Original Article

Healthcare practitioners' perspective on how to best apply health psychology evidence in practice.

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Introduction

One of the key overarching aims of the health psychology discipline is to generate evidence that is implemented in clinical practice and effectively communicated to healthcare practitioners who can benefit from applying it in their day-to-day practice (Presseau et al., 2022). The EHPS Practical Health Psychology Blog provides short summaries and practical recommendations based on cutting edge health psychology research to inform health practitioners and intervention providers worldwide (www.practicalhealthpsychology.com). The National Editors translate and disseminate the posts to the practitioners in 30 languages across more than 50 countries.

In this article, following a Roundtable discussion at the European Health Psychology Society (EHPS) Conference 2022, four healthcare practitioners of various professions (applied health psychology, cardiology, and general practice) were invited from various countries (UK, Russia, Norway, and Australia) to discuss how to best apply health psychology evidence in practice. The main objective of our Roundtable was to give an overview how healthcare practitioners use health psychology evidence to inform their practice. Learning from their experience, new strategies for disseminating our science are generated to facilitate cross-disciplinary knowledge transfer.

In this article, the overall purpose was to outline diverse healthcare professionals' practices and the perceived deficits in knowledge, skills and opportunity among colleagues in their respective fields to facilitate the translation of health psychology research evidence into clinical practice. Each of the contributors discussed how their own discipline can best benefit from behavioural science, particularly focusing on the country where they practice; key points from the discussion are outlined below.

Perspective 1

Dr Ainslea Cross, the Lead Health Psychologist of the Health Psychology Cardiovascular Diseases Service in the UK talked about embedding health psychology research into practice within a multidisciplinary specialist hospital hypertension and lipids service. The aim of the service is to support patients with blood pressure control, optimizing quality of life and reducing future cardiovascular risk. The Behaviour Change Wheel (BCW) model was used to assess how health psychology research could be used to inform

practice (Michie et al., 2011). Clinical needs were assessed through case study review, multidisciplinary team discussions and clinical guideline review. Priority areas for implementing research into routine hypertension self-management care included supporting dietary changes, increasing physical activity, promoting medication adherence and regular blood pressure monitoring. Key intervention functions included environmental restructuring and training/education. This was implemented through designing a health behaviour change manual for hypertension self-management for use in patient consultations and the design of bespoke training.

Dr Cross concluded that the most fundamental change that we need to see in health psychology research, is to identify the practitioners and patients who will most benefit from health psychology research and to involve them at all stages of research projects, from idea generation, execution, to report and then the implementation stage. She further suggested that we need to create opportunities, processes and incentives that bring together scientists, patients and practitioners to co-create and develop research (Cross, 2022). This will help us to carry out research that will have the maximum benefit for clinical health populations, health care services, and raise the profile of health psychology research.

Perspective 2

Dr Evgeny Taratukhin who works as a cardiologist in a Medical Hospital in Russia, emphasized that it is important to note the conceptual nature of the meaning of evidence itself. For clinical medicine, evidence is biological, based on statistics, with almost no qualitative data. For psychology, evidence is grounded upon self-report by subjects, or behaviour observation, or interpretation. For biomedicine, there is no singularity, any patient is a representation of some overlapping averages. On the other hand, phenomenologically, every person is unique. That is why evidence cannot be applied to another person blindly.

An example of a patient, a 37-year-old male, was given, with suspected essential hypertension. Secondary hypertension was ruled out and quite severe raise of blood pressure up to 160/115 mmHg was seen for several years. The hypertension guidelines did not address "unhealthy" behaviour, and behaviour change interventions were not seen as potential solution. Yet, when his personal issues (professional identity and occupation) were solved, a normal blood pressure was reached without drug treatment or additional behaviour change. This suggests that cardiology would benefit from enhancing healthcare professionals communication skills and personalized health communication, and self-help skills for a patient to deal with daily life, i.e., more of partnership between the clinician and patient, than a paternalistic approach that medical professional is superior to the patient.

Dr Tarathukin reflected that clinicians prefer exact and strict outlines of the concepts they must deal with. The best way to approach practicing cardiologists is to provide them with schematic and algorithmic instructions that show actions – results – further actions – outcomes. The clinicians are trained to have a "normalizing eye" with the need to see clear distinction of what is normal and what is not, though for psychology it is probably not a straightforward task.

Perspective 3

Dr Torgeir Gilje Lid, a general practitioner (GP) and researcher at Center for Alcohol and Drug Research in Norway, talked about addressing alcohol in general practice, and a pilot study of a strategy to improve addressing alcohol in primary health care. Screening and brief interventions (SBI) for risky or harmful alcohol consumption are

effective, but not widely implemented in primary care. In a previous qualitative study exploring how and why primary care physicians address alcohol (Malterud & Lid, 2012), it was found that they did so mainly based on potential clinical relevance of alcohol for the patient's health problem, and sometimes as routine (e.g., health certificates). This is called *pragmatic case finding* (PCF) (Lid & Malterud, 2012).

Informed by the BCW and the Capabilities, Opportunities, Motivation - Behaviour (COM-B) Model (Michie et al., 2011), the clinical significance of PCF with stakeholders were explored, and whether it could be a foundation for strategies to improve practice. This involved: initial discussions with GPs and patients; four focus groups with 25 GPs, and a COM-B questionnaire with free text answers from 55 young GPs. The needs identified in this process were matched with intervention functions, in planning a four-session clinical seminar for GPs. The sessions were delivered in clinics, focusing on PCF, case examples, clinical evidence, and a toolbox of strategies (e-health intervention, motivational interviewing, medications, follow-up strategies, and collaborators). The sessions were run by an experienced GP, assisted by a motivational interviewing specialist, a patient and collaborators from primary and secondary care. The study demonstrated important improvements in GPs' self-reported capabilities, opportunities, and motivations to address alcohol when clinically relevant. Qualitative data indicated that GPs' perceived a shift in how they were addressing alcohol with their patients. Conversations had shifted from a prescriptive approach, focusing on addiction and alcohol as a taboo topic to a more normalized conversation in which GPs and patients could make shared decisions about how alcohol impacts on the patient's wider health.

Perspective 4

Dr Rita McMorrow, a General Practitioner and a PhD student at the Department of General Practice, University of Melbourne (Australia) who works part time as a GP in a clinic in Melbourne discussed her role of caring for people living with multiple medical conditions, including type 2 diabetes, and her research interests that align with her clinical work. Dr McMorrow discussed the design and implementation of a solution to support assessment of diabetes distress using the Problem Areas In Diabetes (PAID) scale in Australian general practice. Despite diabetes guidelines recommending routine assessment of diabetes distress, general practitioners and people with type 2 diabetes report infrequent assessment using the PAID scale (McMorrow et al, 2022a, 2022b).

Dr McMorrow presented findings from virtual workshops with Australian general practice healthcare professionals to design the key features and requirements of a digital tool to support the use of the PAID scale. The key features identified to support the implementation of the PAID scale included 1) awareness of the person with diabetes emotions, 2) flexibility within the tool, and 3) the narrative surrounding the tool. During the design sessions, a prototype digital tool, 'PROM-GP' was developed. The PROM-GP tool allows the person with diabetes to complete the PAID scale electronically, receive a summary of their PAID responses, and sends the PAID response to the general practice electronically using secure messaging. PROM-GP has recently been implemented in three Australian general practices. Dr McMorrow suggested health psychologists consider involving a general practitioner on a research team if research is based in general practice.

Summary

The four perspectives provided by the healthcare practitioners have common narratives. They all emphasize the need for cross-disciplinary collaboration and involving not only health psychologists in the clinical practice but also drawing upon talent and skills of practitioners from several disciplines. Knowledge co-creation is important and involving consumers, healthcare professionals, and health psychologists (as well as other practitioners) is crucial to provide complex and comprehensive care (Janamian, Crossland & Wells, 2016). In terms of evidence generation, we need to consider the nature of evidence. Psychological science is rigorous but it is often based on different principles of knowledge generation as compared to medical science. Health psychology often focuses on 'soft skills' (effective communication, empathy), and, in addition to quantitative outcomes, also builds on qualitative outcomes. To holistically understand the patient and condition that they have at the time or are living with, it is important to explore what are the other psycho-social factors that impact patients' lives or even predetermine the condition. Healthcare professionals can gain a lot of insights from psychological science but they need to work collaboratively gathering evidence, implementing, and evaluating useful knowledge and treatments. We see the *Practical Health Psychology Blog* as a developing platform where cross-disciplinary conversations and knowledge exchange happens to facilitate better translation of health psychology research into improved patient health.

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