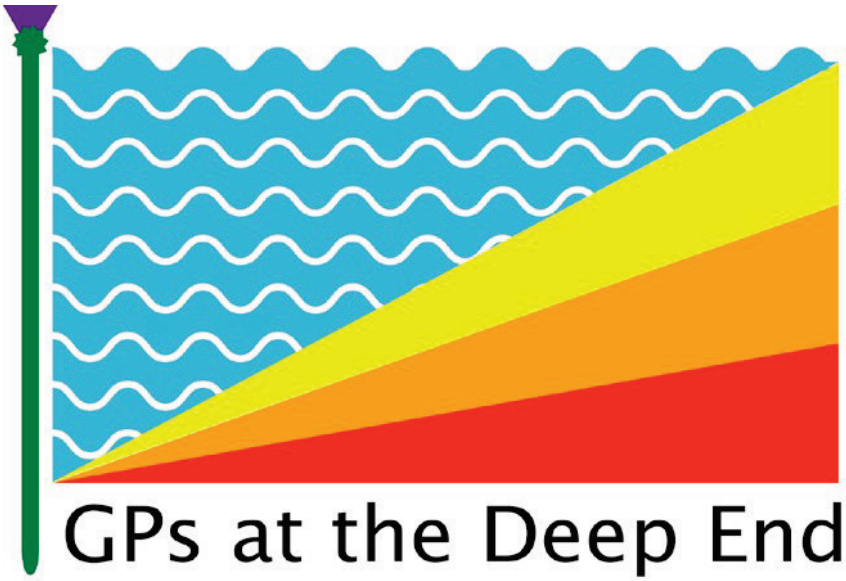


Deep End Report 22

Mental health issues in the Deep End

Ten general practitioners and a psychiatrist met on 25 October 2013 to discuss mental health issues in severely deprived areas. A draft report, collating the evidence and experience which were discussed on the day, was considered by the participants, by members of the Deep End Steering Group and by the Lothian Deprivation Interest Group. This report has been prepared by Andrea Williamson and Graham Watt and is presented for further multidisciplinary discussion.

April 2014

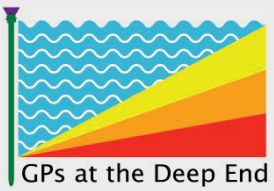
Ten general practitioners and a psychiatrist met on 25 October 2013 to discuss mental health issues in severely deprived areas. A draft report, collating the evidence and experience which were discussed on the day, was considered by the participants, by members of the Deep End Steering Group and by the Lothian Deprivation Interest Group.

SUMMARY

- 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.
- There is a need for increased professional dialogue, sharing experience, evidence and views as to how such care is best delivered.
- **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.**

CONTENTS

"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
Karen MacRae *RCGP Scotland* Karen.Macrae@rcgp.org.uk
Petra Sambale *Keppoch Medical Practice, Glasgow* psambale@googlemail.com
Graham Watt *University of Glasgow* graham.watt@glasgow.ac.uk
Andrea Williamson *Homeless Health Services, Glasgow* andrea.williamson@glasgow.ac.uk

Full report available at www.gla.ac.uk/deepend

PARTICIPANTS

General practitioners attending

Name	Location	List size	Deprivation ranking
Iain Brown	Springburn	6961	41
Susan Langridge	Possilpark	2165	18
William McPhee	Parkhead	4971	17
Raymond Orr	Royston	6113	29
Euan Paterson	Govan	3983	32
Petra Sambale	Possilpark	3085	1
Nicola Smeaton	Dundee	9365	85
Axel Winkler	Dalmellington	3625	89
Alan Winter	Edinburgh Rd	5292	47

Also attending

Michael Smith	Consultant Psychiatrist and Medical Director, Mental Health Services, Greater Glasgow and Clyde
Zara Usmani	GP Academic Fellow, University of Glasgow
Graham Watt	Professor of General Practice, University of Glasgow
Andrea Williamson	Homeless Health Service, Glasgow University of Glasgow

FORMAT

13.45 **Evidence-based presentation**

14.00 **General discussion**

15.30 **Break**

15.45 **Concluding session**

16.45 **Close**

SUMMARY OF EVIDENCE BASED PRESENTATION

- The odds ratio for having any mental health disorder rises from 1.00 in the most affluent tenth of the population to 2.25 in the most deprived tenth (i.e. more than doubling across the social gradient), with a steady increased across all intermediate tenths [1].
- The odds ratio for having any mental health disorder rises stepwise from 1.00 in patients with no physical conditions, to 1.95 in patients with a single physical condition, 2.95 in patients with two conditions, 3.91 in patients with three conditions, 4.85 in patients with four conditions and 6.74 in patients with five or more conditions [1].
- The relationship of mental health disorders with the number of physical conditions is strongest in very deprived areas, with a smooth gradient between affluent and deprived areas [1].
- Only 5% of patients with dementia, 7% with anxiety, 13% with schizophrenia/bipolar disorders and 23% of patients with depression only have this single condition. In each case a large majority of patients also have one or more physical conditions [1].
- Depression is present as a co-morbidity in 17% of patients with coronary heart disease, 14% with hypertension, 17% with heart failure, 21% with stroke/TIA, 18% with diabetes, 18% with COPD, 14% with cancer, 31% with a chronic painful condition, 45% with schizophrenia/bipolar condition, 32% with dementia and 17% with any other condition [1].
- The estimated difference in the weekly number of face to face contacts between the “most deprived” and “least deprived” Scottish general practices is greatest for contacts involving a mental health condition (35 v 16), compared with contacts for cardiovascular disease (25 v 24) and contacts for COPD (5 v 2) [2].
- The difference between the number of drugs dispensed per 1000 patients in the “most deprived” and “least deprived” Scottish General Practices is greatest for antidepressant prescribing (1183 v 388), compared with prescribing for antibiotics (833 v 637) and statins (921 v 653) [2].
- The prevalence of anxiety and depression in patients under 60 years of age with coronary heart diseases rise from 20% of patients in the most affluent fifth of the population to 45% of patients in the most deprived fifth [2].
- In consultations for physical problems, patients in deprived areas report worse health and a greater number of problems than patients in affluent areas. Their GPs also report higher levels of stress following consultations. There are no significant differences in GP empathy, consultation duration or patient enablement [3].
- In consultations for psychosocial problems, patients in deprived areas also have poorer health and a greater number of problems. Their GPs also report higher levels of stress. In addition, however, consultations are shorter and patient enablement is lower [3].
- In a study of 3000 consultations in general practice in the west of Scotland, the patients who were least likely to report being enabled after seeing their GP were patients with a psychosocial problem [3].

GENERAL DISCUSSION

The nature of mental health problems

Many people in deprived areas face daunting combinations of physical, psychological and social problems, affecting themselves and their families. People vary in having the skills and resources to cope. Early in the discussion it became evident that the ways that clinicians understand mental health problems in their day to day practice is important.

Many participants described working to a biomedical model of mental illness. Some patients present with symptoms that neatly fit a diagnosis of mental illness. Other patients present less clearly, describing their difficulties in coping with adverse life experiences. These types of presentation may overlap. For example, “situational stress” does not necessarily involve mental illness but may be associated in some patients with high levels of psychological “caseness”, using the General Health Questionnaire. Similarly, Horowitz and Wakefield lament the “loss of sadness” as a result of how psychiatry has transformed normal sorrow into depressive disorder [4].

Some participants used a developmental life course model of mental health to convey how they understand patient experience, describing how adverse experiences can have a range of impacts depending on when they occur in a person’s life and the level to which they accumulate. Some patients describe serious and significant experiences of adversity in early childhood or adolescence whose consequences extend into adulthood. Other patients with good (or “good enough”) early life experiences, struggle in adulthood with the piling up of adverse experiences related to poverty and the other social determinants of health.

How people develop psychologically following negative experiences in early life can be viewed as a normal adjustment to difficult experiences, enabling personal survival in a negative environment. Some participants used attachment theory to explain how and why some patients acquire insecure adult attachment styles; for example, following early life exposure to very difficult experiences like physical, sexual abuse or neglect [5]. ‘Complex trauma’ theory provides another way of understanding how people respond to really difficult experiences in childhood and into adulthood [6]. In some patients, their resulting ways of functioning, involving their behaviour, thoughts and emotions, may be considered a personality disorder. These all have major consequences for how patients interact with practitioners and services and how they think about their health.

How individual practitioners and health services generally might use knowledge about adult attachment, complex trauma and working with patients with a personality disorder diagnosis to care more effectively for patients is untested in general practice.

Other patients, with “good enough” childhood experiences and more secure attachment styles, may nevertheless sink under the weight of adversity in adulthood (“stress getting under the skin”) with mental and physical health consequences [7].

In many different ways, therefore, patients can develop mental illness symptoms that reach the threshold of a biomedical model diagnosis such as depression, anxiety or psychosis. Such psychiatric diagnoses are often thought as being objective in the same way as many physical illnesses. However, some of the DSM and ICD criteria on which such diagnoses are based are themselves based on subjective assessments of flawed empirical evidence. There are persuasive arguments that mental health services and treatments need to move away from this way of thinking about mental health to a new

model that considers psychological function in its complex context, including social, psychological and biological elements [8].

Practitioners' experiences resonated with the evidence that psychological morbidity increases in direct proportion to the number of patients' physical conditions, especially chronic pain, and especially in deprived areas. Some participants made sense of this with reference to the accumulating evidence for the impact of "allostatic load".

"Allostatic load" refers to the "cumulative effects of chronic and acute stress on the body i.e. the process and the product of 'wear-and-tear' on the body and brain, resulting from chronic over-activity or inactivity (called dysregulation) of the physiological systems involved in normal adaption to environmental challenges. The frequency, accumulation and effects of such exposures over the life course vary between individuals, with different physiological, psychological, and psychosocial effects" [9].

All participants agreed that clinicians and services are struggling to cope with an issue, whose drivers are outside the influence of health care.

Treatments

Discussion of possible treatments began by considering what problems mental health services are trying to solve and how they go about it. At one level, the epidemiological data show a steep social gradient in the prevalence of mental health problems, which services try to address, using antidepressants, counselling and lifestyle change.

Although antidepressants are widely prescribed (especially since the incentivisation of depression by the Quality and Outcomes Framework), they are of uncertain clinical value, especially in people with mild to moderate depression. It was said that 50% of the apparent effect of antidepressants is due to the passage of time while 50% of the remaining effect is due to placebo. There is little evidence for the effectiveness of long term counselling.

It was said that antidepressants can help patients to function more effectively as they try to cope with difficult sets of circumstances. They may also provide patients and GPs with an acceptable basis on which to develop a productive long term relationship. Such "re-framing" of the use of antidepressants could be helpful.

While prescribing an antidepressant can be helpful, it can also provide practitioners with a pragmatic way of ending consultations, for example when practitioners are themselves under stress from high burdens of need and demand, combined with a lack of consultation time.

It was noted that some patients with mental health problems wish to avoid the perceived stigma of attending psychiatric services. Those with the means may access private care, but this is not generally an option for patients in deprived areas.

Referrals and joint working

In Glasgow, mental health services receive 20,000 referrals per year for first level support of mental health problems. Referrals from GPs are reviewed and allocated to what is considered the most appropriate service, not necessarily a psychiatrist. For GPs who refer rarely, and for specific reasons that they perceive as appropriate, this can result in little progress being made, especially when there is a waiting list for first appointments.

It was noted that the Scottish Government had established a HEAT target of 18 weeks as the maximum waiting time for accessing psychological treatment. However, 18 weeks is much too long to be useful in many cases. In general, HEAT targets concern centrally managed services and have little impact in general practice.

An audit of referrals to the service had found 50% higher referral rates from very deprived areas, whereas the epidemiological findings suggest that the rates from very deprived areas should be double those from affluent areas.

There was strong support for closer working relationships between general practitioners and area-based mental health services. Several initiatives were described, involving the attachment of CPNs, or similar staff, to general practices, providing opportunities for quick, local referral to a familiar face, with variable results. One such initiative in Ayrshire had dramatically reduced referrals outside the practice, but the funding had been short term and was withdrawn. Another scheme in Glasgow did not affect the volume of activity but increased compliance with treatment.

On the one hand it was recognised that the current configuration of general practice, with multiple independent contractors serving non-geographical populations, makes it difficult for area-based services to engage successfully with each practice. Although each area-based mental health team in Glasgow includes someone with a specific brief to liaise with local practices, this role was not apparent to most of the practitioners taking part in the discussion.

On the other hand, it was felt that practices with very high concentrations of deprivation, and associated mental health problems, merited the direct attachment of mental health workers, whose caseloads would keep them busy.

There seemed consensus that attached mental health workers would be beneficial for GPs. It remained to be shown that they would benefit patients. It was said that “one person’s integration, is another person’s fragmentation”.

The divisions between substance misuse services and mainstream psychiatry was felt to be a serious barrier to many patients accessing timely appropriate care.

It was felt that the array of health services, each acting as a hub, screening (re-assessing) its referrals and rationing access via waiting times, is unhelpful for patients, and especially patients lacking relationship skills. It was said that a patient who feels secure and resilient in their attachment style “can see anybody”, while a person who is insecure “can’t see anyone”. Traditional service models may label such patients as “hard to reach”. However, the underlying problem may be less a problem of access, and more to do with whether and how services take account of a person’s interpersonal functioning.

When a person cannot have their mental health problems ‘cured’, effective support and harm minimisation are important aspects of treatment.

Counselling and third sector support services are seen as vital, more permeable and community-based approach types of mental health support for practitioners and patients. However there is often an issue with availability and it was noted that recent austerity measures had had a significant impact on provision of these community orientated services.

The use of link workers was described, allowing practices and other services to make better use of community resources for health, especially for people who are socially isolated and unlikely to make new connections on their own.

In making links and referrals, professionals need to be aware of local geography e.g. “gang lines”, which patients from one area will not cross.

The homeless health service and addiction services were described as having developed highly integrated and personalised support arrangements for people with long term problems and complex mental health needs, with positive outcomes emerging. The approach is based on establishing and maintaining long term relationships, collaboration between professionals and the important role of peer recovery groups. Services in Lothian use a case management approach which formalises many of these engagement and care approaches.

The integrated, person-centred nature of services for people with dementia was mentioned as a model for the future.

In general, services show considerable variability, being well managed and effective in some areas, but not in others, often due to the personal characteristics of the people involved. Professionals who know each other by name are more likely to work well together, building confidence and trust. There is a general need to share experience and best practice within and between professional groups, and to set new norms for how professionals and services work together.

GPs described the multiple levels of the NHS with which they may have to relate including the practice, CHP, sector, city and Health Board. On the other hand it was noted that large numbers of separate practices are also difficult to engage with. It was suggested that practices needed to re-group, around catchment populations of about 25,000, to make it easier for other services to engage with them.

CONCLUSIONS

While the challenge of addressing mental health problems in the Deep End is daunting, a positive feature of the discussion was the emergence of some shared understanding of the boundaries between illness, diagnoses, responses to life stressors and the range of psychological frameworks that can inform assessment and therapy.

Different disciplines are coming up with similar conclusions, integrating ideas of “allostatic load”, attachment style, adversity, complex trauma and multi-morbidity. There is a need to share and further develop such thinking.

Shared approaches are also needed to review how general practice and mental health services can work better together.

A fundamental factor affecting what services can provide is the inverse care law. While universal coverage may remove access barriers, practitioners also need the means to respond proportionally to the problems that patients present. The starting point for such care is sufficient consultation time.

It was felt by GPs that specialist mental health services were generally of high quality. What GPs need is quicker access to the “lowest level” of care and mechanisms to ensure that patients “do not get lost” between services e.g. between addiction, alcohol and psychiatric services.

The process of referral requires investment in information, audit, feedback and shared learning.

Attached mental health workers should be tried and evaluated in practices with very high prevalences of mental health problems. GPs should be proactive in make such proposals to local mental health teams.

Link workers could help to put patients in touch with many activities which could improve their mental health without recourse to health services

There needs to be systematic investment in work relationships throughout the system. Current systems do not value, support or reward time spent developing and maintaining professional relationships.

A joint meeting should be arranged for general practitioners and psychiatrists to compare, contrast and share their experiences of working in very deprived areas.

REFERENCES

1. Barnett, K., Mercer, S.W., Norbury, M., Watt, G., Wyke, S., and Guthrie, B. (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet*, **380** (9836).37-43. 10.1016/S0140-6736(12)60240-2
2. Tomlinson J Mackay D Watt G Whyte B Hanlon P Tannahill C. *The shape of primary care ain NHS Greater Glasgow and Clyde*. Glasgow Centre for Population Health, 2008. www.gcph.co.uk/component/option,com_docman/task,cat_view/gid,67/Itemid,71/
3. Mercer SW Watt GCM. The inverse care law: clinical primary care encounters in deprived and affluent areas of Scotland. *Annals of Family Medicine* 2007;**5**:503-510 10.1136/bmj.e4152
4. Horowitz AV, Wakefield JC. *How psychiatry transformed normal sorrow into depressive disorder*. Oxford University Press, 2007.
5. Hunter JJ, Maunder RG Using attachment theory to understand illness behaviour. *General Hospital Psychiatry* 2001;**23**:177-182.
6. BC Provincial Mental Health and Substance Use Planning Council. *Trauma informed practice guide*. British Columbia, Canada. 2013 bccewh.bc.ca/publications-resources/documents/TIP-Guide-May2013.pdf
7. Shonkoff JP Garner AS, The lifelong effects of early childhood adversity and toxic stress. *Pediatrics* 2012;**129** 10.1542/peds.2011-2663
8. Division of Clinical Psychology Position Statement on the Classification of Behaviour and Experience in Relation to Functional Psychiatric Diagnosis: Time for a Paradigm Shift. British Psychological Society. 2013 dxrevisionwatch.files.wordpress.com/2013/05/position-statement-on-diagnosis-master-doc.pdf
9. McEwen B, Palmer M, Anderson R. *Allostatic load: a review of the literature.* Department of Veterans' Affairs, Canberra. 2012 www.dva.gov.au/health_and_wellbeing/research/Documents/allostatic.pdf

ANNEX

Laura

Laura is 22 and spent time in care as a teenager and had a number of assessments by child and adolescent psychiatry. She never talks about her family. She uses street drugs including cocaine and cannabis and used to use heroin until she stabilised on her methadone treatment. She also has asthma and attends A&E a couple of times a month with cough and wheeze. She gets involved in serial risky relationships with young men, has been both the perpetrator and victim of physical violence and is in and out of homelessness partly due to the consequences of this. She is prescribed an antidepressant medication which she reports as helping to stabilise her mood.

She struggles to attend appointments and often turns up late. She also tends to be verbally aggressive at times in the waiting room.

How does the health care system currently work effectively with Laura?

- Laura has an addiction care manager who coordinates her care and liaises with other agencies about how to work effectively with Laura, criminal justice including the Procurator Fiscal. The care manager is based in the same health care centre so has good access to discuss her health needs with the GP. The practice maintains safety for staff but understands the effects that adversity/complex trauma/personality disorder can have on patients' interpersonal function. Consistent respectful boundaries applied and we liaise with her addiction care manager as required.
- We take a long term view and work on the relationship between staff and Laura, her concordance with asthma treatment and attempts to reduce her attendances at A&E.

How could it be better?

- Therapy work is carried out by a separate personality disorder or trauma team, which is great because we have access to it. However, Laura doesn't engage with this separate psychiatry team enough to have an assessment and probably won't attend.
- Laura will (most of the time) prioritise seeing addiction staff for her addiction care and mostly the GP for her asthma care. Over time her concordance with her asthma treatment has improved. However the GP rarely has the time to do more than attend to Laura's immediate needs let alone looking at other health promoting activities like smoking cessation and exercise.
- If Laura did not have an addiction problem she would probably not have a care manager in mental health services. Laura's mental health diagnosis is unclear but her mental health is significantly impaired and has a serious effect on her substance use, physical health and ability to engage in health promoting activities.

Sandra

Sandra is in her mid-fifties. She lived in Brussels until her partner of 18 years left her for someone else five years ago. She moved back to the UK to look after her elderly mother who died shortly afterwards, when she found that she had lost everything: family, friends, partner, career. She entered into a prolonged period of depression,

speaking to very few people apart from her very elderly neighbour who refers to her as "my rock". She feels she has lost her entire personality, from being someone who had travelled widely and had a wide social circle to a lonely recluse who is daunted to cross the street. She did not come to her GPs attention until she attended with symptoms of what turned out to be three smoking related long term conditions- heart disease, peripheral vascular disease and COPD. This was two years ago, and over this time she has struggled to rebuild her life. She was referred to the primary care mental health team, but after a long wait for an appointment did not attend. She did join a smoking cessation group, and for the first time in year felt a sense of being able to talk in a group. Slowly her physical health has improved with treatment and she has been hoping to be able to become involved in looking after animals, as she has a passion for caring for these. She hopes to return to work, but finds even the interviews for her employment support allowance to be overwhelming and wonders how she will cope with working again.

How does the health system currently work well with Sandra?

- The smoking cessation group Sandra attended was enabling and psychologically supportive and two of the outpatient clinics she attended gave her a sense of optimism.
- Her GP gave her time and built a relationship with her.
- She has been a strong asset supporting her elderly neighbour who could not have coped without her.
- She has received ESA which has allowed her to survive financially, although with very limited means.

How could it have been better?

- After one outpatient clinic Sandra came back feeling emotionally destroyed through rude and dismissive treatment.
- The mental health system provided too many barriers for her to negotiate, and so, no support was received. She required quite intensive input from her GP (attendance every 1-2 weeks for several months) – her GP basically had to compensate for lack of access to mental health resource.
- ESA interviews set her back quite far emotionally, although ultimately successful.
- We looked for animal related voluntary work but were unable to find any suitable.
- The main thing that did not go well was the NHS picking up, medicalising and carrying people like her who could be fantastic assets to their community if only there were stronger social networks and a more enabling community. She is well travelled, eloquent, caring and would love to be needed and useful to others, and instead is consigned to the indignity of being a patient.