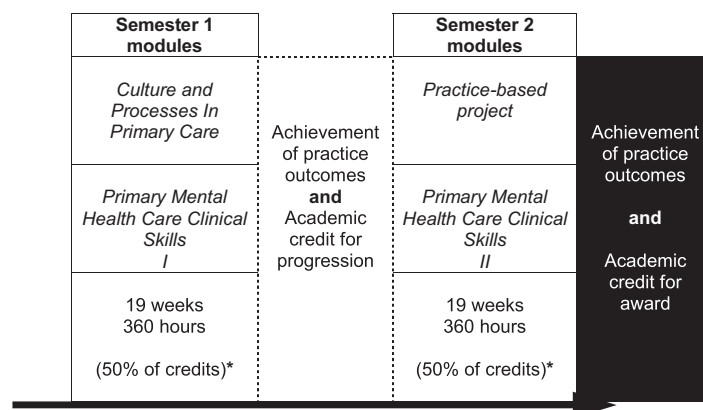
In January 2004, 66 PCGMHWs commenced training in one of three higher education institutions (HEIs), and by the end of 2005 a further 106 will have commenced training. To aid the implementation of these new workers the National Institute for Mental Health in England North West Development Centre (NIMHE NW DC) developed a part-time primary care facilitator post to work with the SHAs and PCTs and a full-time knowledge officer post (see below for further details).

Training

Three universities worked in partnership to set up a 'Postgraduate certificate in primary mental health care practice' designed to equip the new graduate mental health workers with the competencies to function in the three roles outlined above. The universities involved are: University of Manchester, Liverpool John Moores and University of Central Lancashire. The training course is provided over a 12-month period and consists of one day in university per week (or equivalent), and one day in supervised practice. An outline of the training programme is given in Figure 1. Each PCGMHW is also required to have a supervisor and mentor for which the HEIs have developed a person specification and also hold regular training and update sessions to prepare them for their roles.

Support

A number of initiatives were established by NIMHE NW to support the implementation of the PCGMHWs, including local steering groups, PCGMHW review group, and a primary care mental health collaborative.



*720 hours postgraduate certificate

Figure 1 Progression through the programme in order to be fit for practice, purpose and academic award

The local steering groups were established on a SHA footprint and comprised representatives from: NIMHE NW, the SHA, the WDC, three nominated PCGMHWs, a mental health lead, a general practitioner (GP), a mentor, a supervisor, users and carers and the HEI. Representatives from human resources were also invited. These groups meet approximately every three months with the purpose to oversee the implementation process and development of the role in their respective area.

The PCGMHW review group is held biannually and consists of six PCGMHWs from each SHA (this year three PCGMHWs from each cohort per SHA). The PCGMHWs set their own agenda and provide minutes and a report for NIMHE NW. The issues raised are then fed back into the local steering groups and to the primary care board of NIMHE through the primary care programme lead. This has proven to be a very useful and valued forum for PCGMHWs to share ideas and also to highlight any implementation issues.

A Primary Care Mental Health Collaborative has been established in Cumbria and Lancashire jointly funded by NIMHE NW and the SHA. This is a 12-month project which aims to support the implementation of PCGMHWs using a stepped care model. Representatives from all key stakeholder groups attend a series of meetings to develop and review plans to take back to their PCTs, for example recruitment issues. The outcomes of the collaborative will be available later in the year; for further information please contact the lead author.

In order to further clarify the role of the PCGMHW, NIMHE NW in conjunction with the Health and Social Care Advisory Service (HASCAS) produced a practical guide, which added detail to how the PCGMHW role was expected to develop in the region. Alongside this the *Enhanced Services Specification for depression under the new GP Contract* was produced which firmly embeds PCGMHWs within a stepped care model of primary care mental health service delivery.⁸

Knowledge community

The implementation of the PCGMHWs has been further assisted by the use of a web-based resource, the Knowledge Community website. The site is funded and managed by NIMHE. The Knowledge Community (KC) is an interactive website which helps people to:

- connect with other people
- find and share information
- learn and collaborate.⁹

It is the role of the knowledge officer to manage the primary care resource element of the site for the NORTH WEST region. The KC ensures that primary care mental health resources and knowledge are managed and shared in a way that makes them easily accessible by those working in this field.

The KC has the functionality to have specific groups within the site, and several groups have been set up on the KC to assist the implementation of the PCGMHWs. In the north west, groups were set up for each of the three SHA steering groups as well as a group for the National PCGMHW Steering Group. A national support group solely for PCGMHWs has also been established. These groups are a way of communicating between their members to share and develop ideas and learn from their colleagues' experiences. For example one member of the PCGMHW support KC group emailed others members to ask about suggestions on materials to implement guided self-help. There is also a group store for each group, which is a vehicle for storing and accessing key resources. Training sessions on how to use the KC have been given or offered at the HEIs, so that PCGMHWs understand how to use and how to benefit from the KC.

Service user involvement in developing and training PCGMHWs

Peter Anderson is a service user representative for NIMHE NW and writes:

Service Users from NIMHE North West were approached to help develop and take part in the delivery of the training of the Primary Care Graduate Mental Health Workers. A small group of us came together to form a steering group to look at what were the issues for user and carers. The issues ranged from information to confidentiality and how we were going to be involved in the recruitment of the workers and what role we would play in training and educating PCGMHWs.

The user steering group was given the task of recruiting users and delivering the training in conjunction with the programme leads. This did not feel like user, or carer involvement but a partnership, and everyone was made to feel equal in the planning process.

We set out to train users on the role of the PCGMHWs and what to expect. This training was delivered in the three SHA sites. Even though the take up was slow, we managed to average between 8 and 15 users and carers on each course. The participants were from a mixture

of backgrounds and each acted as a representative of their respective PCT.

The work which we were involved in covered career pathways, short listing, interviewing, design on delivery of the training, education, and adverts for users, carers and PCGMHWs. The steering group also designed an evaluation form to be used to monitor how PCGMHWs engage with users.

The whole process for users and carers in our view was a great success.

Experiences of a PCGMHW in the north west

Liz Kell is a qualified PCGMHW who has been employed by Chorley and South Ribble PCT since January 2004, she writes:

During my first year in post I attended the training course at the University of Central Lancashire. I currently work in two GP practices within my locality. I began working in the first of these in June 2004 and my time before this was spent in a number of ways – having a comprehensive induction to the PCT including shadowing a number of different health professionals, making contact with local statutory and non-statutory agencies, and an eight-week placement shadowing the primary care office of a local Community Mental Health Team. I attended university in 4-day blocks once a month where we had clinical skills training which was very useful preparation for my clinical practice. I started in my second GP practice in September 2004 and eventually hope to increase this to three practices.

Due to the set up in my locality, when I first came into post I was not working in a team, which made the job very isolating. However, I worked hard to build links with people, and as the job progressed, I came into contact with a number of people who were very supportive of my role and made the time much easier. The support came from both my mentor and supervisor, practice staff at my identified GP practices, and through building up links with my local mental health services. I also received a great deal of support from the tutors at the university and the other PCGMHWs across the SHA in which I work. From the beginning of the course my PCGMHW colleagues and I have kept in regular contact outside of university which has been an invaluable support network. I was one of the student representatives on the course, and through this attended my local steering group meeting as one of the PCGMHW representatives. I also attend the biannual PCGMHW review group which gives us an opportunity to discuss different experiences and share good practice across the three SHAs. As I work within Cumbria and

Lancashire SHA I am also involved in the collaborative which again has widened my support network, and I feel it has also increased awareness of my role within my own locality.

There have been a number of stumbling blocks since I have come into post, particularly practical issues, for example the identification of a base, and room availability for clinical work, and there were also some problems in identifying a suitable supervisor, but these were all eventually resolved and there is now a Primary Care Mental Health Team in my area, which means I am part of a team. This is something that I am looking forward to and am hopeful that it will make a big improvement to the isolation that I have on occasion experienced over the last year. The past twelve months have definitely been a very steep learning curve both for myself and my colleagues, in terms of what my role is and where I fit in, but things are definitely working a lot better now. I feel I have a strong support network and am able to put my attention into doing my job to the best of my ability.

Key implementation Issues

As Liz's account shows, implementation of PCGMHWs in the north west has not always been an easy process, in fact on occasions it has been an uphill struggle. Some of these issues are highlighted here.

Basic needs

Many services were initially ill-prepared for the arrival of the workers, and issues arose around not having an induction planned, lack of rooms in which to conduct work and lack of clarity over resources (e.g. who was going to pay photocopying costs of self-help materials – the PCT or the GP practice?). These issues have, in the main, been resolved for the second cohort, as services have learnt from their mistakes and most of these now have qualified PCGMHWs who are supporting the arrival of additional workers in the second cohort. Room space remains an issue in some areas, but case management intervention conducted over the telephone has been one way around this.

Supervisors and mentors

In some instances, the identification of suitable supervisors and mentors was difficult. Many primary care professionals lack adequate training themselves in mental health, and therefore are not suitable to act as supervisors for the PCGMHWs. Some PCGMHWs also lacked a line manager as

they had been employed by PCT commissioners of services who rarely have line management responsibilities. In some cases these issues have been resolved by utilising excellent relationships between primary and secondary care where community psychiatric nurses (CPNs) and psychologists have stepped in to the breach.

Models of working

Owing to local arrangements, not all PCGMHWs are employed and based in primary care. Other models include placement within counselling services or within primary care mental health teams, or secondary care psychology services. All models have their pros and cons, with access to adequate supervision and colleagues having a positive attitude towards new ways of working appearing to be key features of a successful model.

Retention

January 2005 saw the qualification of the first cohort of trainee PCGMHWs in the north west. During the trainee 12 months, a small number of PCGMHWs left their posts for a variety of reasons, including some to commence clinical psychology training and some for personal reasons. Other issues affecting the retention of PCGMHWs include there currently being no defined career pathway for this new role, and many remain on the same pay, conditions and job descriptions as their trainee counterparts. A working group nationally is looking at the future career of qualified PCGMHWs, and suggestions include specialist roles within services such as child and adolescent mental health, forensics or taking on co-ordination roles in PCTs where trainee/junior PCGMHWs are employed.

Developments

The north west has been involved in a pilot project where PCGMHWs have supported the use of the computerised cognitive behaviour package 'Beating the blues'. This pilot is currently being evaluated and the results will be published in the near future.

The north west region also has a number of PCGMHWs undergoing complementary training to enable them to work effectively with child and adolescent mental health services.

For qualified PCGMHWs the universities are currently developing a masters' level course to enable

them to develop their knowledge and skills to further enhance primary care mental health. This will hopefully be available from September 2005. In addition the postgraduate training course designed to train PCGMHWs will be offered to existing primary care health teams, so that they can gain training in mental health.

Conclusion

The north west has achieved a great deal in meeting the targets set for implementation of PCGMHWs; this has in part been due to the amount of time and effort that has been invested by a large number of stakeholders in the region and the established partnerships between groups of people such as HEIs, users and carers, and mental health commissioners who all too often work in isolation from each other. In addition the sheer determination and motivation of the PCGMHWs has developed the role into a highly regarded and useful one.

PCGMHWs are an invaluable resource for practices and PCTs which are striving to become National Institute of Clinical Excellence (NICE) -compliant while developing enhanced services. PCTs also need to take on the responsibility for ensuring the role of the PCGMHW continues to be developed and supported in primary care.

For a clearer picture of some of the issues raised, we await with anticipation the results of the National PCGMHW survey which is being led by the National Primary Care Research and Development Centre at the University of Manchester.

Finally, although we have come along way in the north west, we are aware this is not a time for complacency and we will continue to strive to improve primary care mental health services for all.

Key learning points of this exercise are shown in Box 1.

Box 1 Key learning points

- Appropriate supervision needs to be found
- Someone needs to be managerially accountable
- Establishing close working partnerships between all stakeholders is essential
- Greater clarity is needed around career pathways and Agenda for Change
- Evaluations of PCGMHWs in practice need to be conducted to highlight the effectiveness

REFERENCES

- 1 Department of Health. *National Service Framework for Mental Health: modern standards and service models*. London: Department of Health, 1999.
- 2 Department of Health. *The NHS Plan – a plan for investment, a plan for reform*. London: Department of Health, 2000.
- 3 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.
- 4 Department of Health. *Mental health policy implementation guide*. London: Department of Health, 2001.
- 5 Department of Health. *Fast Forwarding Primary Care Mental Health Graduate Primary Care Mental Health Workers Best Practice Guidance*. London: Department of Health, 2003.
- 6 Bower P. *Primary Care Mental Health workers – a qualitative study of a developing role in five sites in the north west*. Unpublished report, University of Manchester: NPCRDC, 2003.
- 7 NIMHE NW. *Primary Care Graduate Mental Health Workers: a practical guide*. NIMHE NW, 2004. www.nimhenorthwest.org.uk/archives/work_primary_care/002096.shtml (accessed 2 May 2005).
- 8 Fletcher J, Bower P, Richards D and Saunders T. *Enhanced Services Specification for Depression under the new GP Contract*. NIMHE-NW, 2004. http://www.nimhenorthwest.org.uk/archives/work_primary_care/002097.shtml (accessed 2 May 2005).
- 9 <http://kc.nimhe.org.uk> (accessed 2 May 2005).
- 10 National Institute for Clinical Excellence. *Depression: the management of depression in primary and secondary care. NICE Guideline*. London: National Institute for Clinical Excellence, 2004.

CONFLICTS OF INTEREST

None.

ADDRESS FOR CORRESPONDENCE

Janine Fletcher, National Institute for Mental Health in England (North West Development Centre), Hyde Hospital, Second Floor, Grange Road South, Hyde SK14 5NY, UK. Tel: +44 (0)161 351 4920; email: Janine.fletcher@nimhenorthwest.org.uk

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