Long-term conditions and medically unexplained symptoms

Managing severe and complex cases

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- Formulating the problem – moving away from diagnosis
- What constitutes complexity + severity
- Models of care:
  - The pathway
  - The pyramid
  - The network

Signs something is going wrong

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Affective	Behavioural	Cognitive	Somatic
Depression - transient - persistent	Tearfulness	Hopelessness Suicidal ideas	Anorexia Weight loss
Anxiety - pervasive - phobic	Reassurance Seeking	Worry Hypochondriasis	Insomnia Pain Tension
Irritability	Non-compliance Aggression		
Apathy	Inertia	Helplessness	Lethargy
Anhedonia	Social withdrawal		
Indifference	Carelessness	Down-playing	
Euphoria	Accident-proneness	Denial of disability/handicap	

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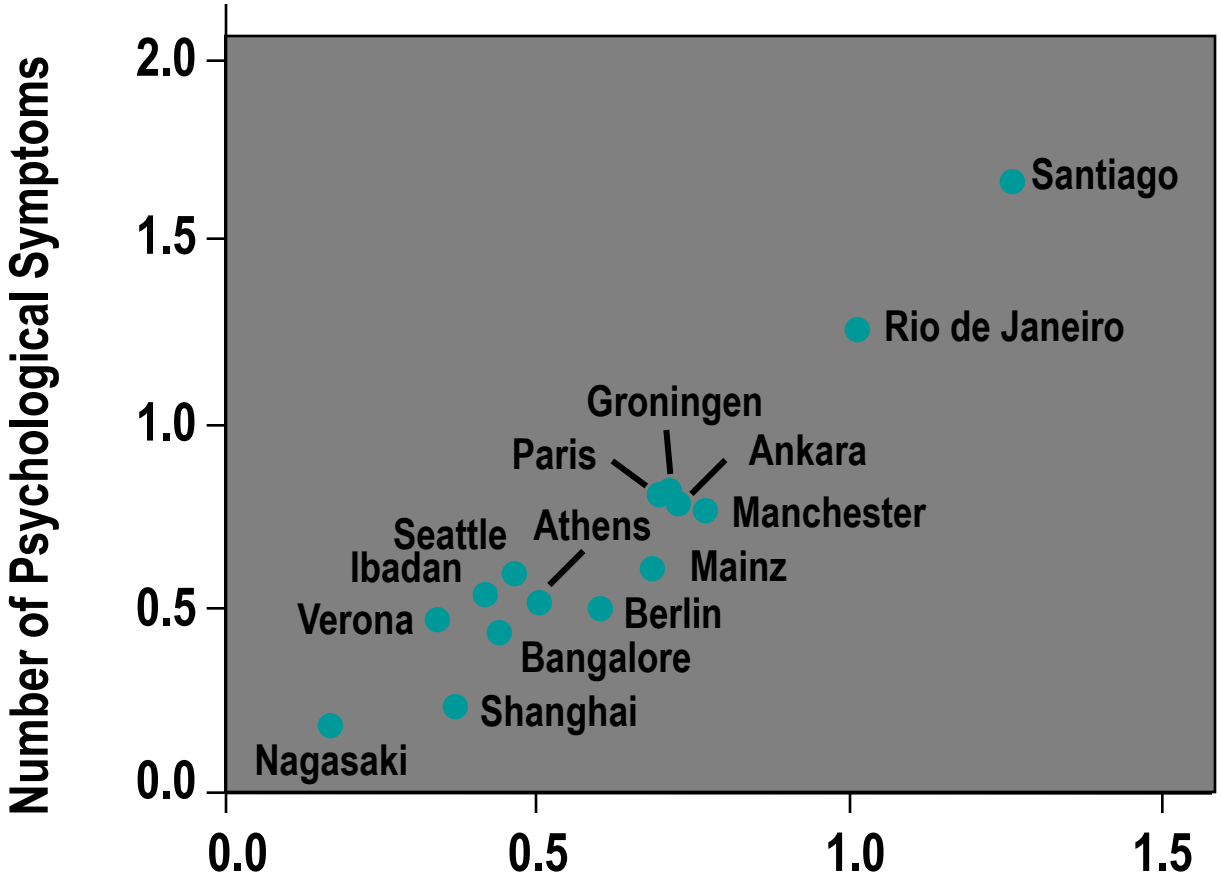

Simon GE, et al. *N Engl J Med.* 1999;341(18):1329-1335.

Distress ≠ depression

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What cognitions really count?

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Is it the *presence* of negative ones?

- Hopelessness
- Sense of personal worthlessness
- Sense of life not worth living
- Suicidal ideas

Or the *absence* of positive ones?

- Positive forward directed thinking
- Optimism
- *Ikigai*
- Pleasure, or enjoyment in life

Distress ≠ depression

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LTC v.s MUS: some difference in balance of presentation

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	LTC	MUS
Distress	Usually overt – depression or anxiety	Less obvious – elements of joylessness and anger
Somatic symptoms	More obviously those of disease or of distress	Many, but difficult to attribute
Behaviour	Typically distress-driven help-seeking	Scheduled and unscheduled consulting, medication, unexplained disability
Cognition	Typically distress-congruent	More oriented to illness experience and its investigation and treatment

LTC v.s MUS: some difference in balance of cause

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	LTC	**MUS**
Illness meaning	Loss Threat Restriction	Dependence and the need for caring Negotiating power and control

What constitutes complexity or severity (and drives costs)?

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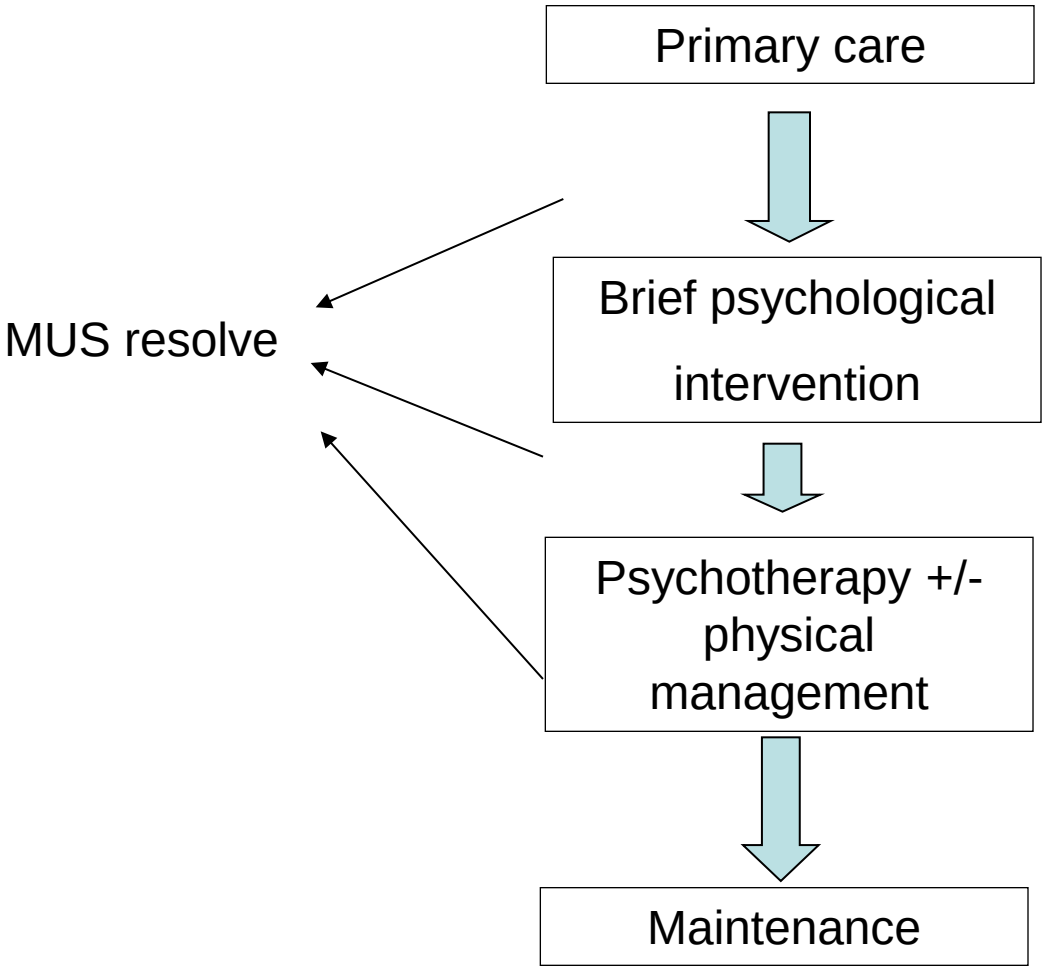
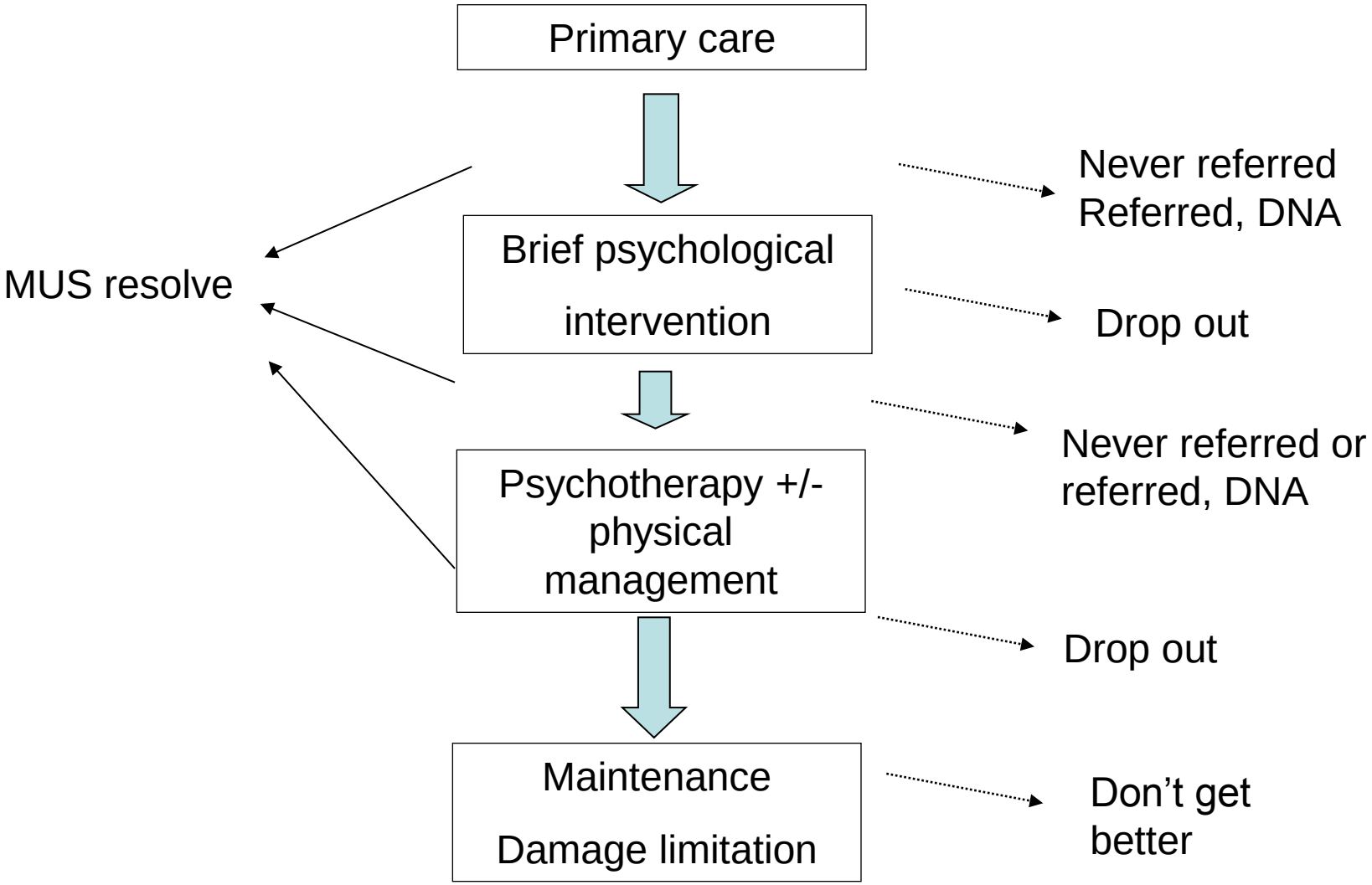
Symptoms	Number, intensity, duration, especially somatic
Help-seeking	Number and frequency of consultations, investigations, medications
Disability	Social function including eg benefit-receipt
Attitudes	To psychological/social aspects of illness; to care-providers (esp. doctors)

Models of care: 3 geographical metaphors

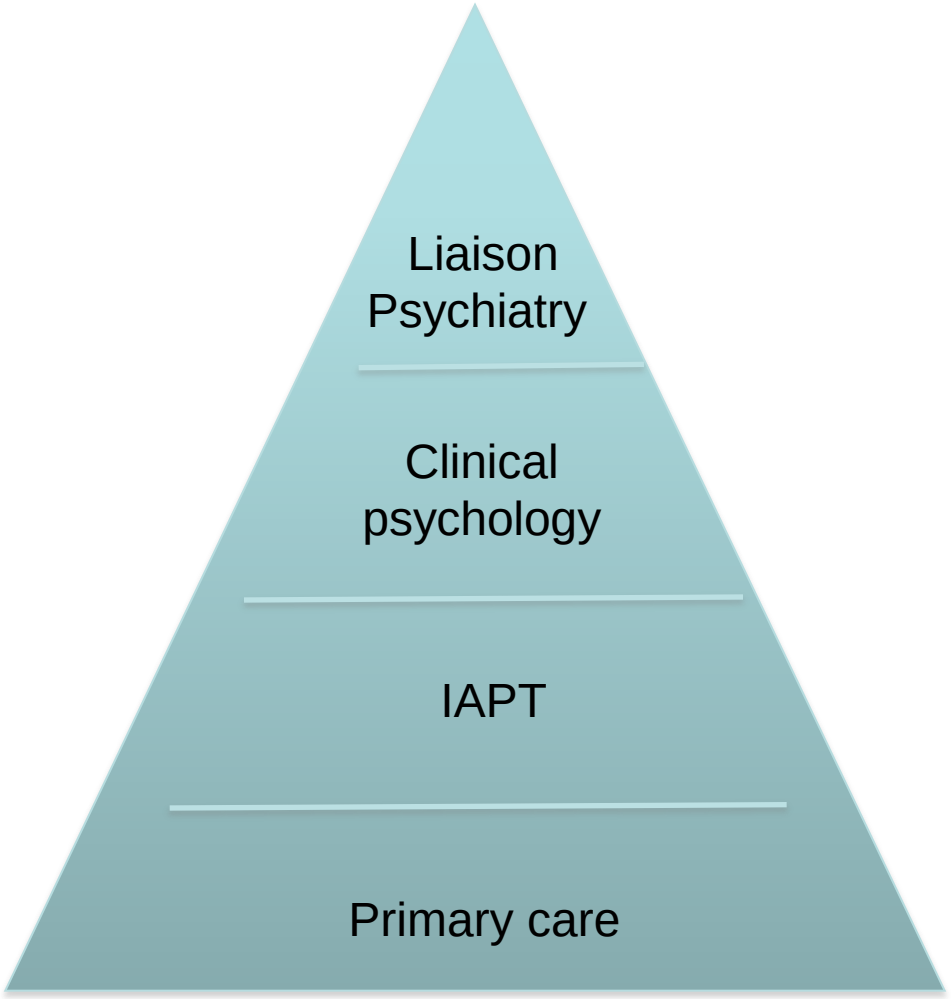
- The pathway
- The pyramid
- The network

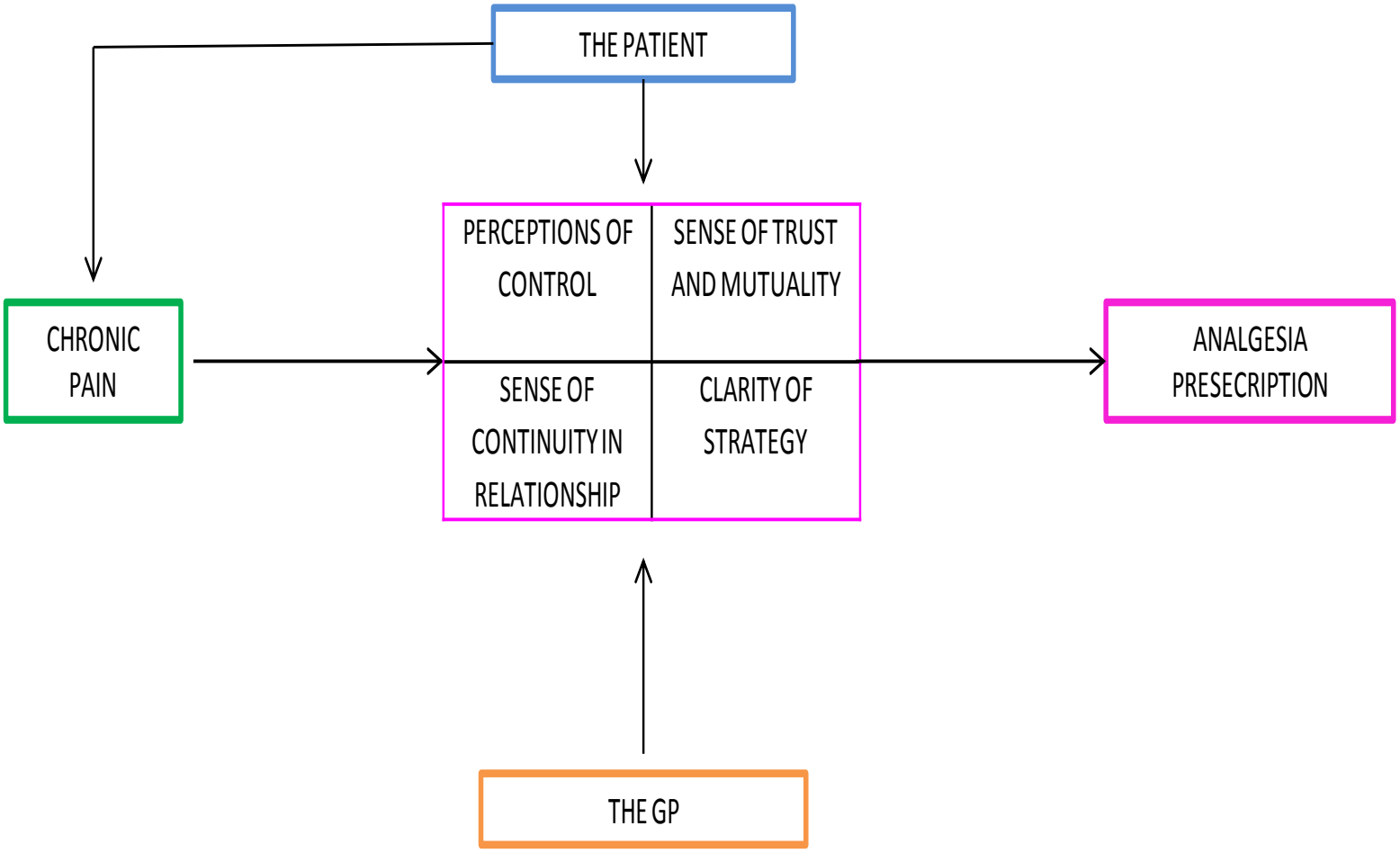

Primary care
Brief psychological intervention
MUS resolve
Psychotherapy +/- physical management
Maintenance

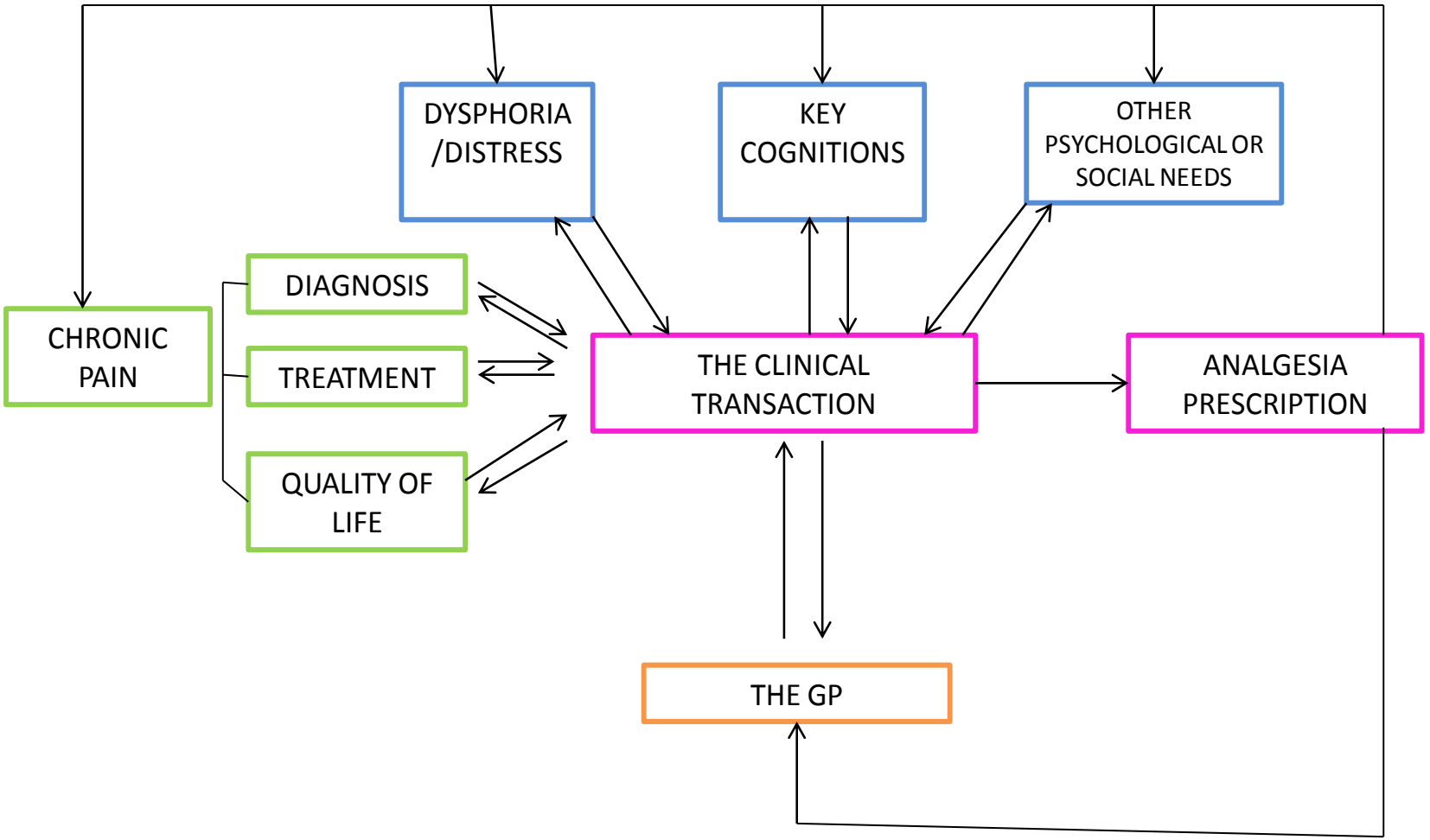

Primary care
Never referred
Referred, DNA
MUS resolve
Brief psychological intervention
Drop out
Never referred or referred, DNA
Psychotherapy +/- physical management
Drop out
Maintenance
Damage limitation
Don't get better

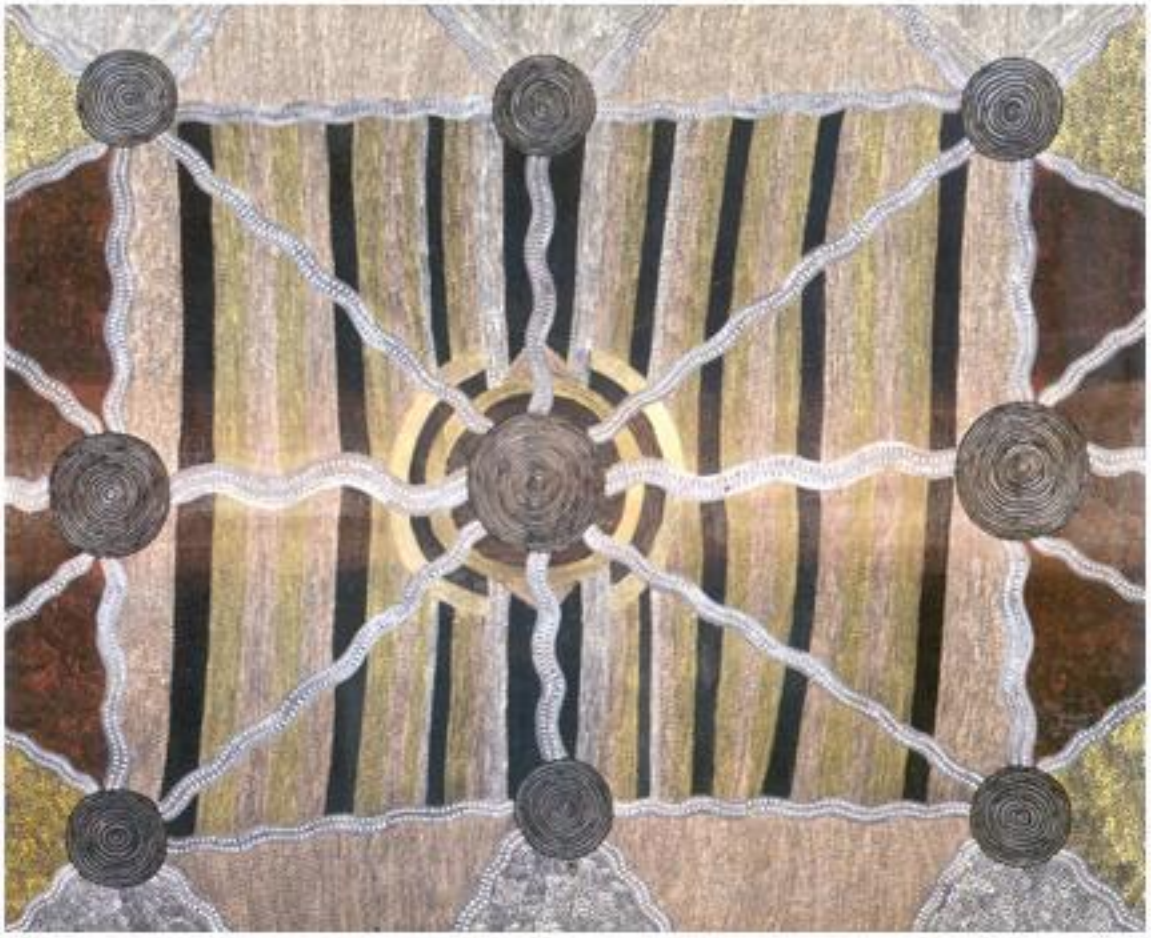
Step 5	Inpatient care, crisis teams	Risk to life, severe self-neglect	Medication, combined treatments, ECT
Step 4	Mental health specialists, including crisis teams	Treatment-resistant, recurrent, atypical and psychotic depression, and those at significant risk	Medication, complex psychological interventions, combined treatments
Step 3 (Joint working between Primary and Secondary Care)	Primary care team, primary care mental health worker	Moderate or severe depression	Medication, psychological interventions, social support
Step 2	Primary care team, primary care mental health worker	Mild depression	Watchful waiting, guided self-help, computerised CBT, exercise, brief psychological interventions
Step 1	GP, practice nurse	Recognition	Assessment

Adapted from NICE Guidance[2]




THE PATIENT
CHRONIC PAIN
PERCEPTIONS OF CONTROL
SENSE OF TRUST AND MUTUALITY
SENSE OF CONTINUITY IN RELATIONSHIP
CLARITY OF STRATEGY
ANALGESIA PRESECRIPTION
THE GP


DYSPHORIA /DISTRESS
KEY COGNITIONS
OTHER PSYCHOLOGICAL OR SOCIAL NEEDS
CHRONIC PAIN
DIAGNOSIS
TREATMENT
QUALITY OF LIFE
THE CLINICAL TRANSACTION
ANALGESIA PRESCRIPTION
THE GP



Acute hospital mental health services

Mental health and community services

Primary care mental health services

Acute hospital mental health services

Some common presentations requiring integrated care

- Co-morbidity in severe physical illness
- Medically unexplained symptoms
- Self-harm
- Alcohol and drug misuse
- Delirium and dementia

Mental health and community services

Some common presentations requiring integrated care

- Co-morbidity in severe mental illness
- Physical illness and learning disability

Primary care
mental health services

Some common presentations requiring integrated care

- Poor adjustment in LTC
- Medically unexplained symptoms

Set up to manage common milder mood disturbances (depression and anxiety).

Moving into managing some common presentations requiring integrated care

- Co-morbidity in physical illness
- Medically unexplained symptoms

Acute hospital Mental health services

Specialist mental health services

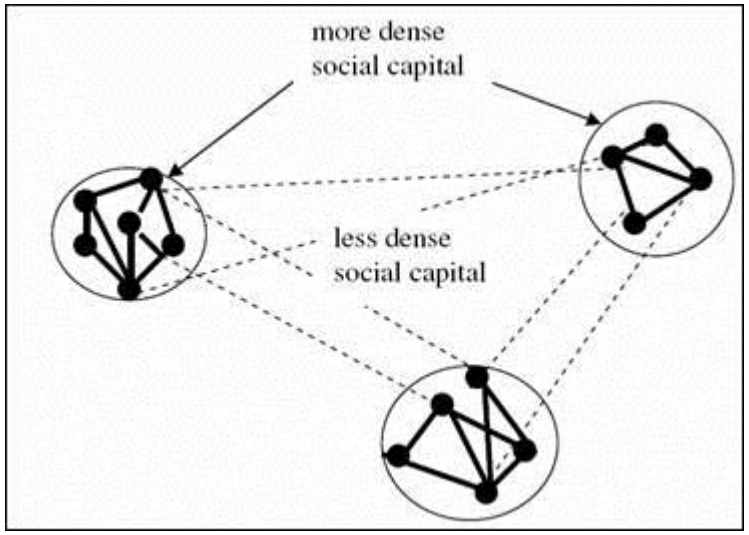
Primary care mental health services

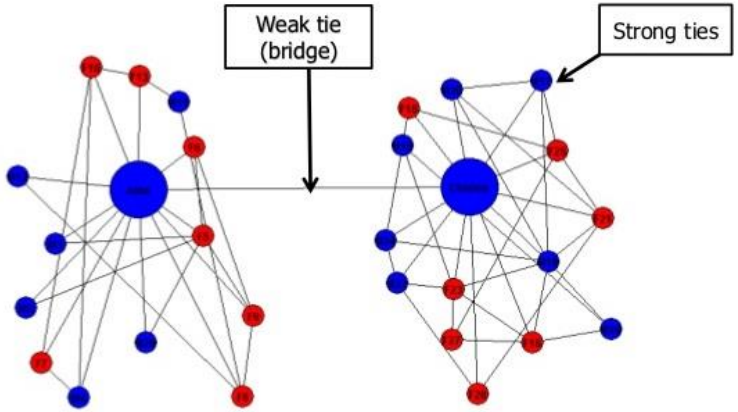
Social Capital in the Creation of Human Capital
James S. Coleman
American Journal of Sociology
Vol. 94, (1988), pp. S95-S120

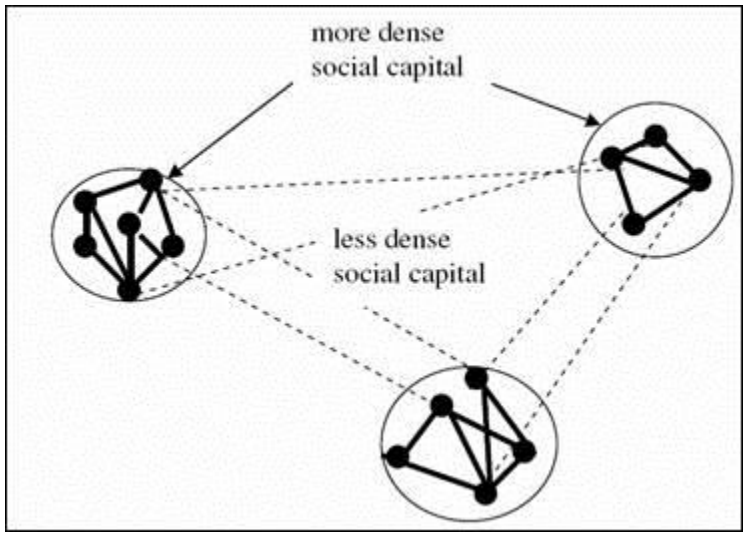
The Strength of Weak Ties

Mark S. Granovetter

American Journal of Sociology, Volume 78, Issue 6 (May, 1973), 1360-1380.





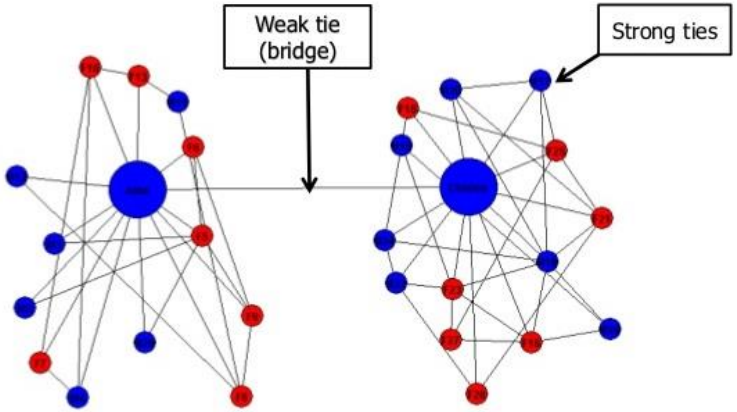


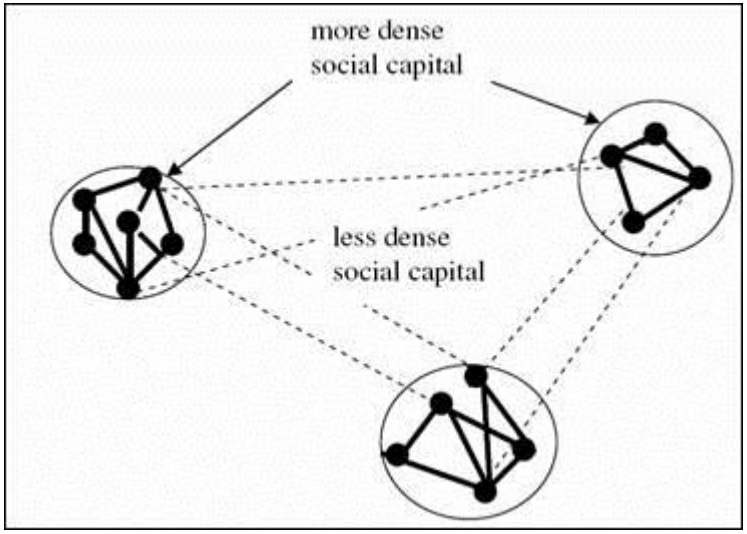
Planning and providing stronger clusters – building expertise and developing transferable learning

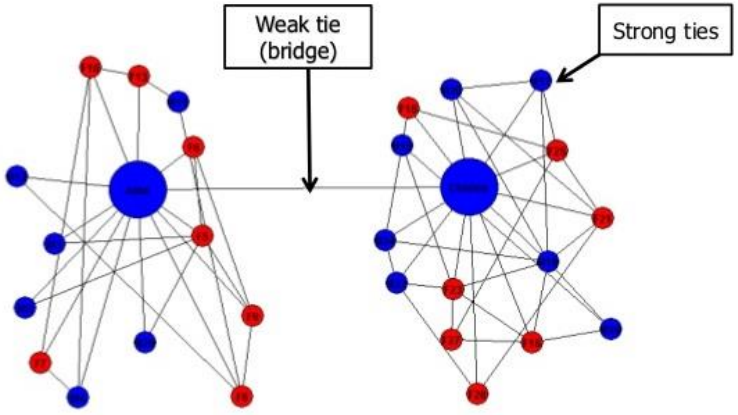
•Liaison services for complex cases in general hospitals

Planning and providing more weak links – building resilient networks of care

•Collaborative approaches to physical health in LD and severe mental illness







Planning and providing stronger clusters *and* more weak links – a mixed economy for mixed problems

- Liaison services in primary care
- Linking IAPT to mental health services

Because it's a zero sum game you have to…

Balance the competing demands of achieving patient-centred and organisationally desirable outcomes

Balance the competing demands of high volume/low impact and low volume/high impact problems

Balance the competing resource needs and working practices of different parts of the care network

Services for people struggling with chronic physical illness and MUS

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4 basic principles

- Not just a distress service
- Ability to deal with individuals and not diagnoses
- Strong interpersonal/social focus
- Co-ordinated with physical health services

3 service characteristics

- Takes barriers to self-management into account
- tackles the challenges in primary care
- Provides more than a chuck-out service in hospitals

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