

Self-help for common mental health problems: evaluating service provision in an urban primary care setting

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Common mental health problems are highly prevalent in primary care, the UK National Service Framework for mental health demanding that effective and accessible services be made available. Although built upon a strong evidence base, traditional psychological therapies are often limited in terms of their applicability and availability. As a consequence innovative self-help programmes are increasingly being advocated as an alternative means of managing mental health illness within primary care. This study reports the results of a three month evaluation of a self-help service provided by a busy UK urban Primary Care Trust. Levels of utilization, effectiveness and stakeholder acceptability were examined through a combination of quantitative and qualitative data. A total of 662 patients were referred to the self-help clinics over a three month period, 67% of whom attended their first appointment. The mean number of sessions per patient was 2.8 (SD = 2.4), with an average total time of 69.6 min (SD = 48.2). Mean Clinical Outcomes in Routine Evaluation (CORE-OM) scores improved significantly between baseline and three month follow-up ($P < 0.001$), 39% of patients demonstrating a clinically significant improvement. Both self-help therapists and referring general practitioners reported moderate to high satisfaction with the self-help treatment model, with the majority of patients perceiving the intervention to be appropriate to their needs. Data demonstrated that, whilst there was a clear need for a simple self-help service to be based in primary care, the ultimate success of this provision necessitates a well developed infrastructure capable of providing sufficient support and information to ensure that it is flexible and responsive to individual needs.

Key words: common mental health problems; primary care; self-help; service education; therapy

Received: June 2005; accepted: February 2006

Introduction

It is estimated that 23% of the total burden of disease in developed countries is a result of mental illness (World Health Organisation, 1999). In the UK, primary care currently assumes responsibility for the management and treatment of approximately 95% of these problems (Goldberg and Gournay, 1997), a significant proportion of which relates to common mental health disorders such as anxiety

and depression (Goldberg and Bridges, 1987). Standards 2 and 3 of the UK National Service Framework for Mental Health (Department of Health, 1999) state that any service user who contacts their primary health care team with such problems should not only have their mental health needs assessed, but also be offered effective and efficient treatments, including referral to specialist services if required. Providing easy access to effective mental health treatment is therefore a key goal for primary care.

The basic criteria of any good service provision are that it is built upon a strong evidence base, that it is cost effective and that it is sufficiently coordinated with other staff and agencies to facilitate continuity

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of care (Department of Health, 1999). In order to meet these requirements, primary care has traditionally relied upon the provision of a variety of psychological treatment options including cognitive behavioural therapy (CBT), interpersonal and short-term psychotherapy, problem-solving and/or individual and couple-focussed counselling. Primary care counselling in particular has expanded rapidly in recent years and now attracts widespread acceptance from patients (Priest *et al.*, 1996). Nevertheless, access to such interventions remains problematic. With hourly face to face sessions recommended as the dominant form of service delivery (Department of Health, 2001), traditional services demand intensive therapist input. The prevalence with which common mental health problems present in primary care settings far exceeds the number of mental health professionals available (Gournay, 2000) and as a result this mode of delivery often results in inaccessible treatment options for the population it aims to serve. With such disparity between need and provision, many services have lengthy waiting lists and waiting times.

Similarly, there exists a huge unmet need in primary care from people with sub-threshold disorders. Although these individuals may still benefit from brief evidence-based therapies, the severity of their problems is not always sufficient to warrant a referral to secondary services (Lovell and Richards, 2000). For this group, treatment in primary care often falls short of optimal practice (Donoghue and Tylee, 1996) and outcomes are correspondingly poor (Rost *et al.*, 1994).

In order to provide effective services that are not only evidence based, but also more accessible, the use of alternative treatment models needs to be examined. Providing briefer treatments is one solution that may lead to decreased waiting times and increased cost effectiveness (Richards *et al.*, 2003). Within this context, both national and international attention has been focussed on the feasibility of primary care based self-help clinics (Ekers and Lovell, 2002; Hodges *et al.*, 2003; Lovell *et al.*, 2003). Self-help interventions are suitable for a wide range of psychological conditions with increasing evidence that for some problems outcomes are equal to those of longer, more costly treatment options (Lovell and Richards, 2000). In a review of guided self-help across a number of disorders, Lewis *et al.* (2003) concluded there was sufficient evidence to recommend this service, providing that the self-help

intervention was itself CBT based and that its use remained closely monitored by a health care professional.

On the basis of such evidence, current UK National Institute for Clinical Excellence (NICE) guidelines for depression (NICE, 2004) recommend the adoption of a stepped model of care. Alongside 'watchful waiting' and other brief psychological therapies, the stepped care model identifies CBT based self-help programmes as an effective intervention for mild depression, reserving antidepressant drugs and intensive therapies for more complex cases or cases where simpler methods fail to produce an adequate response. Although still being run by trained mental health workers, and remaining consistent with the theoretical basis of traditional CBT, this lower level of service demands much less face to face therapist input than conventional methods. As such, the stepped care model seeks to identify the most effective yet least restrictive and least costly intervention for the problems with which an individual presents (Davison, 2000). However, in order to successfully implement this model into local protocols, primary care providers must not only consider the degree of effectiveness that is associated with the treatment, but also its potential rate of patient uptake and the likely impact an unsuccessful intervention would have on other treatment modalities. Research recommendations within the NICE guidelines thus propose that future studies focus on both the efficacy and acceptability of guided self-help provision in primary care.

Aim

The aim of the current evaluation was to examine the levels of utilization, effectiveness and stakeholder acceptability of a new self-help service provided by one UK Primary Care Trust (PCT).

Methodology

Setting

At the time of the study, 34 pilot self-help clinics were operating within the catchment area of North Manchester PCT. Patients were referred to these clinics through a system of open referral that included self-referral without general practitioner

(GP) diagnosis as well as referral by primary care staff. In order to be eligible for assessment, patients had to be aged 16 years or above with a mild to moderate mental health problem. Patients suffering from substance misuse, psychosis, degenerative cognitive disorders or risk to themselves or others were not eligible for referral. No restrictions were placed on patients' first language and interpreters were made available for patients who could not speak English. The new self-help service was advertised via word of mouth, health promotion posters in GP surgeries and extensive and ongoing communication with a wide range of stakeholders including mental health and social care trusts, non-statutory organizations and nursing forums. Waiting times at the time the study was undertaken were approximately eight weeks.

The aim of the clinics was to offer an accessible service comprising of an initial 45-min assessment, and up to ten 15-min follow-up sessions based around problem-solving and monitoring of progress. Most of the interventions used by the self-help clinics were based on CBT principles, with an emphasis on providing behavioural, cognitive and lifestyle advice through published literature (Marks, 1978; Greenberger and Padesky, 1995; Kennedy and Lovell, 2002) and previously validated materials (Ekers *et al.*, 2002). Each patient who attended the clinic received an individually tailored programme of care supported by a trained therapist. The therapists working at the clinics comprised four registered mental health nurses, two counsellors and one social worker, each with more than five years professional experience.

Sample

At the time the study was undertaken, North Manchester PCT was serving a population of approximately 117 000 people, 51% of whom were female. Eighty six per cent were of white ethnicity, 5% Pakistani, 2.5% of mixed origin and the remainder from a variety of other black and ethnic minority groups. Forty four per cent of those aged between 16 and 74 years possessed no formal educational qualifications and 10.4% had either never worked or were classified as long-term unemployed (Office for National Statistics, 2001).

Given that the study was not a test of a specific intervention but rather an uncontrolled observational study designed to examine the operation of a

new service, statistical power considerations were not used to determine sample size. The limits of the available patient population were instead set by the number of individuals who were referred.

Measures

The service evaluation consisted of a quantitative and a qualitative component, both of which are reported here. Service utilization (number of referrals, patient attendance) and efficiency (therapist input per patient, patient use of other services) were evaluated using clinical audit data extracted from service protocols, management information and clinical records over a three month period. Clinical effectiveness was assessed using the CORE-OM (Clinical Outcomes in Routine Evaluation Outcome Measure) 34-item self-report questionnaire (Evans *et al.*, 2000). The CORE-OM is used to measure problem severity over a range of psychological conditions and constituted a routine part of the care offered by the self-help service at baseline and three month follow-up.

User satisfaction and professional views of service acceptability were ascertained through semi-structured interview. Interviews were conducted with a randomly selected sub-sample of (i) GPs working within the locality of the PCT, (ii) mental health workers employed at the self-help clinics and (iii) patients currently or recently in receipt of self-help services. All interviews were conducted by an independent researcher who had had no prior contact with the self-help service or the people interviewed. For ease of access, all GP and patient interviews were conducted via the telephone. Self-help therapists were interviewed face to face. All interviews followed the same topic schedule, which covered the applicability, perceived effectiveness and limits of the self-help service provision.

Permission to undertake the study was granted by the relevant Local Research Ethics Committees. Signed consent was sought from study participants and all data were anonymized at source.

Analysis

Quantitative audit data were analysed using SPSS version 10.0. Service utilization, availability and equity data were summarized using descriptive and inferential statistics. CORE-OM data

were compared with published data from other primary care psychological therapy providers (Mellor-Clark *et al.*, 2001) using measures of clinically significant and reliable change. A clinically significant change in CORE-OM scores moves a person from a score typical of a clinical group to one typical of a normal population based on published data (Barkham *et al.*, 2001). A reliable change is of sufficient magnitude that it is unlikely to be due to measurement unreliability (Jacobsen and Traux, 1991).

Normative data suggest that cut-off mean CORE-OM scores of 1.19 for males and 1.29 for females separate clinical from normal populations. For the purposes of the current study, a clinically significant change was thus defined as a reduction in mean total CORE-OM scores between baseline and three-month follow-up that moved a person from above to below these values. Where the gender of participants was not specified, a weighted mean cut-off of 1.25 was used.

Qualitative interview data were audio-recorded and transcribed verbatim. Two independent researchers manually sorted the data corresponding to each main interview topic in order to identify emergent themes. Analyses were validated against each other and any disagreement between the two was discussed and resolved with a third party.

Results

Service utilization

Twenty seven out of 34 self-help clinics (79%) provided data for analysis. Over the three month study period, a total of 662 patients were referred to these clinics, 216 (33%) of whom did not attend for assessment (Figure 1). Of the 446 who attended, 430 (97%) provided clinical audit data, 252 (54%) also providing data relating to their sociodemographic circumstances (Table 1). Seventy seven of the 430 patients (18%) for whom audit data were available were referred on to other services, 54 of whom were referred immediately following their first appointment.

In accordance with the referral criteria of the self-help service, the vast majority of patients (85%) presented with depressive or anxiety related disorders, 59% reporting relatively long-standing problems of 12 months or over (Table 2). The mean number of sessions per patient was 2.8 (SD = 2.4, range = 1–12, $n = 430$), with an average total time of 69.6 min (SD = 48.2, range = 15–320 min, $n = 421$).

Clinical effectiveness

CORE-OM data were available for 292/446 patients (65%) at baseline and 102/446 (23%) at three month follow-up. Over this period statistically

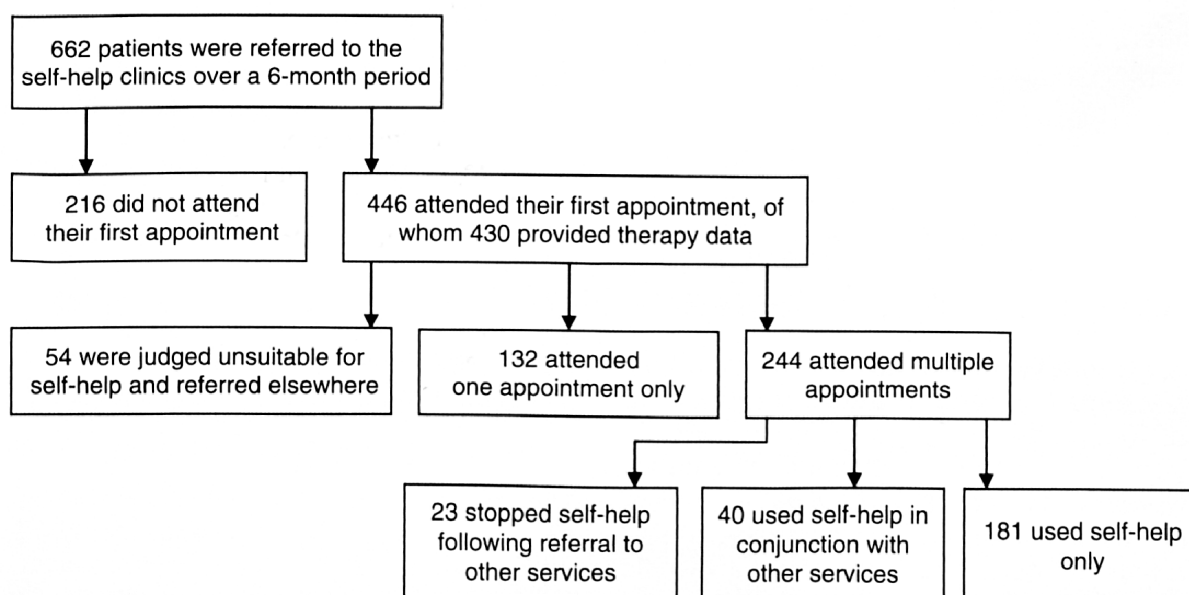


Figure 1 Patient flow through the self-help clinics provided by North Manchester PCT

that this type of intervention was appropriate for all but a minority of individuals:

I'd certainly speak to her [the therapist] again, absolutely no problem at all. Yes definitely ... I've recommended it to a friend of mine who's had similar problems.
(Patient 03)

There is a good range of people who will benefit very much from this, which is what I think we are finding ... I've referred people and they've found it very helpful.
(GP 04)

I'd say for the majority of clients the self-help clinics are appropriate ... and I think the self-help clinics can be used across a range of mental health presentations ... In terms of the relationship between this and other treatments I think it fits in.
(Self-help Clinician 01)

ii) Perceived efficacy

In terms of the perceived effectiveness of the self-help service, six out of eight patients reported that their attendance at the clinics had significantly improved their psychological well-being or daily functioning. For many, the gains that they experienced appeared to emanate from the development of a one to one relationship with the self-help clinician, something that was often considered preferable to more conventional pharmacological treatments. Most service providers also highlighted the potential therapeutic benefits of the clinics, several suggesting that in an environment where there is often a lack of alternatives to psychoactive drug prescribing such a service had made a substantial contribution to readdressing the balance of care:

I just thought I would have somebody to talk to about the way I was feeling and might be able to get some help that wasn't necessarily drug related ... when I left I felt you know like I'd sort of got something off loaded.
(Patient 02)

It's certainly been a very useful strategy as an alternative to simply prescribing antidepressants.
(GP 02)

Although three out of the eight patients interviewed could not recall receiving any self-help materials, the majority ($n = 6$) reported utilizing a number of resources ranging from generic information leaflets to personal thought diaries. All those who had used self-help material regarded it positively and believed it had at least partially contributed to their recovery. Two out of the three self-help clinicians also identified some specific advantages associated with using such interventions:

It wasn't one of those things I needed religiously but it was nice to know that it was there ... if you got yourself in a quiet place, if you sat down and read it, it often took the anxiety or stress away from any situation you were in.
(Patient 06)

I've worked in clinics where people have come in and they've brought in their files ... and there's a thought diary here and a behavioural activation diary here. I've read that and it works brilliantly.
(Self-help Clinician 02)

iii) Service limitations

A common caveat to the perceived success of the self-help service was the notion that not all health care professionals felt they had a clear understanding of the service aims. Within this context, most confusion was centred upon the interface between secondary community services and services based in primary care. In particular, it was felt that a better definition of the self-help service and its criteria for referral was a prerequisite to identifying the most suitable treatment option for people with a moderate severity of mental health problems.

I suppose I was relatively clear at the start ... but the information we get back is very limited. I still feel a little bit like, I don't feel totally confident in what the limits to the service are.
(GP 05)

Some clients that have been referred are clearly not under our remit, not common mental health problems. I've had one or two psychotic presentations.
(Self-help Clinician 03)

Discussion

Analysis of clinical audit data suggested that the provision of self-help clinics in primary care might usefully complement traditional psychological services. More than half of all patients who presented for an initial assessment attended multiple self-help sessions, and qualitative interview data suggested that levels of patient satisfaction were high. A low number of referrals to other services further confirmed that the self-help service offered an appropriate treatment option for the majority of patient needs.

This accepted, a relatively high rate of non-attendance for assessment (one in three) was observed. Ethical limitations prevented the identification of these non-attendees and as a consequence the explicit reasons for their failure to present at the clinics could not be ascertained. However, analysis of qualitative data did provide some evidence to suggest that patients may have been provided with an insufficient amount of information regarding the self-help service objectives. Both service users and referring GPs reported a low level of knowledge regarding this new intervention, its applicability to primary mental health care and the benefits it had to offer. Previous research into patients' understandings of a self-help clinic has demonstrated that user expectations may be improved if GPs provide a greater level of referral information that both clarifies the purpose of self-help and highlights the differences between this and other types of primary care management such as psychological therapy (Rogers *et al.*, 2004). Furthermore, since all mental health service users need to make informed decisions about their care, access to good information is likely to have had a significant influence on patient satisfaction, attendance and service utilization as a whole. Other primary care based studies confirm that the nature of an initial consultation is often critical in terms of increasing patient trust and treatment commitment (Nolan and Badger, 2005).

From the perspective of the referring GPs, a lack of information regarding the self-help service remit was believed to contribute to a small number of inappropriate referrals. This accepted, an analysis of the patients attending the clinic suggested that for the most part, appropriate referrals were indeed being made. Following assessment at the self-help clinics only a very small proportion of

patients were immediately referred elsewhere, with most patients who continued to utilize the service suffering from common mental health problems such as anxiety and depression. The pattern of patient flow through the clinics suggested that the provision of a self-help service did not simply delay access to traditional mental health care but was instead an effective treatment in its own right. This finding was corroborated by the relatively high proportion of patients who demonstrated an improvement in their mental health, as demonstrated by a change in scores on the CORE-OM questionnaire.

The number of patients demonstrating a clinically significant change in CORE-OM scores between baseline and three month follow-up was lower than that observed during a previously uncontrolled evaluation of a self-help clinic based elsewhere (39% versus 48%, respectively, Lovell *et al.*, 2003). Nonetheless, the proportion of patients who demonstrated a reliable improvement in their mental health was broadly comparable to that observed following therapy from more traditional primary care based counselling services (69% versus 75%, respectively, Mellor-Clark *et al.*, 2001). This apparent incongruity in measures of clinical effectiveness can ultimately be explained by the fact that mean CORE-OM scores at baseline were already raised in patients attending the self-help clinics provided by North Manchester PCT. Whilst normative data suggests a mean CORE-OM score of 1.19–1.29 for a clinical population (Barkham *et al.*, 2001), patients participating in the current study began treatment after attaining a mean baseline of 2.16. An audit of a pilot self-help clinic located in the South of England has previously reported a mean baseline score of 1.59 (Ekers and Lovell, 2002). Thus, despite demonstrating a comparable post-treatment change to other primary care services, it appears that the present self-help intervention was unable to initiate an improvement of a sufficient magnitude to move the most severely ill patients from a clinical to non-clinical population.

The exceptionally high level of patient acuity that was demonstrated at baseline can in part be attributed to the unique sociodemographic characteristics of the area. North Manchester PCT provides health services to approximately 117 000 people, many of whom reside in an area of high social deprivation (Department of Health, 2002). In North

Manchester, in particular, the expected level of need for mental health services is more than double the national average. Mental Illness Needs Indices (MINI) for this area range from 1.75 to 3.18 with nine out of eleven wards exhibiting an index of over two. The average index for England and Wales is one (Royal College of Psychiatrists, 1992).

Sociodemographic data provided by a sub-sample of self-help patients reflected the social reality of this situation. The vast majority of individuals who provided data reported that they were educated at or below GCSE (General Certificate of Secondary Education) level, 35% possessing no qualifications at all. Whilst these figures are elevated in comparison to the national picture, they remain commensurate with those of the general population residing within the catchment area of North Manchester PCT. Most recent data at the time the study was undertaken suggest that 34% of Manchester's population and 44% of people living in North Manchester PCT possess no formal educational qualifications (Office for National Statistics, 2001). Within the clinic sample, a slight bias towards women was observed; however, it is recognized that this group often experience greater risk of mental illness as a consequence of exposure to disadvantageous circumstances (Stewart *et al.*, 2001). In particular, high levels of mental health needs are known to exist among ethnic minority women who may be at specific risk of exclusion from current provision. Data from the present service evaluation demonstrated that over 90% of patients attending the self-help clinics were of Caucasian origin. Whilst high, this figure is not substantially different from the proportion of white individuals (86%) within the North Manchester PCT population. There is therefore no evidence to suggest that a self-help service based in primary care is likely to exclude ethnically vulnerable populations.

Qualitative data collected by the present study highlighted the therapeutic advantages of the self-help service with most patients who were interviewed emphasizing the importance they attributed to having someone to talk to. Wherever these therapeutic alliances existed, they were highly valued by patients and regarded as an important component in their recovery. It thus appears that at least part of the success of facilitated self-help relies on aspects of the therapeutic relationship found at the core of more traditional psychological therapies. A similar finding has been reported previously (Rogers *et al.*, 2004). The present study

suggests, however, that by providing psychological therapies as a much briefer intervention, such beneficial treatment options can ultimately be delivered to a much wider population.

Study limitations

Whilst providing a valuable insight into current methods of self-help service provision within one UK PCT, this uncontrolled evaluation is limited by the difficulties inherent in applying a formal research design to a naturalistic setting. The potential for spontaneous remission (Posternak and Miller, 2001) means that outcome data is difficult to interpret particularly given the level of sample attrition between baseline and three month follow-up. A relatively short follow-up period precludes any assessment of relapse or progress in the long term, and it therefore remains unclear whether the benefits that were observed were as sustainable as those emanating from traditional CBT interventions. The ability to demonstrate a similar level of outcome to more traditional counselling services does suggest that the patients who were referred to the self-help service were not receiving markedly less effective treatments. However, rigorous proof of equivalence requires a much larger controlled trial.

A further limitation occurred in the timing of data collection for the current study. Clinical audit data were collected over a three month period close to the start of the new self-help service. Whilst the observed number of referrals was encouraging, more recent statistics suggest a much higher referral rate of approximately 5000 patients per year. The current study was designed to evaluate the efficiency and effectiveness of a self-help service provided by one particular PCT in an area of unique sociodemographic characteristics. In order to confirm the external validity of the results, further studies in other settings are required. The degree to which service quality may vary between individual clinics and less experienced clinicians also warrant additional investigation.

A major strength of this study is that it presents data from real practice, with the qualitative aspect of the design focussing on the range of experiences expressed by a relatively diverse group of stakeholders. It is acknowledged, however, that such subjective satisfaction data is limited by its potential for bias and assessment error. Telephone interviews

in particular have traditionally been seen as appropriate only for short, structured questioning (Fontana and Frey, 1994). Prior comparison of the quality of the data yielded by telephone and face to face methods has produced mixed results. Whilst some researchers report increased evasiveness, response bias and contradictory answers within telephone administered interviews (Jordan *et al.*, 1980), others report no significant response differences (Miller, 1995). Ultimately, telephone interviewing may elicit data from individuals who are reluctant to participate in face to face interviews (Greenfield *et al.*, 2000) or from those who are difficult to access in person (Tausig and Freeman, 1988).

Within the present study, a relatively low response rate to participate in this part of the evaluation was observed and semi-structured interviews were conducted only with patients who had attended the self-help clinics. It may well be that these patients, as well as those who completed treatment but declined to be interviewed, may have held less positive views of the service than has been reported. Nonetheless all data were analysed by an independent researcher, the collection of qualitative as well as quantitative data allowing some triangulation of findings to be achieved.

Conclusion

Delivering effective mental health treatments within primary care is a difficult task which can be affected by organizational arrangements and the varying requirements of different stakeholder groups. The current study has highlighted a need for a simple and accessible service to be made available to patients, suggesting that facilitated self-help may offer a useful complement to traditional psychological therapy. The future success of such services is likely to depend on a well developed infrastructure that provides sufficient support and information to ensure that health professionals can adequately respond to individual patient needs. An increased integration of service delivery and research may help this objective to be achieved.

References

Barkham, M., Margison, F., Leach, C., Lucock, M., Mellor-Clark, J., Evans, C., Benson, L., Connell, J., Audin, K. and

McGrath, G. 2001: Service profiling and outcomes benchmarking using the CORE-OM: towards practice based evidence in the psychological therapies. *Journal of Consulting and Clinical Psychology* 69, 184–96.

Davison, G.C. 2000: Stepped care: doing more with less? *Journal of Consulting and Clinical Psychology* 68, 580–85.

Department of Health. 1999: *National service framework for mental health: modern standards and service models*. London: The Stationery Office.

Department of Health. 2001: *Treatment choice in psychological therapies and counselling: evidence based clinical practice guidelines*. London: Department of Health.

Department of Health. 2002: *Compendium of clinical and health indicators*. London: Department of Health.

Donoghue, J. and Tylee, A. 1996: The treatment of depression: prescribing patterns of antidepressants in primary care in the UK. *British Journal of Psychiatry* 168, 164–68.

Ekers, D. and Lovell, K. 2002: Self-help for anxiety and depression in primary care: an audit of a pilot clinic. *Clinical Effectiveness in Nursing* 6, 129–33.

Ekers, D., Lovell, K. and Richards, D. 2002: Treatment for agoraphobia with a self help treatment manual and telephone guidance: a case study. *Journal of Mental Health Nursing* 22, 18–21.

Evans, C., Mellor-Clark, J., Margison, F., Barkham, M., Audin, K., Connell, J. and McGrath, G. 2000: CORE: clinical outcomes in routine evaluation. *Journal of Mental Health* 9, 247–55.

Fontana, A. and Frey, J.H. 1994: Interviewing: the art of science. In Denzin, N.K. and Lincoln, Y.S., editors, *Handbook of qualitative research*. Thousand Oaks: Sage.

Goldberg, D. and Bridges, K. 1987: Screening for psychiatric illness in general practice: the general practitioner versus the screening questionnaire. *Journal of the Royal College of General Practitioners* 37, 15–18.

Goldberg, D. and Gournay, K. 1997: *Maudsley discussion paper No 1: the general practitioner, the psychiatrist and the burden of mental health care*. London: Institute of Psychiatry.

Gournay, K. 2000: Nurses as therapists (1979–2000). *Behavioral and Cognitive Psychotherapy* 28, 369–77.

Greenberger, D. and Padesky, C. 1995: *Mind over mood: changing the way you feel by changing the way you think*. New York: Guilford Press.

Greenfield, T.K., Midanik, L.T. and Rogers, J.D. 2000: Effects of telephone versus face-to-face interview modes on reports of alcohol consumption. *Addiction* 95, 277–84.

Hodges, J.Q., Martha, M., Keele, C. and Evans, C.J. 2003: Use of self-help services and consumer satisfaction with professional mental health services. *Psychiatric Services* 54, 1161–63.

Jacobsen, N. and Traux, P. 1991: Clinical significance: a statistical approach to defining meaningful change in psychotherapy research. *Journal of Consulting and Clinical Psychology* 59, 12–19.

Jordan, L.A., Marcus, A.C. and Reeder, L.G. 1980: Response styles in telephone and household interviewing: a field experiment. *Public Opinion Quarterly* 44: 210–22.

- Kennedy, A. and Lovell, K.** 2002: *A handy guide to managing depression and anxiety*. Southampton: RTFB Publishing Ltd.
- Lewis, G., Anderson, L. and Araya, R.** 2003: *Self-help interventions for mental health problems*. Report to the Department of Health R&D program. London: Department of Health.
- Lovell, K. and Richards, D.A.** 2000: Multiple access points and levels (MAPLE): ensuring choice, accessibility and equity for CBT services. *Behavioural and Cognitive Psychotherapy* 28, 379–91.
- Lovell, K., Richards, D.A. and Bower, P.** 2003: Improving access to primary mental health care: uncontrolled evaluation of a pilot self help clinic. *British Journal of General Practice* 53, 133–35.
- Marks, I.** 1978: *Living with fear*. New York: McGraw-Hill.
- Mellor-Clark, J., Connell, J., Barkham, M. and Cummins, P.** 2001: Counselling outcomes in primary health care: a CORE system data profile. *European Journal of Psychotherapy, Counselling and Health* 4, 65–86.
- Miller, C.** 1995: In-depth interviewing by telephone: some practical considerations. *Evaluation and Research in Education* 9, 29–38.
- National Institute for Clinical Excellence.** 2004: *Clinical guideline 23: depression. Management of depression in primary and secondary care*. Retrieved 28 June 2006, from www.nice.org.uk/CG023NICEguideline.
- Nolan, P. and Badger, F.** 2005: Aspects of the relationship between doctors and depressed patients that enhance satisfaction with primary care. *Journal of Psychiatric and Mental Health Nursing* 12, 146–53.
- Office for National Statistics.** 2001: *The 2001 census*. London: The Stationery Office.
- Posternak, M.A. and Miller, I.** 2001: Untreated short-term course of major depression: a meta-analysis of outcomes from studies using wait-list control groups. *Journal of Affective Disorders* 66, 139–46.
- Priest, R., Vize, C., Roberts, A., Roberts, M. and Tylee, A.** 1996: Lay people's attitudes to treatment of depression: result of opinion poll for Defeat Depression Campaign just before its launch. *British Medical Journal* 313, 858–59.
- Richards, D.A., Lovell, K. and McEvoy, P.** 2003: Access and effectiveness in psychological therapies: self-help as a routine health technology. *Health and Social Care in the Community* 11, 175–82.
- Rogers, A., Oliver, D., Bower, P., Lovell, K. and Richards, D.** 2004: Peoples' understandings of a primary care-based mental health self help clinic. *Patient Education and Counselling* 53, 41–46.
- Rost, K., Humphrey, J. and Kelleher, K.** 1994: Physician management preferences and barriers to care for rural patients with depression. *Archives of Family Medicine* 3, 409–14.
- Royal College of Psychiatrists.** 1992: *Department of Health Attribution Dataset*.
- Stewart, D.E., Rondon, M., Damiani, G. and Honikman, J.** 2001: International psychosocial and systemic issues in women's mental health. *Archives of Women's Mental Health* 4, 13–17.
- Tausig, J.E. and Freeman, E.W.** 1988: The next best thing to being there: conducting the clinical research interview by telephone. *American Journal of Orthopsychiatry* 58, 418–27.
- World Health Organisation.** 1999: *The World Health Report*. World Health Organisation: Geneva.