



Maximising the Impact of Psychological Practice in Physical Healthcare: Discussion Paper



The Psychological Professions Network

A collaboration of regional networks sponsored by Health Education England to give voice to all psychological professions in workforce planning and to promote excellence in practice

About the Psychological Professions Network

The Psychological Professions Network exists to maximise the benefits to the public of the psychological professions across NHS funded healthcare.

It consists of workforce networks across England that join up twelve psychological professions: adult psychotherapists, child and adolescent psychotherapists, children's wellbeing practitioners, clinical psychologists, cognitive behavioural therapists, counselling psychologists, counsellors, education mental health practitioners, family and systemic psychotherapists, forensic psychologists, health psychologists and psychological wellbeing practitioners.

The Psychological Professions Network provides a joined-up voice for the psychological professions in policy-making and builds bridges between psychological professionals, the public and policy-makers.

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The paper was prepared before the COVID-19 pandemic, but we believe the topics raised are all the more relevant in the changing terrain that we find ourselves in.



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Executive Summary

The impacts that the Psychological Professions can provide in a physical healthcare setting are not widely understood. This paper outlines the possible challenges that are contributing to this and makes a series of recommendations. The paper is intended as the start of a conversation, rather than the conclusion of one. We intend for it to stimulate debate, to highlight areas (both covered and not covered in the paper) that need more attention and action. We want to develop this plan with stakeholders, and hear everyone's perspective.

Recommendations:

1. There should be formal **national representation** of the Psychological Professions that develops and drives a National Strategy for Psychological Professionals working in physical healthcare, and influences policy making.
2. There should be **local representation of the psychological professions** and all physical healthcare trusts should have a **Chief Psychological Professions Officer** who is the lead of the psychological practice and services in the Trust and who possesses both clinical and leadership skills. They need a voice at Board Level in the Trust.
3. A **Competencies Matrix** should be developed and disseminated nationally to increase awareness of the broad range of competencies held by each of the 12 Psychological Professions and how these support integrated healthcare.
4. Pre and post qualification **training** should be provided by specialist Psychological Professionals to all professions working in physical healthcare to enhance knowledge and skills in the following areas:
 - The integration of physical, psychological and social factors in the context of a physical health condition, enabling psychologically-informed healthcare across the system
 - How to communicate and work with clients/patients and their carers who are distressed/have mental health problems
 - Cultural competencies regarding different cultures that exist within local areas
 - The role of Psychological Professions in physical healthcare
5. Psychological Professions training should be reviewed regarding physical health content to ensure an adequate knowledge and skills set when working in physical health.
6. Physical healthcare services should continue to work on **integration**, for example:
 - Achieving parity of esteem
 - Integrated multi-disciplinary teams becoming the norm in physical health services
 - Improving integration across health and social care boundaries to be able to provide co-ordinated physical, psychological and social care
7. Psychological Professions should be more involved in **prevention** work.
8. Commissioners should recognise the importance of the Psychological Professions in physical healthcare, and **commission these services**.
9. **Involvement of Experts by Experience** in service development and improvement should be increased, and communities of practice should be developed to support people with long-term conditions, their carers and families who contribute to involvement work.

1: Introduction

“Every patient has the right to a discussion and interpretation of his or her symptoms within a holistic framework where all relevant biological, psychological, and social aspects of health can be considered.”

(Kvamme et al., 2001)

The 12 psychological professions comprise a group of professionals whose work is ‘informed by the disciplines of psychology and psychological therapy’ (The Psychological Professions Network, 2018). The psychological professions’ professional grouping within the NHS Arm’s Length Bodies currently comprise 12 distinct occupations working in NHS funded care; adult psychotherapists, child and adolescent psychotherapists, children’s wellbeing practitioners, clinical psychologists, cognitive behavioural therapists, counselling psychologists, counsellors, education mental health practitioners, family and systemic psychotherapists, forensic psychologists, health psychologists and psychological wellbeing practitioners. While these occupations are all included under the ‘PPN umbrella’, there are significant differences between them, each with its unique training route, and cannot as such be treated as interchangeable.

Traditionally the vast majority of psychological professionals have worked in the contexts of mental health and learning disabilities but their role has expanded into physical healthcare where there is a movement away from a purely medical model towards a biopsychosocial model. There are differences across the 12 psychological professions in terms of the core competencies necessary for completion of training. Some professions include competencies for working in physical health settings and some do not. However the clinicians in the latter group may develop these skills post qualification.

Despite significant evidence for the clinical and cost effectiveness of this model, in a healthcare system designed for acute conditions this movement is slow and psychological healthcare provision has been patchy due to little national strategic planning. As a result there continues to be many people with physical health conditions, especially long-term conditions (LTCs) who are not supported effectively to develop ways to live well with their condition (Bodenheimer, Wagner & Grumbach, 2002).

The review we have undertaken suggests that the reasons are multifactorial and require consideration and action to support the growth of the psychological professions in physical healthcare settings. This can benefit people with physical health conditions and the healthcare economy.

Physical health conditions do not discriminate on the grounds of age and therefore this review applies from birth to death. The range of physical health conditions in children, young people and adults that do or would benefit from psychological interventions is vast; not all can be mentioned in this document. We suggest that readers refer to the bibliography to gain a comprehensive understanding of the role of the psychological professions in a physical healthcare setting. *Italic text in boxes are direct, anonymised quotes from people who have experience of physical health conditions and healthcare.*

This paper refers to the biopsychosocial framework as a means of highlighting that biological, psychological and social factors all have an influence on the patient’s presentation in a physical healthcare setting. Using the biopsychological framework as a high overview does not preclude the psychological professions from using specific therapeutic models when working with the patient.

Given the vast terrain of the impact of psychological practice in physical healthcare, this paper may not be inclusive and primarily aims to stimulate discussion and potential future workstreams. In addition, this paper was researched and written before the COVID-19 pandemic and many of its recommendations have only become all the more urgent in light of the pandemic and its consequences.

2: The need for psychological professions in physical healthcare settings

"In the presence of psychological distress or mental health problems, doctors dismiss physical symptoms, attributing them to the mental health problem, until the physical health problem becomes worse. In my case it was found that I had a brain tumour."

Normalising the influence of psychological factors in physical health conditions is a central tenet of the biopsychosocial model (Engel, 1977). The model suggests that 'biological, psychological and social processes [are] integrally and interactively involved in physical health and illness' (Suls & Rothman, 2004).

This is not, as many tend to believe, linear and unidirectional where a physical illness causes psychological and social difficulties. Nor is it linear and bidirectional where psychological factors cause physical illnesses, a model that is overused and accompanied by often unhelpful labels of 'psychosomatic' and 'somatisation'. The biopsychosocial model is a non-linear understanding of the normal interaction between biological, psychological and social factors that varies between individuals.

Although many healthcare providers (HCPs) attempt to do so, speculation regarding the degree to which each factor contributes to the physical health condition is often futile. Conversely, an understanding that all factors are involved and need to be addressed is invaluable not only to the person with the condition, but also to the costs and efficiency of the health and social care systems.

In England there are 16.5 million people across the life span with long-term physical health conditions (LTCs); 4.5 million of these experience concomitant psychological distress, whether at a clinical or sub-clinical level. People with an LTC are two to three times more likely to experience mental health problems than the general population (see Box 1).

This increases to seven times in the presence of two or more LTCs (Moussavi et al., 2007). Between 10 and 30 percent of children are affected in some way by physical health problems either directly or through caring roles (Kush & Campo, 1998). Approximately 11 percent of children experience significant chronic illness that substantially limits their daily life (Reulbach et al., 2010; Yeo & Sawyer, 2005), and 10 to 37 percent of children with a chronic illness experience psychological difficulty (The Paediatric Network, 2018).

Children living with a long-term physical illness are twice as likely to suffer from emotional or conduct disorders (Parry-Langdon, 2008), and these figures are thought to be rising (Barnett et al., 2012; Van Cleave, Gortmaker & Perrin, 2010).

Box 1: Psychological conditions in physical health populations

Diabetes

- People living with diabetes are two to three times more likely to have depression than the general population (Fenton & Stover 2006; Simon et al., 2007; Vamos et al., 2009).
- A systematic review and meta-analysis studying children and adolescents with Type 1 diabetes suggests a prevalence of depression and anxiety of 30 percent and 32 percent respectively (Buchberger et al., 2016).

Stroke

- Studies suggest that the prevalence of major depression following stroke ranges from 9–31 percent in the 3–4 months after stroke (Whyte & Mulsant, 2002).

Burns

- 31 percent of adults in the 5 to 7 years following a burn report being depressed or anxious (Spronk et al., 2019).

Dementia

- Figures vary, but it is thought that the prevalence of depression and anxiety in people with dementia is around 25 percent and 75 percent respectively (Orgeta et al., 2014).

Parkinson's Disease

- Although figures vary to a great extent, on average 17 percent of people with Parkinson's disease experience major depression (Reijnders et al., 2008); 40 percent report a level of depression (Aarsland, D. et al., 2012); 40 percent experience anxiety (Broen, M. P. G. et al., 2016).

Cancer

- Around a third of adults diagnosed with breast, colorectal or prostate cancer, non-Hodgkin lymphoma or melanoma in the previous five years experience anxiety or depression (Jefford et al., 2017).
- Figures vary but at least one-quarter of children with cancer develop mental health problems such as major depressive disorder, anxiety disorders, and/or post-traumatic stress disorders (Seitz et al., 2010 ;Kazak et al., 2004).

Respiratory

- Mental health problems are around three times more prevalent among people with chronic obstructive pulmonary disease than in the general population (NICE 2009).
- Anxiety disorders are particularly common; for example panic disorder is up to 10 times more prevalent than in the general population (Livermore et al., 2010).

Asthma

- Children and adolescents with symptomatic asthma are more likely to suffer from a wide range of mental health problems when compared with healthy children (Goodwin, Robinson, Sly, McKeague, Susser & Zubrick, 2013).
- Children with asthma have a higher risk of meeting the criteria of several anxiety disorders including separation anxiety, social anxiety, specific phobia, panic and generalised anxiety disorder (Lu, Mak, van Bever, Ng, Mak & Ho, 2012; Vuillermin, Brennan, Robertson, Carlin, Prior & Jenner, 2010).
- On average there is a prevalence of 34 percent of any anxiety disorder amongst adults with asthma, primarily panic attacks (25 percent) (Weiser, 2007).

Musculoskeletal

- Up to 33 percent of women and more than 20 percent of men with all types of arthritis may have co-morbid depression (Theis et al., 2007).
- More than one in five people over the age of 55 with chronic arthritis of the knee have been reported to have co-morbid depression (Sale et al., 2008).

Brain Injury

- Estimates of anxiety and depression in adults in the first year after traumatic brain injury are 21 percent and 17 percent respectively, rising to 36 percent and 43 percent respectively in the longer term (Scholten et al., 2016).

Given the statistics shown in Box 1, it is unsurprising that at least 25 percent of people admitted to hospital with a physical illness also have a diagnosable mental health condition. A further 41 percent have sub-clinical symptoms of anxiety or depression, with rates rising to 60 percent for the over-60s (Confederation NHS, 2009). This physical and psychological comorbidity can result in significant physical, psychological and social impacts on the person and those around them, and many find themselves in a downward spiral of worsening physical and psychological health and social circumstances. It then becomes extremely difficult to self manage the health condition due to factors such as reduced motivation, which can lead to reduced adherence to treatment, poor self-care and appointment attendance and then a possibility of unhealthy coping behaviours, such as smoking and alcohol consumption.

These difficulties increase in the presence of sociocultural issues such as deprivation (Mercer & Watt, 2007).

The most socio-economically disadvantaged groups in our society are 60% more likely to have a long-term condition than the most advantaged, are more likely to have more than one LTC and are more likely to experience more severe cases of LTCs. On average this population will die seven years earlier (Marmot et al., 2010). The increase in poverty nationwide, alongside an anticipated economic downturn will likely only further exacerbate these inequalities.

A significant amount of research has shown that psychological health has a direct effect on a physical health condition (see Box 2). In the presence of psychological distress:

- physiological measures become worse
- the effectiveness of physical/medical interventions decreases
- mortality increases

Box 2: The effect of psychological conditions on physical health

Cardiac

- Depression doubles the likelihood of a person dying within five years of heart bypass surgery (Blumenthal et al., 2003).
- People with chronic heart failure are eight times more likely to die within 30 months if they have depression (Junger et al., 2005).
- Depression leads to a two to threefold increase in negative outcomes for people with acute coronary syndromes (Barth et al., 2004).
- Depression increases mortality rates after heart attack by 3.5 times (Lesperance et al., 2002).
- Depression increases the risk for onset of coronary artery disease and ischaemic heart disease by between 50 percent and 100 percent (Benton et al., 2007).

Diabetes

- People with diabetes and depression are 36–38 percent more likely to die over a two year period (Katon et al., 2004).
- Co-morbid mental health problems are associated with poorer glycaemic control, more diabetic complications and lower medication adherence (Das-Munshi et al., 2007).
- Children with Type I diabetes are more likely to suffer from retinal damage if they also have depression (Kovacs et al., 1995).

Stroke

- 'The co-occurrence of depression and stroke is associated with even poorer functional health outcomes, compared with each alone, and there may be synergism between the two disorders related to this effect' (Goodwin & Devanand, 2008).

Respiratory

- People with chronic obstructive pulmonary disease (COPD) and co-morbid psychological problems have more than 50 percent more acute exacerbations of their COPD per year (Laurin et al., 2009).

Asthma

- Analysis of the United Kingdom General Practice Research Database suggests that mortality rates for individuals with co-morbid asthma and depression are twice the level among those with asthma alone (Walters et al., 2011).

These complex interrelationships between physical and psychological health results in between £8 billion to £13 billion of the NHS budget in England being spent on the population with LTCs. This accounts for 50 percent of GP appointments, 70 percent of bed days, and 70 percent of acute and primary care budgets (Department of Health, 2012).

When people with this type of co-morbidity do not receive the appropriate psychological interventions there is a 45–75 percent increase in service costs regardless of the severity of medical condition (Naylor et al., 2012), and after adjusting for clinical and demographic variables (Welch et al., 2009; Unutzer et al., 2009) (See Box 3).

Box 3: Cost of co-morbid physical health conditions and psychological difficulties

Cardiac

- Depression is associated with an increase in rehospitalisation rates in cardiovascular disease. People with chronic heart failure have emergency admission rates that are two to three times higher than those who are not depressed (Himelhoch et al., 2004; Jiang et al., 2001; Fenton & Stover, 2006).
- Cardiovascular problems with co-morbid mental health problems increased the average length of inpatient stay from 8.9 days to 13.2 days, with total costs increasing by 49 percent (Hochlehnert et al., 2011).
- Co-morbid congestive heart failure and depression are associated with a 37 percent increase in annual medical costs (Thomas et al., 2006).

Diabetes

- People with co-morbid mental health problems and diabetes have more hospital admissions and GP consultations for physical complaints (Das-Munshi et al., 2007).
- Co-morbid diabetes and depression is associated with increased costs of 48 percent higher over a three year period (Gilmer et al., 2005), 70 percent higher over six months (Simon et al., 2005), and 103 percent increase in one year (Thomas et al., 2006).
- After controlling for diabetes severity, costs relating to depression over six months increased by 54 to 88 percent depending on severity (Ciechanowski et al., 2000).

Medically Unexplained Symptoms (MUS)

- The total cost of care for 227 patients with MUS over a 24 month period was £31 million (i.e. £42,000 per month). They had 8,990 GP contacts at a total cost of £13k per month (Commissioning Support for London: Medically Unexplained Symptoms – Project Implementation Report, March 2011).
- MUS cost the NHS in England £3.1 billion a year (Birmingham et al., 2010), half of which (£1.2 billion) is spent on inpatient care.
- In a five year period the costs relating to each person with MUS when compared with those with a physical explainable condition had greater inpatient (£3,837), outpatient (£957) and A&E (£112) costs (Burton et al., 2012).

Stroke

- Mental health diagnosis after stroke increases inpatient and outpatient healthcare utilisation in the first 3 years post stroke (Ghose et al., 2005).

Dementia

- Poor mental health in people with dementia carries an estimated economic and social cost of £105 billion in England per year (Dementia UK, 2007).

Respiratory

- People with COPD and co-morbid psychological problems experience higher rates of hospitalisation, and spend twice as long in hospital as those without mental health problems (Yellowlees et al., 1987).
- The presence of mental health problems increases risk of admission by 2.8 times, causes slight increases in length of stay and doubles the use of outpatient services (Krein et al., 2006; Vamos et al., 2009).

These increased costs are mainly due to:

- Unnecessary medical investigations
- Frequent attendance at primary care, emergency departments and outpatient clinics
- Increased use of medication
- Increased admissions and longer lengths of stay
- Increased institutionalisation in older people, resulting in increased healthcare support and hospital stay

There are also significant indirect costs such as increased absenteeism and reduced productivity at work (Suhrcke, Fahey & McKee, 2008). These absences require more statutory sick pay costs and employers' general costs. The stress of employment worries increases the chances that the LTC flares up, which in turn attracts more healthcare costs, additional work absenteeism and so forth.



3: Evidence: clinical and cost effectiveness of psychological interventions

“Much can be done to help children and young people with long term conditions experience an ordinary life. A key element of this support should be good mental health input to maximise emotional well-being and prevent or minimise problems.”

(DoH, National Service Framework for Children in Hospital [Standard 6], 2004)

Research evidence has supported the clinical effectiveness (improved psychological wellbeing, quality of life and physical health outcomes) and cost effectiveness of psychological interventions in physical healthcare since the 1960s (Follette & Cummings, 1967). This is not only the case for adults, but also children (Lemanek et al., 2001; Channon et al., 2007; Ellis et al., 2005).

Many current evidence-based interventions use a cognitive behavioural framework (Cognitive Behavioural Therapy; Acceptance and Commitment Therapy) and have been shown to improve treatment adherence, psychosocial adjustment, coping skills

and quality of life for people with co-morbid long-term conditions, as well as reducing use of health care services (for example, Thompson et al., 2011; Spurgeon et al., 2005). However, this evidence has been and continues to be slow in reaching the non-psychological professions, managers and commissioners in physical healthcare. This needs to be addressed.

Box 4 provides examples of the effect of psychological interventions on physical health outcomes.

Box 4: Effect of psychological interventions for physical health conditions

Diabetes

- Integrated multidisciplinary care for adults with Type 2 diabetes that includes psychological professions improves mood, anxiety, relationships with others and quality of life (Diabetes UK, 2010), and physical health outcomes (reduced glycosylated haemoglobin and systolic blood pressure and improved glycosylated haemoglobin by 0.5 to 1 percent) (Alam et al., 2008; Ismail et al., 2004; Diabetes UK, 2010).

Pain

- Cognitive Behavioural Therapy (CBT) interventions for chronic pain have shown to reduce pain and disability (Williams et al., 2012).

Angina

- **Chronic Refractory Angina:** In the year following cognitive behavioural intervention, total hospital admissions were reduced from 2.40 admissions per patient per year to 1.78 admissions per patient per year ($P < 0.001$) and hospital bed occupancy fell from 15.48 days per patient per year to 10.34 days per patient per year ($P < 0.001$). This is a cost reduction of £2,000 per person, which is well in excess of the cost of psychological intervention (Moore et al., 2007).
- **Stable Angina:** Interventions delivered by the psychological professions significantly reduce angina frequency and medication use and psychological wellbeing in patients (McGillon et al., 2008).

Chronic Obstructive Pulmonary Disease

- A psychological component in a rehabilitation programme for chronic obstructive pulmonary disease (COPD) reduces attrition from the programme and the need for re-admission for COPD (Abell et al., 2008).
- CBT packages tailored to COPD reduces anxiety, improves self-management and reduces exacerbations and unnecessary admissions (NICE, 2009).
- Integrating a psychological component in a breathlessness clinic for COPD resulted in 1.17 fewer emergency department presentations and 1.93 fewer hospital bed days per person in the six months after intervention. This is a cost saving of £837 per person, about four times the upfront cost of the intervention (Howard et al., 2010).

Chronic Fatigue Syndrome

- Compared with specialist medical care which produced little change, CBT has a 62.7 percent likelihood of being the most cost-effective option from a healthcare perspective and 59.5 percent likelihood of being the most cost-effective option from a societal perspective (McCrone et al., 2012).

It is the effectiveness of these interventions that have resulted in psychological interventions in physical healthcare being embedded in many NICE guidelines for long-term conditions. However, the commissioning and therefore inclusion of these interventions in the day-to day care of people with physical health conditions is inconsistent across the country.

Health Education Scotland has published 'The Matrix: A Guide to Delivering Evidence-Based Psychological Therapies in Scotland' (2015) in which a section on psychological therapies for persistent physical

symptoms outlines 'the current evidence base, guidance on well-functioning psychological therapies services and advice on important governance issues' (NHS Scotland, 2015); see Box 5 for the conditions covered. This comprehensive guidance is lacking in England. The Matrix is not known by many clinicians and managers working in the English healthcare system.

Box 5: Health conditions included in The Matrix

- Asthma
- Cancer
- Cardiovascular disease (cardiac arrhythmias in coronary heart disease; myocardial infarction and MI with ST-segment elevation); stable angina; unstable angina and non-ST-segment elevation myocardial infarction
- Chronic Fatigue Syndrome
- Chronic Kidney Disease
- Chronic Obstructive Pulmonary Disease
- Chronic Pain
- Diabetes (Type 1 and 2)
- Irritable Bowel Syndrome
- Multiple Sclerosis
- Osteoarthritis
- Rheumatoid Arthritis
- Obesity/weight loss interventions

4: Challenges

Despite there being the evidence to support the role of the psychological professions in physical healthcare, many challenges need addressing if people with physical and psychological co-morbidity are to receive the appropriate co-located multidisciplinary care that includes the psychological professions. These challenges are outlined below.

“Referrals to psychologists [in a mental health organisation] are perceived by parents as labelling their child as ‘mad’ or as ‘obviously making it up’ and could permanently damage the relationship between practitioner and family.”

(Furness et al., 2009)

4.1. The challenge of a dualistic approach to long-term conditions

One of the greatest challenges is that whilst most healthcare providers, managers and commissioners can quote the biopsychosocial model, this does not necessarily mean it is translated into the care the person receives. Many clinicians do not recognise that psychological factors are a normal part of a physical health condition or that this model (as opposed to the purely medical model) is the bedrock of evidence-based, high quality multidisciplinary care. There are examples where multidisciplinary interventions such as pain management programmes have been cancelled as a cost saving measure and replaced by separate psychological and physiotherapy support, resulting in the outcomes deteriorating and costs increasing.

A healthcare provider (HCP) who dismisses the biopsychosocial model and focuses purely on the physiological is at risk of focusing on one small area of the person, and given permission to ignore the other aspects of the person (Naylor et al., 2016). Should the HCP recognise any distress they are likely to pathologise that distress and label the person as having an abnormal response to their health condition, which can result in a referral to a mental health organisation.

If the mental health problem is unrelated to the physical health condition this referral might be appropriate. However, when the distress is directly related to the health condition then a mental health setting is less appropriate and the person is much less likely to receive an intervention to help them manage their physical health condition, and even less likely to receive integrated multidisciplinary physical healthcare.

The label ‘medically unexplained symptoms’ (MUS) has unfortunately reinforced this dualistic approach (Marks & Hunter, 2015). ‘Medically unexplained symptoms’ are often described as ‘physical symptoms that have no currently known physical

or pathological cause’. However, although conditions under the MUS umbrella are not physical symptoms caused by physical disease or injury that can be ameliorated by medical interventions, many can be explained physiologically and thus are not ‘medically unexplainable’. For example, decades of research in the pain field has led to an understanding that all pain is a result of physical and psychological mechanisms, and persistent pain is a result of a sensitised nervous system. However, despite this evidence many place chronic pain in the MUS category (although it has recently been re-categorised as a ‘long-term condition’ in IAPT guidelines). Therefore, when physical mechanisms do not show up on investigations such as x-rays or CT scans, healthcare providers often conclude that there is no physical cause, label the pain as non-organic and an MUS. Many do not consider the alternative explanations that either i) they are unaware of the research evidence and/or that ii) medical science and technology are not yet sophisticated enough to show the mechanisms of pain on scans. Thus the person with pain is penalised and disbelieved due to the shortcomings of education and medical science.

“The physical health system isn’t welcoming of mental health issues. There is a lack of welcoming the holistic. Dualism still prevails.”

“Professionals in physical healthcare need a psychological understanding otherwise we are pushed between mental health services.”

“I’m careful to manage the physical health clinicians so they don’t blame my mental health.”

“I’ve learned not to talk about my mental health history so I can get the physical health services I think I need. I now ‘perform’. If there was mutual trust we could have an open dialogue.”

Example of Best Practice: Understanding the integration of physical and psychological factors in a physical health condition

University College London Hospitals Foundation Trust Pain Management Centre

Based on scientific evidence, the central tenet of the work of all members of the multidisciplinary team (nurses, physiotherapists, pain management doctors and psychologists) at the UCLH Pain Management Centre is that all pain is the result of biological and psychological factors. This integrated model of pain is explained to and normalised with the patients, who also learn that the results of medical investigations are frequently 'negative' because they are currently unable to capture the mechanisms of persistent pain. This removes the stigma of talking about distress in the context of pain and the fear of being labelled as 'somatising' or having 'psychogenic pain'. As importantly, it also helps patients to understand and engage in cognitive behavioural pain management interventions (the cognitive model or the acceptance and commitment model) alongside medical interventions (where indicated). For this integrated approach to be successful all clinicians, regardless of profession and grade need to have some understanding of and respect for the role of each team member.

4.2. Insufficient understanding of psychological professions competencies

For a variety of reasons many healthcare providers, managers and policy makers have little understanding of the competencies of psychological professionals and the outcome research. They are therefore unaware of how these professions can benefit the patient, team and organisation. This is resulting in some patients not receiving the psychological interventions required in the context of a physical health problem.

"No one is looking at the collateral damage of living with a health condition."

The main aim of a psychological professional's work in a physical healthcare organisation is to support people to develop a range of cognitive, behavioural and psychological skills to reduce the physical, psychological and social impact of the physical health condition on them and their lives, and to live well with the condition. This work is carried out with individuals or in groups. Some psychological professions have the competencies to work with couples and families.

For example, if the patient is a child the parents/ guardians and sometimes siblings (all of whom may also be affected by a family member having a physical health problem) might also attend sessions with the psychological therapist (see Box 6.).

Psychological professionals are also trained in a broad range of competencies, the type being dependent on the professional training. Unfortunately these skills are often not recognised or viewed as essential in a healthcare setting (although there is substantial evidence to show that they are associated with significant quality improvements and cost savings). These competencies and their purpose in a physical health context are described in Box 6.

Box 6: The competencies of psychological professions

1. Clinical work

Psychological professions work with people with physical health conditions because the evidence suggests that without this intervention physical health, mental health and outcomes of physical interventions are worse and healthcare costs are greater. The psychological professions work in collaboration with and alongside the person (as opposed to the health care provider being viewed as the expert who tells the person what they should do). This collaboration aids the person's understanding, increases engagement in and adherence to self-management of their condition. Many psychological professions take a 'systems approach' thus taking into account the family, social contacts, environment, employment, education and healthcare, and the effects of these on the person with the health condition.

a. Examples

- i. Individual work: Face to face; telephone; digital healthcare.
- ii. Couples work: This aims to support the couple to work together to meet the needs of both parties in the context of a physical health condition.
- iii. Family work: Taking a family systems approach helps the psychological professional working with a child or young person with the condition to explore their 'developmental, behavioural, emotional and family life' and to understand the health condition in the context of the family, recognise maintaining factors and obstacles to change and begin to address these.
- iv. Group work: A group of people with the same diagnosis or different diagnoses with similar impacts can aid learning, increase support and increase the likelihood of change.
- v. Joint working with other health care providers (HCPs): This helps the person with the condition and the team to address physical and psychological factors in a physical health condition and provides an opportunity for learning between HCPs.

2. Consultation with non-psychology HCPs

The training of many physical health HCPs rarely includes understanding the integration of psychological and physical factors in the context of a physical health condition. This results in HCPs taking a dualistic approach and address physical and mental health separately. Consultation aids cross-learning and helps:

- i. HCPs understand and apply a biopsychosocial integrated approach.
- ii. To formulate and normalise a person's presentation, including their distress, fears and behaviours.
- iii. Improve the care of and rapport with the person.
- iv. Tailor their intervention to the needs of the person.

b. Example

- i. A 45 year old lady frequently attends the emergency department (ED) with back and leg pain requesting strong analgesia. The physical health team label her as a "drug seeker" who "exaggerates" her pain. Consultation with a psychological professional will help the physical health team consider other alternatives such as:
 - The patient holds an acute model of pain and has not been helped to understand the chronic pain model by the healthcare system. She therefore believes that medical interventions (i.e. analgesia) are the only way forward to reduce her symptoms and their significant and frightening impact on her and her life.
 - An HCP has not referred this lady to a pain service that could help her manage her pain. Thus analgesia is her only current coping strategy. While there are times when pain relief is a necessary intervention, other coping strategies may help with longer term pain management.
 - Her partner at home is very anxious about her health and encourages her to attend the ED because they do not know how to help her otherwise.
 - There are difficult social circumstances at home that are increasing her level of distress. This distress will serve to increase her pain experience.

Box 6: The competencies of psychological professions (cont.)

3. Staff support

Working with people who have complex needs can be difficult and distressing for teams. When staff feel supported there are many beneficial outcomes including improved rapport with patients, improved healthcare and outcomes, reduced staff sickness absences, improved job satisfaction and increased staff retention.

- a. Examples: The psychological professions can provide support to staff in many ways including:
 - i. Supervision (group or individual). It is worth noting that the models of supervision used by the psychological professions are reflective and supportive. This is different from some physical healthcare providers' understanding of supervision, which can at times be viewed as a punitive action due to poor performance.
 - ii. Facilitation of Schwartz Rounds (see Point of Care Foundation).
 - iii. Reflections following a critical incident.
 - iv. Coaching and mentoring.

4. Education and training with all staff groups

Many physical healthcare professionals are not trained in the integration of psychological and physical factors in the context of physical health. Some HCPs also need support to help them understand the impact of their behaviour and communication on the patient.

- a. Examples
 - i. Understanding the integration of physical and psychological factors in the context of a health condition.
 - ii. Developing skills in working with and responding to people in the context of them having a physical health condition.
 - iii. Improving knowledge of mental health conditions, presentations and responses to them.
 - iv. Assessment of and responses to suicide risk and safeguarding issues.
 - v. Communication skills (see below).

5. Research and audit

Research and audit are significant components of the doctoral level psychological professions' training. This can drive service improvement, integrate research findings into clinical practice and increase the organisation's visibility in the research field. Unfortunately time for research in a psychological profession's job plan is often absent due to resource pressure and a lack of protected time in job roles.

- a. Examples
 - i. Identifying a service improvement need and implementing quality, service improvement and redesign tools to drive and measure the improvement.
 - ii. Designing and validating questionnaires/ choosing the most applicable validated measure.
 - iii. Measuring and evaluating clinical outcomes and implementing improvements.
 - iv. Publishing and disseminating results.

6. Leadership and management

Leadership competencies in health and social care are viewed as essential for staff at all levels. Current leadership models encompass psychological models, which has resulted in some psychological professionals becoming excellent leaders in healthcare settings when supported to do so. They have competences to understand a whole system and to plan and lead change and improvement.

- a. Examples
 - i. Leading a clinical health psychology service providing evidence-based psychological interventions, managing and further developing this service in hospital and community healthcare settings.
 - ii. Clinically leading an Improving Access to Psychological Therapies Long Term Conditions (IAPT-LTC) service.
 - iii. Advising public health physicians on the psychology of behaviour change.

4.3. Unmet training needs

New approaches to training and development are needed to create a workforce able to support the integration of mental and physical health. This has significant implications for professional education; all educational curricula need to have a sufficient common foundation in both physical and mental health.

(Naylor et al., 2016)

To ensure that non-psychological healthcare professionals work in an integrated way, they need i) some understanding of psychological health and difficulties, ii) skills to explore with a person what their difficulties are, iii) skills in how to respond and iv) knowledge of appropriate services to refer to (Naylor et al., 2016). This will improve a clinician's competencies and increase the likelihood of the person receiving the appropriate care.

"There needs to be a holistic view, not a siloed view of body parts."

"I have pain. People with pain need to have well informed psychological care to manage an on-going health issue. If you know nothing it's impossible to manage the condition."

"The sheer desperation of people living with a chronic health problem and have nowhere to turn. They have needs that aren't known about."

In addition to these areas being taught as part of professional training, throughout their career non-psychological professions would benefit from accessing training and consultation with psychological professions. Unfortunately few physical healthcare organisations provide this resource. This is resulting in staff misunderstanding and having difficulty in managing a person's presentation, which in turn can increase staff stress.

All training curricula would benefit from including communication with patients; a neglected area despite it being one the main reasons why people complain to healthcare organisations. Effective health care provider (HCP) communication is associated with a patient's improved understanding of the physical health condition and treatment needed, increased adherence to treatment, improved attendance at healthcare appointments, improved physical outcomes, reduced distress and improved patient satisfaction. HCPs are not as adept at communicating as they might believe, nor understand the value of effective communication.

"They forget the impact of their words and body language. I've seen people step back from me when I disclose my mental health history. They forget that I can hear their whispers on the other side of the curtain".

"I'll never forget how I felt when I heard myself being referred to as "The self-harmer in bay 6", which was of course accompanied by a sigh and rolling eyes".

"Enhanced, multi-professional training across the physical and mental health interface will be a key part of improving the experience of children and young people with physical and mental health problems."

(Department of Health/NHS England, 2015)

Training must focus on how to explain health conditions, consideration of the impact of words used, an awareness of the unhelpful use of stereotyping, cognitive biases and labelling of people, how to listen to and understand what the person is saying, how to respond to people's concerns and how to ensure that people understand the messages conveyed by HCPs. Also required is an understanding that receiving a physical health diagnosis can have psychological impacts as well as an effect on a person's ability to receive information.

What has not been agreed upon is the amount of physical healthcare training that the psychological professions need to provide integrated care. Many psychological professions who work in mental health as opposed to physical health settings require a greater understanding of integrated psychological models for health conditions, if they are to use an integrative, non-dualistic model (Darnall et al., 2016).

"Mental health teams are not plugged into understanding the implications of living with a health condition and the psychological implications and the care needed."

4.4. Insufficient integration

Patients, providers, and health care economics all suffer when the design of the system (its interlocking clinical, operational, and financial aspects) is mismatched to the basic scientific and clinical realities it confronts daily.

(Blount et al., 2007)

Working “in silos”, whether within or between organisations, has been a feature of health and social care for many years. The King’s Fund (2016) recognised that medical staff and psychological staff working together provide better care for people with co-morbid physical and psychological difficulties, are able to identify those with more complex needs at an earlier stage, reduce delayed discharges, and influence a culture change through changing staff attitudes towards patients experiencing psychological difficulties. Addressing psychological and physical health needs together is unlikely to be accomplished through the traditional acute, episodic model of care, which focuses on one physical health need, tends to view the patient as a passive recipient of care and the treatment aims are to return to normal life (Holman & Lorig, 2000; Piette, Richardson & Valenstein, 2004).

“Almost all patients had adequate physical health monitoring plans made on the general hospital ward but only half the patients had adequate mental health monitoring plans made.”

(NCEPOD, 2019)

The King’s Fund describes ten areas spanning multiple settings where improvements are needed for successful integration between physical and mental health. These are:

- Prevention/public-health
 - Incorporating mental health into public health programmes.
 - Health promotion and prevention amongst people with severe mental illness.
- General practice
 - Improving the management of medically unexplained symptoms in primary care.
 - Strengthening primary care for the physical health needs of people with severe mental illness.
- Chronic disease management
 - Supporting the mental health of people with long-term conditions.
 - Supporting the mental health and well-being of carers.
- Hospital care
 - Mental health in acute general hospital.
 - Physical health in mental health inpatient facilities.
- Community/social care
 - Integrated support for perinatal mental health.
 - Supporting the mental health needs of people in residential homes.

This highlights the lack of integration across many areas, which will be considered in turn and improvements suggested.

4.4.1 Insufficient integration: multidisciplinary care in team

"No 21st century health system should require parents and children to go from place to place or even worse go to multiple appointments to tell the same story."

(Ian Kennedy QC, 2010)

Because psychological difficulties and physical conditions in children and adults frequently overlap, this can make the notion of a separate treatment in a separate service for concurrent psychological difficulties untenable for some. In the absence of an integrated, co-located multidisciplinary physical healthcare team that includes the psychological professions there is an increased likelihood that people who are struggling with their health condition do not receive the appropriate integrated care, and therefore are unable to adapt and manage their health effectively. This in turn is associated with poor outcomes, faster disease progression (Roccaforte et al., 2005; Göhler et al., 2006; de Ridder et al., 2008) and increased costs. Working 'in silos' also stifles cross-learning, which can reinforce the continuation a dualistic model.

Integration and co-location of physical and psychological healthcare, shared decision-making and the use of a holistic and comprehensive treatment plan results in mental health being viewed as an integral part of physical healthcare (as opposed to being stigmatised), better patient engagement and adherence, which can reduce costs by £1,760 per person per annum (NHS England and NHS Improvement, 2018).

"Health care providers work in silos. They must be holistic. Good healthcare is holistic."

Example of best practice: integrated multidisciplinary care

The Derby Parkinson's Disease Service, University Hospitals of Derby and Burton NHS Foundation Trust

The Derby Parkinson's Disease Service¹ is an example of best practice in relation to multidisciplinary team working, which the team place at the heart of their service. In addition to seeing individual patients, the psychologists train the non-psychologists in the team in level one and two psychological skills to enable them to screen patients' mood, assess for risk and be confident in talking about psychological problems. They provide consultation to the team to support them in their work with the patient and so prevent a referral to psychology, thus making the service efficient and increasing the skills and confidence of the team who are working with the patient holistically.

¹ http://www.derbyparkinsons.com/Multidisciplinary_PD_Clinic.html

4.4.2 Insufficient integration: within organisations

Increasing sub-specialisation and the decline of generalism in hospital settings has arguably created a lack of co-ordination and oversight of patients' multiple needs (Finlay et al., 2011), resulting in care being fragmented. This is contrary to what patients want, which is for the NHS to act as one team and for them to be treated as a whole person (Camber, 2016).

"I've been stuck in a quagmire of everyone passing me around the system. No one wants to take responsibility"

"The whole system is now very fragmented. There are no generalists. The only person who knows what's going on generally is me. I'm an expert by experience who can see the whole picture and knows what's happened to me. No one else knows."

If a person is receiving healthcare from more than one team in the same organisation an absence of written or verbal communication between teams is not uncommon. This occurs for many reasons, for example simply not knowing about the other team's involvement; a lack of time to look at all the documents; the organisation having more than one IT system that documents patient information and the health care provider not having access to both.



4.4.3 Insufficient integration: across organisations

In the presence of multiple physical and psychological needs, care becomes increasingly fragmented across the parts of the health and social care system. This is often accompanied by a lack of communication between services (possibly because each is unaware of the input from others, health care providers (HCPs) not valuing the need to communicate between services, and/or data sharing restrictions across organisations) and therefore duplication of services and care, which can result in the patient being given conflicting information about their condition and the treatment needed, causing further psychological distress.

“There’s no communication between services”

This situation is associated with increased costs and unnecessary distress (The Richmond Group of Charities, 2018; see Box 7).

When psychological care is needed alongside physical healthcare the difficulties become more complex. Hence a priority for health, psychological and social care organisations is to work together and develop a model of integrated care for physical health problems that transcends ‘the organisational boundaries of social, primary, community and

secondary care’ (DoH, 2012); ensuring that people’s physical, psychological and social care needs are met in a coordinated framework. This is of course reflected in the development of Integrated Care Partnerships (ICPs) and the aim to provide ‘networks of care’ rather than episodic care (FYFV, 2014). If the psychological professions are to be well represented in this model, Primary Care Networks must make mental health a priority from the start if the local populations are to be supported effectively (Baird & Bell, 2019).

The Richmond Group of Charities (2018) states that the integration of organisations must include the voluntary sector and local organisations because health conditions affect all areas of the person’s life. For example, 4 in 5 people experience a financial impact of a cancer diagnosis and health care providers tend not to have knowledge about the benefits system or available support. The Richmond Group believe that the holistic view taken by voluntary organisations can address issues such as finances, the living environment, and support by their family and communities. They argue that ‘person and community centred approaches to improving health and wellbeing and reducing loneliness can improve outcomes for the individual and build resilient communities with wider social benefits’ (Richmond Group of Charities, 2018, p6).

Box 7: Examples of the effect of lack of effective communication between organisations

- Almost one in five people with multiple sclerosis report that health and care professionals do not work well together.
- Nearly half of stroke survivors report that the failure of health and social care to work together has resulted in worse care for them and feel abandoned after leaving hospital (Stroke Association, 2012).
- In 2013/14, £264.2 million was wasted due to poor dementia care in hospitals as a result of unnecessary extra days spent in hospital, additional care needed because of falls, and avoidable emergency readmissions due to poorly coordinated and insufficient care (Alzheimer’s Society, 2016).
- More than one in three older people report feeling lonely and isolated on returning home from hospital (Royal Voluntary Service, 2013).
- More than 40 percent of breast cancer patients report not being given enough help and care from health and social services after leaving hospital (NHS England, 2014).

4.4.4. Insufficient integration: psychological professions involvement in prevention

"If the nation fails to get serious about prevention then recent progress in healthy life expectancies will stall, health inequalities will widen, and our ability to fund beneficial new treatments will be crowded-out by the need to spend billions of pounds on wholly avoidable illness.

(NHS England, Five Year Forward View , 2014)

People are still living with and dying prematurely from preventable conditions. The Richmond Group of Charities (2015) state that the following can be prevented:

- 30 percent of cases of Alzheimer's
- 40 percent cases of cancer
- 66 percent of deaths from asthma attacks
- 75 percent of cases of cardiovascular disease
- 80 percent of amputations resulting from diabetes

These figures, in addition to the knowledge that factors such as poor diet, physical inactivity, smoking, alcohol and obesity cost the NHS around £43 billion has resulted in the view that prevention work is essential. Despite these figures, in England only about four to five percent of public health money and about three percent of the national health sector budget is spent on prevention (World Health Organization, 2014).

The King's Fund (2016) states that prevention and health promotion work will be more effective when the integration of mental and physical health is applied. Unfortunately many believe that prevention work consists purely of education. However, knowledge gained through education does not necessarily generalise to behaviour change. The planning and delivery of prevention services must be evidence-based and grounded in theory. Teams delivering the service must be trained in behaviour change (NICE, 2007), and have a clear understanding of the social, cultural and economic contexts for the specific populations in which the behaviours occur (Davis, Campbell, Hildon, Hobbs & Michie, 2015). Many psychological professionals have these competencies and yet few are employed in the public health sector and so are rarely involved in prevention work.

4.4.5 Insufficient integration: commissioning

“Managers and commissioners need to be involved”

Many areas in England have separate mental health and physical health budgets, with no or little clarity about where the funding sits for psychological professions in physical healthcare, and psychological professions not being involved in commissioning of acute healthcare (which must include psychological interventions). Unfortunately despite the evidence for the need and effectiveness of psychological professions in physical healthcare they are not the current focus of funding streams in physical health settings.

“People treat you like a lunatic, even if you come from a position of knowledge.”

“They need to be psychologically minded and understanding of the fact that these people understand their own conditions and are talking from a position of experience and knowledge”

The King’s Fund (2015) writes that clinical commissioning groups should prioritise integrating mental and physical health care more closely to improve quality and productivity in health care. Integration is of course the central tenet of Integrated Care Partnerships (ICPs). The partners collaborate, develop an understanding of the comprehensive needs of their population and take responsibility for a system ‘control total’ to manage funding for their population (Ham, 2018). However, the partners need to be supported to understand the role and benefits of psychological professions in physical healthcare if they are to be expected to commission this service.

“The key question must shift from “What’s the matter with you?” to “What matters to you?”

(Patient Voices Network, 2018)

This has resulted in gaps in staffing resources and therefore in the psychological care of patients in acute healthcare settings, despite some guidelines being available (see Box 8).

Box 8: An example of guidance in relation to psychological staffing resources in paediatric settings

District general hospital paediatric service per 20 beds (covering in-patients and out-patients):

- 0.2 WTE consultant child and adolescent psychiatrist
- 0.2 WTE CAMHS practitioner/nurse
- 1.0 WTE paediatric psychologist/psychotherapist.

(Royal College of Psychiatrists, 2013)

4.5 Expert by experience (service user, carer and family) involvement

4.5.1 Expert by experience: involvement in care planning and self-management

The self-management model can provide an effective intervention to help people live life well with a long-term health condition, use health services appropriately, and improve their health outcomes (Coulter, 2006; Rijken et al., 2008). It necessitates the person with the LTC to be an active partner in setting meaningful goals for treatment, plan methods to work towards those goals and work in collaboration with health care professionals (King's Fund, 2013). This increases engagement and the likelihood of a successful outcome (NHS England, 2018), and decreases cost. Hibbard, Greene and Overton (2013) suggest that when people are not actively engaged in managing their own health, their healthcare costs are 8 percent higher in the first year and 21 percent higher in the first half of the second year when compared with those who are highly motivated to manage their health. However, caution should be exercised to ensure the responsibility does not lie solely with the individual to the detriment of those who struggle to engage with their own healthcare.

Although there has been a shift, patient involvement in the planning of their care in an acute physical health setting is certainly not the norm, and people wanting to be involved can potentially be viewed as a threat and be labelled as, for example, "controlling" or "interfering".

Implementing the self-management model requires health care professionals to abandon traditional ways of thinking and behaving, where they see themselves as the primary decision-makers with the expertise, and instead shift to a partnership model in which people play an active part in determining their own care and support needs. The psychological professions have been using this partnership model for many years in the context of physical health problems and are well positioned to support a multi-disciplinary team to work this way.

4.5.2 Expert by experience: involvement in service development and improvement

Embracing involvement and 'co-production' where experts by experience and HCPs work together on service development and/or improvement from design and delivery through to evaluation has been employed to some extent in mental health services, but has yet to take a significant hold in physical healthcare.

Healthcare must increase its recognition that experts by experience often have many years of experience navigating healthcare systems and living with physical health conditions, and have a lot to contribute in the areas of service development and improvement.

Best Practice: partnerships between healthcare providers, experts by experience and relatives.

The Community Head Injury Service (CHIS), Buckinghamshire Healthcare NHS Trust

People with brain injury and their relatives play a vital role in providing the Community Head Injury Service with three clients and two relatives on the service's Steering Group. This embeds both client and family perspectives in the service (e.g. in the annual review and feedback exercise; in setting/evaluating objectives; in reviewing new developments; in wording of standard letters and leaflets; in reviewing any complaints; in contributing to specific policies and in commenting on proposed involvement in research). CHIS include client and family representation on project steering groups and routinely seek feedback on individual and group interventions. They also include clients as volunteers in some individual and group interventions. In essence, they view the clients and relatives as partners in their service development and delivery, who make an enormous and invaluable contribution and help the service to be client/family-centred.

4.5.3 The 'social' aspect of the biopsychosocial model

When embedding the biopsychosocial model in physical healthcare, the 'bio' and 'psycho' elements tend to take precedence and the 'social' aspect can remain unaddressed in the background. It is estimated that people with long-term conditions (LTCs) spend just 1 percent of their time in contact with health care providers (HCPs). The remaining 99 percent of their time is spent in their own social environment. The House of Care model states that it is therefore important that we 'shift away from the medical model of illness towards a model of care that takes into account the expertise and resources of the people with LTCs and their communities' (NHS England, no date). We need to increase our focus on the social element of the biopsychosocial model.

"There is a loss of social connection. People forget that there is a cost of family disintegration. The cost is huge to the state".

"Social connections are ignored. People with long-term conditions need help about what to do when faced with a limiting factor and how to maintain their connections and therefore maintaining their quality of life".

There is an association between long-term physical health conditions and the person's social environment. Relationships can suffer, friendships can be lost, and the mental health of those close to them can deteriorate. Conversely, there is evidence to suggest that social support is associated with improved self-management, fewer hospital admissions, and better health-related quality of life (Lett et al., 2005; Luttik et al., 2005; Nicklett et al., 2013). This is particularly pertinent when considering that there are 6.5 million carers in the UK who provide care worth an estimated £119 billion each year and whose psychological health can be affected by caring for someone with a LTC. For example, parents/carers are more likely to experience a mental health difficulty if they are caring for a child with a long-term health condition. Young carers, individuals aged under 18 who have caring responsibilities, are also more likely than their peers to report a mental health condition.

If we fail to support the carers and communities there will be a cost in terms of the health of people with long term conditions and a monetary cost to the health and social care systems.

"We need to be equipping the community to support the person; we need to address the people around the person. This might increase couples work, family work."

There are also social determinants of health, which include access to economic stability, housing, education, food and support systems. A healthy standard of living is associated with benefits for both physical and mental health and the lower someone's socioeconomic position, the worse their health is likely to be (Marmot et al., 2010). By neglecting to take into consideration these social impacts on health, we miss a key contributor to health and wellbeing.

Integrated care models need to consider the resources in the patient's community and help bolster this essential support for people with health conditions. The concept of Community Conversations is being used in many areas of England with some focusing on bringing together and engaging local stakeholders to help improve the health and care of the local community. Stakeholders include people who live in the community, GPs and other health professionals, social care, local government and the voluntary sector. The psychological professions have the competencies to work with communities in ways that will:

- Support significant others to support the person with the long-term condition
- Address the mental health needs of the carers
- Work with social care and community resources to develop support for people with long-term conditions.

4.6 NHS and social care policies

“When people have accessed mental health services, they often experienced inadequate care not tailored to their needs as a person with Parkinson’s. Under-resourcing of mental health care, combined with a move away from centralised specialist care to community services focused on recovery, has led to specialists such as neuropsychologists and neuropsychiatrists being few and far between. This has left many people with Parkinson’s accessing generic Improved Access to Psychological Therapies (IAPT) not tailored to their needs.

(APPG on Parkinson’s, 2018)

Recent policy addresses the requirement to meet the changing landscape in the population’s health and social care needs (Monitor, 2015), and recognises that people with existing mental health problems do not receive adequate physical healthcare care. Through the IAPT-LTC programme it also addresses the need for evidence-based psychological therapy for people with anxiety and depression in the context of a long-term physical health condition. This development is excellent news for adults with anxiety or depression. However it does not directly address the needs of adults and children with long-term conditions (LTCs) in acute healthcare settings who may benefit from Tier 4 (specialist) level psychological interventions from psychological professions co-located and embedded in the multi-disciplinary team.

The IAPT-LTC services are often not integrated meaningfully with psychological services in acute physical healthcare settings that have existed for many years. This appears to have resulted in the following challenges:

- In some locations there is a sense of competition between psychological professions in physical health care settings and those in IAPT-LTC settings. This can result in both services working in parallel with insufficient communication. It also risks duplication of services and the absence of a pathway with a stepped care model that includes both services.

- The IAPT-LTC key performance indicators (KPI) reporting data does not capture any of the indirect/consultation work that is done so successfully by psychological professions in physical healthcare services. The focus therefore inevitably remains only on the face to face interventions with patients, which although important neglects the competencies held by psychological professions that have been shown to improve team working and patient care. More effective physical health care could be achieved through a greater integration of IAPT-LTC services and broader psychological input to multi-disciplinary physical healthcare teams, recognising the strengths of each component.

4.7 Psychological professions representation in physical healthcare

4.7.1 Policy making

There is a deficiency of psychological professionals involved at the level of national policy making and training in relation to physical health. Arguably this is one of main reasons why the model of psychological professions in physical health care is slow to expand despite the significant evidence base. NHS Education for Scotland has a Psychology Directorate with the role of developing 'a programme of work aimed at addressing the training needs of the NHS Scotland workforce in relation to psychological interventions in physical health care' (NHS Education for Scotland, no date).

Their website has a dedicated section for psychological interventions and physical health that includes a Trainer Network, e-learning modules and The Matrix (2015), which outlines the evidence for psychological interventions in physical healthcare. In contrast, the Health Education England focus on psychological professions is purely located with mental health, so the focus is on IAPT Services rather than physical health settings. Physical health policy and outcomes would be improved if clinical advice from psychological professions was the norm.

4.7.2 National voice for psychological professions in physical healthcare

Embedding psychological professions in physical health services tends to develop opportunistically in response to factors such as available finances and the support of the incumbent teams and service managers. This is unsurprising given the lack of a nationwide strategy for the integration of psychological professions in physical health care and the historic absence of a coherent voice for psychological professions in physical healthcare. In contrast, the nursing profession is represented by the Nursing and Midwifery Council (NMC) and the medical profession has the British Medical Association (BMA) and the Medical Royal Colleges as active bodies.

Having a strong national voice into physical healthcare, for example via the Psychological Professions Networks (PPNs), would enable the development of a nationwide strategy, would reduce

inconsistencies across the UK, and create robust and specific guidance for the inclusion of psychological professions in clinical services. For example, the NICE guideline NG71 (2017) for Parkinson's disease in adults only refers the reader to generic NICE guidelines for anxiety and depression in chronic long-term health conditions whereas this population, and many other long-term health conditions, require interventions that are tailored to and have an evidence base for the specific health problem.

The recognition and application of psychological professions in physical healthcare could be improved significantly through ongoing national and regional psychological professions leadership located within the Arm's Length Bodies.

4.7.3 Representation at local level

Many acute/secondary and community physical healthcare trusts do not have a strategy for mental health and many existing strategies in these organisations do not integrate psychological healthcare into their physical healthcare strategy. There are examples of practitioners without mental health training leading on mental health in an acute healthcare trust, with no input from the psychological professions working in the same Trust.

These oversights result in the perpetuation of a dualistic model of physical healthcare where medical interventions and psychiatry can be seen as the only options for patients in this context.

5: Recommendations

“Psychological healthcare enables better living with chronic health and without this it would be impossible”.

Our primary recommendation is for physical healthcare provision to have psychological professions co-located and embedded in multidisciplinary teams and working in an integrated stepped care model with primary care, IAPT and mental health services and with social care. This will enable people to receive the right integrated care at the right time and in the right place. For this to happen, the challenges outlined in this document must be addressed. We make the following recommendations:

1. National representation of the psychological professions

If many of the recommendations in this document are to be adopted successfully, the psychological professions need ongoing national leadership, located within the Arm's Length Bodies. This will enable the development of a national strategy for psychological professions working in physical healthcare, thus providing support for the development of the professions in this context and increasing the equity of psychological service provision across the country.

2. Local representation of the psychological professions

All physical healthcare trusts should have a Chief Psychological Professions Officer (CPPO) who is the lead of the psychological practice and services in the trust and who possesses both clinical and leadership skills. They need a voice at Board level in the Trust. This may be via a seat on the Board or by working closely with/being managed by a Board member.

Every physical healthcare trust needs a psychological health strategy developed by the lead psychological professional. The strategy must be disseminated to all stakeholders and the CPPO and their team be given the support and time in their job plans to carry out this work.

3. Competencies

The development of a matrix to indicate the competencies of each psychological profession in the context of physical healthcare will support teams and managers to understand these and their benefits. Some of these will be core competencies across the professions and some will be specific to one profession.

Part of the work on competencies would involve the psychological professions working in physical health care and IAPT leaders working together to evolve a shared agenda that evidences the value of both psychological therapy and the indirect or consultative work outlined in Box 6 above, and acknowledges shared core and specialist skill sets across the psychological professions in both services (physical healthcare and IAPT-LTC).

This work on competencies would need to be published.

4. Training

All non-psychological professions, clinicians and non-clinicians, require training at a level commensurate with their role, with the aim being to understand the integration of physical and psychological health, at both pre-qualification and post-qualification level. The King's Fund (2016) stresses that this does not mean that professionals need to be expected to know everything. It does however mean that professionals need a basic understanding of mental and physical health, skills in exploring with the person what the difficulties are, and an understanding of and being able to refer to appropriate services. The objectives of this training, which the psychological professions can design / deliver should include:

- Understand and apply the biopsychosocial model, at a level applicable to their role, in the context of physical healthcare.
- Know the basic research evidence that demonstrates the effectiveness of providing integrated physical and psychological interventions in physical healthcare in relation to physical, psychological and social care outcomes and the benefits to the healthcare economy.
- Understand the role of psychological professions in physical healthcare, and to understand that this role is an essential part of physical healthcare, rather than a 'nice to have' or 'bolt on' intervention, which are phrases often heard in the workplace.
- Increase awareness of the importance of effective communication with patients and with teams, and to develop skills in this area.

Decisions and actions also need to be taken regarding the training required for psychological professions. Pre-qualification training focusing on working in physical healthcare settings already happens for some psychological professions, but consideration should be given to making this compulsory and consistent across all the psychological professions in all training organisations. There is also an argument for post qualification training for psychological professions in specific physical health conditions. The breadth and depth needs to be decided upon.

Training in psychological models for physical health conditions is needed for psychological professionals who do not work in a physical health setting (i.e. work in mental health or learning disabilities) but who will inevitably see people who have physical health problems. Consideration should be given to developing the IAPT-LTC training further to include a more in-depth training and some experience with a physical healthcare team.

5. Integration

a. Within organisations

In addition to the recommendations in this document regarding a lead psychological professional in every physical healthcare organisation and a national training strategy, the Boards of every physical healthcare organisation need to understand the benefits of an organisation having an integrated biopsychosocial approach. They need to provide explicit support for a psychological strategy, led by the psychological professions, that increases the integration of physical and psychological care in a physical healthcare organisation.

b. Across organisations

Successful integrated care requires all clinicians, managers and executives across health and social care and the voluntary sector to work together to meet the needs of their population. Leaders must invest time in building collaborative relationships and move away from the sense of competition which was encouraged in previous versions of the NHS and which created barriers between organisations.

6. Prevention

To be able to harness the knowledge and skills of the psychological professions working in physical healthcare and to optimise prevention work there needs to be more collaboration between Public Health and physical healthcare organisations. This would enable the development and implementation of a strategy in prevention work across both organisations.

7. Commissioning

It could be argued that the advent of ICPs and joint or integrated commissioning will increase the chances of the psychological professions being commissioned to work in physical healthcare. However, many commissioners need support and information to understand the roles and benefits of psychological professions in physical healthcare in order to commission this service. The psychological professions are well positioned to provide this, but the organisation in which they work must support this. Service users and carers should also be represented on commissioning boards.

8. Expert by experience (service user, carer and family) involvement

The shift in culture away from the patient being the recipient of physical healthcare decided on by the medical teams has started but is far from complete. Many clinicians exclaim how different it is being “on the other side” when they receive healthcare and, yet, this experience rarely leads to the behaviour change of involving experts by experience whether they are past or current service users despite them having a vast amount of knowledge, insight and experience that could help improve many aspects of healthcare. Most psychological professions are trained to view their work as being a partnership between them and the patient/client, and the carer or family when appropriate. As a result they have the knowledge, experience and values that mean they are professions that can contribute to the required cultural change. In addition, there is a long history of service user activism in mental health and psychology, with organisations such as the National Survivor User Network (NSUN) existing since the early 2000s. Drawing on this historic knowledge will be key for services to develop effective engagement strategies.

6: Conclusion

The work of psychological professions in physical healthcare results in improved mental and physical health and reduced healthcare costs. There needs to be greater support for the psychological professions to fulfil their potential at a national, regional and local level than is currently provided if people with physical health conditions and the health and social care economies are to gain the optimum benefit from the skills of these professions. The key elements to improvement focus on 'integration' whether this is at the level of knowledge, clinical practice, within and between organisations or commissioning. This cultural change of integration has already begun across the organisations involved in health and social care. However, the voice of the psychological professions working in physical healthcare must be stronger if they are to maximise their impact for the benefit of people with physical health conditions.



7: Bibliography

- Aarsland, D. et al., (2012). Depression in Parkinson's disease – epidemiology, mechanisms and management. *Nature Reviews Neurology*. 8: 35–47.
- Abell, F., Potter, C., Purcell, S., Broomfield, H., Griffin, M., Restrict, L., and Stern, M. (2008). The effect of including a clinical psychologist in pulmonary rehabilitation on completion rates and hospital resource utilisation in chronic obstructive pulmonary disease. *British Thoracic Society Winter Meeting*. 63(Suppl. VII, P47).
- Alam, R., Sturt, J., Lall, R., and Winkley, K. An updated meta-analysis to assess the effectiveness of psychological interventions delivered by psychological specialists and generalist clinicians on glycaemic control and on psychological status. *Patient Education and Counselling*. 75(1):25-36.
- All Parliamentary Action Group for Parkinson's (2018). Mental health matters too. Improving mental health services for people with Parkinson's who experience anxiety and depression. (<https://www.parkinsons.org.uk/sites/default/files/2018-05/APPG%20on%20Parkinson%27s%20mental%20health%20report%20-%20May%202018.pdf>)
- Alzheimer's Society (2016). Fix Dementia Care: Hospitals. (https://www.alzheimers.org.uk/sites/default/files/migrate/downloads/fix_dementia_care_-_hospitals.pdf)
- Baird & Bell, 2019. Primary care networks and mental health (<https://www.kingsfund.org.uk/blog/2019/07/primary-care-networks-mental-health>)
- Barnett, K., Mercer, S. W., Norbury, M., Watt, G., Wyke, S., and Guthrie, B. (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: A cross-sectional study. *The Lancet*. 380 (9836), 37-43.
- Barth, J., Schumacher, M., and Herrmann-Lingen, C. (2004). Depression as a risk factor for mortality in patients with coronary heart disease: A meta-analysis. *Psychosomatic Medicine*. 66(6), 802-813.
- Bermingham, S. L, Cohen, A., Hague, J. and Parsonage, M. (2010). The cost of somatisation among the working age population in England for the year 2008-2009. *Mental Health in Family Medicine*. 7(2):71-84.
- Blount, A., Schoenbaum, M., Kathol, R., Rollman, B., Thomas, M., and O'Donohue, W. (2007). A Summary of the Evidence Professional Psychology. *Research and Practice*. Vol. 38, No. 3, 290–297.
- Blumenthal, J. A., Lett, H. S., Babyak, M. A., White, W., Smith, P. K., Mark, D. B., (2003). Depression as a risk factor for mortality after coronary artery bypass surgery. *The Lancet*. 362(9384), 604- 609.
- Bodenheimer, T., Wagner, E.H., Grumbach, K. (2002). Improving Primary Care for Patients With Chronic Illness. *JAMA*.288:1775-1779.
- Broen, M. P. G. et al., (2016). Prevalence of anxiety in Parkinson's disease: a systematic review and meta analysis. *Movement Disorders*. 31: 1125–1133.
- Burton, C., McGorm, K., Richardson, G., Weller, D., & Sharpe, M. (2012). Healthcare costs incurred by patients repeatedly referred to secondary medical care with medically unexplained symptoms: A cost of illness study. *Journal of Psychosomatic Research*. 72(3), 242-247.
- Camber (2016). I'm an individual – not just a patient in the system. *The King's Fund Insight Magazine*. Summer issue. (<https://www.kingsfund.org.uk/publications/articles/individual-not-patient>)
- Ciechanowski, P. S., Katon, W. T., & Russo, J. E. (2000). Depression and diabetes: Impact of depressive symptoms on adherence, function and costs. *Archives of Internal Medicine*. 160(21), 3278-3285.
- McCrone, P., Sharpe, M., Chalder, T., Knapp, M., Johnson, A., Goldsmith, K., & White, P. (2012). Adaptive pacing, cognitive behaviour therapy, graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis. *PLoS One*. 2012; 7(8): e40808.
- Confederation NHS (2009). Healthy mind, healthy body: How liaison psychiatry services can transform quality and productivity in acute settings. www.nhsconfed.org/Publications.
- Coulter, A., Roberts, S., and Dixon, A. (2013). Delivering better services for people with long-term conditions. London: The King's Fund, 2013.

- Das-Munshi, J., Stewart, R., Ismail, K., Bebbington, P. E., Jenkins, R., and Prince, M. J. (2007). Diabetes, common mental disorders, and disability: Findings from the UK national psychiatric morbidity survey. *Psychosomatic Medicine*. 69(6), 543-550.
- Darnall, B.D., Scheman, J., Davin, S., Burns, J.W., Murphy, J.L., Wilson, A.C., Kerns, R.D., Mackey, S.C., Pain Psychology: A Global Needs Assessment and National Call to Action. *Pain Medicine*, Volume 17, Issue 2, February 2016, Pages 250-263.
- Davis, R., Campbell, R., Hildon, Z., Hobbs, L., and Michie, S (2015) Theories of behaviour and behaviour change across the social and behavioural sciences: a scoping review. *Health Psychology Review*. 9:3, 323-344
- Department of Health/NHS England (2015). Promoting, protecting and improving our children and young people's mental health and wellbeing.
- Diabetes NHS, Diabetes UK. Emotional and psychological care and treatment in diabetes. London: NHS Diabetes and Diabetes UK, 2010.
- Engel, G. (1977, April 8). The need for a new medical model: A challenge for biomedicine. *Science*, 196, 129–136.
- Finlay et al. (2011). Guiding patients through complexity: modern medical generalism. Report of an independent commission for the Royal College of General Practitioners and the Health Foundation.
- Follette, W. T., and Cummings, N. A. (1967). Psychiatric services and medical utilization in a prepaid health plan setting. *Medical Care*. 5, 25-35.
- Furness, P., Glazebrook, C., Tay, J., Abbas, K. and Slaveska-Hollis, K. (2009). Medically Unexplained Physical Symptoms in Children: Exploring Hospital Staff Perceptions. *Clinical Child Psychology and Psychiatry*, 14(4), 575–87.
- Göhler, A., Januzzi, J., L, Worrell SS, Osterziel KJ, Gazelle GS, Dietz R, Siebert U. A systematic meta-analysis of the efficacy and heterogeneity of disease management programs in congestive heart failure (2006). *J Card Fail*. 12(7):554-67.
- Hibbard, J.H., Greene, J., and Overton, V. (2013). Patients with lower activation associated with higher costs; delivery systems should know their patients' 'scores'. *Health Aff (Millwood)*. 32(2):216-22.
- Himelhoch, S., Lehman, A., Kreyenbuhl, J., Daumit, G., Brown, C., and Dixon, L. (2004). Prevalence of chronic obstructive pulmonary disease among those with serious mental illness. *American Journal of Psychiatry*. 161(12), 2317-2319.
- Hochlehnert, A., Niehoff, D., Wild, B., Junger, J., Herzog, W. and Lowe, B. (2011). Psychiatric comorbidity in cardiovascular inpatients: Costs, net gain, and length of hospitalization. *Journal of Psychosomatic Research*. 70(2), 135-139.
- Holman, H. and Lorig, K. (2000). Patients as partners in managing chronic disease: partnership is a prerequisite for effective and efficient health care. *BMJ*. 26; 320(7234): 526–527.
- Howard, C., Dupont, S., Haselden, B., Lynch, J., and Wills, P. (2010). The effectiveness of a group cognitive-behavioural breathlessness intervention on health status, mood and hospital admissions in elderly patients with chronic obstructive pulmonary disease. *Psychology, Health and Medicine*. 15(4), 371-385.
- Fenton, W. S., & Stover, E. S. (2006). Mood disorders: Cardiovascular and diabetes comorbidity. *Current Opinion in Psychiatry*. 19(4), 421-427.
- Gilmer, T. P., O'Connor, P. J., Rush, W. A., Crain, A. L., Whitebird, R. R., Hanson, A. M. and Solberg, L. I. (2005). Predictors of health care cost in adults with diabetes. *Diabetes Care*. 28(1), 59-64.
- Ghose, S.S., Williams, L.S. and Swindle, R.W. (2005). Depression and other mental health diagnoses after stroke increase inpatient and outpatient medical utilization three years poststroke. *Medical care*. 1259-1264.
- Goodwin, R.D. and Devanand, D.P. (2008). Stroke, depression, and functional health outcomes among adults in the community. *Journal of geriatric psychiatry and neurology*, 21(1), pp.41-46.

- Goodwin RD, Robinson M, Sly PD, McKeague IW, Susser ES, Zubrick SR, et al. (2013). Severity and persistence of asthma and mental health: a birth cohort study. *Psychol Med.* 43:1313–22.
- Ismail, K., Winkley, K., and Rabe-Hesketh, S. (2004). Systematic review and meta-analysis of randomised controlled trials of psychological interventions to improve glycaemic control in patients with type 2 diabetes. *The Lancet.* 363:1589-97.
- Jefford, M., Ward, A.C., Lisy, K., Lacey, K., Emery, J.D., Glaser, A.W., Cross, H., Krishnasamy, M., McLachlan, S.A. and Bishop, J., 2017. Patient-reported outcomes in cancer survivors: a population-wide cross-sectional study. *Supportive Care in Cancer*, 25(10), pp.3171-3179.
- Jiang, W., Alexander, J., Christopher, E., Kuchibhatla, M., Gaulden, L. H., Cuffe, M. S. and O'Connor, C. M. (2001). Relationship of depression to increased risk of mortality and rehospitalization in patients with congestive heart failure. *Archives of Internal Medicine.* 161(15), 1849-1856.
- Junger, J., Schellberg, D., Muller_Tasch, T., Raupp, G., Zuqck, C., Haunstetter, A. and Haass, M. (2005). Depression increasingly predicts mortality in the course of congestive heart failure. *European Journal of Heart Failure.* 7(2), 261-267.
- Katon, W. J., Von Korff, M., Lin, E. H., Simon, G., Ludman, E., Russo, J. and Bush, T. (2004). The pathways study: A randomized trial of collaborative care in patients with diabetes and depression. *Archives of General Psychiatry.* 61(10), 1042-1049.
- Kennedy, I. (2010). Getting it right for children and young people. Overcoming cultural barriers in the NHS so as to meet their needs.
- The King's Fund (2016). Bringing together physical and mental health: A new frontier for integrated care. (<https://www.kingsfund.org.uk/publications/physical-and-mental-health/priorities-for-integrating>.)
- Kovacs, M., Mukerji, P., A Drash, A. and Iyengar, S. (1995). Biomedical and psychiatric risk factors for retinopathy among children with IDDM. *Diabetes care.* 18(12):1592-9.
- Krein, S. L., Bingham, C. R., McCarthy, J. F., Mitchinson, A., Payes, J., and Valenstein, M. (2006). Diabetes treatment among VA patients with comorbid serious mental illness. *Psychiatric Services.* 57(7), 1016-1021.
- Kvamme, O.J., Olesen, F. and Samuelsson, M., 2001. Improving the interface between primary and secondary care: a statement from the European Working Party on Quality in Family Practice (EQuiP). *BMJ Quality & Safety.* 10(1), pp.33-39.
- Laurin, C., Labrecque, M., Dupuis, G., Bacon, S. L., Cartier, A. and Lavoie, K. L. (2009). Chronic obstructive pulmonary disease patient with psychiatric disorders are at greater risk of exacerbations. *Psychosomatic Medicine.* 71(6), 667-674.
- Lesperance, F., Frasure-Smith, N., Talajic, M., and Bourassa, M. G. (2002). Five-year risk of cardiac mortality in relation to initial severity and one-year changes in depression symptoms after myocardial infarction. *Circulation.* 105(9), 1049-1053.
- Livermore, N., Sharpe, L., & McKenzie, D. (2010). Panic attacks and panic disorder in chronic obstructive pulmonary disease: A cognitive behavioural perspective. *Respiratory Medicine.* 104(9), 1246-1253.
- Lu, Y., Mak, K. K., van Bever, H.P., Ng, T.P., Mak, A. and Ho, R.C. (2012). Prevalence of anxiety and depressive symptoms in adolescents with asthma: a meta-analysis and meta-regression. *Pediatr Allergy Immunol.* 23:707-715.
- Marks, E.M. & Hunter, M. (2015). Medically unexplained symptoms: an acceptable term? *British Journal of Pain*, 9(2): 109–114.
- Marmot, M., Goldblatt, P., Allen, J. et al. (2010). *Fair Society Healthy Lives (The Marmot Review)*. Institute of Health Equity
- Mercer, S. W., and Watt, G. C. M. (2007). The inverse care law: Clinical primary encounters in deprived and affluent areas of Scotland. *Annals of Family Medicine.* 5(6), 503-510.

- McGillion, M., Watt-Watson, J., Stevens, B., et al. (2008). Randomized controlled trial of a psychoeducation program for the self-management of chronic cardiac pain. *J Pain Symptom Manage.* 36:126–40.
- Monitor (2015). Closing the Gap: Priorities for Essential Change in Mental Health. (https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/281250/Closing_the_gap_V2_-_17_Feb_2014.pdf)
- Moore, R. K., Groves, D. G., Bridson, J. D., Grayson, A. D., Wong, H., Leach, A., and Chester, M. R. (2007). A brief cognitive-behavioural intervention reduces hospital admissions in refractory angina patients. *Journal of Pain and Symptom Management.* 33(3), 310-316.
- Moussavi, S., Chatterji, S., Verdes, E., Tandon, A., Patel, V. and Ustun, B. (2007). Depression, chronic diseases, and decrements in health: Results from the world health surveys. *Lancet.* 370(9590), 851-858.
- National Collaborating Centre for Mental Health. The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical Health Conditions and Medically Unexplained Symptoms. Full implementation guidance. London: National Collaborating Centre for Mental Health. 2018.
- National Collaborating Centre for Mental Health. The Improving Access to Psychological Therapies Manual (2019).
- National Institute for Health and Care Excellence (2009). Depression in adults with a chronic physical health problem: Treatment and management. (Nice Guideline CG91).
- National Institute for Health and Care Excellence (2017). Parkinson's disease in adults. (NICE guideline NG71).
- Naylor, C., Parsonage, M., McDaid, D., Knapp, M., Fossey, M., and Galea, A. (2012). Long-term conditions and mental health: The cost of co-morbidities. London: The King's Fund and Centre for Mental Health.
- NCEPOD (2019). Mental Healthcare in Young People and Young Adults. (<https://www.ncepod.org.uk/2019ypmh.html>)
- NHS Education for Scotland (no date) Psychological Interventions and Physical Health (<https://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/psychological-interventions-and-physical-health.aspx>)
- NHS England (2014). Five Year Forward View. London: NHS England
- NHS England (no date). House of Care: A framework for long term condition care (<https://www.england.nhs.uk/ourwork/clinical-policy/ltc/house-of-care>)
- Orgeta, V., Qazi, A., Spector, A.E. and Orrell, M., 2014. Psychological treatments for depression and anxiety in dementia and mild cognitive impairment. *Cochrane Database of Systematic Reviews*, (1).
- Parry-Langdon N. (ed) (2008). Three years on: survey of the development and emotional wellbeing of children and young people. Office for National Statistics.
- Piette, J.D., Richardson, C. and Valenstein, M. (2004). Addressing the needs of patients with multiple chronic illnesses: the case of diabetes and depression. *Am J Manag Care.* 10 (2 Pt 2):152-62.
- Point of Care Foundation (no date), (<https://www.pointofcarefoundation.org.uk/our-work/schwartz-rounds/about-schwartz-rounds>)
- Reijnders, J.S., Ehrt, U., Weber, W.E., Aarsland, D. and Leentjens, A.F., 2008. A systematic review of prevalence studies of depression in Parkinson's disease. *Movement Disorders*, 23(2), pp.183-189.
- Reulbach, U., O'Dowd, T., McCrory, T. and Layte, R. (2010). Chronic illness and emotional and behavioural strengths and difficulties in Irish Children. *Journal of Epidemiology & Community Health.* 64(Suppl 1).
- Rijken, M., Jones, M. and Heijmans, M. (2008) Supporting self-management. In *Caring for People with Chronic Conditions: A Health System Perspective.* edited by Ellen Nolte, Martin McKee
- de Ridder, D., Geenen R., Kuijer, R. and van Middendorp, H. (2008). Psychological adjustment to chronic disease. *Lancet.* 372: 246–55.

Roccaforte, R., Demers, C., Baldassarre, F., Teo, K.K. and Yusuf, S. (2005). Effectiveness of comprehensive disease management programmes in improving clinical outcomes in heart failure patients. A meta-analysis. *Eur J Heart Fail.* 7(7):1133-44.

Royal College of Psychiatrists (2013). Building and sustaining specialist CAMHS to improve outcomes for children and young people (https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr182.pdf?sfvrsn=8662b58f_2)

Royal Voluntary Service (2013). Avoiding unhappy returns: radical reductions in readmissions, achieved with volunteers. Cardiff: Royal Voluntary Service. (www.royalvoluntaryservice.org.uk)

Sale, J. E., Gignac, M., & Hawker, G. (2008). The relationship between disease symptoms, life events, coping and treatment, and depression among older adults with osteoarthritis. *Journal of Rheumatology.* 35(2), 335- 342.

Scholten, A.C., Haagsma, J.A., Cnossen, M.C., Olff, M., Van Beeck, E.F. and Polinder, S., 2016. Prevalence of and risk factors for anxiety and depressive disorders after traumatic brain injury: a systematic review. *Journal of neurotrauma*, 33(22), pp.1969-1994.

Simon, G. E., Katon, W. J., Lin, E. H., Ludman, E., Von Korff, M., Ciechanowski, P., and Young, B. A. (2005). Diabetes complications and depression as predictors of health service costs. *General Hospital Psychiatry.* 27(5), 344- 351.

Simon, G. E., Katon, W. J., Lin, E. H., Rutter, C., Manning, W. G., Von Korff, M. and Young, B. A. (2007). Cost-effectiveness of systematic depression treatment among people with diabetes mellitus. *Archives of General Psychiatry.* 64(1), 65-72.

Spurgeon, P., Hicks, C., Barwell, F., Walton, I., and Spurgeon, T. (2005). Counselling in primary care: A study of the psychological impact and cost benefits for four chronic conditions. *European Journal of Psychotherapy and Counselling.* 7(4), 269-290.

Stroke Association (2012). Struggling to recover. (https://www.stroke.org.uk/sites/default/files/stroke_association_ni_struggling_to_recover_report_18.2.2019.pdf)

Suhrcke, M., Fahey, D.K., and McKee, M (2008). Caring for people with chronic Economic aspects of chronic disease and chronic disease management. In *Caring for People with Chronic Conditions: A Health System Perspective* edited by Ellen Nolte, Martin McKee. Open University Press.

Suls, J., & Rothman, A (2004). Evolution of the Biopsychosocial Model: Prospects and Challenges for Health Psychology. *Health Psychology* Vol. 23, No. 2, 119–125

The Psychological Professions Network (2018). Delivering the Expansion in the Psychological Professions. (<https://www.kss-ppn.nhs.uk/resources/ppn-kss-publications/2-ppn-brochure-june18-online-singlepages/file>)

The Richmond Group of Charities (2018). Destined to 'sink or swim together'. NHS, Social Care and Public Health. (https://richmondgroupofcharities.org.uk/sites/default/files/final_aw_5902_the_richmond_group_a4_10pp_report.pdf)

The Richmond Group of Charities (2015). Vital signs Taking the temperature of health and care services for people living with long term conditions. (https://richmondgroupofcharities.org.uk/sites/default/files/pdfs-richmond-group-vital-signs-report_0.pdf)

Theis, K., Helmick, C. G. and Hootman, J. M. (2007). Arthritis burden and impact are greater among U.S women than men: Intervention opportunities. *Journal of Women's Health.* 16(4), 441-453.

Thomas, M. R., Waxmonsky, J. A., McGinnis, G. F. and Barry, C. L. (2006). Realigning clinical and economic incentives to support depression management within a Medicaid population: The Colorado access experience. *Administration and Policy in Mental Health.* 33(1), 26-33.

Thompson, R. D., Delaney, P., Flores, I., and Szigethy, E. (2011). Cognitive-behavioural therapy for children with comorbid physical illness. *Child and Adolescent Psychiatric Clinics of North America.* 20(2), 329-349.

- Unutzer, J., Schoenbaum, M., Katon, W. J., Fan, M. Y., Pincus, H. A., Hogan, D. and Taylor, J. (2009). Healthcare costs associated with depression in medically ill fee-for-service Medicare participants. *Journal of the American Geriatrics Society*. 57(3), 506-510.
- Vamos, E. P., Mucsi, I., Keszei, A., Kopp, M. S., and Novak, M. (2009). Comorbid depression is associated with increased healthcare utilization and lost productivity in persons with diabetes: A large nationally representative Hungarian population survey. *Psychosomatic Medicine*. 71(5), 501-507.
- Van Cleave, J., Gortmaker, S.L. and Perrin, J.M. (2010). Dynamics of obesity and chronic health conditions among children and youth. *JAMA*. 303(7):623-30.
- Vuillermier, P.J., Brennan, C.L., Robertson, C.F., Carlin, J.B., Prior, M. and Jenner, B.M. (2010). Anxiety is more common in children with asthma. *Arch Dis Child*. 95:624-629.
- Walters, P., Schofield, P., Howard, L., Ashworth, M. and Tylee, A. (2011). The relationship between asthma and depression in primary care patients: A hospital cohort and nested case control study. *PLOS One*, 6(6).
- Weiser, E.B. (2007). The prevalence of anxiety disorders among adults with asthma: a meta- analytic review. *J Clin Psychol Med*. 14:297-307.
- Welch, C. A., Czerwinski, D., Ghimire, B., and Bertsimas, D. (2009). Depression and cost of health care. *Psychosomatics*. 50(4), 392-401.
- Whyte, E.M. and Mulsant, B.H., 2002. Post stroke depression: epidemiology, pathophysiology, and biological treatment. *Biological psychiatry*, 52(3), pp.253-264.
- Williams, A.C.D.C., Eccleston, C., Morley, S. (2012). Psychological therapies for the management of chronic pain (excluding headache) in adults. *Cochrane Database of Systematic Reviews* 2012, Issue 11. Art. No.: CD007407. DOI: 10.1002/14651858.CD007407.pub3.
- World Health Organization (2014). The case for investing in public health, World Health Organization. (http://www.euro.who.int/__data/assets/pdf_file/0009/278073/Case-Investing-Public-Health.pdf).
- Yellowlees, P. M., Alpers, J. H., Bowden, J. J., Bryant, G. D., and Ruffin, R. E. (1987). Psychiatric morbidity in patients with chronic airflow obstruction. *The Medical Journal of Australia*. 146(6), 305-307.
- Yeo, M. and Sawyer, S. (2005). Chronic illness and disability. *British Medical Journal*. 330: 721

