

Commissioning guidance for Medically Unexplained Symptoms (MUS)

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Joint Commissioning Panel for Mental Health

The Joint Commissioning Panel for Mental Health (JCPMH) is co-chaired by the Royal College of Psychiatrists and the Royal College of General Practitioners. It is a collaboration between seventeen leading organisations, inspiring commissioners to improve mental health and wellbeing, using a 'values based' commissioning model.

Partners:

- Afiya Trust
- Association of Directors of Adult Social Services
- British Psychological Society
- Department of Health
- Healthcare Financial Management Association Mental Health Finance
- Joint Commissioning Panel for Mental Health
- Mental Health Providers Forum
- Mind
- National Survivor User Network
- New Savoy Partnership
- NHS Confederation Mental Health Network
- Rethink
- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Psychiatrists

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What we plan to cover

Context:

- What are MUS?
- Impact on patients & clinicians
- Why is guidance needed?

10 key messages for commissioners

What principles should underpin good MUS services?

Service models and contexts

What are Medically Unexplained Symptoms?

‘Persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology’

Chitnis A, Dowrick C, Byng R, Turner P, Shiers D (2011) Guidance for health professionals on medically unexplained symptoms (MUS). Royal Colleges of GPs and Psychiatry and NMH DU

- **Psychiatric labels**
 - Psychosomatic/Functional/Hysteria/Conversion/Somatoform/bodily distress
- **Medical labels**
 - IBS, functional (non-ulcer) dyspepsia
 - Non-epileptic attack disorder, Tension headaches
 - Non-cardiac chest pain, Chronic Pelvic Pain, TMJ joint pain,
 - Fibromyalgia
 - Chronic Fatigue Syndrome/ME
 - Multiple chemical sensitivity
 - Type 1 ‘brittle’ asthma
- **Colloquial labels**
 - Thick file, revolving door, frequent fliers.....

Why is commissioning guidance needed?

Growing political interest, neglected area of healthcare, good potential for cost-savings.

MUS should be a 'commissioning win' – reducing unnecessary care

There is an evidence-base and some clinical guidelines, but extremely limited service provision.

IAPT tasked with delivering interventions, but GPs may not recognise and refer, IAPT practitioners may not have necessary skills for more complex patients

Why 'MUS' rather than functional syndromes?

Functional syndromes overlap in criteria and co-occurrence

More similarities than differences in mechanisms, demographics, response to treatment, prognosis.....

Arbitrary groupings of symptoms according to medical speciality – IBS, NEAD etc

Risk of 'silo management' of different bits of the patient

Dawn - Depression, somatisation, chronic pain, and also recent episodes of illnesses including bleeding, paralysis, mutism, headaches, pseudoseizures and self-harm, endometriosis, benign intracranial hypertension and migraine.

Dawn's care - community psychiatrist, GP, 2 x gynaecologist, neurologist, neuro-ophthalmologist

5 different hospitals (incl. 'out of area' and second opinions)

The scale of the problem

20% of new consultations in primary care ^{1, 2}

52% of new referrals to secondary acute care ³

20-25% of all frequent attenders at specialist medical clinics ^{4, 5}

Frequent attenders with MUS get investigated more than other frequent attenders ⁶

20-50% increase in outpatient costs

30% increase in inpatient admissions

Annual NHS costs for MUS in adults of working age in England was estimated to be £2.89bn in 2008/9 (11% of total NHS spend)

Sickness absence and decreased QoL costs over £14 billion per annum to the UK economy ⁷

Impact on patients with MUS

Distress and functional impairment – can be severe, chronic and incapacitating, and/or associated with anxiety, depression or personality disorder

Can feel that their concerns are not being taken seriously by their doctor: *“The tests are all normal so there is nothing wrong with you...”*

Patients may amplify symptoms due to doctors’ lack of responsiveness to expressed concerns and psychosocial problems

Repeated unplanned attendances to GPs, A&E

or Disengagement from care (for other health problems)

Impact on clinicians of working with people with MUS include:

Finding consultations challenging^{8, 9}

- Difficulties in establishing a 'diagnosis' (particularly where a biomedical model is being employed)
- Impact of the patient's presentation on the clinician

'Some make your stomach churn when they come in...very nervous. They make it very clear they are taking charge; and they do, they take charge, and there is nothing you can do.' (GP)

GPs devalue their psychological skills in working with people with MUS¹⁰

GPs frequently suggest physical investigations or interventions even when patients are not seeking them ¹¹

Consultation skills necessary to work with patients with MUS are not taught to acute care specialists at any stage of medical education¹²

Evidence-base versus availability of services

Effective evidence-based management strategies for MUS exist^{13,14} but availability is limited due to:

- Lack of specific training in such interventions for doctors
- System problems with healthcare design which separate physical and mental healthcare
- Patient engagement can be difficult - many patients with MUS do not present to mental health services and do not accept psychological explanations for bodily distress, or accept psychological interventions

Where are we now?

MUS are common & distressing to the person

MUS are costly to the healthcare system

Neglected in medical training

Stressful for doctors

Over-investigated

No consistent care pathways

Effective treatments not usually available

Key messages for commissioners

1. Medically Unexplained Symptoms (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology.
2. MUS are common, with a spectrum of severity, and patients are found in all areas of the healthcare system.
3. MUS accounts for a very high proportion of NHS activity, currently estimated at £3 billion per year, which is approximately 10% of total costs.
4. Many people with MUS have complex presentations caused, or exacerbated, by co-morbid mental health problems such as anxiety, depression or personality disorders.
5. Patients are often subjected to repeated unnecessary diagnostic investigations, and unnecessary and costly referrals and interventions.

Key messages for commissioners

6. Without appropriate treatment, outcomes for many patients with MUS are poor. Evidence-based treatments for patients with MUS do exist but are rarely available.
7. Appropriate services for people with MUS should be commissioned in primary care, community, day services, Accident and Emergency departments and inpatient facilities. This will enable patients to access services appropriate for the severity and complexity of their problems.
8. In addition to a range of MUS services, a new kind of multidisciplinary approach is required, bringing together professionals with skills in the following areas: general practice, medicine, nursing, psychology/psychotherapy, psychiatry, occupational therapy and physiotherapy. All healthcare professionals should integrate both physical and mental health approaches in their care.
9. Education and training are essential to ensure that all health professionals develop and maintain the skills to work effectively with patients experiencing MUS.
10. Implementation of appropriate services would result in improved outcomes for patients and substantial cost-savings.

What principles should underpin good MUS services?

A good healthcare system for MUS should be

- Person-centred (not symptom-focused)
- Accessible (not remote)
- Needs-based (not reliant on local champions)

It should have the following elements:

- **Sufficient service provision to meet local needs.** MUS prevalence and consequent healthcare costs can usually be calculated from primary care records. Local need may be estimated from epidemiological studies.
- **Full range of MUS services appropriate to local needs,** delivering evidence-based social, psychological and physical care, with emphasis on effective early interventions.
- **Accessibility within settings which patients find most acceptable.** This may be in primary or secondary care, but not in traditional acute specialist clinics (dealing with one bodily system) or mental healthcare settings.

What principles should underpin good MUS services?

- **Care pathways that integrate physical and mental healthcare** and join primary, secondary and tertiary services seamlessly. This may involve a stepped care model, with the intensity of the intervention being proportional to the complexity of the problem.
- **Protocols** clarifying the respective roles of different health and social care agencies in supporting primary care to avoid unnecessary use of specialist services.
- **Information-sharing agreements** between healthcare providers that will support properly integrated holistic care for MUS, enabling clinicians to access all relevant clinical information. Systems to enable close liaison between GPs, A&E and acute specialists will be important.
- **Qualified and appropriately trained staff** with competence in assessment and management of MUS. All health care professionals should be able to assess the physical and mental aspects of patients' problems, take a positive approach to symptom management, and are committed to collaborative working.

Service models & contexts: community-based services

In settings acceptable to patients – usually GP surgeries rather than generic mental health service settings

May simultaneously provide care for related co-morbid problems, such as long-term conditions (MUS + LTCs) or personality disorder (MUS + PD)

Aimed at patients whose problems are too complex for local IAPT services but not requiring hospital treatment

Multi-disciplinary – psychiatrists, psychological therapists, nurses, occupational therapists, pharmacists, dieticians, physiotherapists, GPs with a special interest in MUS.

Make use of the patient-GP relationship, by advocating for GPs to provide continuity of care

Offer advice, assessment and evidence-based treatment including psychological therapies

Service models & contexts: hospital-based services

Secondary acute care

- Multidisciplinary liaison psychiatry team for the whole hospital
 - Support acute staff
 - Redirect patients from A&E
 - Expedite discharge from wards
 - Offer interventions by therapists familiar with physical problems
- Therapist/team attached to a specific hospital department
 - Intervening with particular functional somatic syndromes eg CFS, IBS, NEAD

Tertiary acute care

- Specialist inpatient MUS unit
 - For patients with high clinical complexity and severity, not helped by other services
 - MUS, psychiatric disorders, medical disorders, iatrogenic problems, secondary physical consequences of their illness (such as chronic inactivity)
 - Broad-based MDT
 - Rehabilitation and treatment programmes, which includes physical, occupational, psychological and medical components

Thank you for listening

Any Questions?

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