Joint Commissioning Panel
for Mental Health

www.jcpmh.info

Guidance for commissioners of

services for people with medically unexplained symptoms

Practical
mental health
commissioning

Contents

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[1].
2. These symptoms are common, and are presented in various degrees of severity[2] in all areas of the healthcare system[3].
3. MUS accounts for approximately 10% of total NHS expenditure on services for the working age population in England[4].
4. Many people with MUS have complex presentations caused, or exacerbated, by co-morbid mental health problems such as anxiety, depression or personality disorders[2].
5. Patients are often subjected to repeated diagnostic investigations, and unnecessary and costly referrals and interventions[5].
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[3].
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.

Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) (www.jcpmh.info) is a collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists. The JCP-MH brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- People with experience of mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH has two primary aims:

- to bring together people with experience of mental health problems, carers, health professionals, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH has published:

- *Practical Mental Health Commissioning*, a briefing on the key values and principles for effective mental health commissioning, and
- a series of short guides describing ‘what good looks like’ in various mental health service settings[6-14].

WHAT IS THIS GUIDE ABOUT?

This guide is about the commissioning of comprehensive MUS services across the healthcare system. In developing this guide, we recognise that 'medically unexplained symptoms' is an unsatisfactory term for a complex range of conditions.

MUS refers to persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology[1]. The term MUS is commonly used to describe people presenting with pain, discomfort, fatigue and a variety of other symptoms in general practice and specialist care. Whilst recognising that the phrase 'medically unexplained symptoms' can be problematic, it is nonetheless widely used, and an appropriate term to use in this guide.

This guide aims to:

- describe MUS and the associated outcomes
- outline current service provision for MUS and detail the components of a high quality comprehensive MUS service
- highlight the importance of commissioning comprehensive MUS services.

WHO IS THIS GUIDE FOR?

This guide is about the commissioning of good quality services for people with MUS. This guide should be of value to:

- Clinical Commissioning Groups (CCGs) and local authorities who should be informed by the principles highlighted in this guide
- Health and Wellbeing Boards (HWBs)
- other bodies who, through various contractual forms, take on commissioning and provision of services that span this patient group, such as multispecialty care providers and primary and acute care systems, as outlined in the *NHS Five Year Forward View*[15]
- service providers across primary, secondary and tertiary services.

HOW WILL THIS GUIDE HELP YOU?

This guide has been written by a group of highly experienced MUS service experts (see page 18 for list of members involved). Evidence-based practice has been summarised where it exists. While robust evidence is lacking in many areas, ideas deemed to be best practice by expert consensus have been included. This guidance encourages services to develop alongside emerging evidence, with a focus on innovation.

By the end of this guide, readers should be more familiar with the concept of MUS services and better equipped to understand:

- the nature of MUS and the effects these illnesses have on physical, psychological and social functioning
- the particular aspects of MUS which can affect engagement, response to treatment and outcomes
- the severity of MUS and the necessity for comprehensive specialist treatment
- the key components of a comprehensive MUS service, including the range of treatments and professional groups that should be available to patients with MUS
- the need for highly integrated services and comprehensive care pathways to ensure the safe and effective management of patients across the spectrum of severity of MUS
- the risk to patients with MUS if commissioning of MUS services is not clinically informed and subject to on-going dialogue between commissioners, service providers, patients and carers.

What are MUS services?

WHAT IS MUS?

Medically Unexplained Symptoms (MUS) refers to persistent bodily complaints for which adequate examination does not reveal sufficiently explanatory structural or other specified pathology[1]. MUS are common, with a spectrum of severity[2], and patients are found in all areas of the healthcare system[3].

Patients with MUS are more likely to attribute their illness to physical causes, rather than lifestyle factors[16]. This can include symptoms such as pain in different parts of the body, functional disturbance of organ systems and complaints of fatigue or exhaustion[17].

Patients with a combination of symptoms will often present to primary care or A&E departments seeking appropriate treatment[16]. This usually results in a referral to a relevant medical or surgical outpatient department for further investigation. Table 1 describes the types of symptoms that can present, the associated syndromes and the speciality the patient is referred to for further investigation[16].

Given the wide-ranging symptoms that can occur, patients have high rates of access to a number of outpatient departments. On average, 52% of patients accessing outpatient services have MUS, with the highest rates relating to gynaecology clinics (66%) and the lowest rate (37%) relating to dental services[16]. Table 2 outlines the proportion of people presenting with MUS across different outpatient clinics.

The risks or associated factors for MUS include being female, younger in age, and currently employed[18]. Childhood adversity and/or abuse, and the severe illness or death of a close relative are also factors associated with MUS[18]. MUS may be caused by physiological disturbance, emotional problems or pathological conditions which have not yet been diagnosed[19]. Psychiatric morbidity is not directly associated with the presence of MUS, but is more likely in those complaining of multiple symptoms. In severe cases of MUS, there is overlap with personality disorder[20].

Consequently, many people with MUS have complex presentations caused or exacerbated by co-morbid mental health problems such as anxiety, depression or personality disorders[2].

There are many different explanatory models for MUS[21] but it is widely recognised that a positive, proactive approach to MUS, with an emphasis on identifying MUS as early as possible, is beneficial. Substantial benefits in terms of function and severity of symptoms can be achieved through the early use of good communication skills, including:

- validating their suffering
- removing blame
- offering explanations which make sense
- focusing on the patient's words, ideas, concerns and expectations, and
- jointly exploring ways of improving function[22].

There should be a positive emphasis on 'function', rather than a focus on 'cure'.

Table 1. Functional somatic syndromes by specialty

Symptoms (combination of)	Syndrome	Specialty
Bloating, constipation, loose stools, abdominal pain	Irritable Bowel Syndrome	Gastroenterology
Fatigue (particularly post-exertional and long recovery) pain, sensitivity to smell	Chronic Fatigue Syndrome/ Myalgic Encephalomyelitis	Infectious Diseases, Endocrinology, Rheumatology, Pain Clinics
Headache, vomiting, dizziness	Post Concussion Syndrome	Neurology
Pelvic pain, painful sex, painful periods	Chronic Pelvic Pain	Gynaecology
Pain and tender points, fatigue	Fibromyalgia/Chronic Widespread Pain	Rheumatology
Chest pain, palpitations, shortness of breath	Non-cardiac chest pain	Cardiology
Shortness of breath	Hyperventilation	Respiratory Medicine
Jaw pain, teeth grinding	Temporo-mandibular Joint Dysfunction	Dentist, Oral Medicine
Reaction to smells, light	Multiple Chemical Sensitivity	Allergy clinic

Getting shared agreement for a model that includes activities the patient can undertake to improve their physical health status, which may or may not include attending to their emotional health, is key.

All models should, however, include an appropriate physiological component that focuses on body malfunction, as opposed to disease processes, and may include the way signals from the body are processed by the brain. Explaining how emotional processes affect the way the brain modulates bodily signals can be useful, but only if both the doctor and patient have agreed previously that emotional issues are relevant. Ideally, a model should arise from a shared understanding between the patient and doctor and all explanations should be presented in a language the patient understands.

However, quite often misinformation and inaccurate advice, provided either by health professionals or other sources patients have accessed, such as the internet, can make it difficult for doctors to know what to do in cases of MUS.

Patients who report multiple physical symptoms, which cannot be readily explained, and significant degrees of worry about their symptoms, are likely to become 'chronic', and frequent users of secondary care resources. Therefore, without appropriate treatment, outcomes for many patients with MUS are poor.

WHAT ARE MUS SERVICES?

MUS services are embedded within defined health sectors, such as secondary/specialist care or primary care. Within these sectors, professionals working independently often deliver care for patients with MUS. In primary care this might be a GP, practice nurse or an Improving Access to Psychological Therapies (IAPT) therapist. In secondary care this might be a health psychologist, liaison psychiatrist, acute physician or physiotherapist.

Throughout the NHS, multidisciplinary teams rarely offer MUS services. Where provision does exist, the type of intervention offered ranges from basic psycho-education about how the mind and body are intimately connected, to well-resourced specialist clinical services aimed at managing highly complex patients.

A health problem of this magnitude requires a new model of NHS care, underpinned by a planned and structured approach to the population's needs. Appropriate services for people with MUS should be commissioned in primary care, community, day services, A&E departments and inpatient facilities. This will enable patients to access services that are appropriate for the severity and complexity of their problems.

Table 2. Proportion of people with MUS in outpatient clinics

Outpatient clinic	Proportion of people with MUS
Gynaecology	66%
Neurology	62%
Gastroenterology	58%
Cardiology	53%
Rheumatology	45%
Respiratory	41%
Dental	37%
Total*	**52%** (of which 42% are men, 57% women)

* From a study of 550 patients

Why are MUS services important to commissioners?

Many people with MUS are inadequately treated. This can lead to poor outcomes and high NHS costs, including unnecessary use of diagnostic services and outpatient referrals, attendance at A&E departments and acute hospital admissions[3,5].

1. THE COST OF MUS

MUS are a common and costly problem in all healthcare settings, accounting for:

- 15-30% of all new consultations and up to 45% overall of GP appointments[5,23]
- 50% of new visits to hospital clinics[24]
- a 20-50% increase in outpatient costs compared to other patients[25]
- 20-25% of all 'frequent attenders' at specialist medical clinics[5,23]
- a 30% increase in hospital admissions and inpatient care[26,27].

MUS accounts for a very high proportion of NHS activity, accounting for approximately 10% of total NHS expenditure on services for the working age population in England[4].

Sickness absence and decreased quality of life for people with MUS costs the UK economy over £14 billion per annum[4]. Effective ways to manage MUS exist and can reduce healthcare costs significantly, but such services are rarely commissioned and therefore remain unavailable to patients.

2. IMPACT ON PATIENTS

Patients often experience stress, distress and anxiety as a result of medically unexplained symptoms. They report feeling that their concerns are not taken seriously by their doctor, which can exacerbate the presentation of somatic symptoms. The suggestion that '*a patient's negative test results means that nothing is wrong physically*' is cited as the most common explanation given by doctors[2], and patients may consequently feel that their symptoms are not believed.

The anxiety associated with symptoms that have not been adequately explained can lead to repeated presentations to GPs and A&E departments, and frequent referrals for investigations and specialist opinions. The patient may also seek alternative therapies, which can be costly, both for the patient and the NHS[3,5].

When coping with MUS, a patient's need for emotional support is often overlooked by health professionals who tend to focus on their physical symptoms. However, research indicates that patients do want to discuss their emotional wellbeing with health professionals[16].

Doctors can cause harm by pursuing inappropriate investigations in their efforts to discover the cause of symptoms[3]. Such procedures can exacerbate anxiety. Over-investigation may cause unnecessary damage to healthy tissues and lead to over-treatment, including unnecessary surgery, with all its complications, and in extreme cases more invasive treatments such as urinary catheters and tube feeding, of various types. Doctors may also prescribe unnecessary medication that can lead to side effects, and addiction[28].

3. IMPACT ON CLINICIANS

There are two main problem areas for clinicians in managing people with MUS. These include the inherent difficulties in establishing a 'diagnosis' (particularly where a medical model is being employed), and the impact of the patient's presentation on the clinician.

General Practitioners (GPs)

There is extensive international literature on the impact on clinicians managing people with MUS. Family doctors have reported that they are less satisfied caring for patients with persistent MUS than patients with psychological problems[29]. GPs also reported that they often find it stressful to work with patients with MUS[30]. Some GPs describe a sense of 'powerlessness' during the course of the consultation. The negative emotions experienced by doctors can have a major impact on the doctor-patient relationship, resulting in their personal feelings impacting on their professional judgement[31].

Studies also suggest that primary care clinicians may experience a sense of inadequacy and insecurity for not being able to treat the presenting complaints, feelings of resentment towards the patient, and a lack of control around the course of treatment[2]. Some of this frustration is attributed to the diagnostic problems that GPs encounter: patients often present multiple problems, with varying degrees of medical explicability and MUS may occur in the context of other, confirmed disease. This diagnostic uncertainty can add to their professional uncertainty and may engender stress and frustration. In addition, GPs may fear missing serious pathology, which may lead to referral for repeated, unnecessary investigations.

Secondary Care Clinicians

There is limited evidence about the attitudes of secondary care professionals working with patients with MUS. However, one qualitative study which interviewed junior and senior clinicians across four medical specialties (neurology, gastroenterology, cardiology and rheumatology), indicated considerable variation in how they approached patients with MUS in terms of level of investigations ordered and the type of explanations given, although all recognised MUS as a significant issue in their practice[32].

Most of the junior doctors described finding such patients "frustrating" or "exhausting" to work with, while a few of their more senior colleagues described this as a "positive challenge". All respondents were clear that they had had little or no specific training in working with such patients, and that they had learnt their management strategies from their own clinical experience or more senior role models. Many suggested that time pressures and lack of continuity were barriers to providing good care for such patients.

Another study[33] reported that junior doctors felt poorly prepared in assessing and caring for patients with MUS and were anxious, frustrated and incompetent in this area. Many spoke of the need to over-investigate patients to rule out physical causes, or even avoid patient contact altogether, due to the challenging nature of MUS.

Such negative attitudes appear to start early in medical training. A study examining third and fourth year medical students' attitudes towards MUS found that many students had already developed negative views about the causes and management of such presentations[34]. This needs to be addressed in both undergraduate and postgraduate training, ideally for all healthcare professionals. The consultation skills necessary to work with patients with MUS are not taught to acute care specialists at any stage of medical education[35].

What do we know about current MUS services?

INADEQUATE PROVISION TO MEET LOCAL NEED

Provision for MUS can be limited, patchy, and does not reflect the level of need across the whole UK healthcare system. Provision is also idiosyncratic, being a product of local commissioning interest and individual clinical expertise. Too often, contracts with providers are short-term, so services come and go.

LIMITED RANGE OF MUS SERVICES

Where provision does exist, it often ranges from basic psycho-education about how the mind and body are intimately connected, to well-resourced specialist clinical services aimed at managing highly complex patients.

LACK OF QUALIFIED STAFF

Whether their symptoms are explained by current models of disease or not, patients want parity in service standards; a plausible explanation including – but not limited to – ruling out serious conditions, followed by appropriate available treatment, support and advice in managing the symptoms[36]. However, studies have shown that many GPs feel unable to explain MUS constructively, and may compensate by over-investigating or suggesting inappropriate treatment[3]. Such procedures can exacerbate anxiety for the patient, for example by identifying incidental findings of unclear significance, whilst over-investigation may cause unnecessary damage to healthy tissues (in the case of excessive irradiation). Over-treatment can lead to unnecessary surgery or prescribing which can lead to drug addiction[37].

Alternatively, GPs may try to reinterpret physical symptoms as signs of emotional distress, without any foundation for this, which may result in resistance from the patient[38].

What would a good MUS service look like?

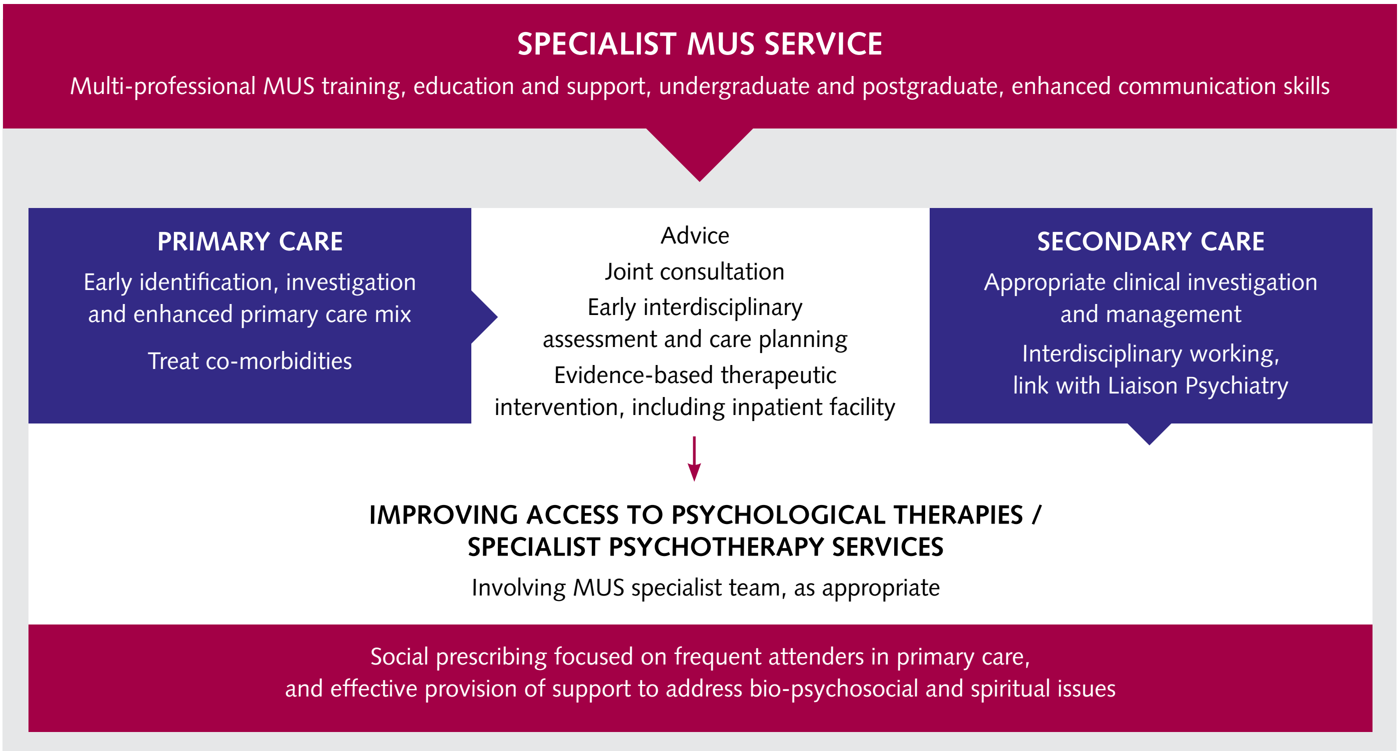
Services for people with MUS must be multidisciplinary and adopt a bio-psychosocial approach. This section covers four key areas:

1 WHAT WOULD A GOOD HEALTHCARE SYSTEM FOR MUS LOOK LIKE?

A good healthcare system for MUS should be person-centred, accessible, and needs-based, enabling patients to recover as fully as possible. It should contain the following elements:

- **Sufficient service provision to meet local needs**. MUS prevalence can usually be calculated from primary care records[39]. Local need may also be estimated from epidemiological studies.
- **Full range of MUS services appropriate to local needs**, delivering evidence-based social, psychological and physical care, with an emphasis on effective early interventions.
- **Accessibility within settings which patients find most acceptable**. This may be in primary or secondary care, rather than in traditional acute specialist (dealing with one bodily symptom) or mental healthcare settings.
- **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. An example is provided in Figure 1.
- **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. Current systems make this difficult and unreliable.
- **Qualified and appropriately trained staff** with competence in assessment and management of MUS. All healthcare professionals should be able to assess the physical and mental aspects of patients' problems, take a positive approach to symptom management, and commit to collaborative working. Specialist MUS staff will have additional competence and capacity to offer training and consultation.

Figure 1. Care pathways that integrate physical and mental healthcare



2 WHAT WOULD A GOOD COMMUNITY MUS SERVICE LOOK LIKE?

All good MUS services, whether community or hospital-based, would have a philosophy of care based on the integration of physical and mental healthcare. They would recognise that MUS are ‘mind-body problems’, and that patients with MUS commonly have co-morbid physical and mental disorders. Such services should be underpinned by excellent communication between clinicians and their patients, a shared understanding of MUS, and agreement of management plans between clinicians.

In some cases, services will simultaneously provide care for related co-morbid problems, such as long-term conditions or personality disorders. Services will be aimed at patients whose problems are too complex for local IAPT services or who require interventions not available in IAPT services.

Competence

- A multidisciplinary team should include psychiatrists, psychological therapists, nurses, occupational therapists, pharmacists, dieticians, physiotherapists, and GPs with a special interest in MUS.
- Staff training should cover all aspects of their work, including awareness of physical illnesses, liaison with other parts of the healthcare system, care planning, therapeutic interventions, and engagement with individuals and their families.
- The patient-GP relationship is at the heart of good clinical care, with continuity of care being particularly important. Seeing the same doctor on a regular basis decreases the likelihood of the patient receiving mixed messages, or being referred for unnecessary new investigations, which can undermine the overall management approach. Helpful guidance for GPs is available and accessible online at www.rcgp.org.uk/clinical-and-research/toolkits/mental-health-toolkit.aspx

Access

- Services must be provided in settings that are acceptable to patients. These might be a dedicated community base or clinical space at a GP surgery, or a secondary care outpatient clinic. This will probably not include generic community mental health locations.
- Referrers will include GPs and local IAPT services, and may include other local medical services such as acute hospital departments, casualty/emergency department and psychiatric teams.
- Referral criteria should be flexible, to allow referrers to request consultations to discuss management of the case when patients are at early stages of their care journey.
- Assessment and treatment criteria will generally include a confirmation that a clear organic diagnosis for the symptoms has been ruled out, and that the patient has agreed to see a MUS specialist. Patients with co-morbid physical problems would not be excluded.

Assessment

- Support with identification through primary and secondary care records.
- An assessment of severity, such as the MUS Severity Scale[40].

CASE STUDY

City & Hackney Primary Care Psychotherapy Consultation Service (PCPCS)[41]

The PCPCS is an outreach service provided by Tavistock and Portman NHS Foundation Trust. It supports GPs throughout the London boroughs of City and Hackney in the management of patients with MUS and other needs resulting in frequent health service use. The service achieves very high satisfaction ratings among local GPs, supporting them partly through case discussions and training and partly by providing a direct clinical service to referred patients through assessments and a range of brief psychological interventions.

The PCPCS is designed to meet the needs of specific groups of patients who fall through gaps in existing service provision.

When the service was evaluated, 75% of all patients showed improvements in their mental health, wellbeing and functioning as a result of treatment. In addition, about 55% were shown to have “recovered”. These improvements compare favourably with those achieved by IAPT services, even though the latter typically treat less severe and complex cases.

Detailed information on health service use was collected for a sample of 282 patients treated by the PCPCS. Based on this data, it is estimated that treatment by the PCPCS reduced the costs of NHS service use by £463 per patient in the 22 months following the start of treatment. Savings in primary care accounted for 34% of this total (mainly fewer GP consultations) and savings in secondary care for 66% (fewer A&E and outpatient attendances and inpatient stays).

- A flexible assessment period with an agreed response time. This is unlikely to be crisis assessment as crises are more likely to present to acute medical services.
- Desired outcomes agreed between patient and healthcare professional.

A recovery focus

- Outcomes must encompass physical and mental domains (ie. not be limited to improvement in physical symptoms).

Outreach

- Capacity to outreach to referrers to provide consultation, assessment and interventions in the place where patients usually receive care, most commonly the GP surgery.

Integrated patient and carer experience

- There should be evidence of patient and carer involvement in service design. All pathways should collect patient and carer experience using a range of methods including questionnaires, focus groups and individualised feedback.

Interventions

The aim of MUS interventions will be to impact on physical and mental symptoms, functioning and quality of life. The following are needed:

- Assessment of mental and physical health and function
- Evidence-based interventions including psycho-education for patients and carers and brief evidence-based interventions such as CBT and focused psychodynamic psychotherapy
- Prescription of medication
- Carer assessment and support
- Discharge planning.

3 WHAT WOULD A GOOD HOSPITAL-BASED MUS SERVICE LOOK LIKE?

General hospital-based services

A basic level of service would provide MUS training to hospital staff and offer advice about how to assess and signpost patients to other services.

A good hospital-based MUS service will be able to:

- support the staff of the acute hospital to optimise patient care, eg. develop joint management plans with acute hospital treating teams to minimise iatrogenic harm
- offer biopsychosocial assessment and treatment on wards and in dedicated MUS outpatient clinics (generic or specialty-specific)
- liaise effectively with GPs and community resources such as physiotherapy, IAPT and mental health services
- facilitate access to regional/national specialist MUS inpatient units for patients with the most complex and costly needs.

The hospital MUS service will redirect patients from the emergency department, expedite discharges from medical and surgical wards, and offer effective interventions. These activities should help avoid unnecessary medical investigations and interventions, reduce length of hospital stays, and prevent frequent referrals and readmissions.

Services must include psychological therapists who would provide evidence-based MUS interventions in a timely manner. The therapists would be sufficiently familiar with physical healthcare to be credible to patients – many of whom may not accept a psychological component to their physical symptoms and therefore the need for psychological therapy.

In many places this type of MUS service would be provided to the whole hospital by the existing multidisciplinary liaison psychiatry service. There are alternative models where a psychological therapist or a liaison team work with a specific unit (e.g. gastroenterology or neurology), and focus on patients presenting with a set of physical symptoms which might suggest a diagnosis of an MUS 'syndrome', e.g. a chronic fatigue clinic or a service for non-epileptic attack disorder (NEAD). These types of services have been historically funded by the unit themselves, rather than externally commissioned. Where stand-alone hospital health psychology services are in place, there is an opportunity for liaison psychiatry and health psychology to work together to match patient need to staff skills. However, the degree to which this could improve the care of patients with MUS would depend upon existing commissioning arrangements and joint working agreements between liaison psychiatry and health psychology, which often operate independently of one another. Depending on local needs and local provisions, this service may integrate and blend with the community model described in the previous section.

CASE STUDY

Leeds Liaison Psychiatry Service[42]

The Leeds Liaison Psychiatry Service is commissioned to provide a multidisciplinary general hospital and outpatient service for patients referred from either primary or secondary care. Interventions are offered via a range of defined pathways, including a specific one for patients affected by MUS.

Patients are considered suitable for the MUS pathway if they meet the following criteria:

- Persistent MUS (or if there is a related medical problem, the symptoms and loss of function are greater than would be expected)
- Significant and sustained loss of function
- Regular help-seeking from primary or secondary care services, or alternative practitioners
- Willing and able to attend regular outpatient appointments.

The first appointment on the pathway is conducted by a Liaison Psychiatrist who checks for any active medical issues, and formulates a diagnosis with the patient. The liaison psychiatrist will also decide, with the patient, which of two treatment options will be the most appropriate based on their presentation:

1 Treatment via the Hospital Mental Health Team (band 6 specialist nurses and occupational therapists) for 10 sessions covering engagement, shared understanding, goal agreement, core intervention, activating therapies, and relapse management

2 Cognitive behavioural therapy (by a CBT specialist in the Liaison Psychiatry service)

The last of the 10 sessions, for both options in the pathway, contains a review of specific, measurable, achievable, realistic and time-bound (SMART) goals and progress made. If the clinician and patient agree that sufficient progress has been made, the patient will be discharged. Otherwise, the case will be taken to a multi-disciplinary (MDT) meeting for further review. Clinical intervention/therapy only continues beyond 10 sessions if there is a clear clinical rationale and a clear motivation to engage. Outcome measures are repeated, for both treatment options, at discharge.

Specialist MUS inpatient units

For some patients the level of complexity and severity of their symptoms makes it impossible to provide effective treatment, or to help them towards recovery, in community/outpatient services. In addition to MUS, psychiatric disorders, and medical disorders, this group of patients may also be suffering from iatrogenic problems and the secondary physical consequences of their illness, such as chronic inactivity. Specialist MUS units could generate significant cost-savings per patient by reducing ineffective care.

Admission and discharge criteria

- Limited to people with severe MUS, for whom multiple local services have been unable to arrest deterioration and deliver effective treatments.
- Aim of admission is to make detailed assessments and deliver the required bio-psychosocial interventions on a recovery-focused basis. The treatment plan should be agreed at admission.
- Discharge criteria will not be time-limited, but determined by monitoring of benefit gained.
- A proactive approach to collaborating with and handing over to appropriate local services will be necessary, with treatment continuing in community and outpatient settings.

Staffing and skills

- This complex work requires a cohesive multidisciplinary team with a broad range of expertise and depth of experience, across a range of professional groups (as described earlier for community teams).
- A wide range of psychological therapies must be provided. These may include psychodynamic (especially for formulation), cognitive behavioural, trauma-focused, interpersonal and/or systemic, as required in each individual case.

Environment

- A general hospital site, with access to medical/surgical opinions, critical care in-reach, cardiopulmonary resuscitation team cover, and investigations provided within general hospital ward timescales
- A highly specialist ward environment which can accommodate both medical and psychiatric aspects of care, and which allows safe delivery of the central rehabilitation function of the service.

Assessment and treatment

- Comprehensive bio-psychosocial assessment and formulation
- Rehabilitation and treatment programmes, which includes physical, occupational, psychological and medical components
- Attention to the impact of inactivity and of reduction of iatrogenic harms.

CASE STUDY

Yorkshire Centre for Psychological Medicine (YCPM)[43]

The YCPM is an eight-bedded specialist inpatient unit at Leeds General for people with complex medically unexplained symptoms and physical/psychological co-morbidities. YCPM takes UK-wide referrals from multiple commissioners on a cost per case basis, and provides expert multidisciplinary bio-psychosocial assessment and treatment.

Patients with very severe levels of disability and illness are admitted regardless of the bodily system(s) involved, and without a requirement for them to engage with any particular elements of treatment before they are admitted..

Typically, patients are:

- bed-bound and highly dependent upon others for feeding, toileting, and personal hygiene
- tube-fed and/or catheterised
- taking numerous medications (many without a clear biological or organic basis) and dependent upon opiate and other analgesics
- living in such a manner that every moment of their daily life is determined by their illness.

The service provided includes a bio-psychosocial assessment, with regard to the range of symptoms and a formulation of the nature of the presentation, including aetiological factors and in particular perpetuating/maintaining factors, across physical and psychosocial aspects. This is followed by physical and occupational rehabilitation including:

- psychotherapeutic interventions as indicated
- biological treatments (for both physical and psychological/psychiatric comorbidities)
- addressing and reversing iatrogenic elements
- addressing and reversing secondary consequences of chronic physical illness.

All of these interventions are carried out in a recovery-focused programme. It is this multi-dimensional approach, delivered by an expert team in an appropriate inpatient setting, which allows progress, which had not been possible before, to be made.

Clinical outcomes, even in a range of very chronic and complex cases, are often very good, and attract positive patient feedback. This is possible due to the nature of the YCPM Unit and its function within the general hospital setting, and to to the depth of experience and breadth of expertise within the team.

What would a good MUS service look like? (continued)

4 WHAT OUTCOME MEASURES SHOULD MUS SERVICES USE?

All services for people with MUS will need to embed measurement and report on process and outcome measures within their core delivery strategy. These measures should include:

- **Process measures**, including monitoring of waiting times, patient contact time including bed days (for inpatients), and service usage, e.g. interventions offered and accepted
- Measures of **patient and carer satisfaction**, including Friends and Family Test.
- **Patient-rated outcome measures**, covering physical and mental symptoms, quality of life, rehabilitation, function in work and social settings, and use of healthcare services. Examples include CORE Outcome Measure, Inventory of Interpersonal Problems (IIP), EuroQol, General Health Questionnaire, Work and Social Adjustment Scale and the WHO Disability Assessment Scale.
- **Clinician-rated outcome measures**, such as the Clinical Global Impression (CGI) scale.
- **Health service utilisation and costs** should be calculated, and include planned and unscheduled primary and secondary care visits, investigations and treatment costs.

Supporting the delivery of the Five Year Forward View for Mental Health

The Five Year Forward View for Mental Health sets out the steps that are needed for a transformation of NHS mental health care with a particular focus on tackling inequalities at local and national levels, for those who are disproportionately affected by mental health problems, including those who already face discrimination. Commissioning that invests in the provision of effective and appropriate MUS services will support the delivery of the Five Year Forward View for Mental Health[15].

COMMISSIONING FOR PREVENTION AND QUALITY CARE

Commissioning effective MUS services across primary, secondary and tertiary care will help improve outcomes, prevent symptoms from escalating and reduce healthcare costs. Ensuring there is sufficient service provision to meet local needs is essential.

GOOD QUALITY CARE FOR ALL, SEVEN DAYS A WEEK

Commissioning a full range of MUS services appropriate to local needs, delivering evidence-based social, psychological and physical care, with emphasis on effective early interventions will ensure good quality of care for all, seven days a week.

INNOVATION AND RESEARCH TO DRIVE CHANGE NOW AND IN THE FUTURE

MUS services should use 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.

STRENGTHENING THE WORKFORCE

Ensuring there is qualified and appropriately trained staff with competence in assessment and management of MUS will strengthen the NHS workforce. All health professionals should be able to assess the physical and mental aspects of patients' problems, take a positive approach to symptom management, and commit to collaborative working. Specialist MUS staff will have additional competence and capacity to offer training and consultation.

A TRANSPARENCY AND DATA REVOLUTION

All services for people with MUS will need to embed measurement and report on process and outcome measures within their core delivery strategy.

Information-sharing agreements between healthcare providers will support properly integrated holistic care for MUS, enabling clinicians to access all relevant clinical information. Systems that enable close liaison between GPs, A&E departments and acute specialists will be important.

INCENTIVES, LEVERS AND PAYMENTS

Sustainable services that enable access to MUS services will have payment models that incentivise quick access, high quality care and good outcomes, and help to reduce avoidable crises.

FAIR REGULATION AND INSPECTION

MUS services should be inspected and regulated to ensure quality care is being provided and that services are safe, effective, caring, responsive and well-led.

LEADERSHIP INSIDE THE NHS AND ACROSS GOVERNMENT

Leaders should ensure MUS services are commissioned across the NHS to ensure patients benefit from effective and responsive treatment that will enable them to have the best possible outcomes. This will also reduce the associated healthcare costs.

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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.

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Co-chaired by:

RCGP Royal College of General Practitioners

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