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Meeting psychological and psychosocial needs in cardiac rehabilitation

There are well established relationships documented between stress, anxiety, depression and increased risks of cardiovascular disease (CVD). Evidence reports a direct effect of psychological distress on physiological changes, including increased hypertension, heart rate and cortisol levels and an indirect negative influence on health-related behaviours such as smoking, physical inactivity, weight gain and sleep. Cardiovascular disease progression is elevated amongst people who experience significant and persistent levels of psychological distress. These adverse/negative relationships between psychological distress, cardiac disease management and progression/prognosis must be targeted within cardiac care pathways to improve medical, psychological and quality of life outcomes.

Cardiac rehabilitation is a key area where psychological input can provide significant benefits. Research evidence reports that psychological factors such as anxiety and depression detrimentally effect engagement levels, with only 52 per cent of patients eligible for cardiac rehabilitation taking up the offer, comparing poorly with the current NHS Long Term Plan ambition of 85 per cent. Helping people to engage with cardiac rehabilitation by targeting the psychological factors underpinning patterns of disengagement such as fear, pessimism and hopelessness are integral to supporting rehabilitation goals and outcomes.

Addressing the psychological, emotional and social contribution to cardiac rehabilitation is a role for the entire multi-disciplinary team (MDT), where this can significantly help in supporting optimal and patient-focused rehabilitation outcomes. Neuropsychological changes in the brain following cardiovascular disease can also affect cognitive function, behaviour and emotional state. Such changes are often under-detected but require specialist psychological assessment and consideration as part of rehabilitation planning to ensure successful outcomes (and avoid misdirected treatment approaches).

It is particularly important that cardiac rehabilitation is available to support patients with the most complex physical and psychological needs, who can often be least likely to engage following a cardiac event. Psychologists have a key role here to support the MDT model of care by providing a psychological framework for understanding the multiple factors contributing to the person's situation and identifying strategies that can benefit rehabilitation goals across specialities.

Establishing clinical psychologists (or other suitably qualified practitioner psychologists) as core members of every cardiac rehabilitation team, is necessary and integral to support optimal MDT engagement and rehabilitation outcomes for all patients.

The role of the psychologist would be expected to cover a number of areas, to influence and contribute to MDT care and rehabilitation outcomes via assessment and therapeutic work with patients (one-to-one and group interventions), joint working, MDT case management discussions, consultation and clinical supervision to colleagues; and through the provision of training in awareness of psychological issues and psychologically-informed ways of working (DCP, 2008).

Guidelines must now be developed to inform appropriate levels of psychologist staffing in cardiac rehabilitation teams, in order to maximise the quality of patient care and rehabilitation outcomes.

This statement is fully endorsed by the British Heart Foundation, British Psychological Society and the Association of Clinical Psychologists (UK).

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STATEMENT