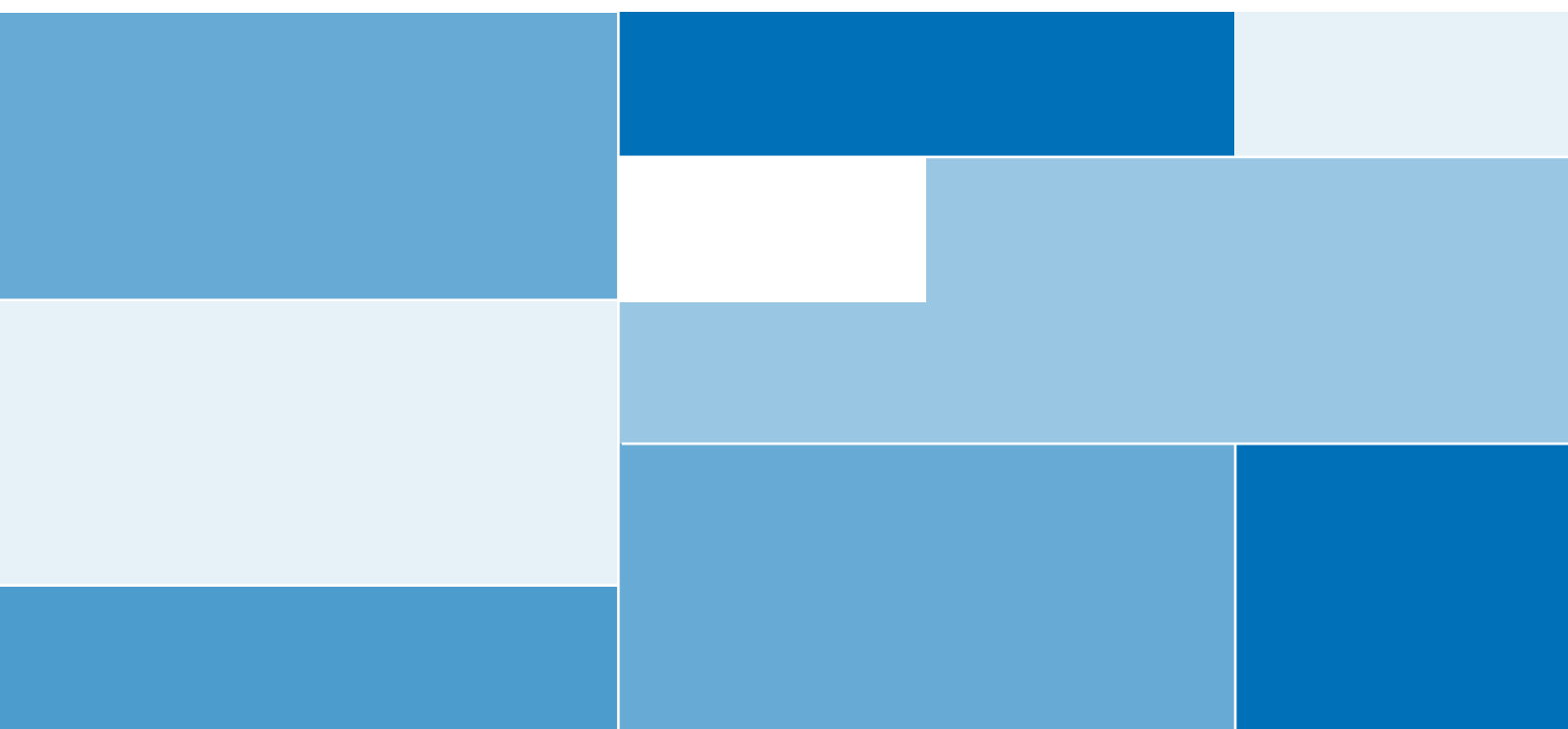


Medically unexplained symptoms positive practice guide



October 2008

Background

1. Medically unexplained physical symptoms (MUPS) are physical symptoms that have no currently known physical pathological cause. They constitute a clinically, conceptually and emotionally difficult area to tackle, with clinical presentations varying greatly, from people who regularly attend GP surgeries with minor symptoms to people with chronic fatigue who are bed-bound.
2. MUPS are common, accounting for as many as one in five new consultations in primary care.¹ The unexplained symptoms can cause significant distress to the patient and, in some circumstances, impair functioning.
3. The vast majority of MUPS, such as pain, irritable bowel syndrome and chronic fatigue syndrome, have no obvious cause and often do not actually require any input from health services. However, studies have shown that between 20% and 30% of consultations in primary care are with people who are experiencing MUPS and have no clear diagnosis. It is estimated that this rises to an average of 52% in secondary care where a substantial proportion of secondary care resources are used by frequent attenders whose symptoms remain unexplained.²
4. People suffering with MUPS are sometimes described by health professionals as somatisers, but this term is often very unpopular with patients as it implies the MUPS are related to a psychiatric disorder, which may or may not be present. However, up to 70% of people suffering with MUPS will also suffer from depression and/or anxiety disorders. This is of significance because these mental health disorders are detectable and treatable, irrespective of the explanation for the physical symptoms.
5. Community mental health teams and primary care mental health services have not been successful in engaging with patients experiencing MUPS, as patients often do not perceive their condition to be related to mental health problems, despite the range of effective interventions available to people experiencing MUPS.

1 Bridges, K.W. and Goldberg, D.P. (1985) Somatic Presentation of DSM-III Psychiatric Disorders in Primary Care. *Journal of Psychosomatic Research*, 29: 563–9

2 Nimnuan, C., Hotopf, M. and Wessely, S. (2001) Medically unexplained symptoms: an epidemiological study in seven specialities. *Journal of Psychosomatic Research*, 51: 361–7

Understanding the local community

6. Commissioners need to understand their local community fully, including local demographic profiles and epidemiological data, if they are to secure Improving Access to Psychological Therapies (IAPT) services that are appropriate for the whole population, including people with MUPS.
7. Evidence suggests that as many as 70% of people with MUPS also suffer from depression and anxiety disorders and people experiencing five or more MUPS have a considerably worse quality of life when compared with people with medically explained symptoms. Those experiencing MUPS have been found to have:
 - 50% more consultations;
 - 50% more healthcare costs; and
 - 33% more hospitalisations.
8. MUPS are commonly found in children and increase as people age into adulthood. Women are three to four times more likely to experience MUPS than men.
9. Presentation with MUPS is associated with twice the standardised mortality ratio for cancer, accidents and suicide. MUPS is sometimes associated with serious mental illness such as severe depression with high suicide risk. Therefore, it is important that people experiencing MUPS are carefully assessed and offered appropriate treatment wherever possible.
10. It seems likely that at least three populations of people with MUPS can be described. First, a larger group who have symptoms intermittently and are well in between episodes; these people are best managed in primary care. Second, a smaller group who recognise that their symptoms may be contributed to by psychological factors and who are amenable to referral for psychological therapy, which could be provided by IAPT. Last, a group, smaller still, of people suffering with MUPS who are not amenable to referral; these people need to be managed in primary care, using best practice principles in different ways.
11. A tool has been developed for IAPT to help commissioners and GP practices identify the numbers of patients in the latter two groups, as an aid to planning services. This tool can be found on the IAPT website (www.nhs.uk/iapt).

Benefits of psychological therapies for people with MUPS

12. People experiencing MUPS make up 40% (in some clinics over 50%) of medical outpatient appointments and 5–10% of in-patient care, with limited evidence of benefit to these patients. Worse still, there is evidence that unnecessary procedures or surgery performed on people with MUPS can create new health problems.
13. Patients with MUPS generally have high levels of health anxiety. They are also often uncertain whether they actually have a physical problem or if their symptoms are stress related. In general, the presenting MUPS will have a physiological explanation related to a mental health problem such as depression and/or anxiety disorders.
14. A range of National Institute for Health and Clinical Excellence (NICE) approved psychological therapies have been shown to be an effective intervention for people suffering with MUPS and depression and/or anxiety disorders.

Removing barriers to access

15. People experiencing MUPS often face a number of barriers that prevent them from having access to psychological therapies for their depression and/or anxiety disorders.
16. GPs and other healthcare professionals may also prevent people who are experiencing MUPS from accessing services providing psychological therapies. GPs and other health professionals may:
 - have time constraints in their surgeries which may not be sufficient for them to diagnose mental health problems effectively;
 - recognise the symptoms of depression or anxiety but fail to recognise that they can be effectively treated by psychological therapies or other treatments;
 - believe that mental health problems may be attributable to the person's reactions to their MUPS and do not consider the patient suitable for treatment; and
 - believe that identifying, investigating and treating any physical health problems are a higher priority than treating mental health problems.

17. People experiencing MUPS may not receive psychological therapies because they may:
 - believe they have physical health problems only and do not recognise they are suffering from depression and/or anxiety disorders;
 - not understand the impact that depression and/or anxiety disorders can have on MUPS;
 - have a fear of being stigmatised by other people's attitudes to mental health problems; and
 - have MUPS health problems or chronic pain that distract them (and the GP) from any mental health problems.

Engagement

18. Proper and effective engagement with people experiencing MUPS is essential if their needs are to be met. This can be addressed by:
 - identifying successful and unsuccessful referral pathways; and
 - working with service users who have experienced MUPS in designing the IAPT services.
19. GPs have an important role in ensuring people experiencing MUPS engage with IAPT services. GPs are usually the first point of contact for people with MUPS and they may need to prepare patients who present with MUPS for psychological therapies by explaining how depression and/or anxiety disorders may be linked to their physical problems. Commissioners need to ensure that GPs are engaged in the IAPT service and understand the benefits of referring their patients to IAPT services.
20. Many people are willing to accept that depression and/or anxiety disorders are linked to their MUPS as long as they believe that health professionals are willing to keep an open mind about the cause of any further physical symptoms. Therefore, the venue or location of an IAPT service should be considered when looking to break down barriers for individuals who are experiencing MUPS. With many patients believing their symptoms are entirely physical problems, a service that is located or embedded in a physical health framework may encourage engagement, i.e. within a pain clinic, part of a Clinical Assessment Service or Intermediate Clinical Assessment Team for musculoskeletal problems.

21. Commissioners setting up IAPT services may wish to seek specialist advice from local GPs (or other health professionals) who have a special interest in MUPS. This will ensure that special requirements for people experiencing MUPS can be incorporated into the service design and will allow other relevant physical health services to be linked into the care pathways of the people with depression and/or anxiety also experiencing MUPS.

A systems approach to the management of MUS in Plymouth

A project is under way to develop a “systems” approach to the management of patients with MUS, aiming to intervene at all levels of the Plymouth health community (primary, secondary and a referral management centre) with a view to supporting the existing practice of professionals in managing patients with MUS, rather than focusing on the creation of new services. The strategy is based on principles of avoiding potentially iatrogenic investigations, optimising the functioning of individuals, positive risk management, maintaining positive patient/clinician relationships and improving patient experience.

To date the team has focused on reviewing national and worldwide “centres of excellence” to obtain knowledge, expertise, resources and “tools” for effective management of the clinical care of patients with MUS. A number of interventions have been proposed to be piloted with GPs, consultants and GPs with special interests, which include:

“Scripts” for GPs and consultants – to provide a framework and practical strategies for difficult conversations with patients with MUS, addressing psychosocial issues prior to and after referrals and investigations.

Written communication advice – to facilitate open, honest and helpful written communication between primary and secondary care concerning MUS issues, such as negative investigations.

“Psychological tool kit” – for use by consultants to support them in explicitly assessing the extent to which psychological variables might be important in a patient’s presentation.

Positive practice guidelines – to inform practice at all stages of the pathway.

Risk management strategies – explicit guidelines for GPs/consultants on issues of risk, supported at board level.

Adapting referral management centre procedures – to investigate new methods for capturing the extent to which clinicians think MUS issues might be important in a patient’s presentation.

The first aim is to put these interventions into action and assess their immediate acceptability and impact on the care of patients with MUS. They will initially be trialled in selected GP practices and the ENT care pathway. Our vision is to create a “tool kit” for all health communities of practical strategies they can utilise to make the pathways of care for patients with MUS more effective.

This is a partnership between Plymouth PCT, Plymouth Hospitals Trust and Sentinel CIC. Please contact caroline.maxted@phnt.swest.nhs.uk or nicola.bray@plymouth.nhs.uk; tel: 01752 434105 for further information.

Acknowledgements

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