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Primary Care Graduate Mental Health Workers: an evaluation of the contribution of a cohort of graduate workers in their first year

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This paper reports on the contribution made by the first cohort of Primary Care Graduate Mental Health Workers (PCGMHW) employed in the Southwest of England. The PCGMHW is one of the new roles envisaged as part of the NHS plan. Aimed at enabling quick access to a range of time-limited therapies, while at the same time engaging in public health strategies to promote mental health in communities, the PCGMHW is at the cutting edge of modernizing primary care mental health. This study demonstrated that PCGMHWs trained in time-limited therapy approaches such as facilitated self-help moved quickly into situations were they were treating people with mild to moderate mental health problems, with evidence of clinical effectiveness. However, the community development aspect of the role was slower to develop, possibly as a reflection of the preference for one to one work in mental health or, alternatively, as an indication of the nebulous nature of public health work. The study identifies a number of key areas for consideration. First is the role of the PCGMHW in signposting people to services or resources. Second, the role of referral protocols in developing service models that profit from the presence of PCGMHWs. Third, the need to develop the role in relation to public health, stigma and social exclusion. However, to achieve this greater clarity over the role is required in Primary Care Trusts and urgent consideration of continuing professional development needs of PCGMHWs.

Key words: community development; facilitated self help; mental health; mild to moderate mental health problems; new roles; primary care

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Introduction and background

> Most mental health problems are managed in primary care. One in four GP consultations are with people with mental health problems. So improving these services will have a major impact on the health and well-being of the population.
>
> (The NHS Plan 2000, para. 14:29)

This paper provides a summary and evaluation of the contribution to primary care mental health made by the first cohort of the new Primary Care Graduate Mental Health Workers (PCGMHWs) based in the Southwest of England. In addition, it makes a number of observations and suggestions that could contribute to the development of the role. The Mental Health NSF (Department of Health, 1999) identified Primary Care as a major site for the management of mental health problems promoting strategies for mental health promotion and community development approaches to building healthier communities, alongside a proposition to increase access to time-limited therapies as an alternative or complement for medication

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based approaches (Nixon and Saunders, 2001). Although some general practitioner (GP) practices employed counsellors, the traditional approach preserved a reliance on secondary mental health services, providing two obstacles to development. First, a boundary between primary care and secondary mental health services privileges diagnostic hierarchies that subordinate mild to moderate mental health needs. Second, it obstructs the development of a specific model of primary care mental health with its own *modus operandi*, operating differently to traditional mental health services with flexibility, rapid contact, non-stigmatizing interventions and self-referral. To support the development of primary care mental health proposals focused on a new role, the PCGMHW. In parallel, workforce challenges facing the NHS, encouraged initiatives to encourage new blood into health work (Department of Health, 2002a; 2002b).

The Mental Health National Service Framework (Department of Health, 1999) and the NHS Plan (Department of Health, 2000) identified the establishment of 1000 New Graduate Mental Health Workers across the country by 2004. Following pilot studies in the North of England (Crosland *et al.*, 2003; Bower *et al.*, 2004; Lucock and Frost, 2004); the Department of Health, decided to roll out PCGMHWs across the rest of England in late 2003/2004 by identifying a number of partnerships between Primary Care Trusts (PCTs) and universities. PCGMHWs were to be PCT employees with day release to undertake a part-time postgraduate training designed to support the development of the role. Supported by best practice guidance *Fast-Forwarding Primary Care Mental Health: Graduate Primary Care Mental Health Workers* (Department of Health, 2003), each PCT was to have 2 to 3 PCGMHWs based on its index of deprivation and monies were allocated in baseline budgets to cover the costs involved.

The PCGMHWs are to provide a fresh new approach to supporting people with mental health problems in primary care (Bower *et al.*, 2001; Bower, 2002; Crosland *et al.*, 2002; Department of Health, 2003). Already graduates in a human science discipline, the employment of PCGMHWs in PCTs aimed to establish the role as part of the primary care team, undertaking a range of mental health activity, reinforced by the acquisition of a postgraduate qualification in primary care mental health. The pilot projects identified three components to the role: direct client work, practice teamwork and wider networking skills with an emphasis on flexibility and local service needs (Department of Health, 2001; 2003; Lucock and Frost, 2004). The Southwest, established the PCGMHW role as part of the rollout, not as a pilot. Preparation consisted of mental health assessment, facilitated self-help (FSH) and Brief Solution Focussed Therapy (BSFT) approaches to the management of mild to moderate mental health problems: supplemented by project work focussed on community development, public health, health promotion and social inclusion (Kupshik and Fisher, 1999; Lawler and Hopker, 2001; Cameron *et al.*, 2003; Department of Health, 2004a; NIMHE, 2004; ODPM, 2004).

In contrast with the three components identified by the pilots the Southwest programme identified four: individual client work, health promotion, community liaison activity, and audit. More than a mere reconfiguration of the activities described in the pilot studies this reflected the different perspectives of the stakeholder PCTs. Nine PCTs employed thirteen PCGMHW with one PCT employing five and the others one each. Each PCT had a different take on the role and was at a different point in its development of primary care mental health services. However, commonalities did emerge in the experiences of the PCGMHWs, which also resonate with issues raised from the pilot studies, and the experiences of first year of the rollout as shared in national forums attended by providers and trainees. During the early part of the evaluation, we added a fifth component to the PCGMHW role: the promotion the PCGMHW.

The study

This is an account of the experiences of the first cohort of trainees in the Southwest PCGMHW programme based on an evaluation of the impact of the role and the programme in the first year. As part of the programme, trainees maintained records of their activities. With client-based work, this indicated the type, duration and frequency of contacts. At the same time, trainees employed a clinical effectiveness tool as a means of evaluating interventions. The interviews did not require trainees to refer directly to their records to answer questions. However, our knowledge of the record meant that trainee's responses to questions proportioning

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time, identifying type, etc. would provide reasonably accurate information. Moreover, we were interested in the subtleties and nuances that might distinguish the role as experienced from its objectified performance, particularly as these trainees were the first in the southwest and some way from the centres where the role was developed.

Data gathering began early in 2005 after the first cohort had received their results from the postgraduate certificate. Initially produced as an evaluation report to the stakeholder group* supporting the development of the role in the Southwest we felt the material provided rich insights into the role of the PCGMHW in an area outside the North of England and the pilot sites. It also echoed a range of issues already noted about sustaining the role, for example PCTs clarifying their mental health function, establishing the PCGMHW role in primary care and carer progression (Crosland *et al.*, 2003). In addition, we believe that it will also provide new insights. The adoption of a qualitative approach aimed to capture subtleties in the organization of the role across the different PCTs. At the same time due to the type of questions asked, it has been possible to use quantitative summaries such as percentages, averages and activity ranges to provide baseline information. Quantification also enabled us to get a feel of what the trainees felt they spent their time doing. While not typical of qualitative approaches neither is it inappropriate (Mason, 1997; Silverman, 2001). In addition, we chose not to audiotape interviews preferring field notes to record key issues, comments, etc. (Mason, 1997).

Aim

The aim of the study was fourfold:

1) To explore the experiences and identify the range of activities undertaken by the trainees during their first year in post.
2) To compare the cohort experience with the PCGMHW role as set out in policy guidance material.
3) To use the data to evaluate how well the programme equipped people for the PCGMHW role as set out in individual PCTs.
4) To identify issues of good practice and recommendations for dissemination to other areas looking to establish this role or similar roles.

Design

The study was based on semi-structured interviews undertaken with all the trainees on the programme n = 13. The interviews took between 1½ and 2 hours conducted in line with an interview guide produced and agreed between the authors prior to the interview (Appendix 1). This guide covered the four key areas of the PCGMHW role discussed earlier. Also included were questions about role development, relationships with other professionals and role identity as issues emerging from discussions in the course of the programme's first year.

Participants

The participants were the 13 trainees who had commenced the programme in January 2004. The cohort consisted of 11 female and 2 male trainees. There had been no attrition from the cohort. All were graduates with the main disciplinary background being psychology. Most of the trainees had postgraduate experience working in health or community development related activity. However, at least one trainee did not fit this general profile but had been selected due to personal qualities and life experiences. Trainees were employed across the Southwest, one PCT had five PCGMHWs while the other eight PCGMHW worked in single PCTs.

Data collection

The interviews took place in the early months of 2005 after completion of the university programme. Interviews with individual trainees took place in the company of both authors. One author (GR) managed the interview process while the other (TG) took notes of trainee's responses and interjected with questions of clarification. As noted earlier we chose not to audiotape. Two reasons for this, first we were not looking to provide a thematic analysis of trainees' accounts. Second, recording and transcribing is a lengthy and costly process. Our approach while initially labour intensive was much less costly and immediate and the notes were available the moment the interview concluded.

*The Stakeholder group comprised of National Institute for Mental Health England: Southwest regional Office [NIMHE SW], Local Implementation Leads, representatives from PCTs and representatives of the Universities of Plymouth and Exeter.

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Rigour

The presence of both authors at each interview was a departure from normal interview practice and might be oppressive. However, because trainees had been discussing issues related to the development of the role with members of the programme team over the past year a level of trust was established. All trainees agreed to participate despite the fact that many had to travel distances. The other advantage the approach offered was that the authors were able to contemporise their understanding of the discussion that had taken place. A report collating the findings of the evaluation circulated to trainees invited feedback and comment prior to final submission.

Ethical issues

The study applied the normal conventions in respect to confidentiality and the individual comments rendered anonymous. All the trainees participated in the study after completion of the programme. Participation was optional and trainees informed that the purpose of the data collection in that it would provide a report for the stakeholder group and for publication in academic/professional journals.

Data analysis

Data analysis took two forms. Trainees provided estimates of the proportion of time they on average spent on undertaking a range of activities. Data treated quantitatively and summed for the total group with mean, percentage and range as appropriate. The broader discussion was analysed qualitatively focusing on content to identify similarities and differences among trainees while also recording their impressions of good practice, barriers and enablers to the role, role identity and continuing professional development (CPD).

Findings and discussion

This section focuses on the way the role evolved for the trainees exploring issues such as the type of activities they engaged in, the relative amounts of time spent in one activity in comparison with another, case-load characteristics and size, the effectiveness of supervision and issues for CPD. The discussion follows the format provided by the interview guide.

Graduate mental health worker roles

All trainees confirmed that they had engaged in the four key roles envisaged for the PCGMHW: time-limited therapy, health promotion, community liaison and development work, and audit/information management. However, it was clear that the greatest proportion of time spent was on time-limited therapy with nine trainees stating that they spent in excess 50% of time and two 80% of their time in this activity. Only three trainees reported spending less (40%). The high level of involvement in time-limited therapy may be due to the programme structure, which provided early exposure to training in this intervention. Nevertheless, in line with the other reports of the role PCGMHWs tended to engage in low-intensity interventions such as FSH, which provide a framework for evidence-based interventions appropriate for primary care while avoiding questions of professional competence (Lucock and Frost, 2004). The majority of trainees highlighted the importance of 'signposting' people to other services as a key outcome of client work.

> Some clients come once, some do not come again – signposted to other services or the issue has resolved.
>
> (Trainee 2)

> Community liaison activity involves signposting … pointing people to services like Routeways, MIND.
>
> (Trainee 5)

> I have seen about 30 clients, about half fall 50:50 FSH and BSFT. The other half are signposted or I am holding a client waiting for another intervention.
>
> (Trainee 7)

The dominance of one to one client work over other elements of the role such as health promotion work and community development activity may be due to the more nebulous nature of these activities. Nevertheless, while time-limited therapy was the major activity, most trainees spent a considerable amount of their time engaged in a wide range of health promotion, community development and audit activities. Health promotion activities took an average 18% of time with trainees reporting involvement in: mental health awareness promotions and training, stress control groups,

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compiling mental health directories and engagement with community activities, for example 'walkabout' – a scheme to encourage people with depression to engage in physical exercise. Community liaison and development work accounted for an average 12% of time. However, the interviews revealed a blurring of this type of activity with health promotion work. New health projects inevitably involve liaison with various community agencies. Community liaison and development work undertaken included involvement with Sure Start projects, developing services around suicide prevention, liaising with and promoting the PCGMHW role with voluntary agencies and societies.

Trainees revealed audit activities to be the least popular. Involvement included reviews of mental health registers, clinical audit of Clinical Outcomes Routine Evaluation (CORE) data and setting up a database and CORE data reference for self-harm at Accident and Emergency Departments. However, two trainees described how involvement with audits linked to the mental health registers provided an important route through which the PCGMHW established their involvement with particular GP practices.

> Audit makes you feel like a spy.
>
> (Trainee 1)

> Establishing the mental health register opened the door … it got me talking to GPs, to reception staff … getting the practice manager onside was a real plus.
>
> (Trainee 5)

FSH and BSFT

The programme prepares trainees in the use of two types of time-limited therapies: FSH and BSFT. The intention was that the trainees would find these two modes of therapy complementary. However, trainees' declared a clear preference for FSH over BSFT. They described the approach as flexible, easy to use and generally well accepted by clients. Three trainees reported not using BSFT at any time, while one trainee used BSFT 80% of the time. Reasons for the difference revealed a complex pattern of use. Some trainees felt that BSFT was more complex and they needed ongoing support to gain confidence in its use. However, a number reported using BSFT to support therapy goals, in particular the 'miracle question' as an adjunct to FSH.

> Used self-help CBT … it's better … I had some grounding from my degree. BSFT more vague … doesn't flow as well as FSH.
>
> (Trainee 10)

> I have used FSH the most … I use this first and then BSFT if it doesn't work. Although I haven't used BSFT in its pure sense … I like to bring in aspects rather than the pure model.
>
> (Trainee 12)

> Used FSH as this was the first technique taught … BSFT tends to be a bit more complex … I have made use of the miracle question though.
>
> (Trainee 13)

This was interesting as it demonstrated that even after only a comparatively short time trainees were becoming eclectic in their approach. 'Eclecticism' came up throughout the interviews and was indicative of the way the trainees as a unique group were sharing ideas and practices with each other and taking these into their own work.

Client and case-load characteristics

Client and case-load characteristics provided an interesting picture of the people PCGMHWs' were meeting. PCGMHWs undertook the majority of their client work in GP practices/health centres, typically working in two facilities with the bulk of referrals taken directly from GPs. Exceptions involved referrals routed via the primary care mental health team or a primary care therapist. In one case, the PCGMHW discussed conducting joint referrals with a Community Psychiatric Nurse (CPN). Trainees described the majority of referrals as coming from primary care. Although circumstances arose where referrals for clients with longer term and more serious conditions such as chronic depression, came to the PCGMHW for FSH, these were likely to come from practice counsellors and CPNs.

Referral patterns for clients varied considerably from trainee to trainee making it difficult to identify any consistent pattern. Even within the same PCT with trainees working in similar inner city deprived areas, different patterns emerged. One trainee discussed wanting to do more health promotion activity

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while another described levels of chronicity and multiple deprivation.

> The problems are different in the inner city due to chronicity, … clients are not motivated. Once their benefits are in place there can be a lack of motivation … Its disappointing not to see the spread of people who will respond to FSH or BSFT approaches.
>
> (Trainee 5)

On balance, trainees reported referrals consisted of more women than men with an average age between 30 and 50 years. Only a small number of referrals were for clients under 20 or over 64 years, begging the question of what happens when these people visit their GPs with mild to moderate mental health problems. The most common reason for referral was anxiety, often with underlying social phobia and panic. Although most of the trainees reported having seen clients with depression, this had tended to occur when depression co-presented with anxiety. One trainee reported taking referrals for clients with stress, drug, alcohol and abuse issues and one trainee, who had been working with refugees, reported clients presenting with issues relating to bullying and harassment, stress and various social issues influencing their well-being. Remarkably, no trainee reported being engaged directly in work that supported medication management.

A feature of the programme is that PCGMHWs take referrals from GPs and other agencies, and then assess for suitability for time-limited therapy, although, in some PCTs clients continued to be pre-screened by a mental health professional. Direct assessment by the PCGMHWs is a departure from the process reported by Crosland *et al.* (2003) where screening occurred but in line with the process described by Lucock *et al.* (2004) where, once competent, PCGMHWs screened clients.

Trainees estimated 10% of referrals as inappropriate and a pattern of inappropriate referral emerged from the interviews including: life-event/relationship problems more appropriate for counselling services; and a small number of clients considered too depressed to benefit from time-limited therapy. There was also a sense that GPs referred a small number of clients to PCGMHWs for 'holding', pending onward referral to secondary mental health services. Referrals taken from a mental health team or primary care therapist were least likely to be inappropriate. During the programme, several trainees developed referral protocols for GPs and other health professionals, which appear to have worked well. In addition, inappropriate referral due to risk to self or others was not a significant issue.

Case-load size and contacts

The average case-load size at any one point was 14 clients. However, there was considerable variation around this figure with one trainee reporting a case-load of 40 and two reporting a typical case-load of six clients. The mean number of reported treatment contacts per client was five with variation typically a session either side, in line with the ethos of FSH. Two trainees reported significantly longer contact, between 10 and 12 sessions. One trainee ascribed this to the characteristics of the client population who came from an area of marked social deprivation with concomitant levels of chronic ill health. However, another trainee working in a similar area had discharged clients after just 4 to 5 sessions.

Group work

As well as preparing PCGMHW trainees to do individual client work, FSH and BSFT techniques are appropriate to facilitate group therapy. On average about 12% of the trainees' time was devoted to group therapy activities. However, this showed a marked variation with five trainees spending between 0 and 2 hours per week. Scrutiny revealed that much of the PCGMHW involvement was at the level of observer. Only one trainee successfully engaged in group work as a substantive activity with full involvement in planning and running groups. In this instance, the main activities had centred on co-running a postnatal depression group and psycho-educational group for stress, much along the lines of that pioneered by Jim White (1995; 1998).

Effectiveness of clinical supervision

PCGMHWs had received supervision from a range of health professionals, which included health visitors, clinical psychologists, mental health team managers and primary care mental health therapists.

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There was no evidence that the supervisor's professional background had any significant bearing on individual trainee's satisfaction with the process of supervision. Feedback on the effectiveness of personal supervision showed a high degree of satisfaction. Most trainees felt well supported in all aspects of personal and clinical supervision. However, some trainees felt it necessary to seek clinical supervision from a further source for FSH and BSFT where the main supervisor was unfamiliar with the approach. Trainees were also quick to acknowledge that their supervisors had been very busy and had often exceeded reasonable expectations.

> My supervisor was a health visitor, which was good for wider issues but not for clinical supervision … I arranged my own clinical supervision with a clinical psychologist … I wanted to talk about specific techniques….
>
> (Trainee 4)

> I had a good relationship with my supervisor … they showed other ways of doing things. They gave time but it was outside their role.
>
> (Trainee 8)

Personal effectiveness

The trainees were asked to rate their personal effectiveness in relation to the four key areas of work. However, it became clear during the interviews that therapy work provided the focus for trainees' assessment of their effectiveness. Circumstances where trainees established good working relationships with colleagues who held genuine beliefs over the efficacy of time-limited therapy reinforced the impression of effectiveness.

> Definitely feels like I am progressing … there is good feedback from the surgery that it's all coming along well.
>
> (Trainee 10)

> I have a good relationship with the counsellors … I have met with the other counsellors who are very supportive of the role. We meet and make the most appropriate … patients referred from the counsellors tend to be motivated and turn up.
>
> (Trainee 12)

When asked how they assessed clinical effectiveness most trainees had routinely used tools such as the Hospital Anxiety and Depression Scale (HADS) or CORE pre- and post-treatment and that scores typically showed a diminution in stress, anxiety and depression over the course of a session. Some trainees preferred a given scale based on (perceived) clinical sensitivity. In other instances, the trainees employed assessment tool scales adopted by their supervisor or mental health team. The weight attached to a scale by GPs was an important consideration for some trainees.

> HAD is better than CORE which misses a lot … its not sensitive enough to pick up differences between anxiety and stress.
>
> (Trainee 7)

> Usefulness of the HAD scale? Quite useful … GPs respect the scale and … certain questions are a good guide to severity.
>
> (Trainee 8)

A couple of trainees suggested that none of the scales were sensitive or broad enough to measure change across a range of mild to moderate mental health problems as presented in primary care. In addition, their work in sessions included 'hidden work', such as signposting and support, which needed accounting for when evaluating PCGMHW role effectiveness. Other trainees suggested that clinical effectiveness might lie more with the attitude and communication skills of the PCGMHW rather than the chosen mode of intervention, that is FSH or BSFT, mirroring the debate over the quality of the evidence underpinning the popularity of cognitive behavioural therapy (CBT) approaches (Ward *et al.*, 2000; Bolsover, 2002; Holmes, 2002).

Continual professional development

Trainees referred to a range of training needs, though the only consensus was further training in CBT and BSFT in particular. One trainee suggested that training in child protection and domestic violence was essential, otherwise areas for further training included counselling skills, phobias, eating disorders, grief and bereavement work, and family therapy. Several trainees suggested that they would be interested in mentoring and eventually supervising PCGMHW trainees. One interesting paradox that emerged from this section was that further training in CBT could take the PCGMHW away from the Primary Care ethos of their role, that is time-limited approaches, easy access, and short waiting times.

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Relationships with other health professionals

Trainees were asked how well briefed others had been about the PCGMHW initiative and how well received they had been by colleagues. Responses to these questions varied quite markedly. In general, it was evident that health professionals were ill prepared for the PCGMHW initiative. Trainees reported having to work hard to promote the role and to build effective working relationships with colleagues. Perceived deficits in general preparation for the role were reflected in trainees' comments, when asked to estimate how well other professionals were briefed about the role at the start of the programme and then towards the end of the training year. This indicated a significant and positive shift as time progressed from 19% to 67%. However, it was also clear that the trainees had done much to create the PCGMHW role.

> The team wasn't prepared … it didn't see the need for the graduate worker … created the role by meeting with the manager each week telling them what was going on and keeping in contact with the team.
>
> (Trainee 3)

> Following a critical incident [suicide] worked with the steering group to develop a key worker approach … plus support … up to and after the inquest … for relatives. Identified and helped to meet targets.
>
> (Trainee 7)

No one professional group can be singled out as having a particularly positive or negative attitude towards PCGMHW trainees during the early phases of the programme; some GPs, CPNs and Health Visitors were highly positive whereas others were apathetic. No trainee reported meeting with outright hostility.

The only recurrent theme was of initial scepticism and anxiety about the direct referral and PCGMHW assessment. This latter issue remained in some cases with a small number of trainees continuing to receive referrals through some form of client 'filtering' system (eg, the referrer was a primary care therapist or mental health team).

Sense of identity as a graduate mental health worker

The final area in the interview focussed on whether trainees had a clear sense of identity as they neared the end of their training year. Role and identity confusion is associated with low self-efficacy and occupational stress while a clear sense of identity would also suggest that the programme had been successful in facilitating the core skills required to work as an effective PCGMHW. Ten of the thirteen trainees reported having a clear sense of identity, though there were some caveats. Some trainees felt that they had a clear sense of identity and purpose but other health professional may not share this view. A smaller number of trainees spoke about a clear sense of identity regarding 1:1 therapy work but this became blurred within community liaison and development work. Indeed, one trainee commented that they were primarily viewed by others as 'therapists' and were not regarded as community workers.

In three cases, trainees stated that they did not have a clear sense of identity. One PCGMHW suggested that the multifaceted nature of the role influenced other health professionals and hindered the trainee from forming a clear sense of role identity. In the remaining two cases, two factors emerge, the disparate nature of the work and role de-synchrony. The latter arose from the trainee's belief that the skills they possessed did not provide an adequate match for the clients' chronic health needs.

Summary and recommendations

The findings indicate the dominant role undertaken by the PCGMHW in the Southwest was in individual therapy, although this was limited in the main to FSH. Thus providing an intervention role that places PCGMHWs outside of conflicts with other professionals (Lucock *et al.*, 2004) while also providing a clinical role and a degree of autonomy. It was interesting to find BSFT was not as attractive due to its perceived complexity with most trainees looking for higher levels of supervision if they were to engage in this activity. However, there is evidence to suggest that FSH is an appropriate intervention in primary care (Lucock *et al.*, 2004) and the opportunity this contact provides for signposting could provide invaluable. The importance of signposting is an aspect of the PCGMHW role that has not received the prominence it might in previous literature.

Related to 1:1 work is the issue of referral, an area where PCGMHWs provided a good deal of reflection and demonstrated initiative in the development of referral protocols. These enabled

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PCGMHWs to set out criteria for referral to the extent that inappropriate referrals were surprisingly low given that this was a new worker offering a new service. Moreover, there were no untoward issues arising out of direct referral, for example frustration from GPs referring people who were then rejected as inappropriate or instances of high-risk clients being referred. Developing clear referral protocols is good practice and a key recommendation. Referral criteria could also help to expand the role of PCGMHWs in areas of low activity. This study identifies low rates of referral for people at the extremes of the adult age range and for depression. However, the reasons for this are unclear and need further investigation.

The relative underdevelopment of the community development aspect of the role was a little surprising especially as five of the PCGMHWs had been employed in areas where this had been the primary motivation in establishing the PCGMHW posts. Possibly this reflects the dominance of 1:1 therapy as the primary mode of intervention in mental health discourse in contrast with the more nebulous activities of health promotion and community development. Whatever, it highlights the need to consider more closely further work in areas of public health such as stigma and social exclusion and the co-morbidity of mental and physical health.

What is clear from this evaluation was that a 1:1 approach via FSH provided an anchor point through which the PCGMHWs were able to establish their identity in relation to other health care workers, an issue of key importance taking the ambivalence of some organizations to the role especially in its early stages. The other activity that proved significant to the PCGMHW gaining access in primary care was involvement with the development of GP registers. Despite being an audit type activity and in contrast with the general unpopularity of audit with PCGMHWs, this provided an effective way for some PCGMHWs to demonstrate their contribution by enabling practices to meet targets.

As found in the pilot projects continuing role ambiguity is likely to blight the development of PCGMHWs: a situation compounded by the apparent invisibility of PCGMHWs in *Agenda for Change* (the newly introduced NHS pay structure). As an essential first step and key to good practice, we recommend that individual PCTs clarify the role they expect their PCGMHW to undertake. It was evident from the study that where PCTs had a clear idea of where the PCGMHW fitted in primary care teams and their remit, the role became established more quickly.

Finally, there was no consensus on further training needs for the PCGMHWs post-qualification, though most trainees indicated that they would pursue further training in CBT. A key consideration has to be whether it is desirable to retain the PCGMHWs focus on clients with mild to moderate mental health problems. Do they specialize in a wider range of time-limited interventions for individuals and groups, and community development approaches? Alternatively, it may be preferable that they gravitate towards more complex mental health problems as they gain in expertise. The publication of the Public Health white paper *Choosing Health* (Department of Health, 2004b) brings this issue into sharper focus and it is recommended that urgent consideration is given to the future roles and development needs of PCGMHW.

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Appendix 1: 2004 cohort – Graduate mental health worker trainee evaluation – January 2005

Method

Flexible, semi-structured interview. Two hours allocated to each interview. Each trainee interviewed separately. Written notes taken by co-interviewer. Thirteen trainees interviewed (100% of the 2004 cohort).

Interview schedule

PCGMHW roles

When planning your programme it was envisaged that you would adopt four key roles:

1. Time-limited therapy work.
2. Health promotion work.
3. Community liaison and development work.
4. Audit and information management.

To what extent have these expectations been mirrored in reality?

In percentage terms mow might these roles be represented out of a total of 100%?

Time-limited therapy

Your programme has trained you to use two forms of time-limited therapy: FSH cognitive self-help and BSFT.

Have you found yourself using one form of therapy more than the other and if so please describe why?

In percentage terms how much time would you estimate you spent on FSH and BSFT during a typical week?

Client and case-load characteristics

- We are interested in learning more about the typical characteristics of the clients and case-loads that you have handled:
- Location (eg, GP surgery, community centre).
- Typical clients (eg, age, gender, primary or secondary care).
- Typical presenting issues.
- Typical case-load size.
- Typical number of contacts per session.
- Typical mode of referral (eg, direct from GP or indirect via mental health team).
- In percentage terms, what proportion of referrals have been inappropriate.

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- Where referrals have been inappropriate please explain why?

Group work

Please describe any engagement in group work (eg, nature of the clients, issues, whether running the group as leader, co-leader or observing)?

In percentage terms, how much time during a typical working week has been given over to group work?

What has been the typical mode of referral for clients taking parts in groups?

Preparation for therapy work

Please estimate how effective the programme has been in preparing you for therapy work, using 100% as an indicator of effectiveness?

Please describe what elements of the programme have been most effective?

Please outline ways in which the programme might be changed to better prepare trainees for therapy work?

How effective was supervision in preparing and supporting you in therapy work, using 100% as an indicator of effectiveness?

Please outline other ways in which the programme might be changed to better prepare trainees for clinical work?

Clinical effectiveness

How effective do you think you have been in a therapy role, using 100% as an indicator of effectiveness?

What indicators of clinical effectiveness have you used to assess your clinical effectiveness (eg, CORE, HADS, other)?

Further training

What further elements of training might enhance your clinical effectiveness once you qualify?

Are there elements of further training for therapy work that you would consider essential post-qualification?

Health promotion work

Please describe the types of health promotion activity that you have been engaged in during the year?

In percentage terms how much time would you estimate you spend on health promotion activities in a typical week?

At whom was the health promotion activity targeted (eg, did the work involve clients from primary or secondary care services)?

Community liaison and development work

Please describe the types of community liaison and development activities that you have been engaged in during the year?

In percentage terms how much time would you estimate you spend on community liaison and development activities in a typical week?

Clinical audit and information management work

Please describe the types of audit and information management activities that you have been engaged in during the year?

In percentage terms how much time would you estimate you spend on audit and information management activities in a typical week?

Role development work

Please describe the types of role development activities that you have been engaged in during the year?

In percentage terms how much time would you estimate you spend on audit and information management activities in a typical week, during the early stages of the programme?

In percentage terms how much time would you estimate you spend on audit and information management activities in a typical week, during the latter stages of the programme?

Relationships with other health professionals

We are interested in learning more about your relationship with other health professionals:

How well received were you by colleagues, such as GP's and CPN's?

What sort of issues have you encountered when working with other professionals groups?

How well briefed were others about your role when you started training, using 100% as an indicator of well briefed?

How well briefed are others about your role as you near completion of your training, using 100% as an indicator of well briefed?

Sense of identity

Do you have a clear sense of identity as a PCGMHW as you near the end of your programme?

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