

Deep End Report 26

Generalist and specialist views of mental health issues in very deprived areas

Deep End Report 22 summarised the experience and views of general practitioners concerning mental health issues in very deprived areas. This follow up meeting was arranged to extend the discussion by involving both general practitioners and specialist colleagues.

December 2014

Seven general practitioners from Glasgow, Edinburgh and Dundee, six specialists from psychiatry and psychotherapy and three observers met for a half day meeting on 26 September 2014 to share and compare views and experience of mental health problems in very deprived areas.

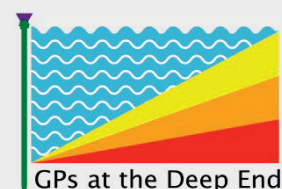
SUMMARY

- Generalists and specialists working in mental health care have different purposes, vantage points, perspectives, resource constraints, experience and language, but common cause in understanding the nature of mental health problems in deprived areas and how they are best addressed.
- Mental health services provide excellent care for patients with psychoses or severe depressive illnesses, but everyone struggles to work effectively with patients with relational difficulties, including the consequences of complex trauma and personality disorder.
- Many adult patients in this context face the “double whammy” of ongoing adversity combined with the lack of social and relationship skills to deal with it.
- Patients who do not “fit” established categories and services for dealing with problems can end up “ping ponging” round and out of services in a chaotic way. Many patients have had experience of multiple exclusion and the challenge is to break this cycle.
- Although all services can provide long term care, specialist services try to focus on where they can make a difference, before referring patients back to general practice.
- In Greater Glasgow and Clyde Health Board, there is an interface group to address problems which occur when patients are referred, in either direction, between general practice and mental health services.
- Multidisciplinary working within homelessness services was described as a positive model of service provision for patients with complex, challenging problems.
- The knowledge and expertise of colleagues working in specialist services could be shared more widely with general practitioners, for example “mentalising” approaches and supervision/peer support for complex cases.
- Deep End practitioners need more consultation time and are keen to assess the role of attached workers in helping patients with mental health problems.
- Almost everyone who is significantly “distressed” will meet diagnostic criteria for depression, but not all will be helped by antidepressant medication. The Scottish Government is reviewing the NHS response to distress, a move which was welcomed by GPs but has significant implications for mental health services.
- There is collaborative work to do, in determining what is meant by “complex, challenging needs”, developing an ideal treatment plan, and comparing current experience against this ideal
- Separate discussion is needed, between GPs and specialists in child and adolescent psychiatry, to consider the contribution of general practice to the prevention of mental health problems across the life course. A key focus is on effective support for children and families.

CONTENTS

Introduction.....	1
Format.....	1
Participants.....	2
Setting the scene (conclusions of the previous meeting of GPs).....	3
Presentations	4
Discussion of problems and challenges	5
<i>Working effectively with complex patients</i>	6
<i>Reconciling disciplinary perspectives</i>	7
<i>A life course approach to mental health</i>	8
Discussion of possible solutions.....	8
<i>Communication between GPs and mental health services</i>	8
<i>Training</i>	8
<i>Service design – attached mental health workers</i>	9
<i>Knowledge gaps</i>	9
Action points.....	9
ANNEX A Mental health Services in Greater Glasgow.....	10

General Practitioners at the Deep End” work in 100 general practices, serving the most socio-economically deprived populations in Scotland. The activities of the group are supported by the Scottish Government Health Department, the Royal College of General Practitioners, and General Practice and Primary Care at the University of Glasgow.



Deep End contacts

John Budd *Lothian Deprivation Interest Group* John.Budd@lothian.scot.nhs.uk

Mairi Russell *RCGP Scotland* Mairi.Russell@rcgp.org.uk

Petra Sambale *Keppoch Medical Practice, Glasgow* psambale@googlemail.com

Graham Watt *University of Glasgow* graham.watt@glasgow.ac.uk

INTRODUCTION

In April 2014, General Practitioners at the Deep End, serving the 100 most deprived populations in Scotland, produced a report “Mental health issues in the Deep End.” (page 3). The meeting shared experience and views on the nature and origins of mental health issues in very deprived areas and how they can be addressed. A follow up meeting was arranged to address the same issues jointly with specialist colleagues working in mental health services in primary and secondary care.

FORMAT

The follow up meeting took place at Maryhill Burgh Halls in Glasgow on 26 September 2014.

13.45 Introductions

Graham Watt, Professor of General Practice, University of Glasgow
Dr Michael Smith, Associate Director for Mental Health, Greater Glasgow & Clyde Health Board

14.00 Attachment in early years and childhood

Helen Minnis, Professor of Child and Adolescent Psychiatry, University of Glasgow

14.20 The consequences of attachment-related problems in adulthood

Alison Linington, Consultant Psychiatrist and Psychotherapist, Homeless Personality Disorder Team, Glasgow

14.40 Discussion of problems and challenges

15.15 Break

15.35 Discussion of possible solutions

16.30 Action points

17.00 Close

PARTICIPANTS

Generalists

Name	Location	List size	Deprivation ranking
Georgina Brown	Springburn HC	7187	51
Susan Langridge	Possilpark HC	2165	27
Jim O'Neil	Lightburn HC	3117	37
Raymond Orr	Glenmill Medical Practice	6113	30
Nicola Smeaton	Mill Practice, Dundee	9365	85
John Budd	Edinburgh Access Practice		
Andrea Williamson	Homeless Health and Resource Services, Glasgow		

Specialists

Helen Minnis	Professor of Child and Adolescent Psychiatry, University of Glasgow
Michael Smith	Associate Medical Director for Mental Health, NHS Greater Glasgow and Clyde
John McTaggart	Consultant Adult Psychiatrist, Springpark, NHS Greater Glasgow and Clyde
Alison Linington	Consultant Medical Psychotherapist, Homeless Personality Disorder Team, NHS Greater Glasgow and Clyde
Angela Cogan	Consultant Adult Psychiatrist, NW Glasgow, NHS Greater Glasgow and Clyde
Trina Ritchie	Acting Lead Clinician, Addiction Services, NHS Greater Glasgow and Clyde

Observers

Lindsay Burley	Chair, Scottish Association for Mental Health (SAMH)
Billy Watson	Chief Executive, Scottish Association for Mental Health (SAMH)
Graham Watt	Professor of General Practice, University of Glasgow

SETTING THE SCENE (conclusions of the previous meeting of GPs)

- Mental health problems, and GP consultations involving mental health problems, are more than twice as prevalent in deprived areas as in affluent areas, and are the commonest co-morbidity in deprived areas, and rise in prevalence in direct proportion to the number of patients' other problems.
- Depression (i.e. being on regular antidepressant treatment) is recorded in about a sixth of patients with most chronic medical conditions.
- In consultations for psychosocial problems, patients in deprived areas have poorer health and a greater number of other health problems; consultations are shorter than in affluent areas and patient enablement is lower; GPs report higher levels of personal stress after such consultations.
- In a study of 3000 consultations, the patients who were least likely to report being enabled after seeing their GP were patients in deprived areas with a psychosocial problem.
- The causes of the high prevalence of mental health problems include the burden of other conditions, the long term consequences of difficult experiences in early life and the combination of these factors.
- Theories of childhood attachment, the consequences of complex trauma and "allostatic load" may lead to better understanding and management of mental health problems and multimorbidity.
- Some patients have difficulty in forming and maintaining relationships, with substantial implications for their use of professional help and health care.
- Medication provides only a partial solution to these problems.
- When care is shared between services, it is essential that the links are quick and effective.
- Although an audit of referrals for first level support of mental health problems in Glasgow showed referrals rates to be 50% higher from very deprived areas than from affluent areas, epidemiological data suggest that rates should be double in very deprived areas.
- The HEAT target on waiting times for psychological services has had little impact on mental health issues in the Deep End.
- In practices with large numbers of patients with mental health problems, attached mental health workers could help to provide more integrated care.
- Counselling and third sector support services are seen as vital and more permeable than statutory services, but are under increasing threat as a result of current austerity policies.
- Services for homeless people have pioneered highly integrated and personalised support arrangements for people with long term problems and complex mental health needs, providing a model which mainstream services should follow.
- A major continuing constraint is the inverse care law in Scotland, which results in less consultation time being available in general practices in deprived areas for patients with mental health problems.
- There is a need for increased professional dialogue, sharing experience, evidence and views as to how such care is best delivered.

For the full version of Deep End Report 22, see www.gla.ac.uk/deepend

PRESENTATIONS

Michael Smith presented data from the Adverse Childhood Experiences (ACE) studies in the US,* showing that people who experience four or more categories of adversity in childhood are:

- nearly twice as likely to have physical health problems such as heart disease, stroke and cancer in adulthood
- 4 times more likely to have depression
- 8-10 times more likely to have an alcohol or drugs problem
- 12 times more likely to commit suicide

A recent UK study suggested that experience of four or more ACEs was strongly correlated with a diagnosis of an STI (30 times more likely in this group)**

More than half of the excess morbidity and mortality in Glasgow can be attributed to violence, suicide, alcohol and drug misuse. MS drew attention to the link between these problems and early life adversity. Work is ongoing to evaluate whether children in the West of Scotland experience more adversity than their counterparts in similar cities in England.

In adulthood, many people face the "double whammy" of ongoing adversity combined with the lack of social and relationship skills to deal with it. Many do not "fit" established categories and services for dealing with problems and can end up "ping ponging" round and out of services in a chaotic way.

A key point from the earlier meeting had been the identification of the "serial encounter" as the mechanism whereby people can engage and work with a small number of known and trusted professional helpers.

* Felitti, V., Anda, R. & Nordenberg, D. *Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) study.* *Am. J. Prev. Med.* 14, 245–258 (1998).

** Bellis, M. a, Lowey, H., Leckenby, N., Hughes, K. & Harrison, D. *Adverse childhood experiences: retrospective study to determine their impact on adult health behaviours and health outcomes in a UK population.* *J. Public Health.* 36, 81–91 (2014).

Helen Minnis discussed whether inadequate attachment and maltreatment in childhood are the roots of multimorbidity in adults.

In 1944 a study of 44 juvenile thieves had shown that 14 were "affectionless psychopaths", of whom 12 had experienced early and prolonged separation from parents. Much has improved since then, with rates of violent crime declining faster in the UK than anywhere in Western Europe. We no longer have state-sponsored neglect in care institutions. Increasingly there is recognition that the most important violence reduction and health promoting agent is a relationship in childhood which helps interpret the world, introduces language, develops stress responses, introduces children to "a culture" and generally helps complete "brain gestation".

In terms of brain development, the areas most susceptible to adverse experiences are those that continue developing long after birth, with a high density of receptors for stress hormones. According to Teicher, maltreatment may cause a "precociously mature cerebrum with stunted final capacity".

A study of 1600 six and seven year old Glasgow children showed that most children were doing well in terms of mental health and that mental health problems were not simply due to poverty. About 1% of children had Reactive Attachment Disorder (RAD), mainly in its disinhibited form. All had at least one other diagnosis and all had been abused or neglected.

An overlap between RAD and Maltreatment-Associated Psychiatric Problems (MAPP) was present in nearly 10% of the population. This group had significantly more outpatient appointments than their peers. Contacting and getting the cooperation of these families was a difficult and lengthy challenge for the researchers, with some families receiving up to 12 telephone calls and 12 home visits, after giving consent, in order to complete an assessment.

Referring to the wider literature, the 10% of children with early onset persistent aggression commit 50% of adult crime; children with conduct disorder cost society 10 times as much by adulthood; young offenders have 10 times higher all cause mortality than the general population; and the risk of psychosis in adult life is increased almost threefold for those who have been maltreated in early life.

In Glasgow in 2010, of children aged 0-5 coming into care, two thirds went home within the first year, but two thirds of them came back into care.

She concluded with four needs:

1. better understanding that ALL babies need loving adults to “plug into”
2. higher quality decision-making concerning whether a neglected or abused child should go home or be adopted
3. MUCH more rapid progress through the social work and legal systems
4. a focus on children’s rights over parent’s rights.

Alison Linington talked about her role in the Homeless Personality Disorder team, Glasgow. They find that attachment style can have long term consequences, ranging from experiencing serial difficulty in engaging with services to being over-friendly and over disclosing on initial contact, but dropping out of contact before long. Many patients had experience of multiple exclusion and the challenge is to break this cycle.

In their 2012 service audit, they found that about half of patients had been in local authority care as children, with a third having had as many as six separate placements. Alcohol and drug misuse are common. Patients present as difficult, challenging and attention-seeking. It is “not that the service is not trying” but successes are hard to achieve.

A video clip of the “still face” experiment was shown which demonstrated how distressed young babies become when their caregiver keeps their face immobile and does not respond (i.e. “attune”) to their needs.

DISCUSSION OF PROBLEMS AND CHALLENGES

In a first meeting between generalists and specialists, there were some rough edges to the discussion, based on different vantage points, resource constraints, experiences

and language, but a willingness to pursue issues of common interest and to find joint solutions.

In general, mental health services were considered to provide excellent care for patients with psychoses or severe depressive illnesses. Services for patients with relational difficulties, including personality disorder and the consequences of complex life trauma, were considered more problematic.

Services are trying hard and were felt to be improving, being less exclusive and more flexible. On the one hand, specialist services try to focus on where they can make a difference (Annex A). On the other, general practice remains with the patient for the long term.

Working effectively with complex patients

Despite good intentions, services can be fragmented, lacking coordination and continuity. General practitioners are well placed in terms of having serial contact with complex patients, which could provide a basis for consistent care and relationship-building. Practices often lack the time and support needed to do this. While professionals cannot replace the relationships that people ideally should have in their personal lives, it is known that some relationships with professionals are of real long term value to patients.

The role of counsellors attached to practices is valued by GPs but evidence of improved mental health outcomes is considered sparse by psychiatric colleagues. GPs felt that the type of attached professional is less important than the type of person. Support workers, “who are there all the time,” could provide the necessary proximity, accessibility and continuity of contact, along with appropriate boundary setting, to achieve this.

GPs vary in their interest, aptitude and skills in dealing with complex challenging patients. Some described “rules of engagement”, limiting contact to fixed times in order to establish more regular behaviour. Such experience could be shared with other practices. Isolated professional experience increases the risk of burn out.

In some practices, the “extreme is common”, with perhaps 3% of patients having complex challenging needs. Many patient encounters involve similar but less extreme problems.

Although patients with the complex challenging needs just described were thought to be costly for services, it seemed that there is little information on this and, in particular, whether use of secondary care services varies according to local strengths in primary care. It is at least a conjecture that if primary care is strong, and able to contain problems within a local network of well-connected services, patients are less likely to take the “fast track” to unscheduled care involving out of hours, accident and emergency and acute hospital services.

A key, generally unmeasured, aspect of the strength of primary care is the quality of communication within and between teams.

Deep End Report 24 – “What are the Continuing Professional Development Needs of GPs working in very deprived areas?” – had identified not only a list of familiar topic areas, but also two generic issues: how to engage successfully with patients lacking engagement skills and how to remain optimistic when dealing with serial, challenging patients. In addressing these issues there is scope for knowledge transfer, with GPs learning from the experience of clinical psychologists and other specialist colleagues.

Personality disorder was used historically in a pejorative way, labelling patients as 'trouble' and 'untreatable'. This is starting to change and examples were given where patients could usefully use this diagnosis to help explain their experiences and to seek help. It was acknowledged that relationship dysfunction is often a big part of the presentation of a person who has personality disorder features and that this often continues in relationships with health care providers. There is scope for improved professional training in these areas. For example, a recent initiative in Greater Glasgow and Clyde has been for mental health professionals to undertake 'mentalizing' training, an evidence-based way of working effectively with patients with personality disorder. One participant had provided some training about personality disorder for a whole GP practice, including reception staff. The practice reported that they found this very helpful and productive.

Reconciling disciplinary perspectives

The discussion moved on to consider patients with less severe difficulties and issues.

A limitation of specialist knowledge can be its exclusive nature, restricting research and resulting knowledge to selected definitions of cases. In general practice, with its unconditional acceptance of patients' problems and general inability to discharge patients (except in extreme cases), such knowledge can have limited applicability.

General practitioner's knowledge of patients is built up incrementally over serial contacts, often over many years. In these circumstances, psychiatric diagnoses are made in an intuitive fashion sometimes referred to as 'clinical gestalt'. There have been very few studies comparing 'clinical gestalt' and formalised diagnostic strategies. In 'medical' diagnoses, studies do generally suggest a high level of diagnostic accuracy by skilled and experienced clinicians. Much less is known about biases and errors when this approach is applied to mental health problems.

There is a move away from applying precise diagnostic criteria to acting instead on manifestations of "distress". It was noted that almost everyone who is significantly "distressed" will meet diagnostic criteria for depression (the previous meeting had noted that antidepressants are often insufficient to help such patients).

Mental health professionals need to manage their work-load, making space to accept new referrals into their service. They described their need to be clear about what they can do for patients and, importantly, when they cannot provide any effective intervention.

GPs refer patients to mental health services when they feel the need for additional specialist input. When referrals are refused they see this as unhelpful and invalidating their request for support and expert input. There is a tension, therefore, between the GP and patient's need for additional input, and the responsibility of mental health services to manage demand and provide clinical interventions likely to benefit the patient.

In the case of general medical and surgical admissions to hospital, it is now acknowledged that a GP's request for admission should be accepted at face value, without prolonged interrogation. This was not the experience of GPs who sometimes described long delays in getting acceptance of their requests for secondary care in mental health emergencies. It was agreed that this issue should be followed up via existing arrangements for addressing interface issues.

From a provider point of view, what seems like service integration to one person, may seem like service fragmentation to another* Ultimately, however, it is the patient experience that counts, and should be counted. Primary care mental health services have introduced self-referral by patients to open up services and improve patient experience.

*(If “your integration is my fragmentation”, then service providers rather than patients need to carry the burden of service coordination and consistency. See Leutz at <http://www.kingsfund.org.uk/blog/2011/07/nhs-reforms-five-laws-integrated-care>).

A life course approach to mental health

The previous meeting (Deep End Report 22) had focused mainly on adult services. A separate report (Deep End Report 23, building on Deep End Report 12) had addressed the role of general practices in supporting vulnerable children and families. The Scottish Government’s Policy Getting it Right For Every Child (GIRFEC) barely mentions general practice, despite its continuing contact with many families, including parents and grandparents, in good times and bad.

In general, the meeting focused more on addressing the long term consequences of emotional damage in early life than on preventing such damage in today’s children. Further discussion is needed to address the latter issue.

DISCUSSION OF POSSIBLE SOLUTIONS

Communication between GPs and mental health services

It would be helpful for GPs to be told when mental health services have done all they can for a patient and need to disengage. A useful example from CAMHS was described. Although this can leave GPs feeling vulnerable, in terms of trying to establish a long term productive relationship with patients, better communication could reduce patients’ feelings that they are getting pushed from pillar to post. Similarly, it would be helpful to GPs to know what interventions, including medications, had been considered and tried by the mental health team.

There was discussion about the pros and cons of providing information to GPs about strategies that might help patients with complex mental health needs in practical, behavioural and emotional terms.

Training

The consultations that the Personality and Homelessness Team already offer to the generic mental health services and voluntary organisations (which colleagues in other services had found helpful in managing more challenging patients with borderline personality disorder diagnoses) could be offered to Deep End GP practices. This would involve offering a reflective space rather than simply “training”, allowing the practitioners to voice their ambivalent feelings towards these patients and to validate

the importance of the relationship the GP is offering to the patient. Experience in working with this model has led to better understanding of the way early attachment experiences influences relationships later in life, and has helped practitioners to tolerate the ups and downs in their relationship with these patients.

Service design – attached mental health workers

Considerations of service re-design focused on the needs of patients and services in areas of concentrated deprivation, and do not necessarily apply to the wider range of primary care mental health services.

Multi-disciplinary working within homelessness services was described as a positive example of service provision. Referrals from the GPs are discussed with the mental health team. They accept referrals for patients who require specialist mental health support but importantly they also see patients in order to signpost them to support outwith mental health services.

The care coordination role that addiction care managers can have for patients is a highly valued by some patients and their GPs.

A practice in Dundee has recently started having an attached clinical psychologist working with the practice. They provide a whole range of services and the benefits are: GPs have face to face contact with them; they help facilitate access for patients; they write in the same notes; they explain what they are trying to do; and all work together to facilitate this. The service includes practical strategies for recovery or coping.

There was a call from GPs (building on discussions at the first meeting) that some kind of mental health resource in practices would be extremely welcome, especially in practices with large numbers of patients with mental health problems

Knowledge gaps

It would be helpful to collate the relevant evidence-base, insofar as there is one, underpinning the experience and expertise reported at the meeting. A future project might determine what is meant by “complex challenging needs”, establish a cohort of such patients, use qualitative methods to describe their difficulties, generate an “ideal” treatment plan and compare their experience against the ideal.

ACTION POINTS

- Develop an attached worker proposal for submission to the GGC Director for Mental Health.
- Develop training initiatives (practice-based small group learning, primary care protected learning events, joint sessions involving generalists and specialists).
- Refer interface issues in GG&C via the NHS Primary Care-Mental Health Interface Group.
- Review the epidemiology of primary and secondary mental health care use (e.g. by deciles of deprivation, based on GP denominators).

- Consider “relationships” as a health technology with ubiquitous indications, like statins or aspirin. If a continuing trusted relationship is an important intervention, how should it be prescribed, provided and reviewed?
- Pursue the contribution of general practice to helping vulnerable families.
- Review methods of assessing the quality of joint working between community mental health services and local general practices, drawing from current examples such as CMHT models, the Homeless Health Service in Glasgow, the Edinburgh Access Practice and the Homeless Personality Disorder team.
- Consider what a strategy for “containing patients with complex mental health presentations problems in the community” with a “recovery focus” would look like.

ANNEX A MENTAL HEALTH SERVICES IN GREATER GLASGOW

Mental health services in Greater Glasgow are currently arranged as follows:

1. **Open Access services**

The plan is to expand STEPS-style open access resources board-wide, to encourage self-management of mild mental health problems. GGC patients can also access internet-based self-help and phone-based CBT.

2. **Short-term intervention for common problems**

Primary Care Mental Health Teams (PCMHTs) help manage the “common mental health problems” presenting to primary care - the teams receive 18,000 referrals a year, and the average wait is 4-6 weeks.

3. **Multidisciplinary, long-term treatment**

CMHTs are multidisciplinary, take on a case management role when appropriate and will see patients (at home or in clinic) for as long as needed – for decades in many cases.

4. **Emergency access**

Crisis and Out of Hours teams are available Board-wide to respond to emergencies, with home visits/treatment if needed. The OOH team receives 20,000 calls a year.