Commissioning guidance for Medically Unexplained Symptoms (MUS)

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What should we be doing about MUS?

1. Improve clinicians’ and healthcare commissioners’ awareness of treatability

2. Make services less dualistic
   - Collaborative professional relationships
   - Joined-up care pathways
   - Multi-disciplinary team
   - Psychological therapies in acute settings

3. Train clinical staff
   - GPs
   - Hospital specialists
   - Mental Health Professionals

Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Co-chaired by:

Royal College of
General Practitioners

Royal College of
Psychiatrists

Membership:

Mind

Rethink Mental Illness

The British Psychological Society

Promoting excellence in psychology

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Mental Health Providers Forum

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The Royal College of Nursing

The New Savoy Partnership

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Development process

This guide has been written by a group of MUS experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts.
Joint Commissioning Panel for Mental Health

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Guidance for commissioners of services for people with medically unexplained symptoms

Volume Two: Practical mental health commissioning
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Ten key messages for commissioners

1. The term Medically Unexplained Symptoms (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology.

2. These symptoms are common, and are presented in various degrees of severity in all areas of the healthcare system.

3. MUS accounts for approximately 10% of total NHS expenditure on services for the working age population in England.

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 diagnostic investigations, and unnecessary and costly referrals and interventions.

6. Without appropriate treatment, outcomes for many patients with MUS are poor. While evidence-based treatments for patients with MUS exist, they are rarely available.

7. Appropriate services for people with MUS should be commissioned in primary care, community, day services, accident and emergency (A&E) departments and inpatient facilities. This would enable patients to access services that are 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 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 healthcare 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 for the healthcare system.
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 \(^7\)
Evidence-base versus availability of services

Effective evidence-based management strategies for MUS exist\textsuperscript{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 made available
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
References