

**REPORT**

Centre for  
Mental Health



# **Managing patients with complex needs**

**Evaluation of the City and Hackney Primary  
Care Psychotherapy Consultation Service**

**Michael Parsonage, Emily Hard & Brian Rock**

## Contents

Foreword	3
Executive summary	4
Chapter 1: Service description	6
Chapter 2: Evaluation	11
Chapter 3: Patient outcomes	13
Chapter 4: Costs and cost-effectiveness	15
Chapter 5: GP satisfaction	21
References	26
Appendix: GP survey	27

## The authors

**Michael Parsonage** is Chief Economist at the Centre for Mental Health.

**Emily Hard** is Assistant Psychologist at the City and Hackney Primary Care Psychotherapy Consultation Service, Tavistock and Portman NHS Foundation Trust.

**Brian Rock** is Consultant Clinical Psychologist and Service Lead for the City and Hackney Primary Care Psychotherapy Consultation Service, Tavistock and Portman NHS Foundation Trust.

## Acknowledgements

Grateful thanks are due to: City and Hackney GPs and Practice Managers, for facilitating access to their record systems relating to the use of services in primary care and also for participating in a GP survey; City and Hackney Clinical Commissioning Group, particularly Dr Rhiannon England and David Maher, for support and advice throughout this project; and to all members of the City and Hackney Primary Care Psychotherapy Consultation Service, particularly Dr Julian Stern, Consultant Psychiatrist, who was instrumental in assembling the eight case studies described in this report.

## A note about the case studies

This report includes a number of case studies. In keeping with good clinical governance and practice, all patient material has been thoroughly disguised in order to maintain and protect confidentiality. Thus names, ages and other identifying information have all been altered.

For some of the case studies, marked with an asterisk \*, merged composites have been created using clinical data from more than one individual to further protect confidentiality.

The remaining studies are based on individual cases and signed informed consent has been granted by the patients concerned.

## Foreword

Every day, across England, people are seeking help for distressing and painful conditions with which their family doctors are unable to help and for which no specialist service is available. Many visit their GPs, hospitals and other health services many times, yet their problems remain unresolved, at a high cost to them, to their families and to the NHS.

People with medically unexplained symptoms, people with personality disorders and those with complex mental health problems frequently get ‘bounced’ around the NHS, passed from one service to another, none able (or willing) to offer them the flexible, personalised and sometimes time-consuming support they require.

A group of GPs in the City of London & Hackney decided to tackle this by setting up a new service for those with mental health problems they could not manage through existing primary care services who fell outside the scope of other local mental health services. The ground-breaking Primary Care Psychotherapy Consultation Service (PCPCS), implemented and run by the Tavistock and Portman NHS Foundation Trust, is the result of that innovation. It offers help for a range of needs, close to home, often in people’s own GP surgeries, rather than in remote clinics. This includes a range of psychological therapies, joint consultations with GPs, and training for primary care staff to enhance their capacity to help. As this report demonstrates, it can change people’s lives and dramatically improve their health and wellbeing.

This kind of innovation should be the hallmark of a twenty-first century NHS. Instigated by GPs, and based on clear evidence of unmet need, the PCPCS offers new hope to people we have not served well. I am therefore delighted that Centre for Mental Health has, with characteristic clarity, shown that the PCPCS does not just get good clinical results but that it represents a good use of scarce public money. On both human and economic terms, supporting people the NHS has too often failed is an affordable and effective investment.

I hope that this report will inspire family doctors and clinical commissioning groups across the country. By combining local innovation with learning from the experiences of others, the NHS can offer better care despite the tough financial climate. This is a challenge we cannot, and must not, ignore.



**Geraldine Strathdee**

National Clinical Director for Mental Health, NHS England

## Executive Summary

This report sets out the findings of an evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS), an innovative outreach service provided by the Tavistock and Portman NHS Foundation Trust which supports GPs throughout the London boroughs of City and Hackney in the management of patients with complex mental health and other needs that result in frequent health service use.

The main conclusion is that the service improves health outcomes and leads to a reduction in health service use in both primary and secondary care settings. The financial savings from reduced service use are equivalent to about a third of PCPCS treatment costs. The service also achieves very high satisfaction ratings among local GPs.

### Supporting GPs

The PCPCS is designed to meet the needs of specific groups of patients who fall through gaps in existing service provision and may be difficult to manage in primary care because of the complexity of their health conditions.

They include patients with

- medically unexplained symptoms or
- personality disorders or
- chronic mental health problems which are not currently being managed by secondary mental health services.

Many patients helped by the PCPCS have two or more of these problems at the same time, often accompanied by poor physical health and social difficulties.

The PCPCS supports GPs in the management of patients with complex needs partly through case discussions and training and partly by providing a direct clinical service to referred patients through assessments and a range of brief psychological interventions.

The number of referrals to the PCPCS runs at 40-50 a month and over 60% of patients seen by the service are from black and minority ethnic groups.

### Outcomes for patients and services

Information on outcomes for patients treated by the PCPCS is available using three different measures, relating to the severity of depression, the severity of anxiety and the ability of individuals to carry out day-to-day tasks.

Averaged across these three measures, about 75% of all patients show improvements in their mental health, wellbeing and functioning as a result of treatment. In addition, about 55% are shown as having “recovered”, defined as an improvement in mental health which moves a patient from above a clinical threshold before treatment to below the threshold after treatment.

These improvements compare favourably with those achieved by IAPT services, even though the latter typically treat less severe and complex cases.

Detailed information on health service use was collected for a sample of 282 patients treated by the PCPCS, covering three time periods: 12 months before the start of treatment; the period during treatment, which on average lasted 10 months; and 12 months after the end of treatment.

Based on this data, it is estimated that treatment by the PCPCS reduced the costs of NHS service use by £463 per patient in the 22 months following the start of treatment. Savings in primary care accounted for 34% of this total (mainly fewer GP consultations) and savings in secondary care for 66% (fewer A&E and outpatient attendances and inpatient stays). Just over a third of the overall fall in service use occurred while treatment was in progress and the remaining two-thirds in the following year.

Compared with the year before referral, the average number of GP attendances per patient seen by the PCPCS fell by 25% in the year after treatment.

A typical course of treatment by the PCPCS lasts for 12 or 13 sessions, at an estimated average cost of £1,348 per patient. The subsequent savings from reduced health service use are equivalent to about a third of this cost: a significant offset.

**Cost effectiveness**

Based on the cost-effectiveness framework used by NICE, it is estimated that treatment by the PCPCS has a cost per QALY (quality-adjusted life-year) of around £10,900. This is well below the NICE threshold range of £20,000 - £30,000, indicating that the service is good value for money.

For a number of reasons, this assessment of cost-effectiveness is almost certainly on the conservative side. For example, because of limitations in data availability, it assumes that the benefits of treatment by the PCPCS last for only one year. More generally, it takes no account of a growing body of evidence which suggests that the QALY as conventionally measured substantially under-estimates the value of mental health, particularly in relation to physical health.

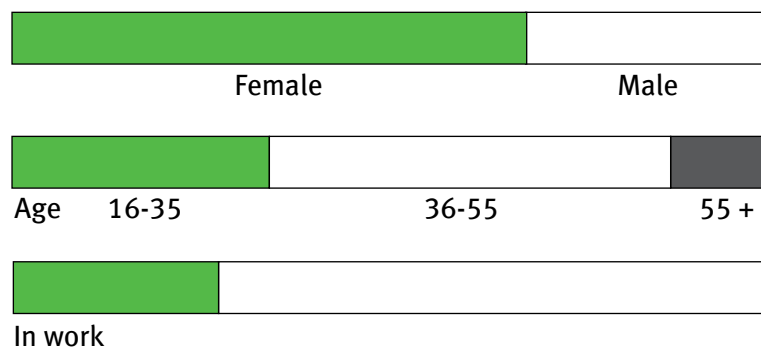
**GP satisfaction**

A survey of local GPs using the PCPCS found very high levels of satisfaction with the service, covering such aspects as the referral process and the accessibility and responsiveness of the service. On a 1-10 rating scale, average scores were typically in the range 8.5 – 9.0 for each question in the survey.

**Patients' profiles**

The clinical profile of patients treated by the service is as follows:

- 49% with medically unexplained symptoms;
- 51% with personality disorder; and
- 52% with chronic or severe mental illness.



The figures add up to over 100% because of a high level of co-morbidity. Overall, around half of patients seen by the PCPCS have two or more mental health disorders at the same time.

# 1. Service description

## Introduction

This report sets out the findings of an evaluation of the City and Hackney Primary Care Psychotherapy Consultation Service (PCPCS), an innovative mental health service provided by the Tavistock and Portman NHS Foundation Trust which first became operational in October 2009. The PCPCS team, named as Psychiatric Team of the Year by the Royal College of Psychiatrists in November 2013, supports GPs throughout the London boroughs of City and Hackney in the management of patients with complex needs that often result in frequent health service use.

## Service description

The PCPCS is designed to meet the needs of specific groups of patients who, for various reasons, fall through gaps in existing service provision and may be difficult to manage in primary care because of the complexity of their health conditions. These groups include patients with:

- medically unexplained symptoms (MUS), i.e. physical symptoms which on investigation cannot be adequately explained by organic disease;
- features or diagnoses of personality disorder (PD) who are not being managed by local PD services; and
- chronic or severe mental illness who are not currently being managed by secondary mental health services.

Many of the patients supported by the PCPCS have two or more of these problems at the same time. For example, as previous studies have shown, medically unexplained symptoms are frequently co-morbid with features of personality disorder (Stern *et al.*, 1993). In addition to multiple mental health diagnoses, patients may also have a complex mix of emotional and physical health problems, coupled in some cases with a history of social difficulties, isolation, neglect and trauma. Such complexity is frequently associated with the long-term persistence of symptoms (Ormel *et al.*, 1994).

Because of complexity, patients supported by the PCPCS do not fit neatly into any single diagnostic category and by the same token their needs do not map readily on to existing structures of service provision (Rock & Carrington, 2012). In particular, the complexity of their needs means that these patients are unlikely to be well supported by local IAPT services, which are mainly set up to deal with relatively straightforward cases of anxiety and depression, while at the same time the severity of their mental health conditions is generally insufficient to meet the clinical thresholds for treatment which are set by specialist or secondary mental health services, particularly at a time when these thresholds are becoming increasingly stringent because of financial pressures. Patient choice is also a factor, because many patients wish to be seen closer to home and their GP surgery can be seen as a familiar environment.

A further complication is that many of the patients supported by the PCPCS, particularly those with medically unexplained symptoms, do not attribute their problems to their mental health and consequently do not find an understanding in these terms helpful. These patients are unlikely to be willing to access help in a traditional mental health setting, while others may also be reluctant to seek specialist help from a service with a mental health label because of negative previous treatment experiences, perceived stigma or cultural issues.

Many patients with complex needs thus remain within primary care for their treatment and are often a cause of considerable concern, stress and frustration to GPs and other practice staff because of the intractability of their problems. Also, these patients are often frequent users of health services, not only in the primary care setting but also in secondary care, including regular attendances at A&E and outpatient departments. This is a point of obvious concern to GPs in their commissioning role. It has been

estimated that at the national level the extra costs of physical health care associated with medically unexplained symptoms among adults of working age amount to around £3 billion a year, with 40% of the total falling on primary care and 60% on secondary care (Birmingham *et al.*, 2010).

Against this background the PCPCS was set up, particularly at the instigation of local GPs in City and Hackney, with the general aim of improving support for patients with complex and chronic needs. The service has two main functions:

1. First, it supports GPs and practice staff in their management and treatment of patients with complex needs through case discussions, joint consultations with GP and patient, and bespoke training. Given the centrality of the GP-patient relationship, these interventions often focus on effecting some change in the dynamics between the GP and the patient, which might in turn mean that the GP is better able to identify a way forward that had not been apparent before, such as a referral to another service, or has greater confidence to hold the patient in primary care while recognising the limits of what is possible.
2. Second, the PCPCS provides a direct clinical service to patients referred by GPs in the form of assessments and a range of psychological interventions of a brief, focused nature (up to 16 sessions). The service adopts a varied approach to interventions, which include Dynamic Interpersonal Therapy, Mentalisation-based Therapy, Cognitive Behavioural Therapy, couple work and Mindfulness approaches, and can offer treatment on an individual and group basis as well as working with couples and families.

When the service was first set up, it was envisaged that the resources of the team would be split roughly 50:50 between these two functions, but in practice it has turned out that the treatment of patients has become the dominant role, with the demand from GPs for the service to see their patients directly outstripping demand for joint consultation.

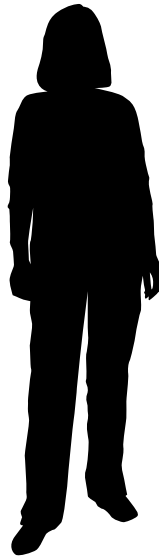
The service model operates on the basis of placing care and treatment within GP surgeries. There are many reasons why GPs choose to refer their patients rather than request a consultation. These range from respite, to wanting an opinion formed from a separate assessment, to feeling less confident to manage the patient on their own, to recognising the need for a specialist intervention.

There are few exclusion criteria for patients referred by GPs, the main ones being that patients need to be at least 18 years of age and should not be in a state of acute psychosis or acute psychiatric emergency. From the outset GPs were keen on a service design that would be less restrictive in terms of referral criteria than other mental health services, in order to lessen the frustrating experience of patients being referred and then not accepted. Such experiences contribute to on-going difficulties with engagement when patients come to believe that they will not be taken on for any form of treatment.

The PCPCS is run by a multi-disciplinary team of professionals from psychology, psychiatry, nursing and social work. The service is organised so that most GPs have a named clinician working in their surgery to foster good working relationships, but each surgery can also draw on the full range of expertise and professional input from the rest of the team. This provides for a greater span of treatment methods and clinical expertise than simply having a stand-alone, in-house professional providing psychological therapy or counselling in each surgery.

## CASE STUDY: Ms J \*

Ms J was originally referred to the PCPCS with a long standing history of irritable bowel syndrome (IBS) and vulvodynia (i.e. persistent, unexplained pain of the vulva, the skin surrounding the vagina), the latter which she associated with having intercourse. She became celibate and withdrew from further relationships. The onset of her vulvodynia coincided with the beginning of her menopausal symptoms eight years ago. She had a hysterectomy as an attempt to deal with the recurrent symptoms, but this was unsuccessful. (Note: in the case of recurrent vulvodynia, there is no clinical indication to undergo this surgery.)



She presented with low mood and anxiety and felt her physical problems were completely out of her control, which caused great anxiety. She was angry with her GP for the referral to the PCPCS, as she thought that this meant her GP had 'given up' on her and thought she was a 'head case'. This upset led her to change GPs, before engaging with the service.

Despite this, in her assessment she became curious about the meaning of her symptoms and decided to 'give it a go', engaging well in therapy and attending all her appointments.

## Outcomes

### Psychological

Ms J reported feeling better towards the end of her work with her PCPCS clinician; she was aware that her physical symptoms were unpredictable and that she might have to make some adaptations to her life. Using standard outcome measures, her scores for depression and anxiety changed from being above clinical thresholds at the start of treatment to being below these thresholds at the end.

### Physical

Ms J's pain fluctuates; she has experienced asymptomatic periods, during which she tried to catch up with her friends and do things that gave her enjoyment, and periods with significant discomfort, when she felt physically very vulnerable. Overall, her IBS is much improved.

### GP attendance

Through her work with her PCPCS clinician, she changed her perspective and started to feel that her old GP had recognised some of the distress she experienced and was concerned for her. This helped establish a good relationship with her current GP. The number of attendances has fallen.



## Patient characteristics

Contractually the PCPCS is expected to work in around half of all GP practices in City and Hackney; in fact around 90% of practices make referrals, which currently average 40-50 a month (England, Rock & Ayling, 2010).

Nearly all the patients supported by the PCPCS live in Hackney, one of the most deprived areas in the country. (The City borough has a tiny resident population – less than 10,000, compared with over 200,000 in Hackney - with levels of income and health status that are well above the national average.) Data covering all patients referred to the PCPCS over the period 2010-2012 show the following demographic and socio-economic profile:

- 68% are female and 32% are male;
- 34% are aged 16-35, 53% are 36-55 and 13% are over 55; and
- 23% are in paid employment, of whom about a third work part-time, and a further 4% are self-employed.

The ethnic profile is highly diverse. Some 36% of patients seen by the service describe themselves as White British, making this the largest single group although the share is somewhat smaller than might be expected from the local demography, which identifies 48% of residents as White British. The most represented – and indeed over-represented - BME group among service users is Turkish Cypriot/Turkish speaking (including Kurdish), who make up 17% of the PCPCS caseload, against only 5% of the local population.

The clinical profile of patients treated by the service is as follows:

- 49% with medically unexplained symptoms;
- 51% with personality disorder; and
- 52% with chronic or severe mental illness.

The figures add up to over 100% because of a high level of co-morbidity. Overall, around half of patients seen by the PCPCS have two or more mental health disorders at the same time.

Finally, Figure 1 shows the analysis based on the “clusters” or patient groupings used in Payment by Results (PbR) for mental health.

Overall, 61% of patients are non-psychotic, very severe and complex (clusters 5 to 8).

**Figure 1: Clinical profile of patients based on PbR clusters**

PbR care cluster	%
2. Common mental health problems	3
3. Non-psychotic (moderate severity)	13
4. Non-psychotic (severe)	24
5. Non-psychotic (very severe)	11
6. Non-psychotic disorder of over-valued ideas	18
7. Enduring non-psychotic disorders (high disability)	20
8. Non-psychotic chaotic and challenging disorders	9
Other	2
Total	100

## CASE STUDY: Mr B

Mr B was originally referred to the PCPCS at his request due to his concern that he might be on the autistic spectrum.

He was also worried about his low mood and obsessional symptoms. He reported a long history of difficulties with his mood, some social anxiety, intrusive thoughts and a rigid personality style.

His current bout of depression started four years ago when a long-term relationship broke up around the same time that his parents and sister moved to Italy. Since then Mr B had struggled with his mood, experiencing difficulties in concentrating and low motivation, to the point that his work as a freelance graphic designer was significantly affected.

The PCPCS clinician first referred him to the learning disability team (after much negotiation) for an assessment, which resulted in a diagnosis of Asperger's syndrome.

Whereas Mr B reported feeling stuck with wanting to know his diagnosis, he was also 'stuck' in other areas of his life for which he wished to receive help, particularly his low mood and problems with concentrating in his work. The PCPCS offered Mr B 16 sessions of weekly brief dynamic therapy with a focus on his difficulty in 'moving on'.



## Outcomes

### Psychological

Mr B's anxieties reduced significantly and he did not feel the need to seek reassurance from his GP so frequently. He improved his relationship with his parents and became more curious about his own past, seeking to create a clearer 'storyline' for his life. His standard outcome measures showed a change from scoring above the clinical threshold for depression at the start of treatment to being below the threshold at the end.

### GP attendance

His frequency of attendance fell in the year following therapy.

## 2: Evaluation

A number of benefits may flow from the work of the PCPCS. These include: improved mental health, wellbeing and functioning among patients; cost savings from reduced use of NHS services; and benefits to GPs including improved capacity to manage patients with complex needs and reduced workload. Relevant information has been collected and analysed in all of these areas.

Two constraints or limitations on the evaluation should be noted from the outset. The first relates to the difficulties of evaluating a service of the type provided by the PCPCS. State-of-the-art research into psychological treatments usually involves the testing of a single well-defined intervention provided for a homogeneous group of patients who all fit into a single well-defined diagnostic category. The PCPCS differs from this model in every respect: the service provides a mix of different interventions to heterogeneous groups of patients who suffer from multiple problems.

The difficulty with the ideal model is that it bears little relation to everyday work in primary care, the reality of which is that patients often present with a range of conditions characterised by varying degrees of complexity, chronicity and severity and where the main concern may be with improving general functioning rather than addressing specific symptoms (Greasley & Small, 2005). As Guthrie has argued, “studies of psychotherapy should have clinical relevance, and should be targeted towards definable clinical populations or characteristics of patients, rather than diagnostic conditions” (Guthrie, 2000). Research studies should in other words be patient-centred rather than illness-centred, but putting this into practice is far from straightforward in the context of multi-dimensional complexity.

Second, only limited time and resources were available for this study, which necessarily imposed a number of constraints on the research design. For example, the impact of the PCPCS on health outcomes and NHS service use has been assessed on a ‘before and after’ basis and is based on data relating to samples

of patients who were directly seen and treated by the service. This means that no allowance is made for possible benefits resulting from the PCPCS’s consultation work with GPs and practice staff. The measurement of these indirect benefits would require a more complex and costly research design than was possible in this study.

A further limitation imposed by constraints of time and resources is the absence of a comparison or control group against which to assess the impact of the PCPCS. In general, lack of a control group in health studies tends to mean that the benefits of an intervention are overstated, for example because part of any observed improvement in outcomes may have happened even in the absence of the intervention in question, as a result of natural recovery. An important counter-argument in this study is that many of the patients seen by the PCPCS have chronic and persistent problems, with a very low rate of natural recovery.

In evaluating the impact of the PCPCS on mental health and wellbeing, use has been made of outcomes data routinely collected by the service at the start and end of every course of treatment. A number of different instruments are used, including: the Patient Health Questionnaire (PHQ9), which provides a measure of the severity of depression; the Generalised Anxiety Disorder Assessment (GAD7), measuring the severity of anxiety; and the Work and Social Adjustment Scale (WSAS), measuring the ability of individuals to do day-to-day tasks including paid work.

Concerning the impact of the PCPCS on NHS costs, detailed patient-level data were collected for a sample of 282 patients treated by the PCPCS where information on health service use was available for three consecutive time periods:

1. 12 months before the start of treatment;
2. throughout the duration of treatment, which on average lasted 10 months; and
3. 12 months after the end of treatment.

The information covers service use in both primary care (mainly GP consultations) and secondary care (A&E and outpatient attendances, hospital inpatient stays). Data on primary care were collected from the records of local GP practices, while information on secondary care was provided by local commissioners using Secondary Uses Service (SUS) data.

Ideally patients should be followed up for longer than 12 months after the end of treatment, but again this was not possible within the resources

available for this study. A cut-off at 12 months is likely to mean that the various benefits of treatment by the PCPCS will be understated in the estimates given below.

Concerning the benefits of the PCPCS for GPs, estimated changes in workload as measured by numbers of patient consultations are given in the data just described on service use. In addition, a short survey of local GPs was carried out in late 2013, asking a range of questions about their satisfaction with the service.

## CASE STUDY: Ms M \*

Ms M was referred with a diagnosis of paranoid personality disorder after she had been discharged by the community mental health team for her abusive behaviour towards their service.

She was referred to the PCPCS by a GP whom she saw weekly, presenting with numerous physical symptoms, and whom she pressured to prescribe lorazepam.

The reception staff felt intimidated by her and she had been given a final warning for her threatening behaviour at the practice. She had previously been discharged by three other GPs in the borough.

She engaged with an initial joint consultation with her GP, a PCPCS clinician and psychiatrist, after which she attended 12 fortnightly sessions of supportive therapy, followed by a final joint consultation with the PCPCS clinician and her GP.



Although she was very disturbed and expressed paranoid beliefs about the nature of the sessions and the service's involvement, she engaged with the process. Working with her could be unsettling to the clinician and the PCPCS team had to be alerted to the possibility of provocative and angry phone calls to the office after one such incident.

## Outcomes

### Psychological

Two months after the end of therapy the patient made contact with her elderly mother, whom she had not spoken with for years, and ended up visiting her fortnightly in Brighton until her mother's death a year later.

### GP attendance

The GP reported that the PCPCS's intervention had had a helpful supportive and containing impact on the practice's capacity to continue to offer Mrs M help. The interest in her at the practice, and the acknowledgment of the difficult feelings it stirred up, helped lead to the setting up of future staff support groups, offered by the PCPCS to the surgery's reception staff.

### 3: Patient outcomes

As noted in the previous chapter, information on NHS service use was collected for a sample of 282 patients treated by the PCPCS. Full information on health outcomes before and after treatment, covering all three outcome measures described above, was available for 101 of these individuals. Results on outcomes are shown in Figure 2.

**Figure 2: patient outcomes by different measures**

Measure	% improved	% unchanged	% worsened	% 'recovered'	effect size
PHQ9	78	10	12	53	0.7
GAD7	73	10	17	58	0.6
WSAS	71	8	21	N / A	0.5

These figures demonstrate that the PCPCS has a positive impact on health outcomes. Averaged across the three measures, about three-quarters of all patients show improvements in their mental health, wellbeing and functioning as a result of treatment, while on both the PHQ9 and the GAD7 over half of patients are shown as having “recovered”. This is defined as an improvement in mental health which moves a patient from a score before treatment that is above a defined cut-off value for clinical diagnosis to a score after treatment that is below the cut-off.

The effect size shown in the final column is a widely used method of quantifying the overall effectiveness of an intervention and a rough rule of thumb is that an effect size of around 0.2 is ‘low’, one of around 0.5 is ‘medium’ and one of around 0.8 is ‘high’. On this basis the overall effectiveness of the PCPCS in improving mental health, wellbeing and functioning is in the medium-to-high range.

For comparison, the overall effect size for the first year of IAPT was 0.7 on both the PHQ9 and GAD7 scales, while recovery rates using these two measures were 42% in 2008/09, rising to 47% in early 2013. Compared with the PCPCS, IAPT services typically treat less severe and complex patients, with correspondingly lower initial scores on these measures, making

recovery after undergoing a course of treatment easier to achieve. Following its first year in operation, IAPT found that patients with more severe initial depression and anxiety were less likely than others to meet criteria for recovery at the end of treatment.

One interesting feature of the outcomes data is that the effectiveness of the PCPCS appears to be somewhat lower among patients with medically unexplained symptoms than among those with other conditions. Thus, effect sizes on all three measures are in the range 0.4 – 0.6 for patients with MUS but in the range 0.7 – 1.0 for other patients. On the other hand, the numbers of patients showing clinical recovery were broadly the same in the two groups. The explanation for the lower effect size in the MUS group seems to be that the number of patients whose condition worsened, while still relatively small, was roughly twice as high among MUS patients as among those with other conditions. Despite the lower effect size for health outcomes, the impact on NHS service use for patients with MUS was broadly in line with that for other groups, as discussed further in the following chapter.

Finally, detailed analysis of the data on cost savings reported below shows that the scale of savings in the full sample of 282 patients is about three times as high as in the sub-sample of 101 patients for whom full information is available on health outcomes as well as service use. It seems plausible to argue that there is always likely to be some relationship between better health and reduced use of health services, i.e. the bigger the improvement in health, the bigger the likely reduction in service use. If so, one implication is that the sub-

sample on which the above analysis of health outcomes is based may be unrepresentative of the wider population of PCPCS patients, with a bias towards those with below-average improvements in health and hence below-average reductions in service use. Put the other way round, if information on health outcomes were available for the full sample of 282 patients, this may well show bigger improvements in mental health and wellbeing than suggested by the analysis of 101 patients given above.

## CASE STUDY: Mrs K

Mrs K is a single Kurdish woman, who was always well-dressed, stern and very serious. She was referred to the PCPCS because her GP struggled to talk to her, was frustrated and left feeling “useless”. Mrs K was on a cocktail of medications and had numerous physical complaints. She was the eldest of eight children, mostly girls, she had little formal education as a child, and her parents were very strict. Her marriage was arranged and she lived for some years with a man she did not like or love and who was violent towards her.



She was offered a course of brief therapy. The primary task of her therapy was to help her become less harsh and judgemental of herself and of others. She started to notice and speak about tiny shifts in her thinking that allowed greater curiosity. She softened and became quite attached to the therapy and to her therapist, but by the end of therapy the therapist felt concerned that her gains were modest.

A month after the therapist concluded treatment with Mrs K and felt disappointed with only a partially successful result, there was a new development. Mrs K had initially rejected the idea of taking part in the service’s Turkish women’s horticultural project, as she felt that her strict adherence to Islam would not allow her near the pig manure. However, a PCPCS clinician approached an Imam who said it would be fine for her to take part in the farm group. Mrs K thus re-made contact with the PCPCS and has become a lively and engaged member of the group. She has subsequently reported how she had developed through this process.

### Outcomes

#### Psychological

As noted above, she reports an improved mental state. Her outcome measures, previously in the “depressed and anxious” clinical range, are now in the normal range.

#### Physical

The PCPCS group worker in the horticultural project has commented on how physically able she is, and how she appears not to be plagued by her symptoms. Her GP reports a significant reduction in GP attendances.

## 4: Costs and cost-effectiveness

### Costs of treatment

Financial data made available by the Tavistock and Portman NHS Foundation Trust indicate that the overall cost of the PCPCS was £0.578 million in 2012/13. Spending on patient treatment represented 70% of this total, with the remainder being largely accounted for by consultation and liaison with GPs and other primary care staff.

It is estimated that the average cost of one session of treatment provided by the PCPCS is £109. (This is a full cost, including not only therapist pay but also an appropriate apportionment of overheads, management and supervision costs and so on.) A typical course of treatment lasts for 12 or 13 sessions, leading to an estimate of £1,348 for the average cost of PCPCS treatment per patient. How much of this cost is offset by any subsequent reduction in NHS service use?

### Impact on NHS service use

The data on service use collected for this study show that in the year before the start of treatment the average monthly cost of NHS services used by the sample of 282 PCPCS patients was £152 per head, or £1,827 over the full year. Three-quarters of this expenditure was incurred in secondary care and the remaining quarter in primary care. If service use had continued at this level during treatment by the PCPCS, lasting 10 months on average, and in the year following the end of treatment, total spending over the combined period of 22 months would have amounted to £3,350 per patient. In practice, actual expenditure worked out at £2,887, a reduction of 14 per cent, or £463 per patient in absolute terms.

Just over a third of this fall occurred while treatment was in progress and the remaining two-thirds in the following year. Monthly spending in primary care fell by 14% per patient while treatment was in progress and by 25% in the following year. This largely took the form of a reduction in the number of consultations with GPs, indicating that treatment by the PCPCS has

a significant impact on GP workload. Spending in secondary care fell by 10% during treatment and by 13% in the following year.

The overall reduction in NHS costs of £463 per patient is equivalent to 34% of the average cost of a course of treatment by the PCPCS. To treat this as a direct cost offset requires an assumption that all of the observed fall in NHS service use was attributable to intervention by the PCPCS; in other words, if the PCPCS hadn't provided treatment, the use of NHS services would have continued at the level of the previous year. In the absence of a matched comparison group, this cannot be established beyond reasonable doubt and, for reasons already given, any bias in the estimate of savings over the 22-month follow-up period (from start of treatment) is likely to be in an upwards direction. On the other hand, it is also possible that the benefits of intervention by the PCPCS extend beyond 22 months. A cut-off at this point does not reflect a judgement that the effects of treatment are inherently time-limited but is rather the result of limitations in data availability. Possible errors in the overall estimates of cost savings may therefore go in both directions.

These findings relate to the full sample of 282 patients. A number of sub-group analyses have been carried out, with the following results.

**Gender:** 201 members of the sample were female and 81 were male. The estimated reduction in the costs of NHS service use as a result of treatment by the PCPCS, calculated as above, was £507 per patient among the female members of the sample, equivalent to 36% of the average cost of treatment in this group, while the equivalent saving among males was somewhat lower, at £351 per patient, corresponding to 27% of the average cost of their treatment.

**Age:** 89 members of the sample were aged 16-35, 147 were 36-55 and 46 were 56+. In the youngest age group, the costs of NHS service use actually increased slightly following treatment, by £57 per patient on average,

equivalent to 4% of the cost of treatment. The biggest savings in NHS costs were found among patients aged 36-55, at £734 per patient or 51% of treatment costs, while among those aged 56+ the average reduction in NHS costs was £353 per patient or 27% of treatment costs.

**Ethnicity:** 101 members of the sample were classified as White British and 139 as BME (information on ethnicity was not available for 42 patients). Following treatment, average expenditure on NHS services increased by £123 per patient (9% of treatment costs) in the White British group, whereas in the BME group it fell by £530 per patient, offsetting 41% of the average cost of treatment.

**Clinical profile:** using the clinical profiles reported in Chapter 2, estimated savings in NHS costs as a result of treatment for the various sub-groups were as shown in Figure 3.

The smallest average reduction in NHS costs is thus found among patients with personality disorder, perhaps reflecting the particularly intractable nature of this condition, while the biggest savings come from those with chronic or severe mental illness. Savings are also significantly higher than the overall sample average among patients with mental health co-morbidities, i.e. those with two or more problems at the same time.

### Cost-effectiveness

In any given year the NHS has a fixed budget and the broad aim of decision makers should be to maximise the total amount of health gain that can be secured within this constraint.

Information is therefore needed on the relative cost-effectiveness of different interventions, so that resources can be directed towards those which yield the highest return in terms of health gain per £ of spending.

Guidance to the NHS on cost-effectiveness is provided by NICE, based on the metric of cost per QALY gained. The QALY (quality-adjusted life-year) is a generic measure of health which combines the quantity and quality of life in a single score. A score of 1 corresponds to a year lived in full health, but is less than 1 if the quality of life is reduced because of ill health.

The specific measure recommended by NICE defines health in terms of five dimensions (mobility, self-care, carrying out usual activities, pain and depression/anxiety), with three levels of severity for each (no problems, moderate problems, severe problems). Altogether this generates 243 possible health states and each of these is given a value or weight, based on survey responses provided by the general public (Dolan, 1997). For example, a year of life lived with severe depression but no other health problems has a score of 0.764, implying that the reduction in health-related quality of life associated with this condition is equivalent to 0.236 QALYs. By extension, an intervention which successfully treated severe depression would yield a gain of 0.236 QALYs for one year altogether free of problems and if the cost of this intervention to the NHS was say £2,000, then its cost per QALY would be £8,475 (= £2,000 ÷ 0.236). Generally, if an intervention costs less than £20,000 - £30,000 per QALY, it would be considered cost-effective by NICE.

**Figure 3: savings by patients' clinical profile**

Patients with:	savings per patient	as % of treatment cost
medically unexplained symptoms (141)	£425	32
personality disorder (129)	£409	29
chronic or severe mental illness (131)	£788	56
2+ mental health problems (126)	£672	47

(Figures in brackets show the sample numbers in each sub-group)



## CASE STUDY: Ms W

Ms W was referred to the PCPCS after many years of chronic health problems, long-term conditions and personality and relational difficulties. Her medical problems included brittle asthma, irritable bowel disease, heart problems and limited physical mobility. She was single with a past history of domestic violence, parental neglect and physical abuse.



She was offered sessions of brief psychological therapy. She understood quickly the idea that the relationships she had experienced as a child and young person had become a blueprint for her experience of herself and others (i.e. she had to do the nurturing but could ask for nothing in return). She was well-known locally for being an over-exuberant, apparently happy-go-lucky person, who gave praise and gifts to anyone who offered her kindness.

Her perceptive GP seemed to ‘see through’ her and was left with the aftermath of numerous medical, social and emotional crises.

Therapy provided Ms W with a ‘breathing space’ where her panic became something that could be talked about and thought through. She started talking to her estranged daughter after many years of conflict.

## Outcomes

### Psychological

She reported a development in her confidence and self-esteem, saying for the first time that she had got something she called assertiveness. She was excited and reported a powerful sense of relief that she has started to say ‘no’ to people. Her outcome measures reflected a change from scores within the “anxious and depressed” clinical range at the start of treatment to being below the threshold for anxiety and just above the threshold for depression at the end.

### GP attendance

She has made fewer GP attendances and secondary care consultations.

Relating this kind of analysis to the costs and effectiveness of treatment by the PCPCS is not altogether straightforward, as the health outcome measures used for assessing the effectiveness of this intervention do not include the QALY. Some progress can however be made by drawing on the information on rates of recovery from depression and anxiety, based on changes in GHQ9 and GAD7 scores, which were reported in the previous chapter. These show that treatment by the PCPCS leads to a recovery rate of 53% for depression and 58% for anxiety, giving a broad average rate of recovery of 55.5%.

As noted above, the QALY includes depression/anxiety as one of its health dimensions, distinguishing between no problems, moderate problems and severe problems. The weights currently used in calculating QALYs indicate that ‘moderate problems’ for depression/anxiety carry a penalty of 0.071 QALYs, while ‘severe problems’ carry a penalty of 0.236 QALYs.

The available data for outcomes in patients treated by the PCPCS show that among all those who recovered (i.e. moved below a clinical threshold after treatment), 45.3% started with problems of depression or anxiety classified as ‘severe’ and 54.7% with problems classified as ‘moderate’. The gain in QALYs resulting from treatment was thus 0.236 QALYs per patient among those in the first group and 0.071 QALYs among those in the second group, giving a weighted average gain among patients who recover of 0.146 QALYs. Given an overall recovery rate of 55.5%, this means that the average gain among all patients treated by the PCPCS is 0.081 (i.e.  $0.145 \times 0.555$ ).

On average, the gross cost of treatment provided by the PCPCS is £1,348 per patient, but the net cost to the NHS is less than this, at £885 per patient, because of the subsequent savings associated with reduced use of health services. Cost per QALY thus works out at around £10,926 (i.e.  $885 \div 0.0649$ ). This is well below the NICE threshold range of £20,000 - £30,000, implying that the intervention is good value for money. Taking the upper end of the NICE threshold range, the estimates indicate that every £1 invested in treatment by the PCPCS yields health benefits valued at around £2.75.

This assessment of cost-effectiveness is almost certainly on the conservative side. For example, it assumes that the benefits of intervention last for only one year. No allowance is made for any improvements in mental health which occur during the 10 months when treatment by the PCPCS is in progress or for any improvements which persist for more than 12 months after the completion of treatment. Against this, some improvement in mental health may have happened anyway, even without intervention, but – as noted earlier – the natural rate of recovery among patients seen by the PCPCS is generally likely to be very low.

A further limitation of the cost-effectiveness analysis given above is that it covers only the benefits associated with reduced depression/anxiety and makes no allowance for any gains in the four other dimensions of health covered in the QALY. These include self-care and carrying out usual day-to-day activities and it is likely that treatment by the PCPCS leads to some improvement in both these dimensions. This is shown by improved scores on the Work and Social Adjustment Scale, the outcome measure used by the PCPCS which assesses the impact of mental health difficulties on an individual’s ability to function in terms of home management, work, leisure and personal or family relationships. As noted in Chapter 3, the overall impact of the PCPCS is almost as large on this measure as on those relating to depression/anxiety. Some of the case studies given in this report provide further evidence of such wider benefits of treatment by the PCPCS, including reductions in the perceived severity of physical health symptoms.

Two other points may also be noted. First, our assessment of cost-effectiveness is based on the NICE threshold range of £20,000 - £30,000 for the implicit monetary value of a QALY. However, this value has remained unchanged since 1999/2000 (House of Commons Health Committee, 2008), despite the fact that between 1999/2000 and 2012/13 the general level of prices in the economy increased by 34%, money GDP per head by 53% and spending per head of population on the NHS by no less than 133% in cash terms (HM Treasury 2013, 2014).

The last of these changes in particular is hard to square with a fixed monetary value for the QALY, as it clearly represents a substantial increase in society's willingness to pay for better health. Any increase in the monetary value of a QALY would of course imply a corresponding improvement in the value-for-money case for the PCPCS.

Second, irrespective of its precise value in absolute terms, an increasing body of evidence, both from this country and elsewhere, suggests that the QALY as conventionally measured substantially under-estimates the value of mental health relative to physical health (see for example: Moussavi *et al.*, 2007; Bockerman *et al.*, 2011; and Fujiwara and Dolan, 2014). There are a number of possible reasons for this. One is that the five dimensions of health used in the QALY are not adequate for capturing the full impact of mental illness; for example, no allowance is made for the stigma and discrimination which add to the burden of many types of psychiatric disorder. Another is that QALYs are based on hypothetical preferences of the general public which may in many cases fail to anticipate correctly the real impact that different health states may have. In particular, there is evidence that it is much more difficult to adapt to mental illness than it is to most physical health problems.

In an attempt to get round these difficulties, use has been made of a survey-based approach which relates people's actual lived experiences with health conditions to their subjective assessments of wellbeing. This direct linking of data on health and wellbeing does away with the need to define health in terms of intermediate dimensions or domains and a clear finding of such studies is that mental health is much more highly valued relative to physical health than suggested by the QALY approach.

The most recent work in this area (Fujiwara & Dolan, 2014) estimates that the adverse impact on wellbeing of depression and anxiety has a monetary equivalent cost of around £44,000 a year. This is far higher than the corresponding figure based on QALYs. As noted earlier, severe depression carries an estimated penalty of 0.236 QALYs and if one QALY is valued at £30,000 (using the higher end of the NICE range), then the monetary equivalent cost on this basis is only around £7,000 a year. The new approach thus implies that the benefits of successfully treating depression/anxiety could be about six times higher than previously thought. While further research may show this to be an overstatement, it seems unlikely to overturn the general finding that existing methods tend to underplay the benefits of better mental health and hence the value-for-money case for services such as the PCPCS.

## Case study: Mrs A

Mrs A was originally referred because of her difficulty in coping with her multiple physical health problems, including diabetes, high blood pressure, a liver problem and multiple pains, particularly in her back. In addition, she struggled with the emotional challenge of helping mentally ill family members, particularly a daughter with severe bipolar disorder who had been sectioned under the Mental Health Act.



Mrs A attended 13 sessions of Brief Dynamic Therapy. During the course of treatment, she was able to identify the ways in which her anxiety contributed to the deterioration of her physical health. She noticed that the more stress she was under, the more pain she felt. She was able to identify ways in which she could deal with her anxiety. Mrs A was also socially isolated and this was an area discussed and thought about. Some solutions were identified and she was happy with the possibility of joining a carer support group. She found a group she felt able to join and was very proactive in organising the paperwork needed to take part in this group.

## Outcomes

### GP attendance

Her GP attendances fell from 34 in the year before treatment to none in the year after treatment.

### Psychological

The standard outcome measures for depression and anxiety show scores which changed from being above clinical thresholds at the start of treatment to being below these thresholds at the end.

## 5: GP satisfaction

### Introduction

As noted in Chapter 2, a short survey of local GPs was undertaken in November 2013, asking a range of questions about satisfaction with the PCPCS. An earlier survey, undertaken by Capita Consulting in 2011, found generally high levels of satisfaction with the service on such matters as its responsiveness to local needs and operational requirements in primary care, the degree to which it complemented rather than duplicated other services, its targeting on difficult-to-engage patients and its impact on health outcomes (Capita Consulting, 2011).

As seen in the previous chapter, there is also evidence from the current study that the PCPCS is of benefit to GPs by reducing workload pressures, with numbers of GP consultations with patients referred to the PCPCS falling by 25% in the year after discharge compared with the year before the start of treatment.

For the 2013 survey an online methodology was used with a mix of open and close-ended questions (see the Appendix for a copy of the questionnaire). A total of 204 GPs in referring practices were invited to respond and 44 did so. Results are as follows.

### Use of the service

Of the 44 respondents, 42 had personal experience of using the service. Of the remaining two, one was not aware of the service and the other used in-house counselling and psychotherapy services and so did not need to refer patients onwards.

Of the 42 GPs who had experience of the service:

- 40 (95%) had referred a patient for assessment;
- 26 (62%) had received a professional consultation (i.e. following a referral, they had an in-depth telephone conversation or meeting with a PCPCS clinician to discuss the management of their patient);

- 20 (48%) had a joint patient consultation (i.e. following a referral, they had a meeting with their patient and a PCPCS clinician to identify the best way forward); and
- 27 (64%) had a case-based discussion (i.e. had a meeting with the other GPs in their practice together with a PCPCS clinician to discuss specific patients who may or may not subsequently be referred).

### Satisfaction with the service

Of the 42 GPs who had experience of the service, 39 (93%) answered questions relating to their satisfaction with particular aspects of the service.

Of these GPs, 100% were satisfied with the straightforwardness of the referral process (rating the service 5 or above on a 1-10 rating scale, where 1 means very dissatisfied and 10 very satisfied). The average score given was 8.77, with 16 (41%) of GPs declaring that they were very satisfied with the referral process (rating the service 10/10).

Similarly, 100% of these GPs were satisfied with the accessibility of the service to their patients (rating the service 5 or above). The average score given was 8.49, with 14 (36%) of GPs declaring that they were very satisfied with the accessibility of the service (rating the service 10/10).

And 100% of these GPs were satisfied with the responsiveness of the service to their and their patients' needs (rating the service 5 or above). The average score given was 8.72, with 16 (41%) of GPs declaring that they were very satisfied with the responsiveness of the service (rating the service 10/10).

Asked to give a general assessment, all but one of the 39 GPs said that they were satisfied with the service overall (rating the service 5 or above). The average score given was 8.85, with 14 (36%) of GPs declaring that they were very satisfied with the service overall (rating the service 10/10).

## **GP comments related to satisfaction with the service (13 in total)**

*“I really got a lot of benefit from the joint consultation.”*

*“Excellent clinicians and very straight forward; waiting list could always be shorter. I think this is longer because there are problems with the quality of the alternate service - primary care psychology IAPT.”*

*“Non-attenders are contacted. Reasons for not attending are considered and flexible approach helps those who find engagement difficult to continue therapy.”*

*“It is very helpful to speak to therapist personally to see whether a referral is appropriate. It is usually reasonably easy to get hold of the therapist.”*

*“Really flexible and patient-centred service (and GP centred!).”*

*“Fab service.”*

*“Several very good meetings to identify on-going management issues with patients.”*

*“Sometimes difficult to know how long patients will wait to be seen once referred.”*

*“Very straight forward referral process, easy accessibility to our patients as the sessions take place in our surgery and I am grateful that the professional seeing our patients is very competent and caring and responsive to our and our patients’ needs.”*

*“Very helpful service, both in terms of response and ease of communication with psychologists.”*

*“Patients being seen in a neighbouring practice added an obstacle for some patients despite not being very far and clearly signposted. Excellent assessments, occasionally frustrating when patient needs would be best met by another service (e.g. therapeutic community or longer term psychotherapy) - a difficult gap to bridge. Often referral to PCPCS has occurred as patient will not attend other services. Would be helpful to think about how PCPCS can help people into more appropriate service most effectively.”*

*“Easy referral process but a number of referrals seem to get ‘lost’. Given how desperate many patients are, this can be very disappointing when they have been waiting for a while to be seen. The service, like any, works well for some patients and not for others. This may be because the service needs to be clearer with professionals about what sorts of people find this type of service useful and who doesn’t. I do get frustrated when my referral makes it clear that the patient is complex and they are then asked to see a relatively junior practitioner who then has to refer them on.”*

*“The service is very adaptable to gender and race issues and needs of patients.”*

## **Net promoter score**

Of the 42 GPs who had experience of the service, 39 (93%) answered a question on how strongly they would recommend the service to a colleague. All but two of these GPs would recommend the service to a colleague (rating the service 5 or above). The average score given was 9.00, with 19 (49%) of GPs declaring that they would recommend the service very strongly (rating the service 10/10). According to the theory behind the use of the net promoter score, 72% of GPs would be likely to be active promoters of the service, compared to just 5% detractors (promoters = scores of 9 or 10; passives = scores of 7 or 8; detractors = scores of 6 or less).

## **Contribution to managing patients with complex needs**

Of the 42 GPs who had experience of the service, 39 answered a question on the extent to which the service helped them manage patients with complex needs. All but one of these GPs answered that that their involvement with the PCPCS team had helped them deal more effectively with patients with complex needs (rating the service 5 or above). The average score given was 8.36, with 13 (33%) of GPs declaring that the service had helped them to a great extent (rating the service 10/10).

## Case study: Mrs B

Mrs B was referred to the PCPCS because of her low mood and difficulties in coping with the stress she experienced during and after a court case that resulted from an alleged assault on her person by a family member. Mrs B's alleged attacker was found not guilty due to lack of evidence. Mrs B reported being afraid of her alleged assailant and that she was afraid to leave the house as she worried she might encounter her alleged assailant. She was withdrawn and isolated.



She was married and dependent heavily on her husband to do most practical things like cooking, cleaning and looking after the children, as well as to do anything the family needed to be done outside the house. Some of this was because of Mrs B's hearing and speech impediment, while some related to her anxiety. Her difficulties had a significant impact on the family and the children who were receiving support from the school counsellor.

Mrs B attended six assessment sessions with the PCPCS, followed by 15 sessions in Couples Therapy.

In her past, Mrs B had lost her father when very young and her elder brothers took up the role of her father as she was growing up. As the youngest daughter, she was used to being protected by her older brothers. When the court case happened and her brothers did not show their support to her, Mrs B felt very let down and rejected by her family. The fear of her attacker and her difficult feelings of being by herself – without the support of her brothers – led Mrs B to become withdrawn and to struggle to move on with her life. During her treatment, her clinician mainly focused on her anxiety with regards to hearing-related problems and employed behavioural activation tasks, involving her husband in the process and negotiating ways how she could get more involved in family life.

## Outcomes

### GP attendance

Her outpatient appointments year fell from 21 in the year before treatment by the PCPCS to 4 in the year after treatment and A&E attendances fell from 4 to none.

## GP suggestions for improving the service

Towards the end of the survey, GPs were invited to share their suggestions for how the service could be improved. These are as follows:

*“Spread a bit thin, need more...”*

*“My patients are in general very satisfied with the care they are receiving from your services. I have no suggestions for any improvements at present but would be grateful if you can continue offering this service. Thank you”*

*“The community groups are fantastic - can we develop more (I am especially interested in developing a craft/arts group in the practice)”*

*“Was frustrated when I had worked quite hard to sell the ‘medically unexplained symptoms’ service to a patient only for them to point blank refuse once the letter for a ‘psychology’ appointment arrived. We had just reached a point where they had agreed to think about the mental and emotional aspects of their condition but did not want to be referred to a ‘mental health’ service... I give this example because I think it is common amongst the group of patients seen by PCPCS and could have been easily avoided by offering appointment by phone or by amending letter head.”*

*“More very practical behavioural approaches would be useful. Many of my patients are operating at a level where they need clear straight forward strategies. Some patients have said how difficult they find it talking to very young people about very difficult things and that they want to see practitioners with more expertise and I suppose more life experience.”*

*“I am aware patients are not that regular in keeping the appointments but clinicians need to be more sensitive, flexible and responsive. Selection of cases too rigid for acceptance for the service which was not helpful in my observation. It is hard to judge from the symptoms whether they need an ordinary specialist or super specialist.”*

## Other comments by GPs

*“Your service is flexible and approachable.”*

*“These patients are often complex and having another way of viewing their issues is extremely useful for on-going care.”*

*“Feedback in meetings are invaluable.”*

*“Invaluable meetings to discuss cases we are struggling with, some startling results for those seen by the service. General feeling of support from the service. It feels genuinely collaborative, the most rewarding relationship in 25yrs of practice”*

*“Great support to us in primary care.”*

*“I have found the service very useful and I hope it is going to continue to be available for my patients.”*

*“Reducing admissions is not always possible, but sharing a way of helping individuals - both patient and GP cope with on-going care issues is essential”*

*“Good service”*

*“One of the few services available which actually meets the needs of service-users who are often not considered/amenable to standard services interventions.”*

*“Good that we have it. The service has certainly helped a number of our patients. I wouldn’t want it to stop.”*

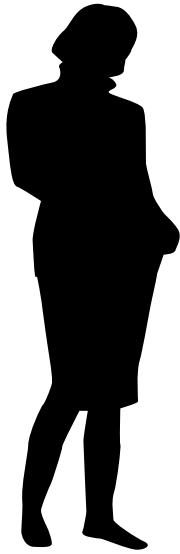
*“The service should be held up as a great example of practice for other areas to consider.”*



## CASE STUDY: Mrs C \*

Mrs C was referred because of her anxiety about her health. She had a myocardial infarction several years ago and since then has been convinced that she would die immediately, experiencing heightened anxiety because of this belief. While her partner was alive she managed to contain her anxiety to a degree, but after his death she felt unable to cope and underwent a number of investigations, all of which returned normal. However, instead of feeling reassured she felt even more anxious about her health and certain that something sinister would cause her death. Her anxiety was so high that she felt it would be preferable to die than to await her natural death. She had previously attempted CBT, numerous antidepressants, as well as 'complementary' therapies, including acupuncture, homeopathy and Reiki.

Mrs C attended five sessions of Brief Dynamic Therapy.



With a background of early experiences of rejection, Mrs C developed a sense that she did not deserve to live and that she would probably die at any point of some terrible disease. When she met her partner she was able to feel a sense of purpose in her life, particularly through the emotional containment he offered her. With his death this containment was gone and Mrs C felt unable to bear her own anxieties, and was struggling to cope with the grief and with the task of trying to create a life for herself without her partner. Mrs C was seen intermittently as she struggled to leave the house due to anxiety. Contact with her was often through the telephone and involved a flexible way of engagement. In the therapeutic work, she was reflective and started to process some of her grief and engage with family life by spending time with her step-children and step-grandchildren.

### Outcomes

Her A&E attendances fell from 18 in the year before treatment to none in the year after treatment.

## References

- Birmingham, S., Cohen, A., Hague, J. & Parsonage, M. (2010) The cost of somatisation among the working-age population in England for the year 2008-2009. *Mental Health in Family Medicine*, 7, 71-84.
- Bockerman, P., Johansson, E. & Saarni, S. (2011) Do established health-related quality-of-life measures adequately capture the impact of chronic conditions on subjective wellbeing? *Health Policy*, 100, 91-95.
- Capital Consulting (2011) *City and Hackney Primary Care Team: Service Evaluation, Final Report*. Unpublished.
- Dolan, P. (1997) Modelling valuations for health states. *Medical Care*, 35(11), 1095-1108.
- England, R., Rock, B. & Ayling, R. (2010) *Medically unexplained symptoms*. GPOonline.com, 12 November 2010. Available at <http://www.gponline.com/Education/article/1039091/Patient-services---Medically-unexplained-symptoms/>
- Fujiwara, D. & Nolan, P. (2014) *Valuing mental health: how a subjective wellbeing approach can show just how much it matters*. London: UK Council for Psychotherapy.
- Glover, G., Webb, M. & Evison, F. (2010) *Improving Access to Psychological Therapies: a review of progress made by sites in the first roll-out year*. North East Public Health Observatory. Available at <http://www.iapt.nhs.uk/silo/files/iapt-a-review-of-the-progress-made-by-sites-in-the-first-roll2008-out-year.pdf>
- Greasley, P. & Small, N. (2005) Evaluating a primary care counselling service: outcomes and issues. *Primary Health care Research and Development*, 6(2), 125-136.
- Guthrie, E. (2000) Psychotherapy for patients with complex disorders and chronic symptoms: the need for a new research paradigm. *British Journal of Psychiatry*, 177, 131-137.
- Healthcare Quality Improvement Partnership (HQIP) (2013) *Second Round of the National Audit of Psychological Therapies for Anxiety and Depression (NAPT): National Report November 2013*. Available at <http://www.hqip.org.uk/assets/NCAPOP-Library/NCAPOP-2013-14/NAPT-Nov-2013.pdf>
- HM Treasury (2013) *Public Expenditure Statistical Analyses 2013*. Available at <https://www.gov.uk/government/publications/public-expenditure-statistical-analyses-2013>
- HM Treasury (2014) *GDP deflators at market prices and money GDP*. Available at <https://www.gov.uk/government/publications/gdp-deflators-at-market-prices-and-money-gdp-march-2013>
- House of Commons Health Committee (2008) *National Institute for Health and Clinical Excellence. First Report of Session 2007-08, Volume 1*. London: TSO.
- Moussavi, S., Chatterji, S., Verdes, E. *et al.* (2007) Depression, chronic diseases and decrements in health: results from the World Health Surveys. *The Lancet*, Vol 370, September 8 2007.
- Ormel, J., VonKorff, M., Ustun, B. *et al.* (1994) Common mental disorders and disability across cultures: results from the WHO collaborative study on psychological problems in general health care. *Journal of the American Medical Association*, 272, 1741-1748.
- Rock, B. & Carrington, A. (2012) Complexity in primary care. Chapter 5 in Lemma, A. (ed.) *Contemporary Developments in Adult and Young Adult Therapy: the Work of the Tavistock and Portman Clinics: Volume 1*. Karnac Books.
- Stern, J., Murphy, M. & Bass, C. (1993) Personality disorders in patients with somatisation disorder: a controlled study. *British Journal of Psychiatry*, 163, 785-789.

## Appendix: GP survey

Dear Colleague,

We would be grateful for your help with improving our service for you and your patients. By taking 2 minutes to answer the following questions, you will help us achieve this goal. We also welcome your further comments and suggestions, which we will collect in free text at the end of the survey.

With thanks,

City and Hackney PCPCS

### 1. Have you personally had experience using our service?

Yes  No

### Engagement questionnaire

This question helps us understand why you have not used the PCPCS yet to help us to facilitate your engagement with our service in the future.

### 2. Please identify the main reasons behind your decision not to use our service to date. (please select all that apply)

- I was not aware of the service
- I do not understand what the service has to offer
- Our needs are already well covered by other City and Hackney mental health and psychotherapy services
- We use in-house counselling or psychotherapy service and do not need to refer outwards
- I had/have no suitable patients to refer
- I could not decide which service option was relevant to my patients
- I have heard negative feedback about the service

Please expand on any of the above or let us know any other reason that you haven't used our service and what we could do to facilitate your service engagement.

### 3. Which of the following options have you used in our service (please select all that apply)?

- Referred patient for assessment

- Professional consultation – following a referral, I have had an in-depth telephone conversation or meeting with one of your clinicians to discuss the management of my patient)
- Joint patient consultation – following a referral, I have had a meeting with my patient and one of your clinicians to identify the best way forward
- Case-based discussion – I have had a meeting with the other GPs in our practice with one of your clinicians to discuss specific patients who may or may not be referred

### Satisfaction questionnaire

We would like to ask you a few questions about your level of satisfaction with our service.

### 4. How satisfied are you with the following aspects of our service (where 1 means very dissatisfied and 10 very satisfied)?

- Straightforwardness of the referral process
  - Accessibility to your patients
  - Responsiveness to your and your patient's needs
- Please expand on any of the above.

### 5. Overall, how satisfied are you with our service (where 1 means very dissatisfied and 10 very satisfied)?

### 6. How strongly would you recommend our service to colleagues (where 1 means not at all and 10 very strongly)?

### 7. Please rate the extent to which involvement with our team has helped you deal more effectively with patients with complex needs (where 1 means not at all and 10 to a great extent)?

Please let us know any suggestions you have for improving our service.

Please add here any other comments you have about the service or this survey.

## Managing patients with complex needs

Published March 2014

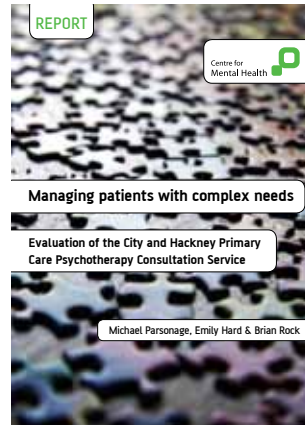
Photograph: istockphoto.com/sharky1

£10 where sold

© Centre for Mental Health, 2014

Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.

Register for our email bulletins to get new publications and keep in touch with our work at [www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)



Centre for  
Mental Health



*Realising a better future*

Centre for Mental Health

134-138 Borough High Street, London SE1 1LB

Tel 020 7827 8300

Fax 020 7827 8369

[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

Charity registration no. 1091156. A company limited by guarantee registered in England and Wales no. 4373019.