GPs at the Deep End

Pioneer Scheme Day-release Programme

Wednesday 15th March 2017 9.30-16.00
Horselethill Road, Glasgow

Complex consultations and trauma

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Dr Traynor works with the Glasgow psychological trauma service Anchor, a recent amalgamation of Compass, SAAS (sexual abuse) and the trauma and homelessness teams. The service is based in Govan but is Glasgow-wide.

- Simple/type 1 trauma can be direct or indirect and is a one-off experience or event e.g. RTA, rape.
- Complex/type 2 trauma is interpersonal, repeated and chronic and has a significant impact on functioning. Examples include combat, hostage situations, torture and all forms of child abuse. (There is an acceptance regarding the importance of identifying and treating childhood sexual abuse but perhaps not other types e.g. neglect and emotional abuse – these are the most hidden types and often patients just regard it as a "typical Glasgow childhood".)

Adverse Childhood Experiences (ACEs) study TED Talk ACEs

- Study of >17000 adults in USA
- Shows clear links between number of ACEs and both physical problems e.g. adult mental health, cancer, diabetes, and social problems e.g. imprisonment, unemployment

Trauma and the body

- Frequent firing of the "fight or flight" response impacts on brain development
    - Overdevelopment of the amygdala (emotion)
    - Reduced development of the hippocampus (memory) and prefrontal cortex (judgement and complex planning)
- This results in the brain not being equipped to deal with stress/difficulties throughout life

COMPLEX PTSD DIAGNOSIS (Judith Lewis Herman, 1992)

1. Alteration in affect regulation
    - "Looks like a diagnosis of borderline personality disorder"
    - Difficulty managing, labelling and controlling emotions

- Impulsive, destructive behaviour e.g. alcohol and drug abuse
- There is a significant role of addiction and it is important to think about what has happened to this person rather than just their addiction TED Talk Addictions

2. Alteration in consciousness
    - Amnesia or hypermnesia for traumatic events
    - Dissociation, Depersonalisation or derealisation – there is link between experienced trauma and psychosis
    - Intrusive re-experiencing or preoccupation of trauma (e.g. patients who seem "not quite there" when you are speaking to them)
    - Traumatic experiences difficult to assimilate
3. Alteration in self-perception
    - Shame, guilt, self-blame, feeling damaged, feeling helpless
    - These are deeply held, unquestioned ideas accepted as fact
    - Often feel undeserving of help
    - Difficulty relating to others and destructive relationships
    - All of the above impedes the patient's ability to seek help or to prioritise their health and wellbeing. As health professionals we should therefore
        i. Reassure the person that this is a normal response to what they have experienced
        ii. Notice what is going/has gone well/right
        iii. Look at the other positive aspects of the person
4. Alteration in perception of the perpetrator
    - Preoccupation, not always negative as the relationship is usually secretive and dysfunctional with the perpetrator being a powerful figure in the child's life
    - Thoughts of revenge
    - Idealisation
    - Sense that it is a special relationship
    - Acceptance of the belief system of the perpetrator
5. Alteration in relations with others
    - Isolation and withdrawal
    - Disruption in intimate relationships
    - Repeated search for a rescuer
    - Persistent distrust
    - The above two can result in difficulties with consultations and engaging with the health service
    - Repeated failures of self-protection (due to previously mentioned feelings of being undeserving, poor judgement and finding alternative ways of coping e.g. substance abuse)
    - Can be diagnosed as personality disorder or simply "personality" i.e. no diagnosis
    - Can be labelled "manipulative" or "self-destructive" but because of previously documented reasons, the person does not know how to do it in another way
6. Alteration of physical problems or illnesses
    - Chronic pain, medical conditions, somatic conditions
    - May be related to physical damage as a result of abuse or more general
    - Chronic fatigue/fibromyalgia/medically unexplained symptoms (MUS)

- Difficulty in our current system/medical model is that we have to separate whether it is a physical *or* psychological problem when in fact it is often an overlap of both

7. Alteration in systems of meaning
    - Loss of sustaining faith
    - Hard to maintain a sense of purpose and meaning in a chaotic and unpredictable world where one has little or no control over their environment

CURRENT MENTAL HEALTH SERVICES

PCMHT

- For mild-moderate MH problems, short term input
- Only psychological therapy available e.g. CBT, counselling, clinical psychology so patient will struggle if they are not able/ready to engage or deal with issues
- Core remit is anxiety and depression (though some PTSD, OCD etc.)

CMHT

- Severe and enduring MH problems (i.e. there is gap for patients with moderate enduring)
- MDT (medical model – psychiatry, CPNs, clinical psychology, OT, SW, HCAs)
- Psychosis, PD, depression, ED, PTSD, OCD
- Longer term input possible for psychosis mainly, there is a shift away from rest

CAT

- Primary alcohol or drug problem but cannot engage in therapy if heavily using
- MDT approach
- Longer term input is possible
- Current issue with separated services - aim with the trauma service is ideally to "join up the dots"

Crisis/OOH

- Emergency contact assessing immediate risk usually by CPN
- The main aim of the crisis team is to keep patients out of hospital when suicidal, where possible

Specialist services

- The Anchor
- Esteem
- Older people
- Eating disorder
- Forensic
- Physical health

THE ANCHOR TRAUMA SERVICE

- 0141 303 8968
- Most severe mental health problems plus additional vulnerability, e.g.:
    - Asylum seekers (AS)
    - Female
    - Victim of trafficking (links with TARA)
    - People leaving care
    - Combat

- Combines Compass, SAAS and trauma and homelessness
- Adults (16+) and unaccompanied children. No upper age limit
- Compass had a much wider remit on its own for AS (now if not severe should be referred via usual pathways)
- Duty worker 9-5 for phone advice
- Clinical psychology, MHP, OT, art psychotherapist
- Takes written referrals from statutory and third sector organisations

Problems with the current set up of MH services:

- Based on the medical model
- Trauma and social context not routinely considered
- Specific remits of services means grey areas and gaps for patients
- Multiple splits, i.e. physical/psychological, health/social, mental health/addiction
- Under-resourced

Tips to get the best out of MH services

- Mention a MH problem in the referral (e.g. “anxiety” rather than “stress”)
- Mention trauma if relevant
- Phone first if unsure and mention the name of the person with whom you discussed in the referral
- Don’t make multiple referrals – this slows down the process
- Don’t refer elsewhere if open to a service as they will not be accepted
- Don’t assume a referral will be redirected
- Active addiction is an automatic exclusion
- Try to have a specific intervention in mind and say this

Realistic medicine

- http://www.gov.scot/Resource/0049/00492520.pdf
- Evidence base often not applicable
- Sometimes we have a “duty to acknowledge powerlessness”, otherwise people are driven to seek treatment, so be open about your limitations
- Inappropriate treatment reduces with increased engagement with lifestyle changes
- Health literacy
    - Social deprivation = low health literacy
    - “The single biggest problem in communication is the illusion that it has taken place” (George Bernard Shaw)

USEFUL IDEAS FROM PSYCHOLOGICAL THEORIES

- Attachment
    - If persistent chaotic environment then engagement and bonding is reduced
    - Consistent relationships
        - Are healing and stabilising
        - Can reverse brain effects
        - Can help to address complex PTSD effects
        - Can make the difference between a child coping/managing/functioning

    - Core aims:
        - Be consistent
        - Be clear
        - Do not make promises
        - Establish clear boundaries with the patient – personal, time, purpose of appointment. Be explicit
        - Seek supervision and support
- Conditioning (operant)
    - Reinforcement of behaviour (positive and negative)
    - Punishment (positive and negative)
    - Reinforcement is more powerful than punishment (positive is the most powerful)
    - Immediate response more powerful than delayed
    - Response is stronger when person is deprived rather than satiated
    - Intermittent reinforcement of behaviour is more powerful than continuous reinforcement
    - We can reinforce behaviours in our patients, for example that presenting in crisis/suicidal results in action being taken rather than if they present less unwell when they then have to e.g. "wait for next appointment" or using diazepam as an immediate response.
- Containment
    - Providing a safe space for reflection
    - Responding with calm and empathy
    - Not being drawn into patient's distress
    - Hearing and acknowledging patient's experience
    - By trying to do something, we can give the impression of not being able to cope/manage it either
- Radical acceptance
    - Acceptance of how things are
    - Allows us to focus on responses and outcomes which are possible rather than those which we wish were possible
- Motivational Interviewing
    - Addiction
    - Ambivalence is a natural and normal part of any change process
    - Change is difficult – pushing a person into a corner about our own vision is less effective than if change is based on a person's own decisions and choices

MEDICALLY UNEXPLAINED SYMPTOMS

- NES MUS Toolkit
- Poor relationship with GPs results in more frequent consulting and more symptoms reported
- Physical problems and stress – circular problem
- What can we do to improve QOL
- Acknowledge biological and psychological factors
- Remember psychological impact of trauma

Further Resources

1. NES Matrix Psychological Therapies
2. ACEs Study

Key Learning Points:

- Complex PTSD is not in ICD-10 or DSM-V as it is not seen as a core diagnosis in the current medical model and there is not much evidence for treatments
- Current services are not well equipped to deal with complex trauma and deprivation
- The amalgamation of services into Anchor has resulted in more criteria for patients to fit to be seen by the service
- The separation of mental health and addiction services pose significant barriers to our patients
- Ways to improve referrals to mental health services
- NES matrix – who to refer when (there is a gap for patients who fall into the category of moderate enduring mental illness, who fall between PMHCT and CMHT)
- Tips to try in consultations and psychological theories that can be applied in practice