The Role of Clinical Psychology within an Acute Hospital Setting

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- Medicine and Surgery Speciality (1.6 wte)
- Neuropsychology (2.4 wte)
- Paediatric and Adult Burns (1.5 wte)
- Paediatric Diabetes (0.5 wte)
- Spinal (1.5 wte)
- Occupational Health (0.5 wte)
- Pain Management Service (0.5 wte)
- Complex Eating and Weight Management Service (0.5)
- Bariatric Service (0.5 wte)
- Oncology and Palliative Care (2.7 wte)
- Pain Management Service (0.5 wte)

NB: Similar services at Leeds and Bradford (and to a lesser extent Harrogate)

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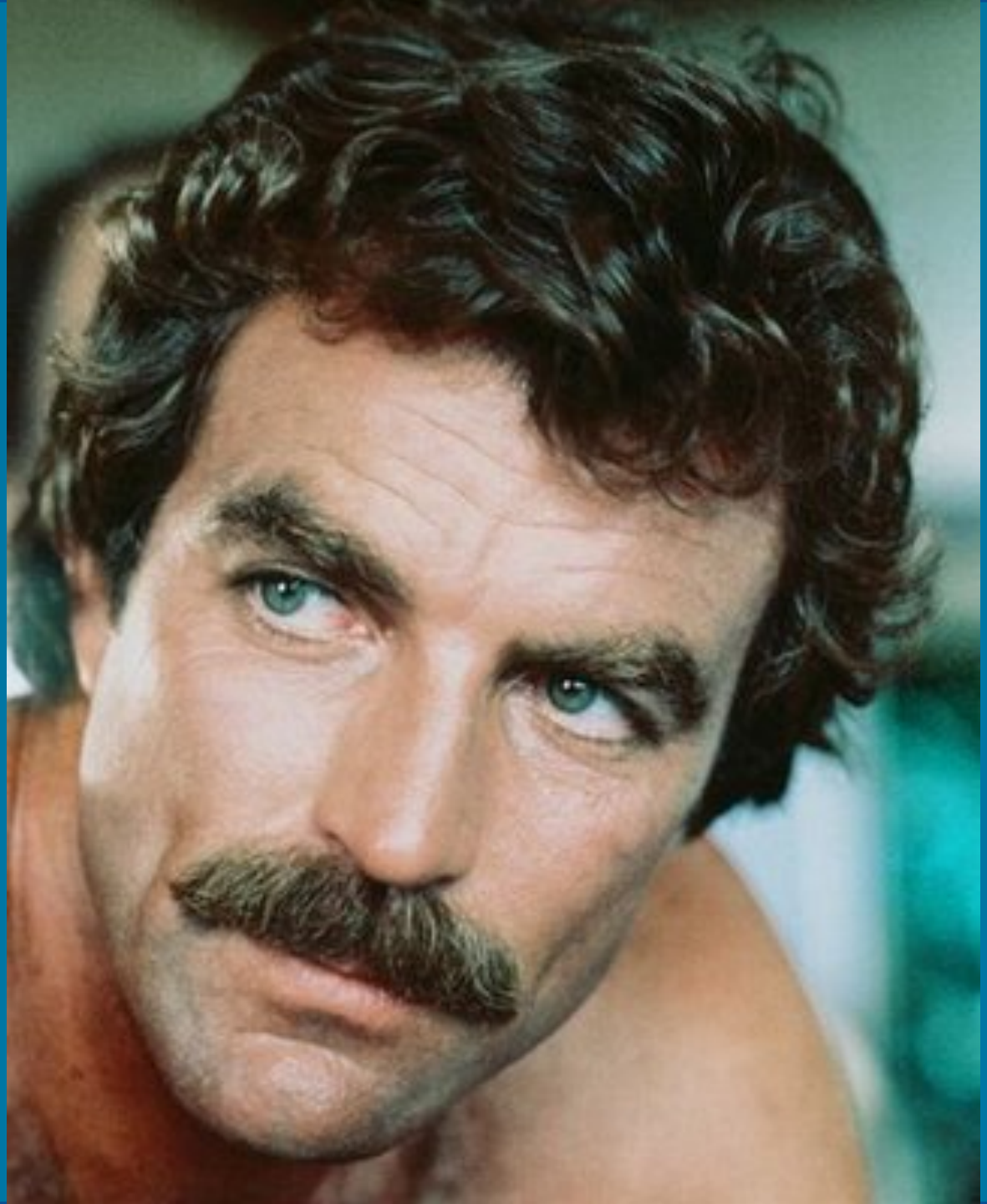
Medicine and Surgery Speciality (M&S)

- Dermatology
- Cardiology
- Diabetes
- Respiratory
- Rheumatology

Input into all other services that do not impinge on the aforementioned specialities (see Slide 2). Therefore referrals accepted from:

- ENT
- Urology
- Orthognathic Surgery etc. etc.



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Is there a need for Clinical Psychology within an Acute Hospital Setting?

- Direct in-patient and out-patient contact (i.e. assessment and treatment)
- Clinical supervision
- Consultation (e.g. within an MDT setting: Trust level)
- Research
- Teaching (i.e. Cardiac Rehabilitation Programme: Pulmonary Rehabilitation Programme)
- Schwarz rounds
- Psychological support as part of Occupational Health Department
- Reduction in pharmacotherapy
- Reduction in utilisation of medical resources (e.g. A+E admissions)
- Mortgage!

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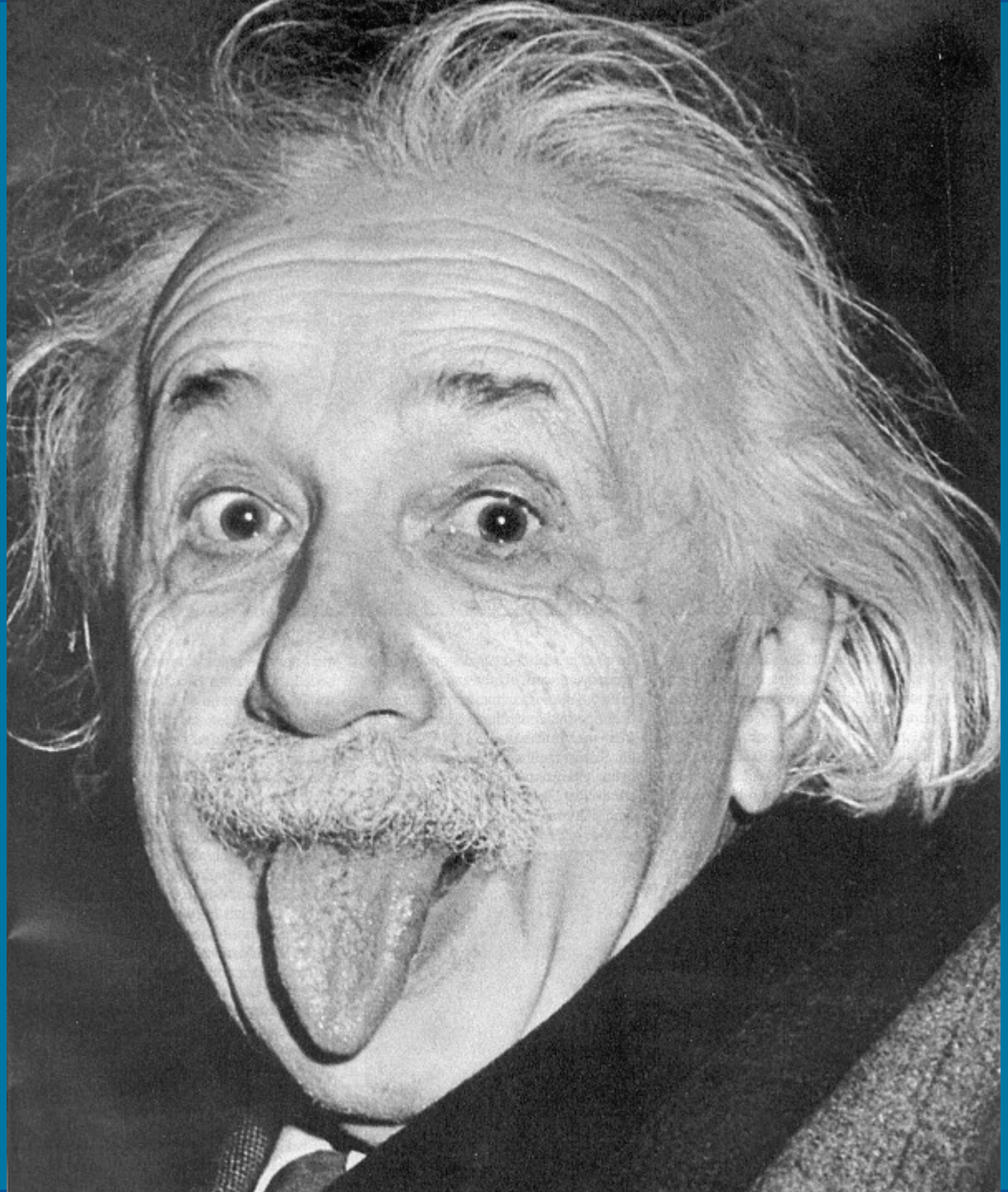
Psychopathology

- There are increased rates of mental (emotional) disorders across those patients experiencing physical health problems (e.g. diabetes: pain: cardiology etc.)
- Psychopathology impacts on management of physical health condition (e.g. diabetes etc.)
- Psychopathology impacts on course of physical health condition (e.g. chronic pain: MI: sleep etc.)
- Psychopathology impacts on treatment costs (e.g. treatment adherence etc.)

Psychological support

- Psychological treatment as effective (if not more so) than pharmacotherapy with a broad range of mental (emotional) disorders
- Psychological treatment can improve adherence to other treatments



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Most common problems:

- anxiety (e.g. post-MI)
- low mood and or depression (e.g. COPD)
- adherence issues (e.g. alleged denial of diabetes – T1DM and T2DM)
- pain management (e.g. failure of all other treatments)
- assessment (e.g. neuropsychological: orthognathic: bariatric etc.)
- anger management difficulties (e.g. due to NHS incompetence: failure of other treatments)
- over application of guy-liner

The majority of patients do not meet an ICD or DSM criteria.

- Remember – clinically significant distress and or impairment to everyday functioning

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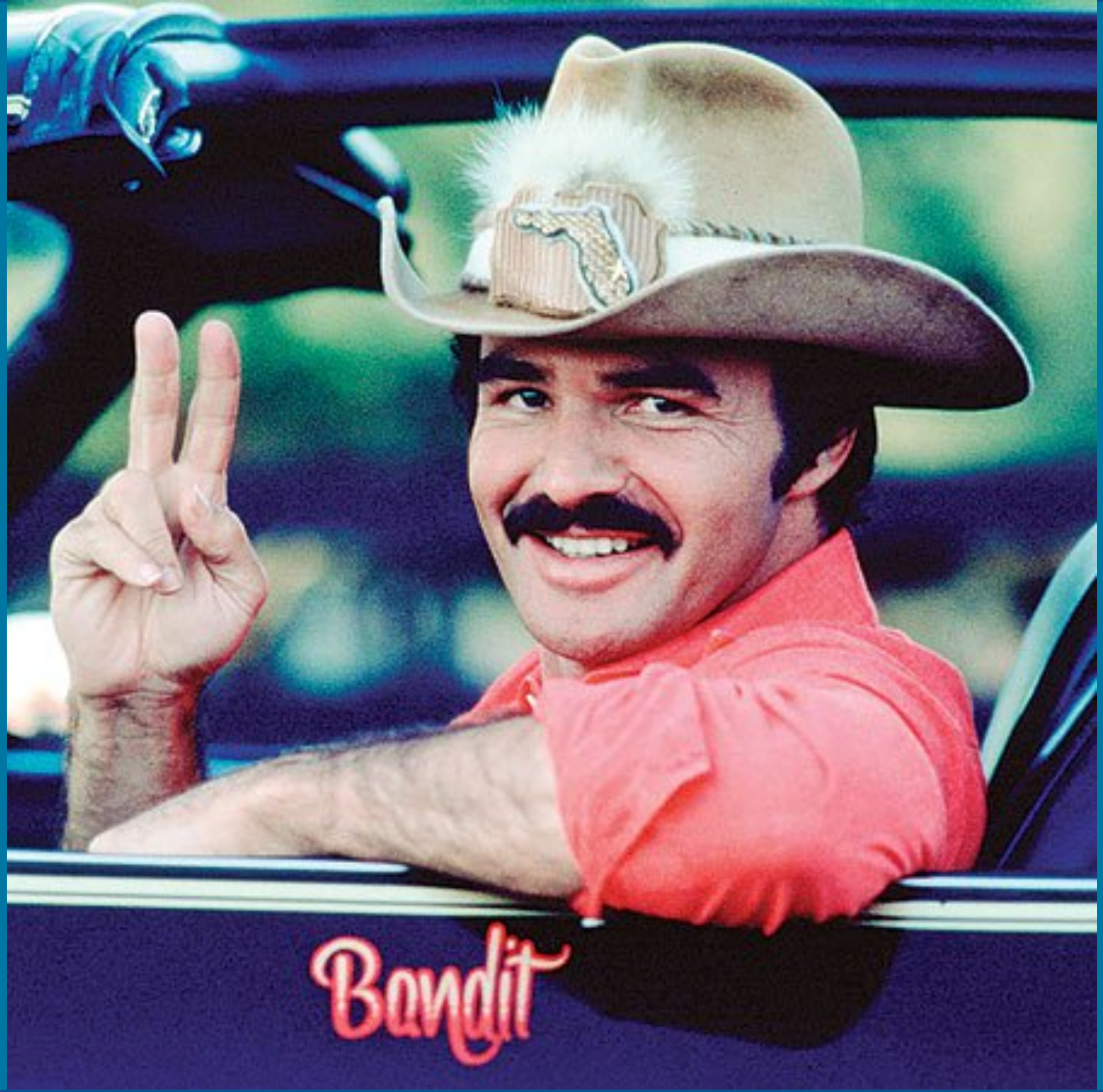
Recommendations (from a Sheffield United fan):

- listen (and remember – 2 ears and 1 mouth for a reason!)
- provide kindness
- admit to your ignorance (it demonstrates honesty and reduces omnipotence)
- admit to your mistakes (it demonstrates honesty and reduces litigation)
- treat patients as you would hope that a family member would be treated (obviously – a family member that you like)
- do not try and treat the emotional disorder (unless you are a colleague in psychiatry) …. assess and refer on

Last – all meta-analyses on the mutative factors in psychotherapy demonstrate that it is the relationship that cures (or at least helps) and not the therapeutic model.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