

**REPORT**

Centre for  
Mental Health



# Clinical psychology in primary care

Dr Graham Durcan

## Contents

---

	Executive summary	3
1	Introduction	4
2	Bradford Primary Care Wellbeing Service	7
3	Catterick and Shropshire's GP style psychology services	10
4	Project Future: a community-based, psychology-led service	13
5	The economic case for clinical psychologists in a primary role	15
6	Conclusion	16
	References	18

## Acknowledgements

We would like to thank Cathy Byard, Suzanne Heywood-Everitt, Laura Fisk, Angela Moulson, Vanessa Tobin, Annette Schlosser, Barry Ingham, Lawrence Moulin, Fatima Bibi and Suchi Bhandari, and the teams and practice staff from Bradford, Catterick, Ludlow and Telford and Project Future for supporting us with this project. The review was funded by a grant from the British Psychological Society to Centre for Mental Health.

## Executive summary

---

There is a growing recognition of the important role of primary care services in supporting people's mental health, and of significant gaps in the current provision of mental health support in many areas.

This report describes two promising approaches in three local areas where clinical psychology has been provided in a primary care setting. They are:

- **Bradford Primary Care Wellbeing Service:** a multi-disciplinary team led by a clinical psychologist which supports people with unexplained medical symptoms or a long term condition
- **Catterick and Shropshire:** offering direct access to a clinical psychologist within a GP surgery.

We also describe Project Future in Haringey, a psychology-led community initiative working with marginalised young people, as an alternative approach located outside primary care.

All of the sites used core principles of clinical psychology to understand people's needs and to develop strategies for meeting them, complementing existing primary care services and psychological therapy provision.

These sites demonstrate the therapeutic and cost benefits of clinical psychology being offered directly in communities. It can offer effective support to people who previously got little or no effective help for their mental or physical health from the NHS.

From 2021, Primary Care Networks will be able to use additional funding from NHS England to employ mental health professionals directly, including clinical psychologists (Naylor *et al.*, 2020). This is an opportunity that must not be missed. In the wake of Covid-19, the importance of easily accessible clinical psychology will be greater than ever for individuals and communities that have experienced trauma through the pandemic.



## Introduction

Primary care services are most people's first and most frequent point of contact with the NHS. Located in every community, GP surgeries in particular are the places we go to when we're worried about our health and when we first need help. A recent survey of over 1,000 GPs found that 40% of contacts involved a mental health element (Mind, 2018).

Primary care services are under pressure, struggling to meet ever-growing demand with limited resources. GPs themselves have variable levels of knowledge and confidence in meeting people's mental health needs, especially when they are linked to other health or social issues (Mind, 2018).

The NHS Long Term Plan sets out a ten-year vision that sees primary care growing and taking on ever greater levels of responsibility for people's health care, including prevention and managing complex needs outside hospital. It requires all GP surgeries to cluster into Primary Care Networks that will take on responsibility for a range of enhanced health services and it pledges funding to enable them to meet these needs. This raises the question of what would enable primary care services to meet more effectively their patients' mental health needs.

This report describes the potential benefits of clinical psychology as a front-line health service in primary care. It does this by describing two different approaches to bringing psychology into GP surgeries to meet two different, and quite distinct, types of mental health need. We have also described a model of community psychology to demonstrate the wider range of ways that psychology can meet the needs of the most marginalised groups of people 'where they are at'.

There are currently 13,460 registered clinical psychologists across the UK (HCPC, 2019), most of whom work in secondary and specialist care in the NHS. This report explores the impact of extending and locating this valuable resource differently, in GP surgeries and communities.

## Improving Access to Psychological Therapies

Psychological interventions are, of course, not only delivered by clinical psychologists: they have become very widely available in England, primarily via Improving Access to Psychological Therapies (IAPT) services, during the last decade. Around a million people a year are seen by an IAPT service currently, and over half have a course of therapy (the remainder are assessed, and some will be signposted or referred on to other services). The NHS Long Term Plan wants the service to expand to see 1.9 million people by 2024 (Clark, 2018 & NHSE, 2019a).

To date, approximately 10,500 practitioners have been trained to provide IAPT interventions and their most common offer is Cognitive Behavioural Therapy. Most people will be supported to guided self-help or low intensity sessions (perhaps 5 or 6 treatment sessions), but more intensive offers are also available. Clinical psychology does have a presence in these services, but the bulk of intervention is delivered by practitioners who have received accredited IAPT training, usually at the postgraduate diploma level rather than the doctoral level training of the clinical psychologist.

*"...IAPT services are fantastic and are a fit for a quite a number of patients I see, but CBT is not right for everyone and IAPT services cannot really help if the patient presents with any complexity..." (GP)*

Several of the people we spoke to for this review gave similar accounts of IAPT, i.e. that it did not accept clients with more complex needs, and this in part was due to the access and recovery rate targets these services are expected to deliver. In its current form, IAPT does not typically offer the level of intervention required by people with more complex needs and this represents a significant gap in many local areas.

## The unique role of clinical psychology

Clinical psychologists are trained to reduce psychological distress and to enhance and promote psychological wellbeing by the systematic application of knowledge derived from psychological theory and research. Interventions aim to promote autonomy and wellbeing, minimise exclusion and inequalities, and enable people to engage in meaningful interpersonal relationships and commonly valued social activities such as education, work and leisure.

Clinical psychologists are highly trained to Doctorate level and have a distinctive role to play because of their broad training, which covers the lifespan and equips them to work effectively with individuals, families, and organisational systems. They are trained to work with a wide variety of mental health needs in various settings, including services for children, adults, older adults, families, people with developmental and intellectual disability, physical health presentations, chronic conditions and forensic services. This is in contrast to multiple, often sub-doctoral, programmes which prepare graduates for work with only circumscribed groups, presentations or models of therapy.

A defining feature of the clinical psychologist is the capacity to draw from and utilise different models of therapy, and evidence based interventions, as appropriate to the needs and choices of the service user. They are trained not just to deliver interventions, but also to promote psychological mindedness and skills in other health, educational and social care providers.

Llewelyn and Aafjes-van Doorn (2017) describe clinical psychology as “dealing...with people’s thoughts and emotions, and often their

distressing difficulties. Rather than labelling these experiences as symptoms of an illness or an indication of madness, clinical psychologists are curious about why these symptoms occur, wanting to understand feelings, thoughts, or behaviours in their context. Our intention is to empower people to find a way to feel better, by learning to tolerate, accept, or manage their distress differently, or by changing how people see themselves and their situation...” (page XV)

The training required to deliver the above is both broad and in-depth, and enables the clinical psychologist to make autonomous determinations (although often delivered as part of a multi-disciplinary effort):

*“...I think one of the distinguishing features of clinical psychology is the ability to be autonomous and to diagnose or rather make formulations...well actually we do this with the client or patient... to do that and to do it across a range of people and of all ages you do need a training in breadth of theories and different practices...”* (Clinical Psychologist working in primary care, interviewed for this project)

Formulation has its roots in Kelly’s personal construct theory (1955). Formulations are an attempt to understand an individual in their context, and to do so using ‘plausible account’ (Butler, 1998 cited in BPS, 2011) in the form of a shared narrative rather than a categorical diagnosis. The formulation provides a hypothesis to be tested and its narrative changes as the individual does.

*“...In the short period we have with the patient...we are listening and testing ideas to develop the formulation, and this guides the intervention...”* (Clinical Psychologist working in primary care, interviewed for this project).

### Formulations can be described as having the following characteristics:

- A summary of the service user's core problems
- A suggestion of how the service user's difficulties may relate to one another, by drawing on psychological theories and principles
- The aim to explain, on the basis of psychological theory, the development and maintenance of the service user's difficulties, at this time and in these situations
- Indication of a plan of intervention which is based on the psychological processes and principles already identified
- Being open to revision and re-formulation.

(Johnstone and Allen (2006) cited in British Psychological Society (2011) p. 6)

Reprinted from Durcan (2016)

## Methodology

The case studies featured in this report were selected to explore the contribution of clinical psychology to primary care in areas that have taken innovative approaches to meeting people's needs close to home, embedded within GP surgeries and working closely with primary care colleagues. In each we undertook interviews with stakeholders, including clinical psychologists, GPs, service managers, commissioners and patients. Additionally, we describe a model of community psychology that operates outside of primary care in order to demonstrate the value of engaging with people from the most marginalised communities in the most accessible and acceptable ways for them.

For all sites we were able to access some reports and policy documents (internal and external) and from one (Catterick) we were able to collect quite detailed audit data from the service's routine data collection, as well as data (where appropriate) on other local GP practices.

Few patients or users of the three services were accessible, and their voice is underrepresented

in the case studies. For Bradford, this may be in part due to the nature of the people they work with, who may have sometimes been resentful that their problems were being "psychologically framed" and thus reluctant to join in the evaluation as a result. The Catterick service had closed a few months before the stakeholder interviews took place (it had originally been planned as a one year pilot but was extended to collect further data on the model) but it had conducted surveys of those using the service and found very high levels of satisfaction (98%).

In the case of Project Future, which we have presented as an additional model working outside primary care but within a community, we have the views of over 40 young people involved in the project, taken from an independent evaluation by Centre for Mental Health (Stubbs *et al.*, 2017).

This report was written prior to the global outbreak of coronavirus in 2020. It is, however, very likely that its findings and conclusions will be more applicable than ever given the evidence of the impact of the pandemic on mental health.

## Bradford Primary Care Wellbeing Service

The Bradford Primary Care Wellbeing Service (PCWBS) is a psychology-led multi-disciplinary team, including clinical psychology, occupational therapy, physiotherapy, dietetics and a Personal Support Navigator (employed by Age UK).

The function of PCWBS is to work with patients with unexplained medical symptoms and long-term conditions, who GPs have identified as frequent attenders of their service; and, critically, where they suspect there is a significant psychological component and where the frequent service use is not beneficial.

PCWBS is funded as a Cost Improvement Plan (CIP) by the local Clinical Commissioning Group (CCG). It was funded to initially work with four general practices to pilot whether an alternative psychological formulation informed approach would lead to more appropriate care and bring about savings. The service has been evaluated twice (Bestall *et al.*, 2017 & Pemberton, 2018) and shown both positive clinical outcomes and significant savings. The service has developed and expanded to cover further practices.

PCWBS's primary function is to support GPs by providing a formulation to a group of patients who individually and collectively use a considerable amount of NHS resources, usually to no benefit and indeed sometimes to their detriment. It is common for PCWBS patients to have received numerous assessments, treatments, and some to have undergone invasive and traumatic surgical procedures.

*"...I'm about to conduct some radical surgery on a young person...I think we all knew that there was a significant psychological component to this... but we do not have the skills and knowhow within our service. If we had PCWBS involvement earlier we might have been able to avoid this, but now it is a necessity..."* (Consultant in acute medical care).

*"I think if you ask most of our colleagues in the acute hospital they will tell you that a not insignificant group of their patients are unlikely to benefit from further assessment and investigation and have a significant psychological component, but that they, like us, feel pressure to offer some care and treatment and do not have the knowledge and confidence in psychology and mental health to do otherwise...PCWBS offers that..."* (GP)

PCWBS works with a wide range of clients of all ages; for example, at the time we visited, the service was working with a family where the identified patient was a toddler.

Some PCWBS patients are also frequent users of emergency services, accessed via dialling 999 as well as accident and emergency departments.

In addition, PCWBS offers a community tertiary service for people with chronic fatigue syndrome. In the past these patients may have been referred out of area.

A service user and chronic fatigue sufferer interviewed as part of the Shropshire case study described how psychological intervention and specifically the intervention of clinical psychology had helped:

*"...I had years of no or very limited help... then I experienced a residential programme of care...which helped at the time but which I experienced relapses after discharge... the psychological help I received there but also since then in the community has been a significant help to me and has helped me move on...I still have problems, but I have been helped to manage them..."*



## Identifying patients for the PCWBS

Each of the practices PCWBS works with has gone through a process of identifying frequent users of their general medical services for whom there is a history of unresolved and unexplained medical symptoms and long term conditions:

*“...Before I refer to PCWBS I do a detailed review of the patient’s full history, and it is a very demanding and labour intensive task... it might take quite a few hours spread over a week or two...but as demanding as it is, it is also an extremely useful task...This is not an opportunity we get very often and it is not until you review the case notes in such detail that you start to see the patterns and explanations...I mean at the back of my head I will have known that there must be some psychological explanation for their behaviour, but the case review provides the evidence...”* (Bradford GP)

## Engagement and formulation

Once the GP file review is complete, where all ‘red flags’ have been explored and alternative diagnosis eliminated, this is shared with the multidisciplinary PCWBS team and the patient is offered an assessment appointment within two weeks. This is not always a straightforward process:

*“...most of those we work with are heavily invested in seeing the issues they bring into the practice as being physical, and often there are genuine physical components, perhaps quite serious and/or chronic ailments, and [they] consequently may be resistant to being offered an assessment by a psychological service...”* (Clinical psychologist)

*“...some people may resist the idea that there is a psychological component to their problem, throughout their contact, but it doesn’t mean they can’t be helped... Sometimes people can be engaged with if they come to understand that everything, including their physical or medical issues, also have a psychological component...and that support with this might help manage pain for example...”* (Clinical psychologist)

This is where formulation comes to the fore, as a key component will be understanding how the patient views the links between their physical and psychological health and how they understand causes, triggers, maintenance factors and what steps they need to make to work towards their goals. This enables PCWBS to attempt to deliver any interventions in an acceptable way to the patient. Sharing the formulation with other professionals in contact with the patient is also vital.

## Working with GPs and other health care teams

PCWBS clients may be in contact with one or more acute medical care teams, and the team and GPs stress the importance of all those working with the client to develop a shared understanding and, where appropriate, a ‘script’ for all services involved in the patient’s care (e.g. reception staff; GPs; ambulance crew; police etc) to understand the formulation and grounding techniques:

*“...everyone working with the patient needs to be saying the same thing, otherwise they go further down an unhelpful and potentially harmful route...it’s a difficult task because everyone in all teams who is likely to have contact needs to be brought on board...and that is hard enough in general practice, let alone with more than one acute care team...”* (Bradford GP)

The scripts are about reinforcing the formulation and wellbeing with each client, and helping them utilise the psychological help rather than a focus on symptoms and an illness message/model.

*“...it is enormously difficult not to offer more [physical] investigation, even when you doubt it will help...we have very little psychological or psychiatric knowledge and so we tend to offer what we have in our ‘tool kit’, which will be more tests and investigation...the involvement of PCWBS gives us confidence and reassurance and fills the gap in knowledge we don’t have...”* (Acute care consultant).



At the time of writing, PCWBS was working across four GP practices. The degree to which each practice participated was perceived to be variable. It was reported that some GP partners had less knowledge and interest in the links between physical and mental health and were less inclined to use the service, and some may have found the requirement for intensive case review prior to referral off-putting.

*“...we have a big educational function; a lot of people see a referral as a resolution of a problem, but we expect quite a lot of work to go into that referral and to continue working in partnership with the GP and patients after this... We see the GP as part of the team and not all those we want to work with see that...”*  
(Clinical psychologist)

*“...when we were establishing the team we initially had psychiatry, but we changed this...we already have the medical model well represented, we are all doctors!... What we wanted was an alternative way of viewing patients’ needs, something that was different and complementary and helped us achieve a fuller understanding...”* (Bradford GP)

In some cases, the PCWBS has worked with the patient and the Frequent Attenders Police and Ambulance Teams to help patients avoid prosecution or further prosecution. One example given was of a woman who was calling emergency services, when in distress, sometimes several times a day or at least daily. She has been supported to dramatically reduce this so that it is now an occasional occurrence.

*“...this is someone in their 50s, they have had years of domestic violence and attachment issues and these behaviours have been going on for some time ...you cannot expect to completely transform them overnight...it’s about taking first steps and then some more, it’s a gradual process of progression...”* (clinical psychologist)

## Catterick and Shropshire's GP style psychology services

The models of provision in Catterick, North Yorkshire, and in Ludlow and Telford, Shropshire were broadly similar, though not identical. The services in Shropshire were provided by a single clinical psychologist, with some trainee psychologist support, and operated in one general practice in each area (two days per week in each practice). The service in Catterick was provided by a single clinical psychologist, also with some trainee support.

Catterick is a small town known for both its racecourse and for its large military garrison, and it is the latter which perhaps has the most impact on the GP practice. Veterans have chosen to retire and settle in Catterick and there is also a significant military and ex-military family population, and in the case of the former often with a family member on a lengthy deployment.

Ludlow is a market town, also famous for its racecourse, in Shropshire. It serves a similar size population to that of Catterick and whilst it is more affluent, it does have one area within the town in the top 20% of deprived areas nationally and another in the top 30%, both close to the GP practice where the clinical psychologist was based. The practice, one of two serving the town, has a population drawn from the town and the surrounding rural areas.

Telford is a large new town, developed mainly in the 1960s and '70s. It has areas with significant deprivation and the GP practice where the project was based was one of these. The practice also served communities affected by a recent sexual exploitation and abuse scandal, and this was reflected in some of the patients who used the project.

The services in Catterick and Telford have both closed; Catterick closed a few months before data collection began and Telford soon after data collection completed. Both had been pilots and had non-recurring funding. The service at Ludlow has also changed and the practice now funds a single day of a mental health practitioner.

Both models were described as offering “a GP of the mind service” where they largely offered a fairly rapid access and unrestricted service. In both services, professionals or patients could freely and directly book appointments to see the clinical psychologist. In the Telford service, the majority of appointments were booked by the patient's GP and fewer appointments were booked for the under-18 age range. In Catterick and Ludlow, however, appointments were mainly booked by the patients and there were a greater number of young people accessing the service.

*“...the intention was to provide a genuine GP-style service and to deal with a large volume of patients, just as we do...”* (GP, Catterick)

Both services offered much shorter appointments than would be typical of clinical psychology (usually hour-long appointments). At Catterick the appointment times on offer were 15 minutes in length (these accounted for 42% of appointments), but with the option of the patient choosing to have two 15-minute slots together (i.e. a 30-minute slot – these accounted for 58% of all appointments). A total of seventy 15-minute appointments were available over a week (this could increase when a trainee psychologist was in post).

At both Ludlow and Telford, 30-minute appointments were offered:

*“...the way it worked was that you just had to work at a more rapid pace....so we would spend 10 minutes listening to the patient describe the problem, 10 minutes developing a formulation and 10 minutes offering the intervention....so we are basically doing things at twice the standard pace...”* (trainee psychologist)

*“...This is why it requires someone with both considerable experience and training... and it is very similar and indeed based on how GPs work...they are just the same, they have a very broad training and like us are an expensive resource... but it is the skill level you need to work successfully at that pace...”* (clinical psychologist).

Telephone consultation was also a significant part of the offer on all sites.

## Working with a range of needs

The style of working on all sites was essentially similar and the vast majority of people attending appointments were accepting of there being a significant psychological, emotional or mental wellbeing component to the issue that they were seeking help with. This is of course in contrast to many of the patients attending the Bradford project, who often had heavily invested in their issue being solely a physical condition.

The range of clients and presenting problems was very similar both in Catterick and Shropshire. At Catterick, the youngest patient had been under one year of age and the oldest well into their 90s. The types of problems seen on all sites included:

- Forms of psychological trauma
- Depression or low mood
- Anxiety symptoms
- Relationship and emotional difficulties
- Grief reactions
- More severe mental health symptoms (including those with suicidal ideation)
- Drug and or alcohol problems
- Chronic physical health problems
- Symptoms of chronic pain
- Autistic spectrum disorders
- Personality disorder
- A mixture of some of the above issues.

## The importance of formulation

*“...we often won’t know the outcomes of our consultations, as much like with GPs, people come and consult and don’t see a need to come back... Very often I am helping someone start off a new way of thinking about their problem or need...”* (Clinical Psychologist, Catterick)

For all three sites where this model was offered, it was important to understand, quite rapidly, the way in which each patient ‘mentalises’, i.e. the way they think about things and the way they understand others:

*“...if you want to deliver a message to a patient and want them to take it on board, it is vital that you know how they perceive things and think...you have to adapt the message and coat in the language that the patient you are with speaks...”* (Clinical Psychologist, Shropshire)

*“...I had a mother and their child with me just last week...they been through some difficult times and had been to various services...essentially the things they were experiencing were entirely normal reactions to traumatic events...and other services had told them this. Possibly what I did differently was to listen, not just to their story, but also how they told their story and how they thought about [it], and I essentially delivered the same message again, but tailored to how they thought...the reaction I got was enormous relief from both and they relayed that this is the first time they had been told this....”* (Clinical Psychologist, Catterick)

## Benefits of the approach

All three sites reported positive feedback from both patients and families, and we found professionals in primary care to be very enthusiastic about the services offered:

*“...the patients and their families like the service...I get really positive feedback...”* (GP, Shropshire)

*“...There were a number of patients I’d see every day [before the service started] who I was never really helping...”* (GP, Shropshire)

*“...In the past I might have offered extra time but probably not have helped patients much and some I might have referred on to IAPT or secondary care, sometimes with little hope they would be accepted...”* (GP, Shropshire)

## Data from the Catterick service

Data on actual service use had been collected for local audit and evaluation purposes (covering a 22-month period) and was made available from Catterick for this report.

Appointments and consultation (including Trainee appointments etc)	Total <sup>1</sup>
Appointments/consultations offered (number of patients)	3,190 (887)
Appointments/consultations attended (number of patients seen)	2,141 (790)
Non face to face consultation <sup>2</sup>	403 (218 <sup>3</sup> )
Phone intervention	394 (211 <sup>4</sup> )
Total appointments/consultations and patients receiving intervention	2,535 (979)
Did not attend (DNA – unplanned)	295 (233)
Cancelled	360 (273)

<sup>1</sup> Less than 5% of appointments offered were with a trainee psychologist, the vast majority of offers were with the senior clinical psychologist.

<sup>2</sup> These were consultations offered about specific patient given to another professional.

<sup>3</sup> These are included in the total figure above

<sup>4</sup> 89 patients received only intervention by phone consultation. The phone contacts are in addition to the appointments/consultations offered.

Had the project run for two years rather than 22 months, the number of appointments offered would have equated to 1,955 per year, or 163 per month. These appointments would have been offered to an estimated 1,064 individuals (532 each year).

Of patients who were seen by the service, 63% were female. Twenty-three per cent of patients were aged 17 or less, 74% were 18-65 and 3% were over 65.

The service had a dramatic effect on referrals to other services. Referrals overall to services in the local mental health trust reduced over the course of the pilot by 27%, and even more dramatically to community mental health teams by 47%. Referrals also reduced to the local Improving Access to Psychological Therapies service (IAPT), where there was a 60% reduction.

Some services, in contrast, received an increase in referrals, for example CAMHS increased by a third, but all those referrals were accepted by CAMHS. Referrals to a separate Primary Care Mental Health Service also increased by a similar margin (29%). These are teams of link workers and counsellors, provided by Tees, Esk and Wear Valleys NHS Foundation Trust, working with primary care and providing brief interventions for adults with mild to moderate mental health problems. Virtually all onward

referrals (mental health and non-mental health) were accepted. So, whether the Catterick service reduced referrals to some services or increased them to others, it appeared to significantly increase the likelihood of any onward referral being accepted, which, as previous quotes reveal, was not the experience prior to the pilot.

Though data was not available for onward referrals in Shropshire, the clinical psychologist there felt they had made an impact on other services by ensuring onward referrals were only made when necessary:

*“...the vast majority of referrals that we make are accepted and ‘stick’ with the service we refer to...”*

This was due to quite detailed work being done by the clinical psychologist in ensuring that the case was appropriate for referral, but also due to the psychologist preparing the patient on what to expect from secondary care (or other) services, so that they more were accepting of any offer made to them: this was described as “psychological readiness”.

Referrals from the GP practice in Catterick to secondary care have increased since the closure of the project and it was estimated this increase would be 28% by the end of the year post project.



## Project Future: a community-based, psychology-led service

Project Future is a psychologically led mental wellbeing project delivered directly to a community in Haringey. (It is a partnership that includes Barnet, Enfield & Haringey Mental Health NHS Trust, Haringey Council, Haringey Mind and formerly MAC-UK.) It was developed from three previous projects, in two other London boroughs (Camden and Southwark) by the charity MAC-UK. It is included in this report to demonstrate the value of clinical psychology being located in a community of people who do not readily engage with primary care and do not trust statutory services.

The project features clinical psychologists working alongside other professionals such as youth workers, but critically it works with young people to coproduce the project. Some of these young people will be employed to work as part of the core project team. Centre for Mental Health has evaluated all four projects and recruited from the young people using the project peer researchers (Stubbs *et al.*, 2017 & Durcan *et al.*, 2017).

The project works with young men aged 16 to 25, with experiences of the criminal justice system, specifically those exposed to serious youth violence and often labelled "gang-affiliated". Most of the young people do not seek help from formal services, often even when in severe need, for issues surrounding mental wellbeing, general wellbeing and for social and broader issues.

### Peer referral

The project is unusual in a number of ways and the referral route to the project, through peers, is a key example. Friends bring friends to the project and this ensures safety (young people from rival and conflicting peer groups do not mix) and helps in engagement; young people attend the project on recommendation from friends. This is particularly important as the young people largely do not trust anyone outside of their family or peer group: as one

young person stated, "...everyone is police until proven otherwise...". Another key feature is that young people do not have to be identified as having a problem with their mental wellbeing and are never obliged to take up offers of psychological support but can still use and benefit from the project.

### Coproduction

The project is a partnership between the local NHS trust (Barnet, Enfield & Haringey Mental Health NHS Trust), Haringey Council and Mind in Haringey. The project began with clinical psychologists building relationships with young people and, having identified a safe space (a property owned by the council), co-designed what the project would be like and what its focus would be. As with previous projects, young people wanted to develop creative skills (through music and film), fitness, cooking and support in finding work amongst other things. The young people also got involved in social activism and have met with local and national politicians and policy makers to champion the needs of young people and their community more generally.

### Therapy in 'bite sized chunks'

Whilst the everyday activity of the project is often not directly about psychological wellbeing or even wellbeing more generally, all of the interactions with the young people are clearly thought through, and this even includes text messages and emails. The founder of the original MAC-UK project and charity, Dr Charlie Howard, described the therapeutic approach as being "...evidence based interventions divided up into bite sized chunks..." which are designed around the needs of the young people they are working with. This is not all that dissimilar to the approaches in Bradford, Catterick and Shropshire, where likewise an understanding of the how the person 'mentalises' their world is felt to be crucial to effecting change.

## Formulation and mapping

As with the primary care models described, formulations form a key part of how the psychologists work with the young people. Understanding the wider context and social determinants for each young person is vital. This is referred to in the project as ‘mapping’ and is a process the whole team engages in weekly; this allows the whole team to share the same understanding of the young person. The mapping, as with formulation in the other projects, enables the team to draw on theory and evidence-based approaches to develop the intervention that best fits.

Stigma around mental health was very high among the young people at the outset and this changed over the course of the project. The initial stigma meant that many and indeed most young people would not seek help for any problems they experienced.

*“...I don’t know how long I could have carried on sweeping things under the carpet, but now I can bring it here and talk about it and feel free, get peace of mind, pour out what I’ve been keeping in for many years...”*

## The economic case for clinical psychologists in a primary role

There is a lot of evidence that psychological interventions work and are cost effective. The Washington State Institute for Public Policy (WSIPP, 2014-2016) found that for every £1 spent on interventions such as Cognitive Behavioural Therapy, for depression and anxiety, anything between £15 and £50 can be saved, and with at least an 84% likelihood that the benefits of programmes will exceed the costs. The case for IAPT is based on such evidence.

Delivering such interventions in primary care is also cost effective. For example, 'collaborative' primary care (which involves a mental health/psychology professional working in collaboration with primary care) for people with depression has a spend to benefit ratio of £1:£12, with a 98% chance that costs will not exceed benefits. Similar care for people with co-occurring medical problems has a spend to benefit ratio of £1:£7.50, and a 100% chance the cost will not exceed the benefits.

A recent UK case study of a pilot project addressing persistent physical problems in primary care in Nottingham demonstrated that the service produced savings equivalent to 72% of the total costs of delivering the service and 111% of the cost of staffing the service (O'Shea, 2019).

A local review of the model in Catterick found that the cost per contact for the clinical psychologist in the practice was £66, which was 36% less than the average psychology contacts (£103) and 253% more productive (i.e. seeing considerably more clients) than the mean across mental health services. This is due to the high-volume nature of the service. The degree of difference in cost and productivity would likely be less (but still significant) in Shropshire, due to longer appointments. What we do not have is an evaluation of the clinical outcomes produced, but satisfaction among those who used the service was high.

A published small scale evaluation of the Bradford PCWBS (Bestall *et al.*, 2017), in the first year of its operation and using a small sample of 19 patients, found that it reduced use of both secondary and primary care and within nine months had reduced the cost of intervention for those patients by £63,950 (i.e. a potential £85,267 over 12 months). Some costs such as out of hours contacts and prescriptions were not fully included (they were too resource-intensive to fully collect for the evaluation) and service use data was not available for all of the patients using the service. It is therefore possible that the total savings may have been significantly greater. Pemberton (2018) also evaluated the service and, reviewing costs for care of 65 patients, found a mean saving of £577 per patient (a saving in total of £37,496), made up of reductions in elective and non-elective admissions and use of Accident & Emergency departments.

The model in Bradford is working with the costliest patients in primary care and is showing promising results from an economic perspective. Evidence from Catterick (which will likely apply in a large part to Shropshire, too) indicates that such a service can see a significant number of patients and this reduces referrals to other services significantly, while those who are referred are more likely to be accepted by receiving services. We do not have sufficient evidence here to state that there is a proven cost-benefit case for the particular models we have explored, but it is likely that such models will have cost as well as clinical and human benefits.

## Conclusion

All of the services featured in this report offered help to people who may get little or no benefit from other health services, in some cases at a very high cost to them and to the NHS.

Newbigging and colleagues (2018) describe a huge gap between primary and secondary mental health care, where cases are too complex for IAPT services but yet fall short of secondary care thresholds (which have risen in recent years). The clinical psychologists in all of the services we have described were able to make an offer to many of the people falling into this ‘chasm’, and for others were able to offer an intervention that would improve engagement with other services:

*“...a lot of the people that attend the surgery have complex needs and GPs will find them very difficult to deal with, but these same patients often fall below the threshold of entry into secondary care and will not be accepted by them, or are also going to be too complex for IAPT... I was able to make an offer to many of those patients and found that the referrals to both secondary care and IAPT were accepted...in addition, prior to referral I worked with the patients to help them understand how the service worked and how it might help. This is actually really important and helps with engagement...”* (Clinical Psychologist)

The models described in this report have all brought psychological intervention and formulation closer to communities, either through GP surgeries or in alternative locations. In so doing, they may have an important contribution to current developments in the provision of health care, such as Integrated Care Systems, Primary Care Networks and the implementation of the NHS Long Term Plan.

The aim of Integrated Care Systems is to support joined up care from a variety of providers and sectors, and to bring this closer

to communities. The lessons from the Catterick project are being applied to local thinking on Integrated Care Systems: at the time of the interviews for this report, this included the contribution clinical psychology can bring to a primary care led ‘one stop shop’ for children and young people.

Primary Care Networks are currently funded to employ additional physiotherapists, pharmacists and some other professionals, and from April 2021 this will be extended to mental health professionals, including clinical psychologists (Naylor *et al.*, 2020). This represents a major opportunity for the NHS to benefit from the knowledge, expertise and distinctive approach that psychology can bring to primary care. The services featured in this report show the benefits that taking this step can bring.

The Community Mental Health Framework (NHS England, 2019b) creates a further opportunity to expand primary care clinical psychology provision. It sets out an expectation that the gaps between primary and secondary mental health care will be closed with the development of a ‘whole person, whole population’ approach to community mental health services for adults in England. The services described in this report will be essential to bridge the gaps and offer a genuinely ‘whole population’ approach to mental health in primary and community care.

The models we have described show that different approaches can be applied to meeting different types of need in different places: there is no one-size-fits-all to primary care psychology, and in some cases, such as Project Future, it need not be in primary care settings at all. But by bringing clinical psychology into the heart of primary care and into communities, the NHS could reach people whose needs have rarely been well met and provide better care close to home.



## Recommendations

The recommendations set out below will help to extend and embed clinical psychology within primary care in England. Similar approaches can be taken in the devolved nations to bring about equivalent outcomes in each part of the UK.

- **NHS England/Improvement** should ensure that the implementation of the NHS Community Mental Health Framework is aligned with the development of Primary Care Networks to maximise the opportunities to bring clinical psychology expertise into primary care, drawing on the models presented in this report. This should include robust and independent evaluation and impact measurement to assess which models work in which places and in what circumstances.
- **The Department of Health and Social Care** should ensure that the national recruitment campaign for 26,000 more primary care professionals working over the NHS in the next 5 years has a focus on psychological approaches. This would include family and community approaches and population-based prevention initiatives. The psychological workforce profile should be considered in the context of meeting the needs of the local populations, taking account of demographic and diversity characteristics. The psychological workforce should include clinical psychologists and other applied psychologists and psychological professions to support a more balanced and integrated workforce to better meet people's mental and physical health care needs.
- **Primary Care Networks** should take the opportunity to offer clinical psychology to their patients by employing mental health professionals from April 2021.
- **Clinical commissioning groups** and integrated care systems should develop plans and local recruitment strategies for extending clinical psychology provision in primary care as part of the implementation of the NHS Community Mental Health Framework.
- **Integrated care systems, clinical commissioning groups and local authorities** should explore the potential for innovative community psychology projects to address unmet needs in the most marginalised communities whose members do not routinely seek help from statutory services.

## References

- Bestall, J., Siddiqi, N., Haywood-Everett, S., Freeman, C., Carder, P., James, M., Kennedy, B., Moulson, A. & House, A. (2017) New models of care: A liaison psychiatry service for medically unexplained symptoms and frequent attenders in primary care. *British Journal of Psychiatry Bulletin*, 41:340-344.
- British Psychological Society (2011) *Good Practice Guidelines on the use of psychological formulation*. Leicester: British Psychological Society.
- BPS (2019) *What is clinical psychology?* [Online] Available at: <https://www.bps.org.uk/public/az-of-psychology> [Accessed 3 September 2020]
- Clark, D. (2018) *A guide to Improving Access to Psychological Therapies services* [Online] Available at: <https://www.england.nhs.uk/blog/a-guide-to-improving-access-to-psychological-therapies-services/> [Accessed 3 September 2020]
- Durcan, G. (2016) *Mental Health and Criminal Justice: views from consultation across England and Wales*. London: Centre for Mental Health
- Durcan, G., Stubbs, J., Appleton, S. & Bell, A. (2017a) *The Future of the Mental Health Workforce*. London: Centre for Mental Health
- Durcan, G., Zlotowitz, S. and Stubbs, J. (2017b) *Meeting us where we're at*. London: Centre for Mental Health
- Eells, T. (2013). The case formulation approach to psychotherapy research revisited. *Pragmatic Case Studies in Psychotherapy*, 9(4), 426-447.
- HCPC – Health Care Professions Council (2019) *Total Registrants at 12/03/2019* [Online] Available at: <https://www.hcpc-uk.org/resources/freedom-of-information-requests/2019/number-of-clinical-psychologists---march-2019/> [Accessed 3 September 2020]
- Kat, B. (2019) *Associate Psychologist: Is it 'groundhog day' again?* Available at: [https://acpuk.org.uk/associate\\_psychologists/](https://acpuk.org.uk/associate_psychologists/) [Accessed 3 September 2020]
- Kelly, G. (1955) *Theory of personal constructs*. Norton. New York (Routledge 1991 edition)
- Llewelyn, S. & Aafjes-van Doorn, K. (2017) *Clinical Psychology: A very short introduction*. Oxford University Press . Oxford.
- Mind (2018) *GP Mental Health Training Survey Summary* [Online] Available via: <https://www.mind.org.uk/media-a/4414/gp-mh-2018-survey-summary.pdf> [Accessed 3 September 2020]
- Naylor, C., Bell, A., Baird, B., Heller, A., Gilbert, H. (2020) *Mental health and primary care networks: understanding the opportunities*. London: The King's Fund and Centre for Mental Health
- Newbigging, K., Durcan, G., Ince, R. and Bell, A. (2018) *Filling the Chasm: Reimagining primary mental health care*. London: Centre for Mental Health
- NHSE (2017) *Implementing the I've year forward view for mental health* [Online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/07/fyfv-mh.pdf> [Accessed 3 September 2020]
- NHSE (2019a) *Breaking down barriers to better health and care: How health and care improve when the NHS, councils and communities all work together*. [Online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2019/04/breaking-down-barriers-to-better-health-and-care-march19.pdf> [Accessed 3 September 2020]
- NHSE (2019b) *The Community Mental Health Framework for Adults and Older Adults* [Online] Available from: <https://www.england.nhs.uk/publication/the-community-mental-health-framework-for-adults-and-older-adults/> [Accessed 3 September 2020]
- O'Shea, N. (2019) *A new approach to complex need: Primary Care Psychological Medicine first year evaluation*. London: Centre for Mental Health.

Pemberton, S. (2018) *Medically Unexplained Symptoms Project: Part 1 evaluation of the effectiveness of the pilot*. London. Dr Foster – Tesla Health.

Stubbs, J., SC, D, M, T, R and Durcan, G. (2017) *Unlocking a Different Future: An independent evaluation of Project Future*. London: Centre for Mental Health

Wortman, M., Lokkerbol, J., Vanderbilt Wouden, J., Visser, B., van der Horst, H., olde Hartman, T., (2018) Cost-effectiveness of interventions for medically unexplained symptoms: A systematic review. *PLoS ONE* 13(10): e0205278. <https://doi.org/10.1371/journal.pone.0205278>

WSIPP - Washington State Institute for Public Policy (2014-2016) *Benefit-Cost Results: Adult Mental Health* [Online] Available at: <https://www.wsipp.wa.gov/BenefitCost?topicId=8> [Accessed 3 September 2020]

## Clinical psychology in primary care

Published September 2020  
Photograph: FatCamera, iStock

£10 where sold

Centre for Mental Health is an independent charity and relies on donations to carry out further life-changing research. Support our work here:  
[www.centreformentalhealth.org.uk](http://www.centreformentalhealth.org.uk)

© Centre for Mental Health, 2020  
Recipients (journals excepted) are free to copy or use the material from this paper, provided that the source is appropriately acknowledged.



Centre for  
Mental Health



Centre for Mental Health

Office 2D21, South Bank Technopark,

90 London Road, London SE1 6LN

Tel 020 3927 2924

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

Follow us on social media: @CentreforMH

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