Medically Unexplained Symptoms in General Practice: Realities and service innovation

The Tavistock Psychotherapy Consultation Service Model
Brian Rock

Medical Psychotherapy Faculty Annual Residential Meeting
A joint conference of the Royal College of Psychiatrists and the Royal College of General Practitioners
19/20 December 2012
Overview

• Context in relation to the development of the service
• Distinctive features
• Makeup of the team and the work of the service
• Outcomes
‘Geography is destiny’
‘Geography is destiny’

James Ellroy
Mental health needs index (MINI2000): variations across Hackney and the City

national average = 1

(City & Hackney Joint Strategic Needs Assessment, 2008)
‘Geography’ of Primary Care

• ‘... like the proverbial iceberg, the greater mass of human mental pain is hidden below the diagnostic waterline.’ [Royal College of GPs, 2005]

• GP is usually the first health professional to whom people turn when they develop symptoms. [Joint report between the Royal College of Psychiatrists and the Royal College of General Practitioners, 2009]

• Distinctive role of the GP and the local surgery

• Inverse care law (Justin Tudor Hart, 1971)
“The seriousness and complexity of cases seen in primary care can certainly rival that seen in any secondary or tertiary care institution. Indeed, there is an “inverse care” law at work ... GPs, practice nurses, and health visitors often have to manage by themselves with the most intractable and complex cases because an onward referral is not practical or acceptable to these patients.”

Dr John Launer, GP & Systemic Psychotherapist
Reflecting on reality: Psychotherapists at work in primary care (2005)
Experts: cuts create mental health crisis

Tests for incapacity benefit harming most vulnerable people, say charities

Matthew Taylor and John Domokos
Distinctive features

- GP led
- Integrated care embedded in GP surgeries plus access to a team
- Addressing complexity in PC – ‘gaps’ & ‘heartsink cons.’
- Dual focus
  - *Capacity & capability-building* of the primary care system through various interventions aimed at supporting GPs and surgery teams
  - Providing a *direct clinical service* to patients and their families with brief, focused interventions
- Few exclusion criteria
- Active collaboration with other services: integrated pathway
Minding the gap

Medically Unexplained Physical Symptoms

Complex, co-morbid (Personality Disorder)

Severe and Enduring Mental Illness

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Some patient characteristics

- 40% MUS patients
- 46% diagnosis or features of PD
- 45% more than two previous treatment attempts
- 33% frequent attenders at their GP surgeries
- 80% present with severe (23%) or very severe and complex (57%) non-psychotic mental health problems
The Team

- 10 wte
- Multi-disciplinary
- Secondary care experience
- Multi-modal
- Qualified – range of experience
- Research & Data Coordinator
- Honoraries / Trainees
GP Support

- Case-based discussions
- Professional consultation
- Joint meetings
- Case management
- Signposting
- Liaison
- Training

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Medically Unexplained Symptoms Practical Process Steps

A. Search and Identify

B. MUS identified

C. Allocate usual GP

D. Flag up patient - Code 16H (READ code - unexplained symptoms continue)

E. Screen and Assess

F. Possible Interventions

G. Clinical Review

**Clinically appropriate physical and psychological assessment**

- Consider screening for depression and anxiety disorders
  - GAD7 and PHQ9 and PHQ15

- Assessment and Consider Intervention Required
  - Consider including:
    - Psychological triggers, mediators and modifiers
    - Affective Disorders
    - Misuses of substances including alcohol, illicit and prescribed
    - AUDIT and DUDIT

**Low Intensity**
- Examples:
  - Watchful waiting
  - Guided self-help
  - Advice on lifestyle
  - Patient Self-help groups
  - Employment support therapies
  - Include info on MUS for patients
  - Computerised CBT

**Moderate Intensity**
- Examples:
  - Time limited psychological interventions, e.g. CBT and other
  - Medication

**High Intensity**
- Examples:
  - Medication
  - Long-term psychological therapies
  - Practice discussions and joint consultations, including specialists

Continuity is important for patients who are disabled by this condition. The GP needs to have a system that offers continuity and regular reviews (annually or more frequent for high cost patients) of patients coded 16H would support this approach.
A range of therapeutic interventions

- Individual Tx
- Groups
- Family/Couple work
- Case management
Philosophy

- Pragmatic
- Flexibility
- Engagement
- Partnership

Assertive outreach
The story so far: The “reach” of the service

From Oct 2009 – present:

- Present in around 40 surgeries (approx. 90% of surgeries in City and Hackney)
- From one referral in the first month to over a range of between 50 – 70 referrals each month
- 1400 patients referred (85% accepted referrals)
- External evaluation: GP/Service providers/Patients
- 2 year extension to contractual period

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Clinical outcomes
Preliminary Health Economics data

Appointment counts before and during access to PCPCS
Preliminary Health Economics data (2)

% reduction in appointments during access to the service

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## Collaboration with the local IAPT service

<table>
<thead>
<tr>
<th>MUS-Intensity Level</th>
<th>Primary Care Psychology [&amp; some Primary Care Voluntary Sector Services]</th>
<th>Primary Care Psychotherapy Consultation Service</th>
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</thead>
<tbody>
<tr>
<td><strong>Red</strong></td>
<td>Severe MUS–Frequent GP Consultation/Referrals &amp; Use of Acute Care</td>
<td>Predominantly patients with severe MUS, possibly without associated Physical Health Conditions e.g. Personality Disorder with Chronic Pain</td>
</tr>
<tr>
<td><strong>Amber</strong></td>
<td>MUS in Patients with Diagnosed/Linked Physical Health Conditions</td>
<td>Physical health problems with severe &amp; enduring mental health problems; Physical Health Problems &amp; anxiety or depression unwillng to attend or engage with Primary Care Psychological Services.</td>
</tr>
<tr>
<td><strong>Green</strong></td>
<td>Patients with mild-moderate MUS and no Diagnosed/Linked Physical Health Conditions</td>
<td>Patients with presen ting with mil d/ moderate MUS but no associated medical condition, • common mental health problems • sub-ICD 10 threshold psychological health problem.</td>
</tr>
</tbody>
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Collaboration with other service providers

- Liaison psychiatric service operates single point of entry into the mental health Trust
- Secondary care psychotherapy service
- Personality disorder service
- Voluntary organisations - Derman
Conclusion

- Prescient commissioning in light of more recent developments in the commissioning landscape

- Health policy: No Health without Mental Health

- Long Term Conditions / MUS (clinical / economic / usage)

- Integrated care – opportunities and barriers (King’s Fund)

- Bespoke - Localism
References


Thank you

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