Primary care mental health workers

Bridging the gap

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on a new role for psychologists.

IMAGINE the scene. It's 10am; an overworked GP has already seen 15 patients walk through his door. His next patient is John, who sits down and begins to describe feeling low in mood, tearful and losing his appetite over the last month. He also talks about the loss of his wife six months ago. The doctor listens empathetically, exchanges a few words and ten minutes later John walks out of his room with a prescription for a course of antidepressants and is asked to come back in two weeks for a review.

How do you think John is left feeling? Glad that his problem has been recognised and that he has been offered treatment? Or maybe slightly frustrated because he didn't think he had a chance to talk about his feelings, and would like to have been offered something other than pills?

Up to one in four patients attending their GP for any reason will have a mental health problem (Department of Health, 2001), but the quality of care for those diagnosed successfully is variable. This is largely due to time and workload constraints in primary care and limited mental health training. At present if a GP sees a patient with depression, they have few options, and they often settle for a course of antidepressants. If the patient appears to have more complex problems or is more severely depressed and at risk of self-harm, they may also be referred to the local secondary mental health teams for a full assessment. However, referrals to secondary mental health teams may at times be inappropriate (e.g. because some less complex needs, such as stress management, may be better met in the voluntary sector). Furthermore, there is still an element of stigma attached to mental health services. These issues may lead to high 'Did Not Attend' rates, which are 30 per cent nationally (Gournay & Booking, 1995) – this is not only a waste of resources but may also suggest a high level of patient dissatisfaction.

The NHS Plan (Department of Health, 2000) highlighted the need for extra input into primary care mental health services, and heralded the recruitment of 1000 new primary care mental health workers by 2004, most of whom are likely to be psychology graduates. The structure of these roles may vary across trusts, but the new workers will primarily be helping GPs manage and treat patients between 16 and 65 with common mental health problems, such as depression and anxiety.

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The University of Birmingham and the Heart of Birmingham Primary Care Trust have collaborated to evaluate the effectiveness of this new service by initially employing five psychology graduates in this role. We are two of these workers based in inner-city GP practices within Birmingham where there is high prevalence of social and mental health problems (Outline Business Case, 2002).

Imagine once again that John is presenting with symptoms of depression, but this time he is a patient at one of the practices we are placed in. The GP in this case may still prescribe medication but then also mentions that there is a mental health worker within the surgery, who may be able to offer John other resources for support. With John's consent he is then referred to us with some suggestions for the type of intervention required.

John may be apprehensive when he first comes to see us, so we begin the consultation by explaining that we are not counsellors or therapists but can give him the time and space to talk through his problems. We can then offer him details of local resources as well as self-help material. We also emphasise that we are bound by the same confidentiality policy as the practice.

In John's case it appeared that his depression was a grief reaction to his wife's sudden death. He felt that he was a burden to his friends and family and that no one could understand what he was going through. After John concurred with us that he would benefit from receiving counselling for his bereavement, we then gave him details of CRUSE, a national organisation who offer bereavement counselling. Because we have visited the counselling service ourselves we can also give him more details of how to contact them, where they are based and what to expect. In this case we are able to provide a service within one consultation, asking John to come back if the service is not appropriate and he wants to discuss other options. However, if we do not have the resources readily available or the patient requires more input we are able to see them for up to three sessions, depending upon the situation.

Although depression is by far the most common diagnosis presented to us, there is a variety of mental health problems we can deal with – for example stress, anxiety and sleeping problems – some of which may be clinical in their aetiology or may be triggered by underlying social problems, such as domestic violence, financial worries and work. In our experience so far, many people presenting to the GP with common mental health problems have benefited from having a listening ear and

WEBLINKS

Fast-forwarding primary care mental health:
www.doh.gov.uk/mentalhealth/fastforward.htm

University of Birmingham Health Inequalities Research Team:
medweb5.bham.ac.uk/pcgp/stories/storyReader$58

guidance in accessing local resources and self-help material. The advantages for the patient are to be seen within a few days of seeing the GP in the familiar surroundings of their own surgery. We also have the added luxury of time, as we can see patients for up to an hour.

We understand that the employment of graduates within this position has aroused a great deal of scepticism among psychologists and other mental health professionals, largely due to the perceived amount of responsibility and unsupervised client contact. We are, however, fully aware of our own limitations. At present our intervention is brief, as we do not provide any form of therapy or counselling. Our conversations with patients are limited to allowing them to talk freely about their problems so that we can give appropriate information about other agencies that can provide help.

Patients with psychotic disorders, opiate addiction or suicidal risk are not referred and the GP has full clinical responsibility. All our consultations are documented and we feed back any concerns to the referring clinician. We also receive weekly supervision with a clinical psychologist and monthly group supervision with a consultant psychiatrist, giving us the opportunity to discuss cases and reflect on our own personal development. In addition to this we receive ongoing training in various mental health issues and social problems.

Although we are not based in the traditional setting of a psychology department, the role may appeal to psychology graduates because of the high level of patient contact. However, working with patients is only one aspect of our role – we are also involved in liaison with local voluntary and secondary services, performing practice-based mental health audits and mental health promotion.

As the role has progressed we have received a great deal of positive feedback from GPs and service users in our practices. There is of course room for improvement, and there have been teething problems typical of any new service. But we feel that the role is extremely valuable and will continue to strengthen and develop the infrastructure of primary care mental health. We therefore feel that as long as we are well supported and supervised within our roles, and have the enthusiasm of helping people improve their psychological well-being, we clearly have something to offer.

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