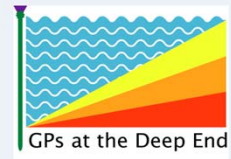


Primary care support for problem
alcohol use in areas of highest
deprivation

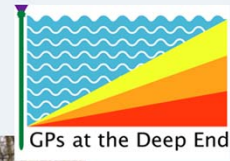
Dr Andrea Williamson
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Overview



- Introductions
- GPs at the Deep End- background, themes, activities
- Theoretical perspectives
- Attached alcohol nurse pilot, Glasgow
- The future/discussion

Introductions

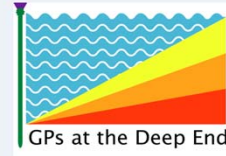


I would like to get a sense of your backgrounds with a show of hands please. Folk who work in community based services? Folk who work in secondary care? Mixed primary and secondary care? Doctor? Nurse? AHP? Psychiatry specialty training background? General practice? Does anyone work in a setting outside of the UK?

I have worked in a variety of roles in this service for around 15 years. Very early on I found that the very good communication skills training and what I thought I knew about how patients engage in care in my GP specialty training just did not make sense when trying to work with patients in this setting! I have a clear memory of sitting in a rather manky (sorry that's a scots word for dirty) consulting room in one of the old Glasgow hostels having just had another unsatisfying and mystifying consultation with a patient. I also live- as I am sure many of you do- with an ongoing sense of grappling with encouraging patients to engage in care.

So in the various work roles I have- university, GP, addictions- I continue to attempt to make my own skill set- and the health care system I work in a better fit for those patients. That gives you some sense of why I focus on what I do.

Background



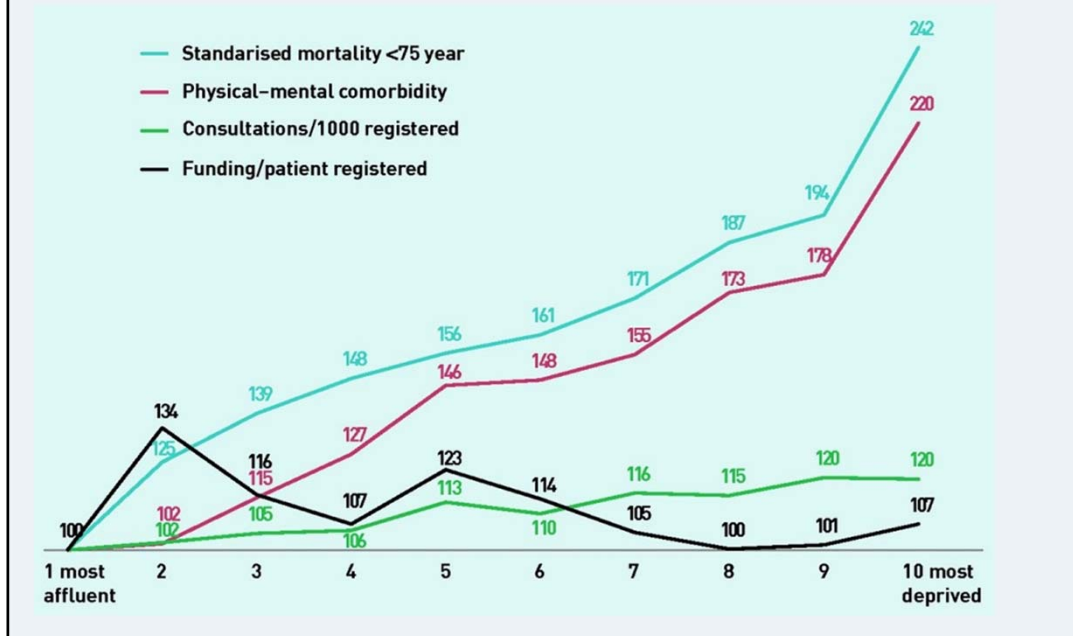
- 100 most deprived practices in Scotland
- Blanket deprivation
- 76 practices in Glasgow
- Complex co-morbidity and premature mortality

The GPs at the Deep End project was set up 7 years ago driven by a realisation that general practice (and wider health care) delivery was just not working in areas of high socio-economic deprivation.

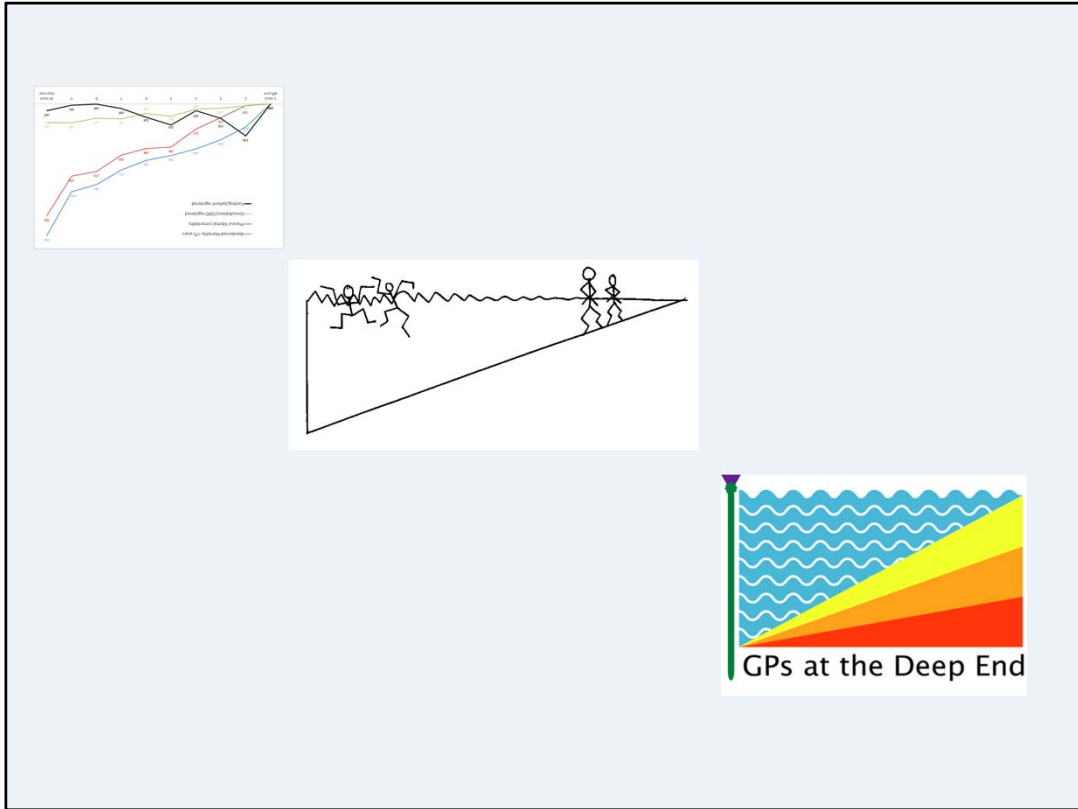
It is a voluntary collective of both service and academic GPs who have been meeting regularly over those past 7 years convened by my academic colleague Graham Watt. By SIMD scoring, the deep end project includes the 100 most SE deprived practices in Scotland- 76 of those are in Glasgow. The deep end is characterised by blanket deprivation so the majority of people living in those areas experience this. The evidence tells us that people living in deep end areas experience complex co-morbidity and premature mortality.

Scottish GP resource v outcomes

(figure 1 McLean et al BJGP e 799, Dec 2015)

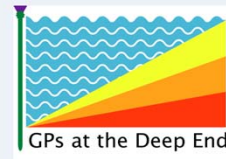


This graph from a recent paper by deep end colleagues illustrates this. The left hand side of the graph is the most affluent 10th of the Scottish population, the right the most SE deprived. The top line is standardised mortality rate, the next physical and mental co-morbidity. The two bottom lines are consulting rates and GP funding respectively.



It's this reality of how much unmet need is NOT met by health care provision that was the inspiration I

Deep End Themes



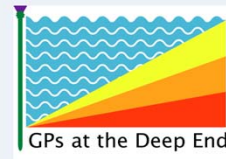
- Addressing the Inverse Care Law
- Meeting complex social and health needs more effectively:
 - GP time
 - improved team working - primary care
 - improved team working -secondary care
 - Proper attention to patient engagement in care
 - Role of the wider social determinants of health

So what have we been focussing on?

The most important has been addressing the Inverse care law- just described and illustrated where those with the greatest need do not receive the greatest care. Linked to that is how people's complex health and social care needs can be met more effectively.

This includes more GP time to see patients, better links within primary care and between primary and secondary care. A key focus is improving patient engagement in care. This surprised me initially- these are the same kind of issues we struggle with in people experiencing multiple exclusion in homelessness and addictions- these are pertinent in deep end practices too. We would not be taking account of the evidence base and our roles as patients' advocates seriously if we did not also pay proper attention to the wider social determinants of health outside of health care delivery. Some work on welfare reform is an example of this.

Deep End Activities



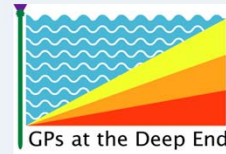
- Listening to what Deep End GPs have to say- 30 Deep End reports
- Volunteering local/national strategy and service delivery input
- Getting political (small p)
- Getting (a bit) media savvy
- **Importance of independence and collectivism!**
- Going global Ireland, NE England, Australia

So we have been listening to what GPs working in deep end areas have to say, this has produced 30 reports so far.

We have provided input to local and national strategy development across primary care mental health and social security. This has meant we have engaged with civil servants and politicians- mostly in Scotland – but not exclusively. We have also worked with the media to some degree. It's been a steep learning curve and sometimes uncomfortable. However we have been listened too, some important implementation research has also resulted (eg the Links worker project) and we think we are making a difference. Being involved has prevented burnout for a number of us. Key to that has been the skills and resources that each of us have brought and the mutual support.

We have even had our model of getting active replicated!

Theoretical perspectives (1)



- Impact of adversity across the life course
 - Adverse Childhood Experiences
 - ‘Toxic’ stress
 - attachment style
 - complex (type 2) trauma
- Cross disciplinary learning

(Smith et al 2016, BMC Public Health 16;655)

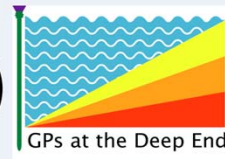
Shortly I am going to talk about a pilot that was triggered by Deep End work in collaboration with Glasgow Addiction Services. However before that I want to talk a wee bit about some important theoretical perspectives that have shaped our thinking about what we want to see changing. These are most apparent when considering mental wellbeing and problem substance use- but as GPs we are generalists so they actually pervade all that we are thinking about. Also in the deep end physical and mental co-morbidity are so intertwined.

We now know from a range of disciplinary perspectives of that the experience of adversity in childhood and across the life course are important. A group from mental health public health and the deep end were grappling with whether this might help us better understand the so called Glasgow effect. Firstly this is in terms of outcomes- as evidenced by epidemiological work on Adverse Childhood Experiences. These are linked to a range of physical, mental illness and health harming behaviours (Mark Bellis presenting later today led on the really important UK work on ACEs). In terms of a way of thinking about the impact of early childhood adversity the work on toxic stress helps us think about the factors that lead to a good enough childhood or a toxic constellation of experiences and lack of key supports. This includes the attachment style people develop that lead to negative outcomes in relationship function. Also importantly the role that cumulative negative life experiences that manifest as complex or type 2 trauma in adulthood. Working in a trauma informed way has particular relevance for us as health professionals because it provides tools for working with patients and helpful guidance about service design.

These are deaths from drugs alcohol suicide and violence. The role of deprivation and many other factors have been tested as causes and do not fully explain the problem.

A key to this is that in trying to solve complex problems we utilise theories and perspectives from a range of disciplinary backgrounds- not just our own.

Theoretical perspectives (2)



- Relevance of these perspectives for services
 - Health harming behaviours= low engagement?
 - Relationship function
 - Low trust
 - High impulsivity
- Escape coping - problem substance use

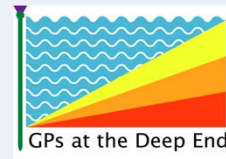
So why are these theories relevant when thinking about the deep end GP setting and more specifically working effectively with patients with problem alcohol use?

One potential way to look at health harming behaviours is to consider whether low service engagement might be a component of this. I am leading on a big data and linkage project looking at serial missed appointments (folk have patterns of missed appointments) across general practice and into secondary care. This will start to test this hypothesis.

These theoretical perspectives put relationship function at the core of how we think about consultations and health service design. Low trust needs to be turned around and impulsivity needs to be accounted for.

More implicitly is that problem substance use for people in the deep end- is about escape coping from distressing feelings or memories.

Theoretical perspectives (3)

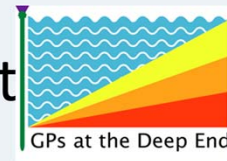


- Adaptive coping to being unsafe and insecure
- Impact of poverty, housing, work, violence
- From resilience to a tipping point

Finally if we think about what we do from these perspectives the majority of people we work with are adapting to coping with feeling unsafe and insecure. What does that mean for how our services should respond?

But we cannot escape the impact that the social determinants of health have on people. A final point- as health professionals we often encounter people at crisis points in their lives- people have moved from a position of resilience to a tipping point of not coping when they meet us.

Alcohol attached nurse pilot



- 6 Deep End GP practices NW Glasgow
- 2 FTE band 6 specialist alcohol nurses
- 1 session per month lead GP
- Quarterly team meetings
- Funded by Alcohol Drug Partnership
- One year (July 15-16)
- Usual care +

So now to a pilot that has not long finished set in NW Glasgow set up between GPs at the deep end and Glasgow addiction services. The pilot ran for a year and formal evaluation was not embedded in it. The attached alcohol nurses and the addiction services research assistant worked hard to get the data we did get.

The pilot report is in the final stages of write up and will be available soon on the deep end webpages.

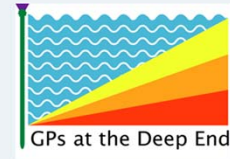
So-6 practices identified by addiction services were offered (and all accepted) this service.

2 FTE band 6 experienced specialist alcohol nurses were attached to these practices and line managed by the nurse team leader from the local community addiction team. A lead GP from each practice was paid one locum session per month so that they had an element of protected time to liaise with the nurses and take part in quarterly team meetings.

The pilot was funded by the ADP and ran for a year from July 15-16.

The nurses provided what would be considered usual care in the context of the alcohol teams in Glasgow. With some important differences that I will come onto shortly.

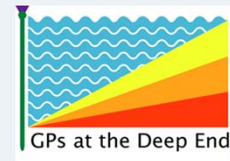
Pilot patients



- 95/132 referred patients received care from the pilot service
 - 58% daily dependant drinkers
 - 46% drinking at hazardous levels
 - 53% on antidepressants
 - 59% on thiamine
 - average alcohol intake 125 units per week
 - 42% lived alone
 - 21% in employment
- Overlap with recent Glasgow alcohol deaths profile report striking

95/132 referred patients received an assessment or care episode. These are some of their characteristics. What brought us up short as the pilot neared its end was the publication of an in-depth report about alcohol related deaths in Glasgow. There were striking similarities between those and the patients in the pilot. The alcohol deaths report is not yet available online – but will be soon and I will include a link for the short report of this talk.

Theory of change



- Addressing stigma
- Focus on engagement
 - ~ 70% patients previously known to addiction services
 - **Responsiveness**
 - **'Stickability'** (16 patients referred >once)
 - **Flexibility** – 96% seen at home
- Liaison & 2 way communication, inc. clinical recording, with GP team

So with a short timescale and limited data what did we think we achieved with the pilot? This boils down to the theory of change that the whole project team thought was important.

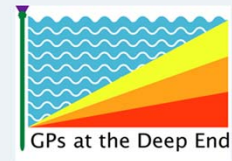
There was a general sense that patients felt reduced stigma by being offered support in their GP setting with no need to visit addiction services.

The focus on engagement was the core component of our theory of change. 70% of patients had been known to addiction services in the past. This was thought to be in 3 areas. The first was responsiveness- patients were seen quickly-average 5 days.

Stickability (a phrase used in settings like homelessness where professionals stick to patients no matter where they go) 16 patients were referred more than once. Thirdly flexibility- very quickly this pilot became a home visiting service with 96% of contacts in the patients home.

A vital component of the pilot was the team working relationship and function that built up between the GP practice and the attached nurses. Clinical recording was in the GP records so GPs knew what was happening with complex patients in crisis and the nurses received positive support from GPs.

'Stickability'

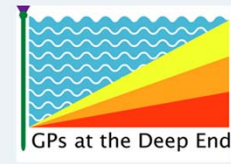


Missed Contacts before being Seen



This graph illustrates stickability. Of the 13 patients who required more than one contact to achieve engagement for assessment the majority needed only one extra. A small number required more!

The future



- Learning from this pilot:
 - Collaboration between specialist services and GP for targeted patient populations welcomed by GPs
 - Engagement strategies core in Deep End settings
 - Clinical recording and communication vital

So what does the future hold for this work?

This pilot has demonstrated that effective collaboration between specialist services targeted in high prevalence general practice settings is welcomed by GPs.

It reinforces our thinking that engagement strategies are key in deep end settings.

Also that clinical recording and communication is vital.