



The national service framework for long term conditions

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amounts to about 1% of the earth's magnetic field, which affects all of us all the time. Studies of animals and of cells in culture have found no evidence of a plausible biological mechanism whereby such very weak magnetic fields could influence the development of leukaemia.^{w2}

In this issue (p 1290), Draper et al report on a very large case-control study, which found that a child's risk of leukaemia increased steadily with proximity to high voltage power lines of the home they lived in at birth.¹² However, this study did not include estimates or measures of the magnetic field from either the power lines or other sources. So it provides little evidence that the increased risk closer to power lines is due to magnetic fields. Furthermore, its matching of controls to cases on the basis of administrative areas may have yielded controls who were not completely representative of the distance of children's homes from power lines. Finally, the risk of childhood leukaemia varies geographically, so the increased risk closer to power lines may reflect some other factor that varies geographically. Even if the effect is causal, it could account for only a tiny proportion of cases.

We don't yet fully understand the aetiology of childhood leukaemia. Nevertheless, we are now reasonably sure that it often involves damage to DNA before birth—probably in response to infection, chemicals, ionising radiation, or other environmental exposures.⁶ These preleukaemic cells are converted into overt disease after birth if children are susceptible—because of their genetic make up and early protection from infection—and experience one

or more further events, often a delayed challenge from infections. Further insights will almost certainly come as advancing technology helps us to understand the molecular events that drive leukaemic changes.

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- 1 Parkin DM, Kramarova E, Draper GJ, Masuyer E, Michaelis J, Neglia J, et al, eds. *International incidence of childhood cancer*. Vol 2. Lyons: International Agency for Research on Cancer, 1998. (IARC Scientific Publication No 144.)
- 2 Stiller CA. Epidemiology and genetics of childhood cancer. *Oncogene* 2004;23:6429-44.
- 3 Hjalgrim LL, Rostgaard K, Hjalgrim H, Westergaard T, Thomassen H, Forestier E, et al. Birth weight and risk for childhood leukemia in Denmark, Sweden, Norway, and Iceland. *J Nat Cancer Inst* 2004;96:1549-56.
- 4 Little J. *Epidemiology of childhood cancer*. Lyons: International Agency for Research on Cancer, 1999. (IARC Scientific Publication No 149.)
- 5 Stewart A, Webb J, Hewitt D. A survey of childhood malignancies. *BMJ* 1958;1:1495-508.
- 6 McNally RJQ, Eden TOB. An infectious aetiology for childhood leukaemia: a review of the evidence. *Br J Haematology* 2004;127:243-63.
- 7 Kinlen LJ. Infection, childhood leukaemia and the Seascale cluster. *Radiol Prot Bull* 2000;226:9-18.
- 8 Greaves MF, Wiemels J. Origins of chromosome translocations in childhood leukaemia. *Nat Rev Cancer* 2003;3:639-49.
- 9 Gilman C, Peto J, Simpson J, Roman E, Eden TOB, Greaves MF, et al. Day care in infancy and risk of childhood acute lymphoblastic leukaemia (ALL): findings from a UK case-control study. *BMJ* 2005;330:1294-7.
- 10 Linet MS, Wacholder S, Zahm SH. Interpreting the epidemiological evidence: lessons from studies of childhood cancer. *Pediatrics* 2003;112:218-32.
- 11 Ahlbom A, Day N, Feychting M, Roman E, Skinner J, Dockerty J, et al. A pooled analysis of magnetic fields and childhood leukaemia. *Br J Cancer* 2000;83:692-8.
- 12 Draper G, Vincent T, Kroll ME, Swanson J. Childhood cancer in relation to distance from high voltage power lines in England and Wales: case control study. *BMJ* 2005;330:1290-3.

The national service framework for long term conditions

Aims to meet psychological, social, and emotional needs in neurological disorders

In March 2005 the UK Department of Health released the national service framework for long term conditions.¹ This framework comprises 11 requirements for improving, over the next 10 years, the quality of health and social care services for people with long term neurological conditions: persistent brain disorders with a wide range of complex physical, social, and psychological complications. This document may go some way towards raising awareness of some of the greatest unmet needs in the NHS.

The burden of such conditions is huge. Fifteen years ago the World Health Organization showed that broadly defined neuropsychiatric disorders were the most important cause of disability worldwide.^{w1} Some 10 million people across the United Kingdom have a neurological condition, and nearly 2 million care for someone with either a neurological or a mental health problem.^{w2}

Around half the patients with long term active neurological conditions in the United Kingdom receive no help beyond that of their general practitioner.² Unmet needs reduce quality of life both of patients and carers.³

The needs that are most commonly overlooked are psychological, psychiatric, and behavioural—often referred to collectively as “neuropsychiatric” in nature.⁴

Most of the principles of care are shared across specialties for people with neurological and psychiatric disorders. Yet some will disagree with the idea of a combined strategy for these disorders, especially those who have trained in the UK, where the two services are almost entirely separate. Relatively disparate training and service provision may explain why referrals from neurology to psychiatry under-represent the burden of psychiatric comorbidity and why patients' psychological needs may be detected relatively late.⁵ Conversely, the detection of important chronic medical conditions in psychiatric settings is often delayed.^{w3} Diagnostic delays seem to be particularly lengthy for conditions with prominent neuropsychiatric features, such as epilepsy,^{w4} motor neurone disease,^{w5} Parkinson's disease,^{w6} and Wilson's disease.^{w7} Yet, although the new



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framework highlights the need for specialist care from mental health services, it does not mention the need for better medical care within psychiatric services. Relatively few specialists working in local services will be equipped to deal adequately with such combinations of neuropsychiatric problems. But neurologists could be required to give further emphasis to psychiatric aspects of disease and psychiatrists may need to give equal emphasis to neurological aspects.⁶

The framework's focus on patients' psychological, social, and emotional needs is of more than academic interest. Half of people newly assessed in neurological outpatient clinics have a comorbid psychiatric disorder, and at least a third of neurological patients want additional psychological support.⁷ Psychiatric and behavioural symptoms are often the earliest presenting complaints of many common neurological conditions.⁸⁻¹¹ In addition, psychiatric complications predict poor outcomes from rehabilitation in most chronic neurological disorders and may even be associated with early death in several conditions.¹²⁻¹⁴

Equally importantly, psychiatric complications considerably reduce quality of life in all neurological conditions studied to date.¹⁵⁻²⁰ Moreover, psychiatric complications of neurological disease cause most distress and burden to patients and their carers.⁸ But will the framework be sufficient to change practice, when the evidence base for such interventions is incomplete and acceptable interventions that can improve quality of life for chronic conditions are not uniformly available?⁹

Evidence shows that inpatient rehabilitation for people with injuries to the spinal cord and brain is most effective when delays are short, when the package of care is comprehensive, and when there is follow-up in the community.²¹⁻²² The framework supports such care from multidisciplinary specialist teams, and those that can provide little neuropsychiatric care should forge clear and accessible links with mental health services to ensure that patients with comorbid psychological conditions are recognised and treated appropriately. Holistic and integrated care will require further improvement of neuropsychiatric services. Quality improvement approaches can help multiprofessional teams to detect psychiatric disorders among patients in acute neurological wards and in long term care settings.¹⁰ Studies in primary care and accident

and emergency units show that participation in educational programmes can improve staff's recognition of mental health problems: similar training could be adopted in neurology. However, to retain skills staff will need ongoing education and support.²³

The national service framework for long term conditions heralds a welcome shift away from the narrow medical models of the past and, if interpreted in the right spirit, it could be a catalyst for much better care. Although the framework applies only to the NHS, its criteria for high quality care are universally applicable. The cost of providing such good quality care will undoubtedly be high, but the cost to society of not providing it could be much higher.¹¹⁻¹²

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- 1 Department of Health. The national service framework for long-term conditions. www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4105361&chk=j17dri (accessed 25 May 2005).
- 2 Freeman JA, Thompson AJ. Community services in multiple sclerosis: still a matter of chance. *J Neurol Neurosurg Psychiatry* 2004;69:728-32.
- 3 Corrigan JD, Whiteneck G, Mellick D. Perceived needs following traumatic brain injury. *J Head Trauma Rehabilitation* 2004;19:205-16.
- 4 Heinemann AW, Sokol K, Garvin L, Bode RK. Measuring unmet needs and services among persons with traumatic brain injury. *Arch Physical Med Rehabilitation* 2002;83:1052-9.
- 5 De Jonge P, Huysse FJ, Herzog T, Lobo A, Malt U, Opmeer BC, et al. Referral pattern of neurological patients to psychiatric consultation-liaison services in 33 European hospitals. *Gen Hospital Psychiatry* 2001;23:152-7.
- 6 Reuber M, Mitchell AJ, Howlett SJ, Crimlisk HL, Grünwald RA. Functional symptoms in neurology: questions and answers. *J Neurol Neurosurg Psychiatry* 2005;76:307-14.
- 7 Fink P, Hansen MS, Sondergaard L, Frydenberg M. Mental illness in new neurological patients. *J Neurol Neurosurg Psychiatry* 2003;74:817-9.
- 8 Chipchase SY, Lincoln NB. Factors associated with carer strain in carers of people with multiple sclerosis. *Disabil Rehabil* 2001;23:768-76.
- 9 Wilson T, Buck D, Ham C. Rising to the challenge: will the NHS support people with long term conditions? *BMJ* 2005;330:657-61.
- 10 Boyle VL, Roychoudhury C, Beniak R, Cohn L, Bayer A, Katz I. Recognition and management of depression in skilled-nursing and long-term care settings - Evolving targets for quality improvement. *Am J Geriatr Psychiatry* 2004;12:288-95.
- 11 Goetzel RZ, Long SR, Ozminkowski RJ, Hawkins K, Wang SH, Lynch W. Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting US employers. *J Occup Environ Med* 2004;46:398-412.
- 12 Horn SD. Limiting access to psychiatric services can increase total health care costs. *J Clin Psychiatry* 2003;64(suppl 17):23-8.

The new pope and medical ethics

Can Benedict XVI strike a balance between Catholic doctrines and health?

Given that more than 37 million people worldwide are living with HIV,¹ the late pope's opposition to the use of condoms attracted much criticism. Indeed, some critics blamed John Paul II directly for the loss of millions of lives from AIDS in Africa, where the Catholic church is flourishing; 2.3 million died in 2004 in sub-Saharan Africa alone. The new pope, Benedict XVI (formerly Joseph Ratzinger), also comes from the conservative wing of his church and is therefore very likely to endorse the encyclical of

Pope Paul VI that bars Catholics from using any kind of artificial contraceptive.² But what do we really know of his views on condom use and other medical and ethical issues?

As a cardinal, Joseph Ratzinger led the Congregation for the Doctrine of the Faith, an organisation descended from the holy inquisition. He worked closely with Pope John Paul II and was known to share many of his views. Three years ago Ratzinger wrote that "there are final boundaries we cannot cross