

SCIM Project Executive Summary

1. Study aims

This scoping study aimed to provide up to date information regarding the potential for an integrative medicine (IM) approach in treating multimorbid musculoskeletal and mental health conditions in a UK general practice population that could be tested in a randomised controlled trial. The intervention would need to be potentially effective, cost-effective and safe, as well as acceptable and feasible for implementation in or via UK NHS primary care. IM is the integration of complementary and alternative medicine (CAM) with conventional Western medicine.

2. Background

Musculoskeletal disorders (MSDs), including low back pain, neck pain, osteoarthritis, rheumatoid arthritis, and fibromyalgia, are a large and increasing problem in the UK, with a major impact on health, disability, productivity and health care use. Mental health (MH) problems are also common and cause significant burden for individuals and society. Multimorbidity (coexistence of two or more conditions) is increasingly prevalent in the ageing population. In many areas of MSD, MH and multimorbidity, conventional medicine struggles to treat patients effectively, and CAM may have therapeutic potential. CAM is healthcare outside of mainstream medical care and includes osteopathy, chiropractic, acupuncture, herbal medicine and homeopathy amongst others. This project focusses only on CAM delivered by a practitioner, which is used by at least 10-12% of the UK population in any one year. An IM approach is in line with the NHS focus on self-management and patient-centred care. However, integration of CAM into the NHS presents a number of philosophical and practical challenges.

3. Methods

This project was a scoping study, an approach particularly useful to identify gaps in the research base and priorities for future research, with four phases. The first was a scoping literature review to map the evidence for effectiveness and cost-effectiveness of CAM for MSD and MH, by reviewing systematic reviews from the past 10 years. The second phase engaged with healthcare professionals (GPs and CAM practitioners) and commissioners to obtain their views on and experiences of providing CAM to primary care patients. The third phase was a national survey to obtain the views and experiences of the general population regarding consulting CAM practitioners, particularly via primary care. The final phase used case studies to examine models of care that provide CAM in an integrated service accessible from primary care, to begin to develop the intervention for evaluation in a future trial. The results from the four phases were combined to identify priority areas (conditions and CAM) for the future trial, where there was evidence of effectiveness, cost-effectiveness, safety, potential impact on multimorbidity, acceptability to professionals and the public, and feasibility of implementation in NHS primary care.

4. Patient and public involvement

A patient and public involvement (PPI) group of seven people advised the research team on a variety of issues as the study took shape and progressed. In particular they helped to develop the public survey questions, the case study methodology, and the topics for discussion in the focus groups for GPs and CAM practitioners. They also reviewed participant information sheets and provided ideas on ways to disseminate the findings to the general public and to patient groups, in order that the findings were communicated using accessible language. We held four PPI meetings throughout the project, which were well attended. Members of the PPI group felt that they were able to contribute to the project and were keen to continue to be involved in future stages of the work.

5. Equality and diversity issues

The research project had no boundaries in terms of diversity as defined by the Research Governance Framework. The largest part of the study was a literature review whose studied populations were predefined. In analysing the data we took into account findings which related to particular sectors and how those findings might impact on future empirical work. The public survey used standard Ipsos Mori sampling to ensure maximum diversity. In addition when sampling GPs and CAM professionals for the focus groups, we recruited from as wide a base as possible.

6. Results

Our review highlighted the large and increasing number of systematic reviews in the area of CAM for MSD and MH disorders, covering 29 different CAM approaches. The MSDs with the best evidence were low back pain (yoga, acupuncture, spinal manipulation/mobilisation, osteopathy, spa/balneotherapy and tai chi), osteoarthritis (acupuncture, tai chi), neck pain (manipulation/manual therapy), fibromyalgia (acupuncture, manual therapy), myofascial trigger point pain (acupuncture), and lateral epicondylitis (manual therapy). The MH areas with the best evidence were depression (MBSR/meditation/mindfulness, tai chi, relaxation and acupuncture), anxiety (meditation/MBSR, moving meditation, yoga), sleep disorders (meditative/mind-body movement), and stress/distress (mindfulness). Very few systematic reviews considered multimorbid populations, however, acupuncture, yoga, tai chi and mindfulness approaches appear to have evidence for both MSD and MH conditions.

‘Complementary and alternative medicine’ was a difficult term for many NHS professionals and included a range of treatments which varied widely in their acceptability. All three groups (GPs, CAM practitioners and commissioners) felt that CAM has a role in primary care and MSD-MH multimorbidity (where there were limited conventional treatment options). Key barriers to integration were philosophical differences and having to ‘secularise’/reduce CAM to adapt to the NHS, NHS structural/organisational barriers, the challenges of adhering to evidence based medicine and finances (limited budgets, unpredictable funding and need for cost-effectiveness). A minority of GPs were concerned that integrating CAM into NHS primary care may not be feasible and would present challenges in terms of extra work in understanding the paradigm in which complementary practitioners work. A strong theme (from all three groups) was the need for improved education of GPs about what CAM is and what it can do.

Our public survey found that 16% of the adult population in England have seen a CAM practitioner in the last 12 months, mainly manual therapies and most commonly for musculoskeletal conditions. CAM use was associated with being female, having a higher socioeconomic status and income, being employed and living in southern England. Strong negative views about CAM therapies or their effectiveness, safety, or lack of availability are uncommon reasons for not using CAM. Although the majority of CAM use is via self-referral, a small proportion of CAM use results from a GP referral/recommendation, mainly acupuncture, physiotherapist-delivered CAM, chiropractic and osteopathy. NHS funding and GP referral are likely to increase use.

We identified a number of services where CAM is integrated into NHS provision, using various models and with varying degrees of perceived success. Acupuncture and homeopathy were most commonly provided, followed by massage, osteopathy and mindfulness. Most was NHS-funded CAM, free to patients. GPs were often instrumental in service initiation and NHS staff enthusiasm facilitated integration. Perceived success, sustainability and acceptability may depend on: providing a wide range of CAM; full integration into an NHS service; dual NHS and CAM trained clinicians; and evidence. Barriers to integration were funding, anti-CAM attitudes, and negative NHS staff attitudes or lack of knowledge.

7. Implications for policy and practice

Integrative medicine may offer the NHS an effective and cost effective way of managing MSD-MH multimorbidity, and appears to have support from the public and NHS professionals, particularly for areas where conventional medicine offers limited options. IM may well offer one way to deliver some of the recent NHS initiatives promoting self-care and holism.

Implementation of IM in NHS primary care appears feasible and appropriate, particularly given GPs' increasing role in addressing patients' overall mental and physical wellbeing, and the expanding interest in initiatives such as social prescribing. Questions remain around the way to fund IM, with co-payment and integrated personal commissioning as possible options.

IM requires GPs and CAM practitioners to improve their communication and to understand and respect each other's philosophical and professional approach. Attention needs to be paid to medical education, which currently rarely includes complementary approaches, and to GPs' awareness of CAM regulation.

This project highlights the importance of patient/public involvement in the NHS, which was a valuable component of many existing IM services, and is an important commissioning criteria.

8. Implications for research

This study, in particular the literature review, highlights the need for further research in the area of CAM for MSD, MH and multimorbidity, particularly high quality, large, long-term RCTs measuring effectiveness and cost-effectiveness. Many GPs, commissioners, case study informants and particularly CAM practitioners supported our proposal for a feasibility trial. We identified the following research priorities:

- Yoga for low back pain, anxiety and sleep
- MBSR/mindfulness/meditation for mental health (depression, anxiety, stress, distress)
- Acupuncture in a population with an MSD and depression
- Tai chi for low back pain or osteoarthritis and depression
- Meditative/mind-body movement (yoga or tai chi) for sleep disorders perhaps in a population with chronic pain or fibromyalgia

9. Conclusions

Integration of CAM in NHS primary care for MSD-MH multimorbidity is a potentially fruitful area for further investigation. CAM is fairly commonly used in England, with some NHS provision, and both NHS and CAM practitioners and the public agree that CAM has a potential role in NHS primary care for MSD-MH multi-morbidity, given the limitations of conventional medicine in this area. Integrating CAM into the NHS may also be in line with the current NHS agenda for person-centred and self-care.

Five possible priority areas for an RCT are: yoga for low back pain with anxiety and/or sleep disorder; mindfulness for MH alongside a specific MSD; acupuncture in an MSD with depression; tai chi for depression and low back pain or osteoarthritis; and meditative movement for sleep disorders with an MSD. Feasibility work is needed prior to a definitive trial, particularly regarding intervention design, recruitment and retention, education/information needs of professionals and patients, outcome measures, and follow-up duration.

10. Dissemination plans

We plan to submit four papers to peer reviewed journals, based on the four phases of the study. A project summary will be sent to the participants, steering group, PPI group, and an extensive mailing list which includes practitioners, professional bodies, patient/public groups and parliamentary groups. Press releases will be sent to both mainstream media and discipline-specific publications. Announcements will be made on social media. Finally, the work will be presented at appropriate conferences.