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Supporting Integrated Management of Multi-morbidity (SIMM)

Emily Wood and Sally Ohlsen
Mental Health and Comorbidity theme

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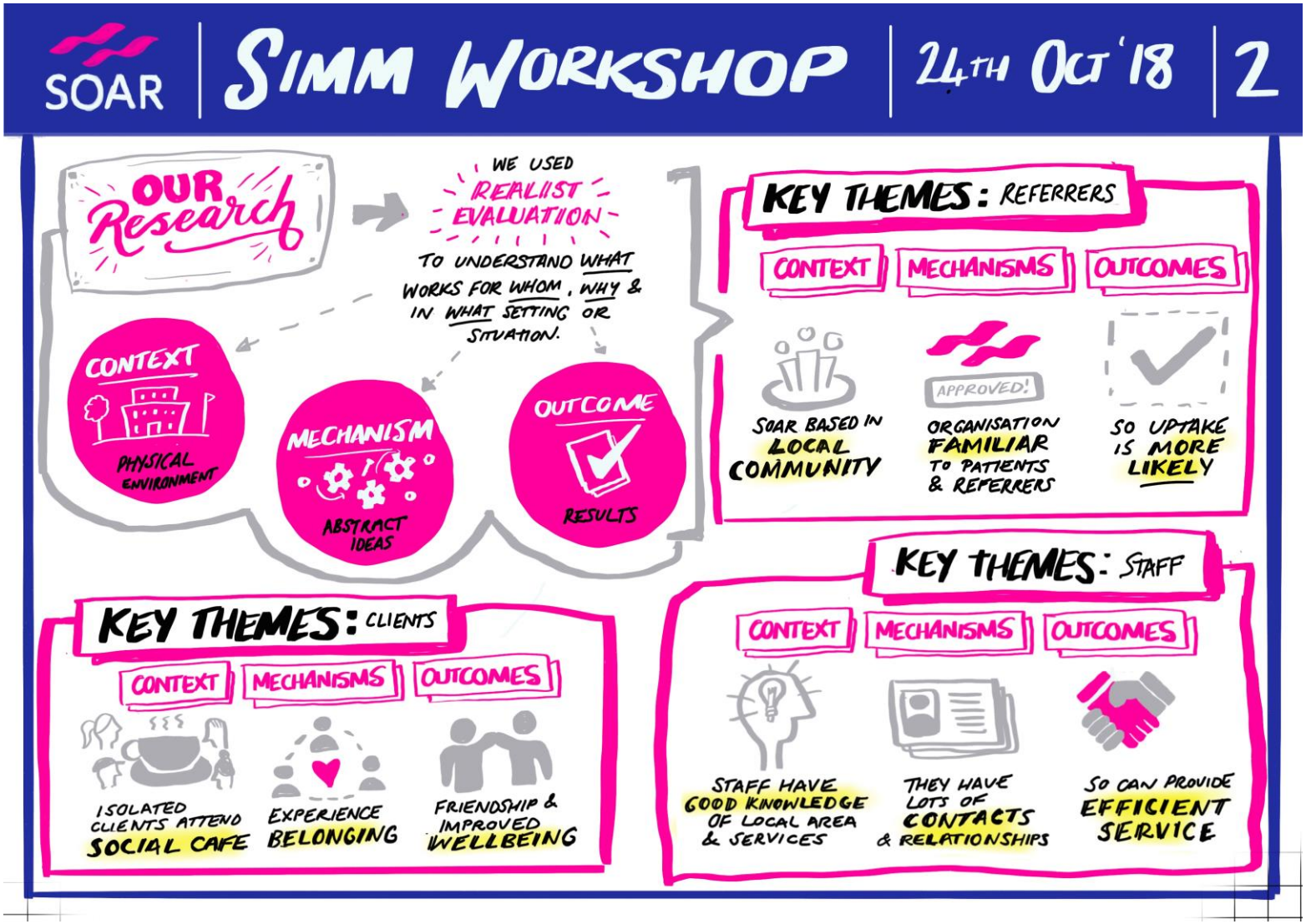

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Initial programme theory: Logic model of collaborative care in healthcare. Does this work in social prescribing.

Contexts

Clients:

Adults over 18+.

Depression.

Multi-morbid chronic physical health conditions.

Setting:

Within primary care and community health services.

Collaborative Care Interventions

(Gunn et al 2006)

Case worker:

Trained in depression and anxiety, who has regular contact with the person and organises care, with other professionals.

Multi-professional approach to patient care.

Enhanced inter-professional communication:

Including team meetings, case-conferences, individual consultation /supervision, shared medical records.

A structured management plan.

Scheduled patient follow-ups: One or more scheduled follow-up appointments to provide specific interventions.

Mechanisms

(Wood et al 2017, Hudson et al 2016)

Client:

Accessible pathways in.

Reduced stigma.

Participative social functioning.

Case worker:

Trusting interpersonal relationship.

Knowledgeable/Experienced staff.

Engaging staff, positive attitude.

Service/Intervention:

Patient centred interventions.

Adaptability of interventions.

Shared systems & standardised.

Client Outcomes

(Gunn et al 2006, Coventry et al 2014, Archer 2012)

Mental health:

Reduced depression symptoms.

Improved quality of life.

Social:

Improvements in social functioning.

Medication use:

Increased anti-depressant compliance.

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Modified programme theory: Logic model of social prescribing.

Contexts

Clients:

Adults over 18+.

Depression.

*Depression/ Anxiety often without diagnosis.

Multi-morbid chronic physical health conditions.

*Social issues.

*Isolation.

Setting:

*Community non clinical (can self-refer).

*SOAR charity organisation with staff members specialise in different areas.

Social Prescribing Interventions

Lead Social Prescribing worker (linked worker): Supported by other colleagues but not wider healthcare MDT.

Enhanced communications:

Within SP and variable across different agencies.

Personalised client centred management plan:

Follow up:

In some services, not all.

Fluid pathway:

Often evolving and circular rather than linear.

Mechanisms

(Wood et al 2017, Hudson et al 2016)

Client:

Reduced stigma.

Participative social functioning.

*Familiarity and routine.

* Supportive relationships.
*Meaningful - motivation

Case worker:

Trusting interpersonal relationship.

Knowledgeable/Experienced staff.

Engaging staff with positive attitude.

*Flexibility of role/time

Service/Intervention:

Patient centred interventions.

*Flexibility of interventions.

Outcomes

(Gunn et al 2006, Coventry et al 2014, Archer 2012)

Mental health:

Reduced depression symptoms.

Increased quality of life.

Social:

Improvements in social functioning.

*Improvements in housing, finance and employment/ volunteering.

*Increased engagement.

Physical health:

*Targeted physical health improvements.

Health service use:

*Health services: appropriate service use.

*Social prescribing services: increased service use.

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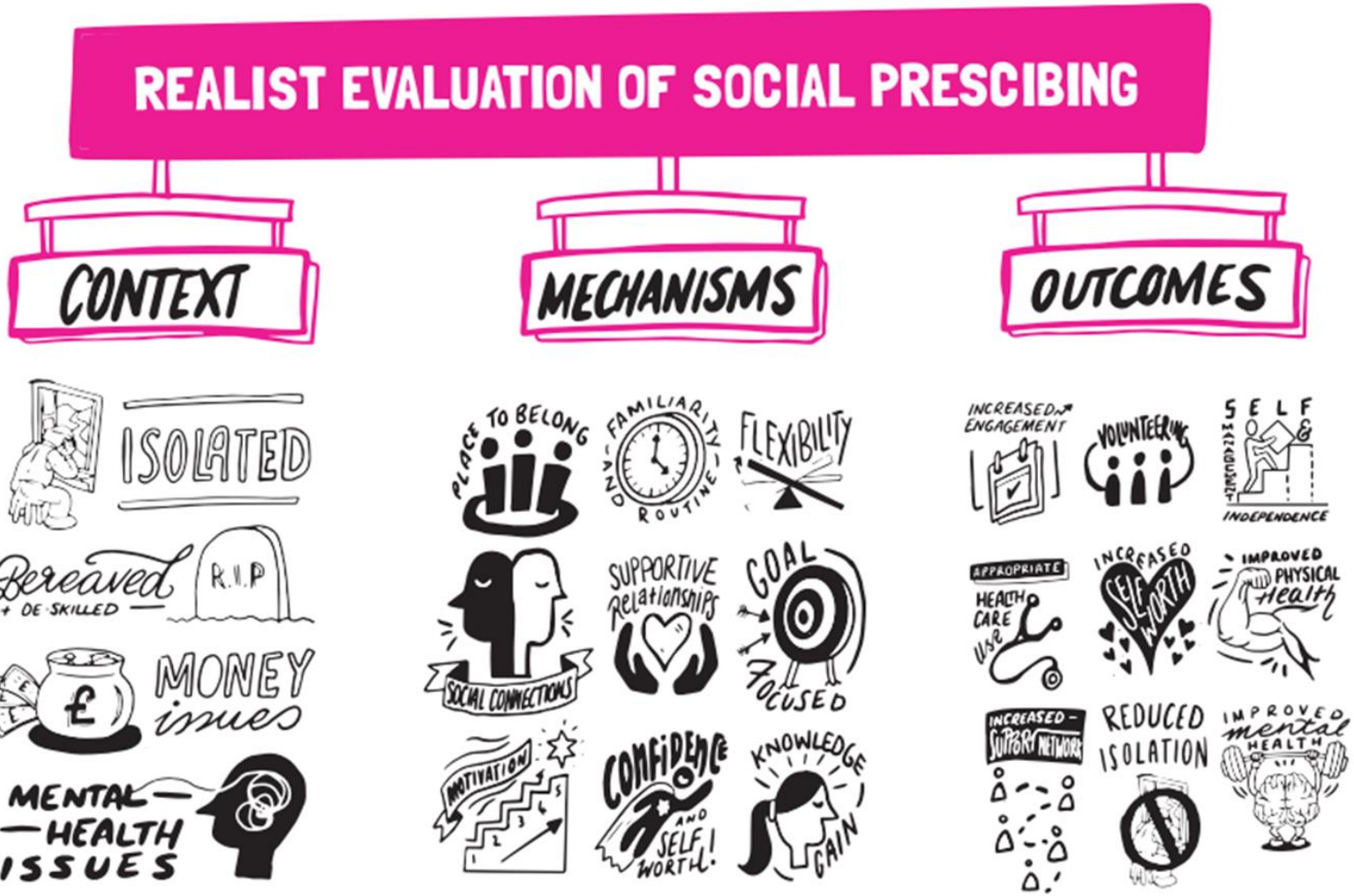

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REALIST EVALUATION OF SOCIAL PRESCIBING

CONTEXT

MECHANISMS

OUTCOMES

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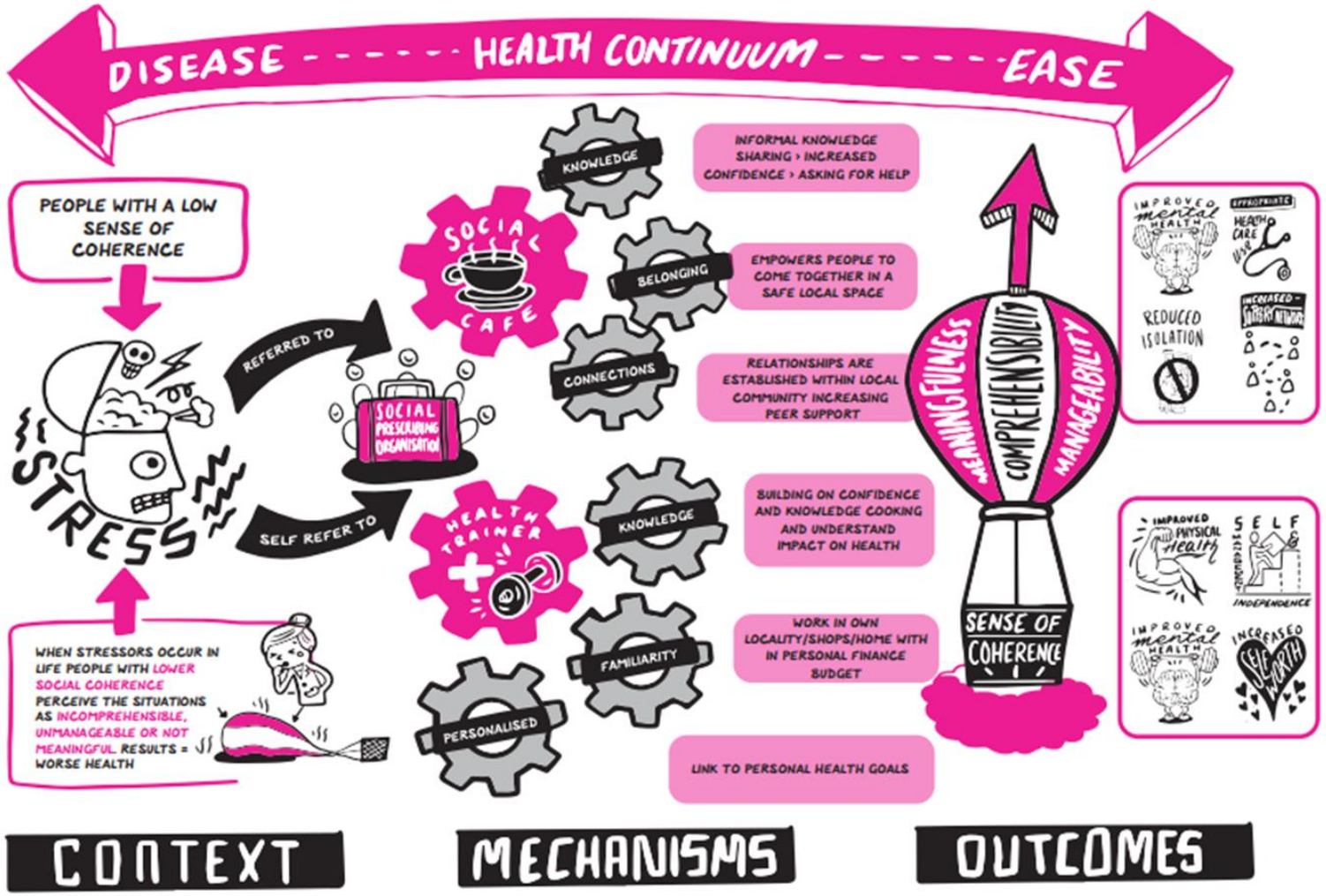

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Any Questions

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