Scoping the need for primary mental health care in the West Midlands

Paul Turner
GP
Joint Clinical director
NHSE West Midlands
The imperative...

We estimate in the West Midlands:

- 150k with generalised anxiety
- 730k in distress
- 315k with 4 or more ACE
- 890k with chronic widespread pain
- 530k with 1 or more MUS
- 140k with suicidal thoughts / 64k self-harming
people with learning difficulties, autism or neurodevelopmental disabilities, undiagnosed personality disorders, longterm effects of adversity in childhood, domestic violence, drug & alcohol difficulties,
Community MH funding – designed to ‘close the distance’ between PC and SC....how do we create better understanding of need in those areas and help make the money follow the patient?
Let’s count what we can’t quite cope with....

• some groups within society are disproportionately affected by a) their circumstances and b) the availability of support and services that meet their needs.

• Through our analysis we are attempting to demonstrate that the need, thus approach to, primary mental health care falls outside of current service provision.

• We are, specifically for the West Midlands region:
  • Quantifying the extent and likely future trends of the pre-determinants of mental ill-health
  • Estimating the scale and nature of the most common mental wellbeing reasons for consultation in Primary Care settings
  • Identifying groups of patients that have needs but either don’t fit or miss out on specialist support
Who are we talking about?

1. Frequent A&E attenders not in touch with MH services
2. People attending chronic pain clinics not in touch with MH services
3. Those presenting at hospital with MUS and not in touch with MH services
4. Patients with multiple DNA for MH outpatient appointments
5. Patients referred to IAPT or community mental health teams but rejected from or not completing treatment
6. Areas with high socio-economic deprivation but low referral rates
7. People involved in criminal justice system with unmet MH needs
8. Frequent attenders at GP
1. Frequent A&E attenders not in touch with MH services

Generally speaking, the more times during a year someone attends A&E departments, the more likely they are to have mental health needs. In 2017/18:

- 872,831 only attended once
- 425,026 with multiple attendances
- 166,215 with 3+ attendances
- 22,692 with 6+ attendances
- 4,791 with 10+ attendances

Out of these, 14,000 with no MH contact are candidates for support?

Are psychiatric liaison services evenly distributed?

Are patients from poorer backgrounds less likely to be referred and/or offered specialist support?
2. People with chronic pain and the potential need for support

Chronic pain + depression(?) co-occurs in around 60% of complex/expensive cases.

Chronic pain present in > 20% of primary care consultations.

It is estimated that around 900,000 people across the West Midlands have some form of widespread chronic pain.

During 2017/18 37,000 people had multiple outpatient attendances in chronic pain clinics or day case / ordinary admissions for pain-management related HRG.

Typical characteristics of those in contact / not in contact.... ?

17,100 with likely depression not seen at all by specialist MH teams.
3. People presenting with acute Medically Unexplained Symptoms (MUS)

Patients with one or more MUS or somatoform disorder are thought to number around 1.3 million across the West Midlands.

Evidence suggests that almost half of all GP consultations involve MUS and around 11% of all NHS expenditure cost society 4-5 times much in sickness absence and reduced quality of life.
4. Patients with multiple non-attendance to MH appointments

- Are less likely to receive the right service or effective treatment
- More likely to lapse into crisis.
- In 2017/18 30% did not attend 2 or more scheduled appointments
- Patients from BAME groups, people of working age and those from more deprived areas are more likely to regularly not attend appointments with MH services.
- What practical support can they get to maintain contact and treatment?
5a. People with rejected referrals from community mental health teams

During 2017/18 there were around 100,000 (completed) referrals of West Midlands patients to CMHT and general mental health services.

- 4,000 were explicitly rejected (assumed to be sub-threshold),
- 12,000 were implicitly unsuitable (patient defaulted or declined treatment) and X were referred back to Primary Care teams.

- Patients from BAME groups are more likely to have referrals rejected.
- Patients living in the most deprived areas are most likely not to receive specialist support.
- Younger males and maternal age women are most likely not to receive support after referral.

Do some areas have capacity issues, lack of specific services or different thresholds for treatment?
IAPT is the default psychological intervention in primary care. It is not a magic bullet and many patients don’t meet service thresholds, don’t find the treatment suitable or don’t improve as a result of treatment.

In 2017/18 there were around 140,000 completed referrals to IAPT across the West Midlands, with around a 1/3 coming from primary care teams.

- Rejection of referral is most likely in both males and females aged 18-34.
- Patients living in the most deprived areas are most likely not to receive specialist support.
- Where recorded, post-traumatic stress disorder and recurrent depressive disorder (mild) are the diagnosis least likely to result in being offered therapy.

Why are local authority referrals so ‘successful’ and internal MH referrals not?
Healthcare for offenders in the community is included within the healthcare provided to the general population....isn’t it....?

• A formally funded study of a stratified random sample of offenders on probation in the UK (Brooker et al 2012) found:
  • 39% of offenders had a current mental illness
  • 49% had a past / lifetime mental illness
  • 18% had a mood disorder (major depressive episode or mania)
  • 27% had an anxiety disorder (panic disorder, agoraphobia, social anxiety, generalised anxiety, OCD, PTSD)
  • 11% had a psychotic disorder (with or without mood disorder)
  • 5% had an eating disorder
  • 47% has a probable personality disorder
Primary care mental health:

Summary of evidence

What else should we count/map/collate?

How could this information best be used?

Is this a useful direction of travel?

Want to get involved?