Institution: University of Nottingham

Unit of Assessment: UoA4 - Psychology, Psychiatry and Neuroscience

Title of case study: The development of psychological treatment pathways and better identification of Medically Unexplained Symptoms (MUS) in primary care

1. Summary of the impact

Work on better management and identification of Medically Unexplained Symptoms (MUS) has led to the introduction of new treatments in primary care in England through the Improving Access to Psychological Treatment (IAPT) programme as well as having an impact on service planning and commissioning. These approaches have also been implemented into the routine training and practice of General Practitioners (GPs) in parts of Europe. A clinical and economic evaluation of a psychosocial approach to chronic fatigue syndrome using general nurses and development of a cognitive behaviour therapy approach has changed general practice and enhanced the patient experience for those with MUS.

2. Underpinning research

Barriers to identification and treatment of MUS

Medically unexplained physical symptoms such as abdominal pain, headache, back pain and fatigue are common, accounting for as many as one in five new consultations in primary care. Professor Richard Morriss (Professor of Psychiatry and Community Mental Health at Nottingham from 2006-present) first published work on MUS conducting qualitative interviews and recording consultations between GPs and patients with MUS in 2007. Findings showed that patients presenting with MUS in primary care were often poorly managed leading to iatrogenic harm. Interviews showed that GPs found MUS patients challenging to work with and had no specific training about their management. In particular, co-morbid psychological problems in patients with MUS are common and counterproductive to medical symptoms. Previous research had suggested that GPs held a negative attitude to MUS patients with psychological symptoms, whereas Morriss's work showed that many GPs were simply under-confident regarding their abilities to tackle the complex psychological issues raised by patients with MUS[1].

Effectiveness of reattribution training

In order to provide a framework for GPs to tackle these issues through the use of a structured approach to increase confidence, a psychosocial approach called reattribution was adapted for a broader group of patients with MUS. Reattribution refers to an intensive structured consultation delivered by a GP, which aims to provide a psychological explanation to patients with somatised mental disorder.

To explore the potential advantages of reattribution within a clinical setting, a randomised controlled trial ('Training family practitioners in reattribution to manage patients with Medically Unexplained Symptoms: MUST- see section 3 for details) was conducted[2]. The trial compared reattribution with treatment as usual in 16 GP practices with 74 GPs and 141 MUS patients to explore feasibility. A six hour training package was developed and adapted for use by GPs to deliver reattribution to patients with MUS. Morriss and colleagues developed training materials and practice-based delivery of such training by mental health facilitators to improve both the recognition and management of such patients. Findings showed that such practice-based training improved doctor-patient communication and highlighted a number of attitudinal, practical and organisational issues that needed to be addressed e.g. that patients needed GPs to demonstrate to them that they would take any new symptoms seriously in terms of physical disease rather than assume them to be psychologically created.

Challenges in the implementation of reattribution in a clinical setting were explored through qualitative methods and results showed that barriers included the complexity of patients' problems and patients' judgements about how to manage their presentation of this complexity. Many patients reported not trusting doctors with discussion of emotional aspects of their problems and therefore chose not to present them. Therefore it was concluded that simply improving GP explanation of unexplained symptoms is insufficient to reduce patients' concerns. Rather, GPs need to help patients to make sense of the complex nature of their presenting problems, communicate that attention to psychosocial factors will not preclude vigilance to physical disease and ensure a quality of doctor-patient relationship in which patients can perceive psychosocial enquiry as appropriate[3].

In light of this, more recent research funded by the Medical Research Council showed that with training and ongoing supervision, psychological treatment for some MUS patients with specific syndromes such as Chronic Fatigue Syndrome could be delivered by adult specialty general nurses who had received four months' training, including supervised practice, in each of the supportive listening and rehabilitation interventions[4]. This streamlined the process and reduced barriers to delivery such as patients not disclosing psychological problems to GPs.

Better identification of patients with MUS

Previous research highlighted the need for a streamlined process of identification of MUS within general practice. Therefore, Morriss and colleagues conducted Department of Health (Care Services Improvement Partnership, CSIP) funded research investigating streamlined diagnosis of MUS by developing methods for estimating the number of patients suffering with MUS using electronic patient records held by practices[5]. With additional support of CSIP, Morriss developed a search tool 'The Nottingham Tool'. This searches a GP Practice Database, to identify a cohort of patients that fulfil the criteria for MUS. This cohort provides an overview to the commissioners, or the practice, about the number of people likely to have a MUS. The tool is designed to generate a list for GPs of patients with possible MUS. The GP can then refine the list to exclude or include patients known to have the condition. Morriss noted that whilst identifying the individual patient is important, it is also important for commissioners of services to have a better understanding of the numbers of people who are likely to have a MU symptom. It is important so that appropriate services can be planned and commissioned[6].

As a result of such work on both the organisation of care and the development of The Nottingham Tool to help GPs estimate the care needs of patients in their practice, the National Health Service (NHS) in England extended the provision of specialist psychological care as part of the IAPT programme for such patients. Therefore, in summary, taken as a whole, Morriss's body of research about MUS has shown how GPs can be taught to deliver better doctor-patient communication, organise care for such patients, estimate the numbers needing care, better identify patients and develop strategies to engage patients in psychological treatment at a time when the NHS in England will be spending nearly £200 million over a 3 year period on such treatment.

3. References to the research

1. Salmon P, Peters S, Rogers A, Gask L, Clifford R, Iredale W, Dowrick CF, Morriss R. (2007).Why do general practitioners decline training to improve management of Medically Unexplained Symptoms. *Journal of General Internal Medicine*; 22; 565-571. DOI: 10.1007/s11606-006-0094-z. IF: 3.278; Citations: 41.
2. Morriss R, Dowrick C, Peters S, *et al.* (2007). Cluster randomised controlled trial of training practices in reattribution for medically unexplained symptoms. *British Journal of Psychiatry*; 191: 536-542. DOI:10.1192/bjp.bp.107.040683. IF: 6.619; Citations: 50.
3. Peters S, Rogers A, Salmon P, Gask L, Dowrick C, Towey M, Clifford R, Morriss R. (2008). What do patients choose to tell their doctors? Qualitative analysis of potential barriers to reattributing medically unexplained symptoms. *Journal of General Internal Medicine,* 24: 443-449. DOI: 10.1007/s11606-008-0872-x. IF: 3.278; Citations: 54.
4. Wearden AJ, Dowrick C, Chew-Graham C, Bentall RP, Morriss R, Peters S, *et al.* (the FINE Trial Writing group on behalf of the FINE Trial group). (2010). Nurse-led home-based self-help treatment for patients in primary care with chronic fatigue syndrome: A randomised controlled trial – the FINE Trial. *British Medical Journal*; 340:c1777. DOI: 10.1136/bmj.c1777. IF: 17.215; Citations: 21.
5. Morriss R, Lindson N, Coupland C, *et al.* (2012). Estimating the prevalence of medically unexplained symptoms from primary care records. *Public Health*. 126: 846-54. DOI: 10.1016/j.puhe.2012.05.008. IF: 1.350; Citations: 0
6. Morriss R, Kai J, Atha C, *et al.* (2012). Persistent frequent attenders in primary care: costs, reasons for attendance, organisation of care and potential for cognitive behavioural therapeutic intervention. *BMC Fam Pract*. 13:39. DOI: 10.1186/1471-2296-13-39. IF: 1.61; Citations: 3.

Selected Funding

Medical Research Council: Exploratory randomised controlled trial of training general practitioners to manage patients with persistent medically unexplained symptoms (trial number and details http://controlled-trials.com/ISRCTN44384258/44384258). PI- R Morriss

Care Services Improvement Partnership funding to develop The Nottingham tool. “Developing a tool to enable primary care clinicians to identify early people with medically unexplained symptoms”. PI- R Morriss**,** T Avery. Awarded January 2007 for 24 months.

4. Details of the impact

The key beneficiaries for Morriss’s body of work are GPs, other clinicians (such as psychologists and practice nurses) and patients with MUS through the following mechanisms:

- Successful attainment of government funding for IAPT for MUS
- Changes to general practice training
- Reattribution training taken up by clinicians and researchers internationally based upon Nottingham methods
- Better identification of patients through the development of The Nottingham Tool, an aid to identification of MUS within the clinical and patient community

Introduction of a national streamlined pathway for psychological treatment (IAPT)

In April 2008, the Government announced that they would invest approximately £33 million in 2008/09, a further £70 million in 2009/10 and an additional £70 million in 2010/11 (totalling £173 million) to introduce IAPT treatment for MUS and long-term conditions[a]. This document was prepared in collaboration with the Care Services Improvement Partnership (CSIP) and the NHS commissioning team for MUS/long-term conditions (LTC). Later, in October 2008, the Positive Practice Guide published by IAPT[b] outined changes in clinical practice proposed by Morriss and colleagues, discussing barriers to treatment, identification, the impact of psychological problems and gaps in GP training. Morriss is a key member of the MUS/LTC special interest group for IAPT who also aim to improve access to psychological therapies for the whole community by removing barriers to treatment and increased understanding of patient needs, thus translating the work directly to local communities[c]. Work conducted by Morriss through this group has had impact on patients by raising awareness of MUS as a long-term debilitating condition and a disability[d]. This formed a major part of the need for increased government funding to address the issue. Based upon more recent work by Morriss[6], the government have decided to introduce nurse-delivered and CBT psychological interventions for MUS in primary care. This has resulted in a major training programme to be developed to expand the psychological therapist workforce in order to respond more effectively to the needs to patients with MUS/LTC and co-morbid anxiety and depression[c].

In 2009, Morriss’s work on reattribution training (cited in research from 2007)[1,2] informed the Royal College of Psychiatrists Practical Management Guide for Patients with Physical and Psychological Problems in Primary Care[e] as well as the practical guidance document for GPs to help manage MUS by encouraging reattribution and reducing GP anxieties about tackling psychological problems with the patient[f]. More recently, in 2012, a NHS Emotional Wellbeing and Physical Health Care Case for Change described Morriss’s findings on symptom reattribution as a successful technique as part of a wider package of care for people with MUS[g] thus further improving the patient experience.

Looking forward, and as evidence of government acknowledgment of its importance, in 2010 the government decided to increase the funding of IAPT services to £400 million over the next 4 years to fund the expansion of work into further areas including medically unexplained symptoms[h].

Impact on cost-effectiveness of care and international uptake

Although it is hard to give a precise estimate of cost savings at this early phase, previous estimates made independently (Bermingham et al., 2010) suggest that if IAPT were to deliver psychological treatments based on approaches in the MUS and LTC Positive Practice Guide[b] (based on Morriss’s work), savings of at least £75 million per year may be made (9% of GP estimated expenditure of £837 million per year). Morriss’s work has also been instrumental in finding and translating the message that many patients could be better managed clinically and more cost-effectively in primary care. As such, work on clinical communication and organisation of care for patients with MUS is now part of standard GP and psychiatry training in England through the Royal College of General Practitioners[i] and internationally in Denmark, Germany, Netherlands and Spain. The Denmark group has taken up reattribution methods using Morriss’s framework through the development of ‘TERM’. There is also evidence of uptake in the US[j].

Increased recognition of MUS in general practice through The Nottingham Tool

For further impact on GPs and patients, Morriss’s work has increased recognition of MUS cases in primary care through the development of The Nottingham Tool. This tool has helped estimate the need for psychosocial treatment through better identification of patients with MUS within the general practice community. In 2009, NHS Commissioning Support for London recommended The Nottingham Tool for general practitioners to increase recognition of MUS within the local community by scanning medical records to generate a list of patients with MUS[k]. The Tool has its impact primarily on commissioners, raising awareness of numbers of individuals within local communities with MUS so that funding can be distributed appropriately. The Tool has been praised by practitioners, including the chair of Sainsbury Centre for Mental Health and IAPT MUS/LTC special interest group.

‘Your work in producing the Nottingham Tool, to allow practices to estimate prevalence of MUS was of great value to the programme, and informed much of the national thinking on this very important topic’[l].

Finally, Morriss’s continued work on this topic continues to be cited as important in informing the thinking of health-care decisions, in particular in the domain of mental health. Publications are on-going with new advances being made in 2012 (e.g. Morriss: Role of mental health professionals in the management of functional somatic symptoms in primary care). The chair of Sainsbury Centre for Mental Health commented on these on-going contributions.

‘*I have no doubt that your work has advanced national and international knowledge and practice, and continues to do so; I am currently a CCG Governing Body Member, leading on mental health - but I am still asked regularly for advice on this subject, part of my reply usually references your work’*[l].

5. Sources to corroborate the impact

a. Improving Access to Psychological Therapies, Commissioning Toolkit. Department of Health and Care Services Improvement Partnership April 2008, p1 for Government spending figures.
b. Medically Unexplained Symptoms a positive practice guide. NHS IAPT. Improving Access to Psychological Therapies October 2008.
c. Commissioning IAPT for the whole community. NHS IAPT. Improving Access to Psychological Therapies. November 2008.
d. Equality Impact Assessment (EqIA). NHS IAPT. Improving Access to Psychological Therapies. October 2008.
e. The management of patients with physical and psychological problems in primary care: a practical guide. Report of a joint working group of the Royal College of General Practitioners and the Royal College of Psychiatrists January 2009 CR152.
f. Guidance for health professionals on medically unexplained symptoms. Making sense of symptoms, managing professional uncertainty and building on patient’s strengths. GCGP, RCPsych, Trailblazers and National Mental Health Development Unit.
g. Emotional Wellbeing and Physical Health Care Case for Change. Medically unexplained or ‘physiologically explainable’ symptoms? NHS September 2012.
h. Talking therapies: A four-year plan of action. A supporting document to ‘No health without mental health: A cross-government mental health outcome strategy for people of all ages’. Department of Health. December 2010.
i. Psychological therapies in psychiatry and primary care. Royal College of General Practitioners and Royal College of Psychiatrists CR151. June 2008.
j. The Primary Care Toolkit: Practical Resources for the Integrated Behavioral Care Provider Larry C. James, William T. O'Donohue, Springer 2008.
k. Nottingham Tool (screenshots- http://www.iapt.nhs.uk/ltcmus/medically-unexplained-symptoms/the-nottingham-tool/) and Morriss R (2009). Unpublished. *Medically Unexplained Symptoms Commissioning Tool: Workshop*. Nottinghamshire Healthcare NHS Trust.
l. Chair of Sainsbury Centre for Mental Health (SCMH) e-mail supporting Morriss’ involvement in IAPT for MUS/LTCs.