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The process of setting up a self-help clinic in primary care: one graduate primary care mental health worker's experience

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ABSTRACT

One thousand graduate primary care mental health workers (GMHW) were introduced to practices throughout England this year. Their role is to increase primary care capacity within National Health trust areas by providing safe and effective therapeutic interventions. A key objective is to reduce the number of clients needing referrals to secondary care by treating mild to moderate mental health problems in the general practitioner (GP) surgery. Training for GMHWs consists of a one-year postgraduate certificate in mental health in primary care. This was introduced in January 2004. The first graduates will complete the course in January 2005. As part of training the graduates have been placed in GP surgeries to carry out one-to-one therapeutic interventions.

This paper examines the challenges faced by a graduate, trained on the Plymouth University programme, in taking up this new role. It provides an insight into one graduate's approach to the task of promoting the benefits and supporting role of a GMHW to all those in the GP practice. This includes a presentation of the strategies used to gain GP and other support in setting up a successful self-help clinic. The paper provides details of the main stages in setting up the clinic and focuses on the collaborative processes, client profiles, therapeutic work and success indicators used such as referral rates and GP feedback. A case study of a client is also included to illustrate key aspects of the approaches used. In total this account and analysis provides a progress report and insight into one of the most important roles held by the GMHW.

Keywords:

Introduction

> 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.

This is the mission statement announced in *The NHS Plan* (2000).[1] It reflects a new strategy to tackle the ever increasing demands on primary care mental health teams. *The NHS Plan* supports the aims of the National Service Framework (NSF) (1999) which set out a major programme of reform, modernisation and investment for mental health services.[2] The National Institute for Mental Health England (NIMHE) provides support for the implementation of *The NHS Plan*. The NSF standard policies are based

on evidence that most people with mental health problems are cared for by their general practitioner (GP) and primary care team.[3] Mental health problems are prevalent in the population. Depression, anxiety and phobias affect up to one in six people at any one time. A quarter of all GP consultations are for people with mental health problems, with depression being the third most common reason for consultation in general practice in the UK.

The role of the graduate mental health worker (GMHW) has a number of key aims.[4] These include:

- auditing work within the practice on mental health registers
- mental health promotion
- stigma reduction
- psychological interventions by way of group work.

However the role which holds particular significance in supporting the aims of the NSF is that of one-to-one therapeutic interventions for mild to moderate mental health problems in primary care. In particular standard 2 of the NSF states:

> 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.

The external drives for the implementation of the GMHW within a general practice setting are clear. One thousand GMHWs have been placed across England primarily in GP practices in the bid to strengthen the capacity of primary care.

What follows is my account of the strategies that I developed and used in a GP practice (Referred to as 'N') in addressing the above key purpose and aims.

Internal drives: profile of practice area

Practice N is an inner city practice and covers four main deprived areas. The practice has a list size of 7121 prescribing analysis and cost data (PACT) (2004), and the patients cover all social classes with a high turnover rate. Through the profiling of practice N it was found that the average percentage of mental health consultations was 15% for three partners. When the mental health consultation rates from 2001 to 2004 for two of the partners (referred to as Dr X and Dr Y) were analysed, it was clear there was a significant increasing trend (see Figure 1).

It is clear from the table that the need for further mental health provision was needed to cope with the increasing demand on GPs. As a GMHW I was appropriately placed in this inner city practice. Research shows that mental health problems are showing a significant increasing trend particularly in areas of high social deprivation.[5] Closer inspection of the mental health consultations in Practice N indicated that 37% were related to depression, 17% to anxiety, 14% to anxiety with depression, and 19% to stress. The outcomes of these consultations showed that 54% were dealt with by prescribing antidepressants. In a recent survey more than 80% of GPs openly admitted to over prescribing antidepressants such as Prozac or Seroxatine to patients suffering from depression, anxiety or stress.[6] Many more affluent people now pay for private talking therapies due to lack of availability within the NHS. Lower socio-economic groups have more limited access if they are unable to pay for treatment. Thus the role of the GMHW will assist in filling this gap in mental health provision, and make talking therapies more accessible to the whole community. In doing this it is possible that many mental health problems can be treated before they become too severe and have to be referred on to secondary care.

The training

The postgraduate training course embarked on by each graduate in January 2004 and ending in January 2005 consisted of three modules. The first module covered how to deliver a facilitated self-help intervention based on cognitive behavioural therapy

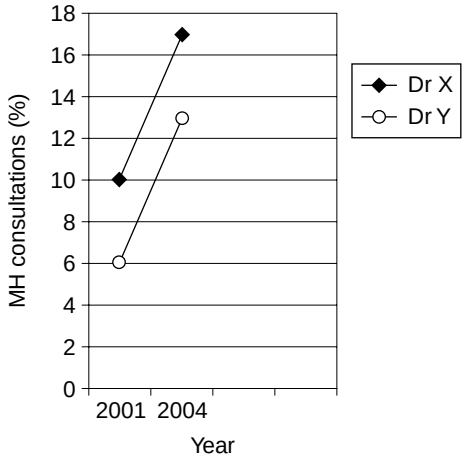

Figure 1 Mental health consultations in 2001 and 2004 for each GP

(CBT) techniques. The second module included training in a second therapeutic model called solution-focused therapy. By June our training in these two brief therapeutic models was complete, and we were qualified to take on our own clients in our assigned practices. The third module covered NHS policies, organisations and social support networks, and is due to finish in January 2005 when our final grade for the course will be assessed. Those who successfully complete the course will have gained a Certificate in Mental Health in Primary Care.

Setting up of the clinic: collaborations and practicalities

At the beginning of June 2004 the first two modules in the training course were complete. The challenge then was to establish ourselves in our allocated primary care settings. This marked the beginning of our collaborations with other health professionals. Weekly supervision meetings had been set up by our clinical supervisors. These meetings also involved five other GMHW and their supervisors. The supervisors are trained health professionals. At these meetings we had the opportunity to discuss ideas and give updates on our progress and the issues we were encountering. During these meetings we established the criteria that would be used to select the patients we would be able to treat. The general profile of appropriate patients included adults, aged 18–65 years, who were experiencing mild to moderate mental health problems. We excluded those with psychoses and children. We then developed the referral criteria and processes we would be operating in our surgeries. These included how people would refer and who could refer to us, and how we would refer back to GPs or onto further specialist services.

My entry into the GP surgery was critical and involved a number of stages. The first involved a series of introductory meetings. The first and most important meeting was with the practice manager at the surgery. The aim of this meeting was to raise awareness about my role. Most staff in the surgery had little or no awareness about the GMHW role. This meeting set the tone for most of the initial meetings and informal discussions that I had with other professionals linked to the surgery. The second stage was a meeting between myself, my supervisor, the practice manager and the link GP within my surgery. At this meeting I discussed my role within the practice and explained what type of therapies I would be using and the categories of patients I would be seeing. My supervisor who was an experienced community psychiatric nurse played a key role in all of the stages. Her advice, encouragement and expertise, and her clear enthusiasm for the role of the GMHW gave me confidence about my role. The theme of this meeting was very much about promoting my role to the GP and practice manager and convincing them that I would be an important and beneficial asset to the surgery. The next stage was to seek agreement on the referral criteria with the link GP. At this early stage it was agreed that we would only take referrals from GPs until our role became more widely known throughout primary and secondary care. I was reassured by this decision, as it would reduce the chances of receiving inappropriate referrals.

The next stage was to become acquainted with the staff working at the surgery. The practice manager identified some days when I could sit in with the nurses, the phlebotomists, the GPs and the secretaries. This was a very valuable stage, as my awareness and understanding of their roles increased and I had the opportunity to discuss my role informally with them. By the middle of June I felt ready to introduce myself formally having already primed my audience about the GMHW role.

The practice manager arranged for me to give a presentation at a clinical governance meeting in the practice. I welcomed this opportunity to formally address the staff. I worked with my link GP who set out the agenda for the day with the staff. I reflected carefully on what they would make of this new role and how I would be received, especially as they already had talking therapy provisions in the form of a counsellor and a CBT therapist in the practice. I began by introducing myself and talking a little about my personal background, which included my psychology degree and caring for special needs children. I described what I thought my role would mean for the practice. I explained who I would see and who the GPs could refer to me. I explained how the health visitors and nurses, the counsellor and CBT therapist could also refer to me by going through a client's GP. I handed out the official GMHW course leaflet which focused on the graduate training course. This provided information about my therapeutic training at Plymouth University. I also outlined our training in the NHS structures and policies, group work planning and auditing work. I was received well, as was my role, and I had the opportunity at the end to answer questions. I answered a question about the CBT model I would be using and the self-help scheme that my sessions would include. I took the opportunity at the end to hand out the referral criteria that I and the five other GMHWs in my area had produced.

Each GP received a copy together with a referral form that my link GP had created.

The next important stage involved a meeting with the secretaries to arrange some clinic times and a place to hold a clinic. This was fairly easy to work out, as the secretaries were very supportive and helpful. This stage was made easier as it built on the relations formed through the informal discussions in the introductory stage. By this stage the secretaries knew exactly what my role involved. The course handbook states that the GMHW will spend a minimum of one morning a week in the surgery. I began with a Friday morning slot in the counsellor's room. Time for three client sessions was available. I anticipated the next stage – my first referral.

The clients

The clients I have seen have come from a range of backgrounds with a number of mental health problems. A summary of my client caseload shows that over the last six months 18 of my clients have been female and 15 male; five have been in their teens, six in their 20s, ten in their 30s, ten in their 40s and eight in their 50s. I think this is a very positive aspect about the role of the GMHW in that the brief therapy can be successful for a range of ages. The criteria include that we can see people with mild to moderate levels of depression, anxiety, stress, anger and adjustment problems. Eighteen of my patients presented with symptoms of depression, two with combined depression and anxiety, two with anger, five with stress, five with anxiety alone and one with obsessive compulsive disorder. In total I have had five clients who I have referred onto specialist services, two of whom I referred on to the in-practice counsellor. Both had more deep rooted problems stemming back to childhood that they wanted to discuss.

The brief one-to-one therapy focused on problems in the present and tried not to bring into focus issues from the past too much. Two patients showed clinical symptoms of depression and personality disorder, and so I referred them onto secondary care. I felt that due to symptoms of low self-esteem and mild social phobia, the final patient would benefit from a group therapy environment more than a one-to-one environment. As the majority of the referrals were appropriate I think this is a good indicator that I had explained my role successfully in the practice and that the referral criteria are clear. I have seen individual clients for an average of five sessions over a number of weeks. After the initial assessment I see clients one week later to start them on self-help approaches including the use of workbooks.[7,8] The succeeding sessions are then booked at two-week intervals. I have found this to be a good timescale where I use the workbooks, as it allows clients sufficient time to read, understand and complete the workbooks fully. Each session lasts approximately 60 minutes.

Brief self-help therapy

Using the CBT model as a framework, clients are given an initial assessment. The 'five areas approach' developed by Chris Williams provides an assessment tool to complete during an assessment.[7] This allows the client to be interactive and play a lead role in defining their own problems. The tool provides a clear structure to illustrate the relationships between practical problems and relationships, triggers and stressors and thoughts, feelings, physiology and behaviour. The focus is on the present situations and enables the client to see in a visual way reasons for the way they are feeling. Although I have focused primarily on the cognitive behavioural model, it is important to note that I have used brief solution-focused therapy techniques where appropriate such a 'The miracle question' and 'Scaling'.[9,10]

Through the use of self-help books, clients are supported in identifying main problems and looking at practical ways to overcome these problems. Clients have to be motivated, as it is they who have to devise their own problem-solving plans and carry them out and report back on them.

As the work book prescription scheme is not yet in operation in my area, on occasion I recommend which books clients may like to purchase for themselves. The book prescription scheme involves GMHW or GPs using book prescription pads. The book prescriptions indicate a specific book for a client to collect from their local library. A large number of libraries are involved in the scheme. I have mainly focused on the Chris Williams series Overcoming Depression and Overcoming Anxiety, which I have found to be very useful.[7,11] Feedback from clients has been positive. Clients have had very little trouble understanding the activities. Client understanding of the activities was an initial concern discussed in supervision meetings. Seventeen of my clients are employed and 15 are not. The practice is based in an area of deprivation, and so reading and writing is not always of a high standard. However, using the Chris Williams books has overcome this potential problem. I also use handouts from other sources, for example, to explain the physical symptoms of anxiety or stress diaries. I have also made my own anger management pack. It is important at this stage in my training that all of the resources I use with

clients are screened first by my supervisor. One of my roles as a practitioner is to build up my own catalogue of resources that I can use with clients. I have not yet come across a client where English was not their first language. I would welcome a buddy system whereby the client would have e.g. a member of their family or friend who would agree to help them with the workbooks. An alternative would be that I read out the workbook to them during the sessions.

During supervision, the tools I use to track clients progress are discussed. It was agreed that the Hospital Anxiety and Depression Scale (HADS) was an effective tool and also the Beck Depression Inventory.[12,13] I have found both very useful indicators of severity of the problem and progress made by the client. However, I feel as I progress in the role and become more familiar with the available scales I will increase my range of resources.

The clinic: indicators of progress

In order to evaluate the progress of the clinic it is useful to look at a number of indicators of progress. I have chosen to focus on three areas:

- referral rates
- GP feedback
- a client case study.

When the clinic began in June I received a small number of referrals from the GP in the practice who has a special interest in mental health. Figure 2 shows the increase in referral rates from the start of the clinic to the present month (November 2004).

The figure clearly shows that the GPs in the practice are beginning to integrate the role of the GMHW into the practice. This indicates that the collaborative processes in the early stages were successful, and the referral criteria are clear and acceptable. As a result of increased referrals I increased my clinic hours in the surgery to two mornings a week. In order to confirm these assumptions I carried out a questionnaire feedback form with the doctors in the practice.

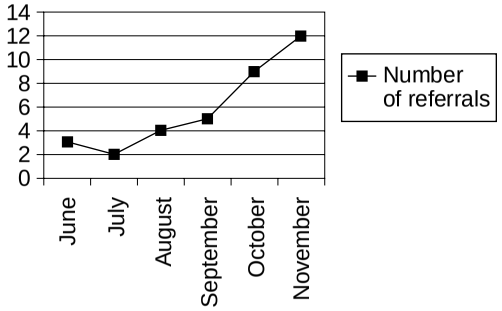

Figure 2 Number of referrals per month

The feedback forms were given out to each doctor in the surgery and were filled in anonymously. The first question asked the doctor to interpret the role of the GMHW. I asked this question to gauge whether or not the doctors had a clear understanding of my role. I was satisfied by their responses that everyone had an accurate appreciation of my role. Each response mentioned key words such as self-help, mild to moderate mental health problems and brief cognitive behavioural therapy. The next question asked whether the doctor had made use of the graduate. All GPs responded positively. The third question was particularly useful to see if there were more doctors making use of the service than others. Each GP was asked to circle the number of referrals they had made so far. The category of between 4 and 8 was circled by all except one who circled 12 or more. On average the GPs are all referring to me at a similar level. The second to last question provided a clear indication of the feelings of the GPs at this time in the practice. It asked whether or not the doctor had found the GMHW useful to have in the practice. All answered 'yes' to this question. Finally I asked if the GPs would find it useful to have a chat with myself about the role. There was a mixed response here, and so I plan to do a presentation on the progress of the clinic to the GPs in January. This will also give them the opportunity to ask questions. Feedback from the GPs indicates that the clinic is valued and is productive and effective.

As part of my auditing work at the surgery I carried out some research into the way in which the GPs treat mental health consultations. The data showed that on average 54% of clients with mental health complaints were treated with antidepressants. The PACT data for September 2004 show that for practice N, money spent on antidepressant prescriptions was £16 732. This is an 11% decrease from September 2003. Therefore, the additional service of the GMHW this year may have been one of the contributing factors leading to a decrease in the cost of antidepressant prescriptions.

A final way to gain an insight into the effectiveness of the clinic is to look at the progress of the clients. A useful way to do this is to examine a case study.

Case study: client PO

Initial presentation

PO, a 27-year-old office worker for a children's service was referred by her GP. At the initial assessment she described symptoms of anxiety, agitation, low self-esteem and issues with control. She was having trouble with her boss at work and often found herself in situations of conflict which upset her. She enjoyed her job but found her relationship with her boss was affecting her ability to do a good job. Although PO had a stable relationship with her partner and social support, she did not use them and more frequently found she was shutting herself off from them. This left her feeling lonely and insecure. PO felt that her feelings of insecurity and low self-esteem had been gradually building up over the past 10 years of a previously emotionally abusive relationship. PO wanted help to become more assertive in situations of conflict and help to raise her self-esteem and reduce her levels of anxiety. Pretreatment measures on the HADS were 10 for anxiety and 5 for depression (cut-offs for clinically significant depression and anxiety are 7).

Formulation

The following formulation was developed with PO in relation to her anxious mood. PO had considerable insight into her situation. She knew that her anxiety was stemming predominantly from her stress at work and her feelings of an inability to cope. Instead of explaining this to her partner, a potential source of support, they would end up arguing and this made her anxiety worse and damaged her self-esteem further. She often talked of how she felt at the beginning of her previous relationship. She spoke of being confident and outgoing and always having friends around her. At that time she was also working as an academic researcher and enjoyed not working with the public or having a boss. PO's previous partner had been very critical and often dismissed her feelings and reinforced a negative view of herself. PO was very busy at work and did not have a lot of time to herself. Her partner, although supportive, was demanding and expected a lot from her. When she came home from work tired and frustrated she would get upset with her partner and storm off in a bad mood instead of telling him how she was feeling. One of PO's core beliefs about herself was that she was a happy and confident person, but this was not how she felt or behaved and this conflict was leading to a state of anxiety.

Goals

PO identified the following goals as priorities: to be more assertive at work and put her own views across instead of meeting all of the demands of others; to improve her communication skills with her partner; to improve her self-esteem and confidence.

Progress and outcome

PO was seen for a total of seven sessions for facilitated self-help over a period of 16 weeks. The following areas were tackled using Chris Williams *Overcoming Anxiety* workbooks:[11,14]

- increasing PO's knowledge of anxiety and how it can affect many areas of life, and developing techniques to manage her anxiety
- monitoring negative thoughts and challenging negative thoughts about her low self-esteem in relation to work and her relationships with her partner
- exploring ways in which she could relax; this included relaxation exercises
- exploring ways she could use her social support network better, by getting in touch with friends again
- exploring ways to improve communication with her partner.

Thought patterns

With the use of Chris Williams' workbooks it was possible to identify where PO's negative thinking patterns lay. In relation to work, PO was not feeling confident enough to be assertive in situations, because she felt that she was not receiving enough praise or acknowledgment for the work she was doing. PO was then losing confidence in her ability, something she had always been sure of in the past. PO then developed a negative bias against herself and became very self-critical. Williams' workbooks helped PO to look at this thought pattern and how it was affecting her relationship with her partner at home. PO felt that her partner saw her as being a very 'together' person who was confident and sure of herself. PO felt very anxious about letting him know how she was feeling in case he though badly of her. PO was arguing with her partner to keep him at a distance. PO's partner had now become detached from her and did not ask her how she was feeling for fear of an argument. This made PO more insecure about herself and the relationship, and so she became very clingy and got upset when he went out without her. Using the workbooks, PO worked to

gain a more realistic expectation of herself and her relationship.

Behavioural experiments

With the help of the workbooks PO successfully devised and carried out behavioural experiments to challenge some assumptions about the consequences of her anxiety. In all cases it was a positive learning experience that she utilised well. For example she prioritised demands made on her at work into important and not important, and only carried out those on her important list. She felt this gave her a great sense of control, and although it created some minor conflict with work colleagues she was able to handle them and in the end gained greater respect for it. After some time PO also then felt confident enough to approach her boss, who reassured her about the level of her work. This gave her a much needed confidence boost. A second behavioural experiment was carried out at home. PO would try going for a walk or to a café on her own for 20 minutes after work each day. This gave her an opportunity to wind down before getting home to her partner. In her more relaxed state she was able to discuss her day with him more effectively, instead of automatically getting into an argument. This worked successfully and then gave PO the confidence to get in touch with her old friends and go out without her partner. This improved her self-esteem and gave her back a sense of independence.

Although PO's relationship with her partner had greatly improved, she requested some couple's counselling to make sure their communications skills remained effective. PO felt ready for this because she had worked through her own issues independently of her relationship. I gave her the phone number for 'Relate' for further treatment.

PO's post-treatment measures on the HADS were anxiety 5 and depression 4 (both below the clinically significant cut-off level of 7).

Discussion

This paper clearly describes the progress made by a GMHW through the stages of setting up a one-to-one self-help clinic in a primary care practice. It is important to emphasise that each GMHW will have a different experience in their own primary care setting. The stages described here do not exemplify a generic route that all GMHWs will go down, but instead provides a unique snapshot into one experience.

The paper supports the findings made by Lucock *et al* that GMHWs that have no previous therapeutic training, can, with the appropriate levels of support from the practice and supervision, carry out evidence-based therapeutic interventions.[15] This paper highlights the importance of the collaborative efforts in developing a self-help clinic. The primary care team, the doctors, nurses, secretaries and practice manager all had to liaise effectively for the clinic to operate effectively within a safe framework with clear boundaries.

The importance of collaborating effectively with the practice is illustrated in the paper. If the referral criteria and the mode of referral are not made clear to the referring health professionals then it will result in a lack of referrals or inappropriate referrals.

Collaboration with a clinical supervisor is equally important for creating a safe framework. As this is a training year there is still a lot to learn. As a GMHW in the first year of training, the setting up of the self-help clinic has been met with a number of challenges that are unique to the fact that the role is a new one. A large part of the success the clinic has is due to effective education. This refers not only to the health professionals in the practice, but also to the clients. Clients my feel intimidated by the title GMHW as it is an unfamiliar one and so comes with no prior expectations or standing. This is why it is important to involve the client in developing all stages of the treatment to make them feel secure and confident during the sessions.

This paper has detailed the main stages involved in the setting up of the self-help clinic, and highlights the critical importance of clear communication, shared, common understanding of roles and effective collaborative strategies. The progress indicators suggest that the clinic is running effectively. An important factor in the success of the clinic is also related to the feedback and ideas from other GMHWs. I have been collaborating with the GMHWs throughout the year and have presented this paper to them. It is useful to share ideas and experiences.

It is important to emphasise that while the self-help clinic is a very important role of the GMHW, it only covers one area of the job. While running the clinic the GMHW is also running therapeutic groups, carrying out audits in the surgery and is involved in mental health promotional work e.g. in schools and community centres.

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CONFLICTS OF INTEREST

None.

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