Health Equity Evidence Centre

In partnership with GIRFT Getting It Right First Time

ARMA Arthritis and Musculoskeletal Alliance

Integrated primary and community support for people living with chronic pain, musculoskeletal problems and mental health conditions

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The Health Equity Evidence Centre is an academic collaboration hosted by Queen Mary University of London which seeks to build the evidence base of what works to address health and care inequalities. Decades of evidence have shown that the structures and systems within society lead to health inequalities. We believe that it is only by tackling the unequal distribution of the social determinants of health that we can achieve health equity and that the benefits of health care should reach the most marginalised in society.

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Declarations

This Evidence Brief has been commissioned by the Getting It Right First Time (GIRFT) team at NHS England to support their statutory responsibility, with funding from the Joint Work and Health Directorate (Department for Work and Pensions and Department of Health and Social Care). Policy interventions beyond health care services were not in scope. The views expressed in this publication are those of the author(s) and not necessarily those of NHS England, Department of Health and Social Care.

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Foreword

Lesley Kay

Vice-chair of the MSK improvement board at NHS England's Getting It Right First Time (GIRFT) programme

People living with musculoskeletal conditions, chronic pain and mental health problems rarely experience these conditions in isolation. Their lives are shaped by the interaction between physical symptoms, emotional wellbeing, social circumstances and the way health and care services respond to them. Yet our systems have too often been organised around individual diagnoses rather than around the people living with them.

The result is a familiar story. Patients move between services, repeat their experiences to different professionals, and struggle to navigate fragmented pathways at a time when they have the least capacity to do so. Too many people continue to receive care that focuses primarily on medication or a single condition, rather than co-ordinated support that helps them to live well.

This review brings together the best available evidence alongside the voices of people with lived experience, clinicians and community organisations. Together, they present a remarkably consistent message. Effective care is biopsychosocial, person-centred and co-ordinated. It recognises that improving quality of life depends not only on treating pain, but also on supporting mental wellbeing, strengthening self-management, connecting people with their communities and addressing the wider factors that influence health.

This report arrives at an important time. As the NHS continues to develop neighbourhood health services and integrated models of care, there is a real opportunity to redesign services around the needs of people with complex long-term conditions. The evidence suggests this is not primarily about creating new services, but about organising existing expertise differently, bringing together multidisciplinary teams, working more closely with voluntary and community organisations, making better use of digital information sharing, and supporting a workforce equipped to deliver psychologically informed care.

Importantly, this review also reminds us that evidence alone is not enough. The experiences shared by people living with chronic pain demonstrate that being listened to, believed and treated as a whole person is every bit as important as clinical expertise. These voices have shaped the recommendations throughout this report and provide an essential perspective on what good care should look like.

The recommendations that follow are intended to support national and local leaders, commissioners, clinicians and community partners as they work together to reduce fragmentation, improve outcomes and tackle inequalities.

Delivering truly integrated care will require sustained collaboration across organisational and professional boundaries, but the prize is considerable: better lives for millions of people living with chronic pain, musculoskeletal conditions and mental health problems, and a more effective and equitable health and care system for the future.

Supporting statement from the Arthritis and Musculoskeletal Alliance (ARMA)

Adrian Bradley

ARMA Chief Executive

For people living with musculoskeletal conditions, success is not measured simply by lower pain scores or fewer appointments. It is measured by whether they can continue working, care for their family, remain independent, stay connected to their community and live the life they want to lead.

Too often, the health and care system makes that harder rather than easier. People describe having to navigate separate services, repeat their story, coordinate their own care and fit around organisational boundaries that bear little resemblance to how they experience their health. The cumulative burden of pain, reduced mobility, poor mental wellbeing, fatigue and social isolation is rarely experienced as separate problems requiring separate solutions.

This report provides a compelling evidence base for changing that. It demonstrates that better outcomes come from seeing the whole person, recognising the interaction between physical, psychological and social factors, and organising care around people's needs rather than professional or organisational boundaries. Just as importantly, it gives equal weight to the experiences of people living with these conditions, reminding us that feeling heard, understood and involved is fundamental to good care.

Its conclusions resonate strongly with ARMA's own vision and values. For many years we have argued that improving musculoskeletal health requires organisations to work better together, that support for self-management and participation should sit alongside clinical care, and that reducing inequalities must be integral to service design rather than an afterthought. The report also reflects an important truth: integrated care is not achieved simply by writing integrated policies. It is achieved when people experience joined-up support throughout their journey.

As the alliance representing organisations across the musculoskeletal community, ARMA is pleased to support this report. We hope it will help accelerate practical action nationally and locally, bringing together health services, local government, voluntary organisations and people with lived experience to create care that is more connected, more compassionate and more effective. Ultimately, success will be judged not by how well organisations collaborate with one another, but by whether people living with musculoskeletal conditions experience better lives as a result.

Glossary

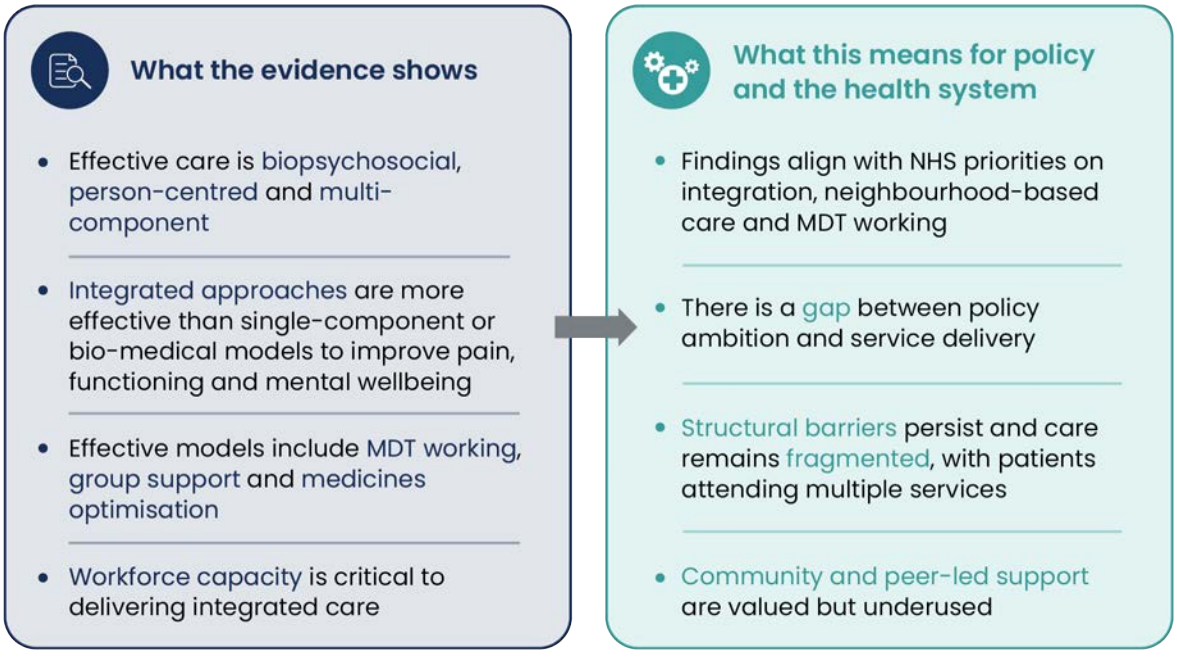
ACT	Acceptance and Commitment Therapy
CAD	Community Appointment Days
CBT	Cognitive Behavioural Therapy
CCG	Clinical Commissioning Group
CCM	Collaborative Care Management
CNCP	Chronic Non-Cancer Pain
CPRD	Clinical Practice Research Datalink
FCP	First Contact Physiotherapist
GIRFT	Getting It Right First Time (NHS England programme)
GBD	Global Burden of Disease
GOTT	Gabapentinoid and Opioid Tapering Toolkit
GP	General Practitioner
ICB	Integrated Care Board
IMGV	Integrative Medical Group Visits
INT	Integrated Neighbourhood Team
LMIC	Low- and Middle-Income Country
MDT	Multidisciplinary Team
MH	Mental Health
MORE	Mindfulness-Oriented Recovery Enhancement
MSK	Musculoskeletal
NHSBSA	NHS Business Services Authority
NICE	National Institute for Health and Care Excellence
PA	Physician Associate
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCT	Randomised Controlled Trial
SMA	Shared Medical Appointment
SPA	Single Point Access
VCFSE	Voluntary, Community and Faith Sector Enterprises

Executive summary

People with coexisting musculoskeletal (MSK) conditions, chronic pain and mental health (MH) problems represent one of the largest, most unequal, and least well-served populations with long-term illness in England. Global Burden of Disease (GBD) data indicates that MSK conditions and MH problems account for around half of all years lived with disability in England, a proportion that has continued to rise over the past three decades. In England, chronic pain affects approximately one quarter of adults, with higher prevalence, greater severity and poorer outcomes in more deprived communities. Around 40% of people living with chronic pain also experience anxiety or depression.

Despite this substantial and growing burden, care for people living with MSK conditions, chronic pain and MH problems remains fragmented. The NHS continues to be largely organised around single-condition speciality-based models, with pain services, MSK services, and MH services tending to operate in parallel rather than in partnership. As a result, patients frequently attend multiple appointments with little integration across services, which can result in a biomedical approach to care, dominated by medication rather than integrated, holistic person-centred care. These issues disproportionately affect underserved communities, compounding health and care inequalities.

This rapid evidence review explores models of primary and community care to support adults living with MSK conditions, chronic pain and MH problems. The review synthesised evidence from systematic reviews and primary studies using a prioritisation framework. In addition, it was supplemented by two community engagement workshops with people with lived experience, clinicians and voluntary sector organisations in East London and North East England.



What the evidence shows

Based on a review of 134 studies, supported by community workshops, we found that:

Effective care is biopsychosocial, person-centred and multi-component
The strongest and most consistent finding across the evidence base is that integrated approaches addressing physical, psychological and social needs are more effective than single-component or biomedical models. Biopsychosocial approaches are more likely to improve pain, functioning, mental wellbeing and reduce reliance on medication. Supported self-management is a central mechanism that helps people live well with pain.

Integration depends on how services are organised
Effective models are multi-component with multidisciplinary team (MDT) working, complemented by group sessions, peer support and medicines optimisation. Partnering with community organisations to help address the wider social determinants of health is important. There are now emerging examples of community-led pain management services.

Workforce capability is critical to delivery
Delivering integrated care requires a workforce with the skills to provide psychologically-informed and person-centred care. Evidence supports expanded and hybrid roles, including care managers, physiotherapists trained in psychological approaches, and MH professionals embedded within MSK and pain pathways. There is evidence that training staff leads to improved knowledge and confidence, but the impact on patient outcomes is uncertain.

Policy and system implications

Current NHS policy emphasises integration, neighbourhood-based care and multidisciplinary working. The findings of this review are strongly aligned with this direction. However, there remains a significant gap between policy ambition and the reality of service delivery.

Community engagement identified persistent barriers to services: poor interoperability of electronic patient records, organisational silos, rigid referral pathways, and limited trust between services. These structural issues often result in patients being passed between services, with responsibility for coordination falling on individuals who may have the least capacity to manage it.

At the same time, the potential role of community and peer-led support is not fully realised. While the formal evidence base is limited, these approaches are relatively low-cost and highly valued by patients, suggesting that they should be incorporated into service models alongside clinical care.

Based on a review of the evidence and community workshops, we make the following recommendations.

Recommendations

Recommendations for national organisations: Support commissioning of integrated, person-centred care with supported self-management

1. Prioritise a strategy for integrated chronic pain, MSK conditions and MH support.
2. Prioritise a service specification template on how to commission integrated pain, MSK and MH services with single points of access to multidisciplinary care.
3. Prioritise an interoperable electronic health record with agreed minimum summary-level clinical information for this cohort across GP, community, MH and social care interfaces to allow sharing of information.

Recommendations for local decision-makers: Deliver coordinated, multidisciplinary services

4. Prioritise people with chronic pain, MSK conditions and MH problems for neighbourhood health and care planning, and use local population health management capabilities to generate insights.
5. Commission Voluntary, Community and Faith Sector Enterprises and provide grants for peer support groups as part of integrated care.
6. Ensure medicines optimisation is part of the integrated multidisciplinary model, with a specific focus on reducing avoidable long-term opioid and gabapentinoid dependence.

Recommendations for workforce planning: Developing workforce capability for integrated care

7. Workforce planning should focus on innovative skills and roles, rather than traditional professional boundaries.
8. Existing staff should be upskilled to support a biopsychosocial approach to caring for people with chronic pain, mental health problems and MSK conditions.

Recommendations for national and local system planners: Continually build and share evidence of the most effective models of care

9. Agree and publish a basket of outcomes for this cohort.
10. Build the evidence base through a learning health system approach which incorporates real-time evaluation, monitoring and feedback.

Background

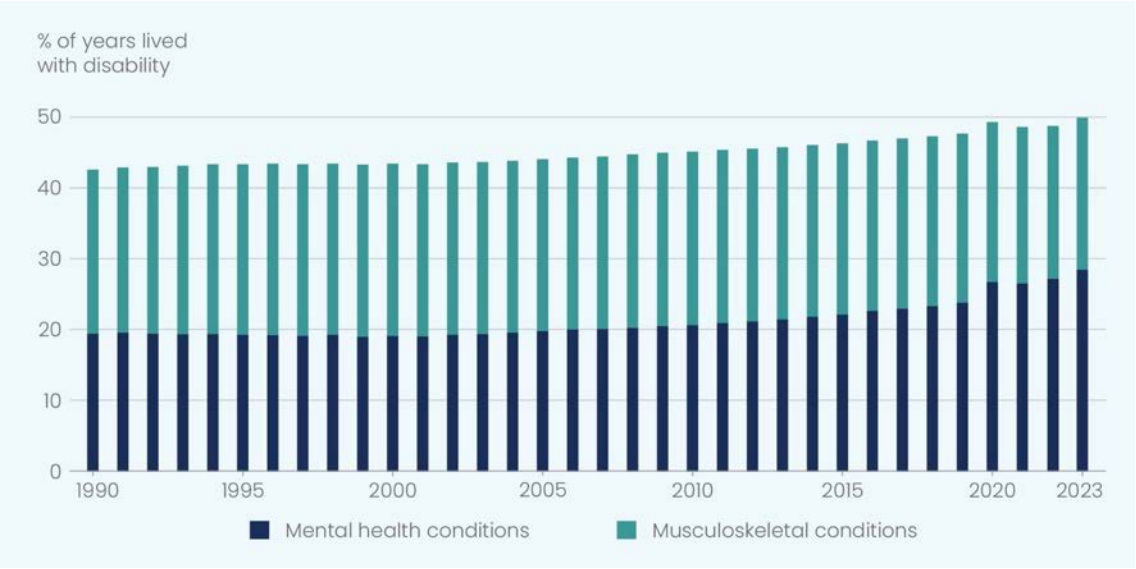
The burden of chronic musculoskeletal pain and mental health comorbidity

Chronic pain is defined in this report as pain that persists or recurs for longer than three months, as per ICD-11 classification (1). MSK conditions are the commonest cause of chronic pain (2). They can cause chronic pain either as secondary to an underlying condition, such as osteoarthritis, or as a primary chronic pain condition, such as fibromyalgia (3).

The 2024 Health Survey for England found 26% of adults reported chronic pain and 13% reported high impact chronic pain, with higher rates among women, older ages and those in areas of deprivation (4). Among those with chronic pain, musculoskeletal (MSK) conditions were the most prevalent comorbidity at 39%, rising to 49% of those with high impact chronic pain (4).

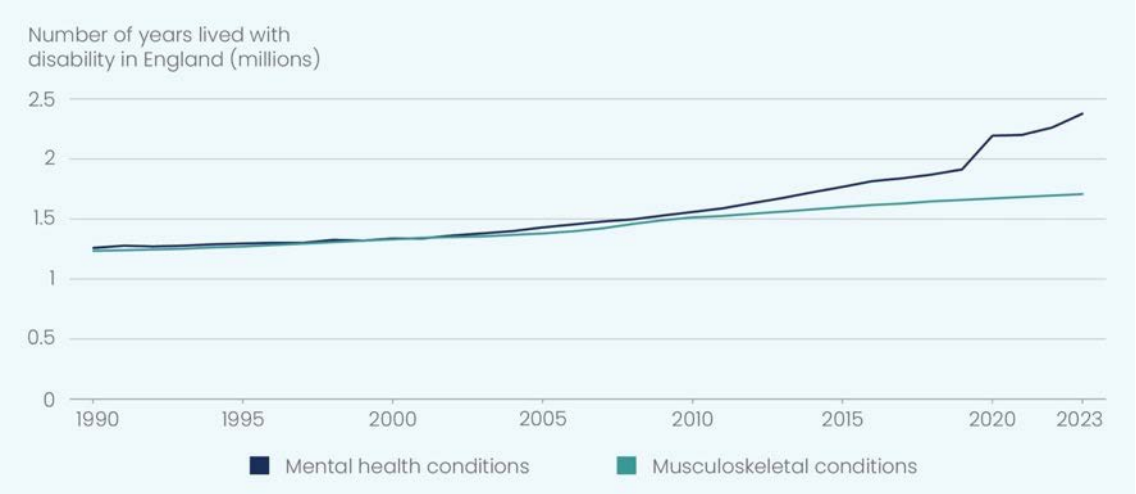
Approximately 40% of people with chronic pain have clinically significant anxiety and depression (5). MSK conditions and mental health (MH) conditions together make up half of the years of life lived with disability in England (Figure 1). Since the pandemic, the number of years lived with disability due to MH conditions has increased (Figure 2).

Figure 1: Percentage of all years lived with disability for MSK and MH problems in England (1990-2023)



Source: Global Burden of Disease, Institute of Health Metrics and Evaluation (6)

Figure 2: Number of years lived with disability for MSK and MH problems in England (1990-2023)



Source: Global Burden of Disease, Institute of Health Metrics and Evaluation (6)

The co-occurrence of MSK conditions, chronic pain and MH illness creates bidirectional relationships in which psychological distress can worsen pain perception and disability, while persistent pain worsens MH (7,8). This can result in severe pain leading to increased severity of depression and worse outcomes, and improvement in pain resulting in a decrease of depressive symptoms (8). Coexisting chronic pain can interfere with the identification of depression, somatic symptoms such as pain can be the presenting complaint for depression and comorbid patients may be more likely to receive pain treatment than management for their depression (8). The complexity of chronic pain and MH problems varies across conditions. For example, 66 to 96% of people with Post Traumatic Stress Disorder also experience chronic pain (9).

There may be common contributing factors leading to the development of both chronic pain and mental health problems such as exposure to previous psychological trauma, deprivation, cognitive factors such as catastrophising (10), behavioural patterns such as fear-based avoidance of activity (10) and challenging work conditions (11). Research has tended to focus on the narrower biomedical view of shared neuronal pathways for pain and mental health symptoms rather than social and structural determinants of health (10).

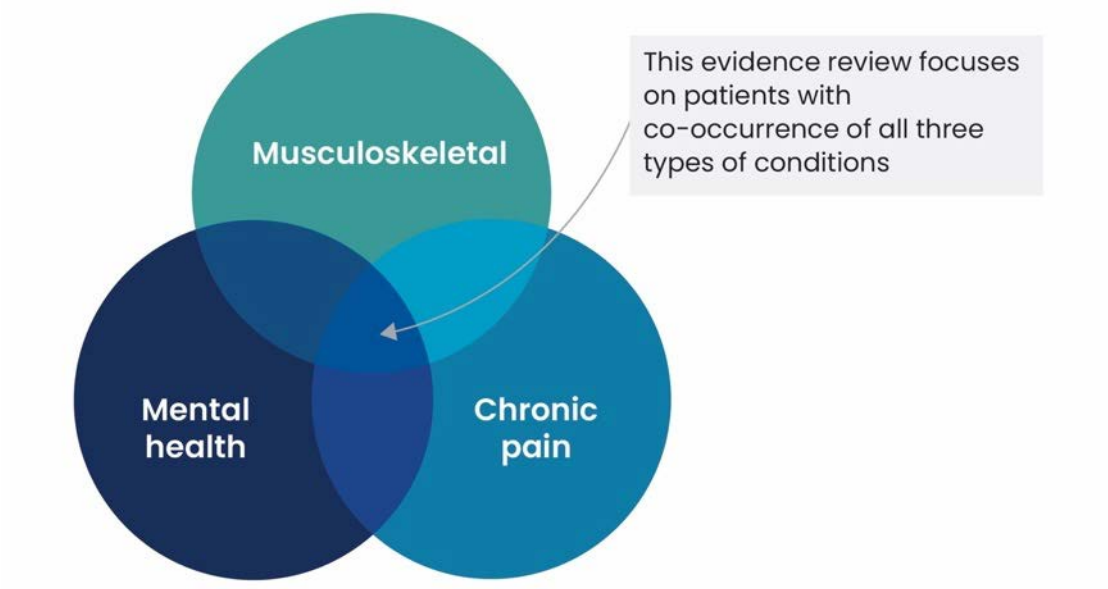
Having pain and comorbid depression leads to increased medical visits and higher healthcare costs (8). All these elements of connectedness point to the importance of recognising comorbid diagnoses of chronic pain and mental health problems and the need for joined-up management that addresses how these conditions impact on each other. Individuals may be referred sequentially between services, repeating their narratives without receiving integrated care. This results in fragmented care that does not reflect what people with lived experience say they need (12).

Over-prescribing

In 2024/25, the NHS in England spent £270 million on opioid drugs (13). NICE guidance for chronic primary pain recommends against initiating the most common pharmacological treatments (14), and NICE guidance for common causes of secondary chronic pain (osteoarthritis, low back pain and sciatica) recommends weak opioids only for short-term use (15,16). This reflects evidence that opioids achieve negligible improvements in pain, function and quality of life for chronic pain (17), and that they can cause significant harm (18). The current spending on opioid drugs suggests clinical practice may not be fully aligned with evidence and guidelines.

Lack of integrated care can lead to an over-reliance on medication as a 'quick fix' for pain, often because frontline clinicians may not have time for patients to fully tell their story and may not be equipped to recognise or respond to the psychological factors underlying a patient's pain. Patients tend to believe that painkillers are the most effective treatment for chronic pain (19). A UK study of patients in primary care with chronic MSK pain showed over half were prescribed opiates, and over half of the prescriptions were for strong opiates. They defined over-prescription as long-term prescribing of strong opioids (>3 prescriptions a year) and that 40% of patients prescribed opioids for chronic MSK pain may have been over-prescribed, estimating that at UK level this would equate to a cost of over £100 million per year, without considering the costs of dealing with the management of side effects, overdose and societal harms (17). Over-prescription is linked to opioid misuse and abuse (17). History of mental health problems increases the risk of opiate medication abuse in chronic pain (20). The risk of developing opioid addiction among people with chronic pain is estimated at 8–12% (21).

Higher opiate prescribing is linked to increased severity of chronic pain, self-reported bad health status and those with extreme anxiety and depression (22)



Barriers to providing integrated care

Our community discussions revealed difficulties in accessing referral pathways. Often there was no process for some allied health professionals to directly refer to services, requiring patients to be referred by their GP. Rigid exclusion criteria created barriers to services, such as people with severe mental illness not being eligible for MSK chronic pain pathways. While guidelines have recognised the need for dual-diagnosis care for people with MH and substance misuse problems, this does not occur in practice. Patients frequently still find themselves declined from MH services (and chronic pain services) until they have recovered from substance misuse, leading to patients being caught in a loop.

For people with chronic pain, there is a tension for health professionals between giving patients hope for improvement in their pain and functioning, while being realistic about the likely trajectory. For example, psychological approaches such as acceptance and commitment therapy (ACT) encourage individuals to accept difficult thoughts, feelings and sensations to reduce their impact on daily life. Navigating this tension requires multiple health professionals balancing treatments to reduce pain and psychological support to live well with pain.

Despite this recognised overlap between MSK problems, chronic pain and MH conditions, the NHS remains largely organised around single-disease models. This means that pain management, MH services and MSK services are frequently delivered in parallel rather than in partnership. This can lead to duplicated assessments, under-recognition of psychological need, inconsistent follow-up and unclear clinical ownership. While national policy continues to emphasise holistic, person-centred care, at the level of service delivery structural integration remains poor and inconsistent. Consequently, patients with coexisting MSK pain and MH conditions often find navigating health and care systems difficult or even impossible. Traditionally, pain clinics were led by anaesthetists with minimal input from MDT professionals. When areas do have MDT staff, teams may not operate effectively due to communication or organisational barriers. Data from the GP Patient Survey reflects these challenges. Patients who suffer from MSK problems report lower satisfaction with general practice and greater difficulty accessing care compared to those without chronic illnesses (23).

Even where access has been consolidated through Single Point of Access (SPA) pathways, these are typically organised around MSK and pain rather than integrated with mental health and are frequently bypassed via Right to Choose or direct specialist referral. In some areas there is patient self-referral to physio or the SPA, for most this is done through someone in their GP surgery, for example a first contact physiotherapist (FCP), GP, physician associate (PA) or nurse. They may assess them via telephone, face-to-face or refer directly following an eConsult review. The SPA generally involves further triage and assessment by physiotherapy or an Extended Scope Practitioner (ESP), and possibly direct or secondary referral to orthopaedics, neurology, rheumatology, chronic pain clinics, or chronic pain management programmes. However, some may bypass the SPA by referral to a private provider of chronic pain clinics via Right To Choose or direct referrals to orthopaedics, neurology, or rheumatology. There is evidence that self-referral may have less uptake among patients with low socioeconomic status but also that there may be barriers in GP referral with disproportionately higher referral rates for white patient groups (24).

Personal experience: “My life with fibro”

Rani Power

‘Fibro’ is often used by patients with fibromyalgia as shorthand for their condition. Fibromyalgia is a chronic primary pain disorder characterised by widespread increased sensitivity to pain, muscle stiffness, fatigue, sleep difficulties and brain fog as well as other symptoms (25)

“The first sign I remember was travelling to India when my children were younger, and I could feel my feet were not quite right. It got a lot worse, and I became increasingly exhausted – at times too exhausted to socialise with other parents.

About that time, I was diagnosed by my GP with fibro in addition to other conditions. “What is fibro, doctor?” “Go and Google it.” It was a tough read. It took me years to come to terms with my diagnosis. Time passed slowly and I felt depressed about my health. The borderlines between my illnesses – fibro, Rheumatoid Arthritis, Sjogren’s Syndrome and Osteoporosis – often blur, making it difficult to work out which symptoms belong to which condition. I have pain and fatigue like us all, particularly in the shoulders, neck, groin and feet.

After a few years I accepted, ‘I am where I am’ and I am going to make the most of my life. I realised that while time stretched out, it would only be short parts of the day that I could use effectively. My children have a perception of time that differs from mine. They say, ‘you are so old?’ I say, ‘I’m not old, I’m ill.’

I now pace myself. If I go out, I plan it. I prioritise what is important and prepare – a half-day going out takes a few days to prepare and recover. Poor mobility forces me to a slower pace and limits my travel. This prioritisation is tough – less time to socialise with friends, fewer things to experience and even less time to think and write.

I have a supportive family. I ask for help. I get help. They understand my lack of energy. But asking, explaining and receiving takes time. Simple things become complex. And the illness creates work to do – treatment, appointments and more. I cook once a week with the help of my family and rely on ready meals (which I loathe) the rest of the time.

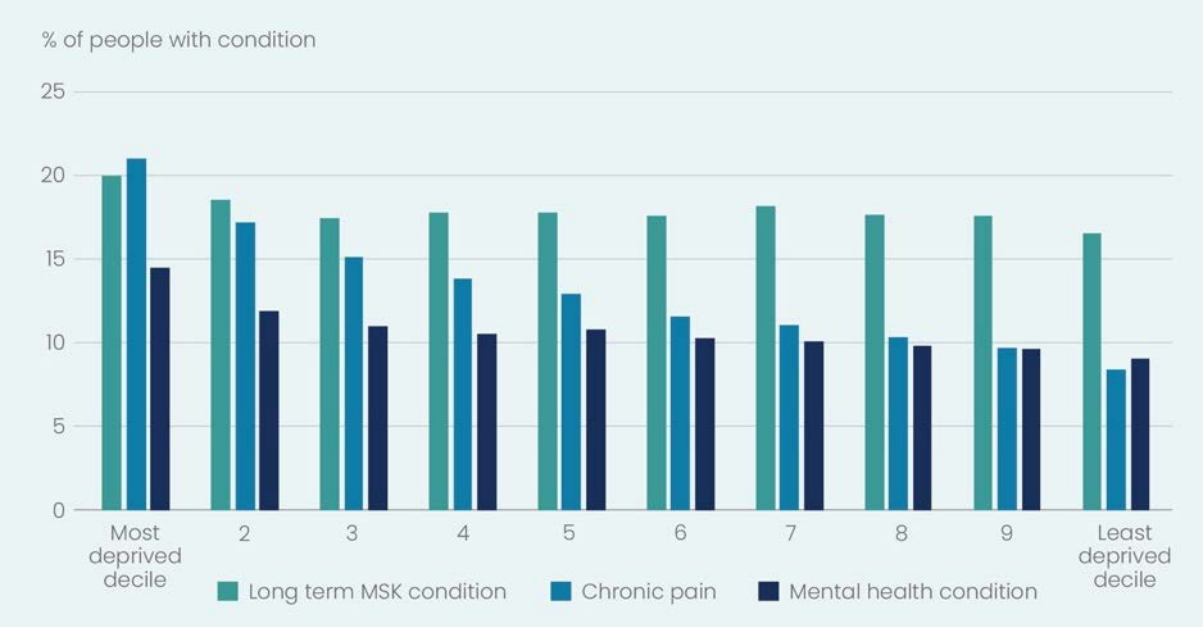
First in the morning, I exercise by clenching my toes, stretching my arms and moving. Steroids, a part of my treatment, bring their own set of challenges – night awakenings and weight gain. The stress induced by fibro has also led to insomnia, creating a cycle that makes the condition worse. Relaxation, massage and hot baths have become essential tools in my coping toolkit. All these help me regain a sense of control.

Maintaining a sense of self in the face of chronic illness requires resilience. Putting on a happy face and engaging with the support group that I set up – Fibro London East have become important. Shared knowledge leads to a sense of understanding on a human level rather than focusing solely on the illnesses we share. We encourage one another to live our best lives.”

Inequality and system impact

The burden of chronic pain and MH comorbidity is unevenly distributed with a greater prevalence in poorer areas, compared to richer counterparts (26). Those with comorbid chronic MSK pain and anxiety and depression have higher rates of obesity, smoking and physical inactivity greater than the additive risks for the conditions separately (27). Fingertips data from the Office for Health Improvement and Disparities show that the prevalence of long-term MSK problems is higher in more deprived areas (see Figure 3) and is also patterned by ethnicity, with White British and Black Caribbean communities being more likely to report long-term MSK problems (see Figure 4). Chronic pain, anxiety and depression are also more prevalent in areas of greater deprivation (see Figure 3). Chronic pain often exists alongside multiple long-term conditions, which also follow a socio-economic gradient – people with a lower socio-economic status develop more illness at a younger age (28). Chronic pain is also strongly linked to place. There is a North-South divide in chronic pain severity and prescribing of opioids that is linked both to deprivation and to the post-industrial histories of much of the North of England (18,22).

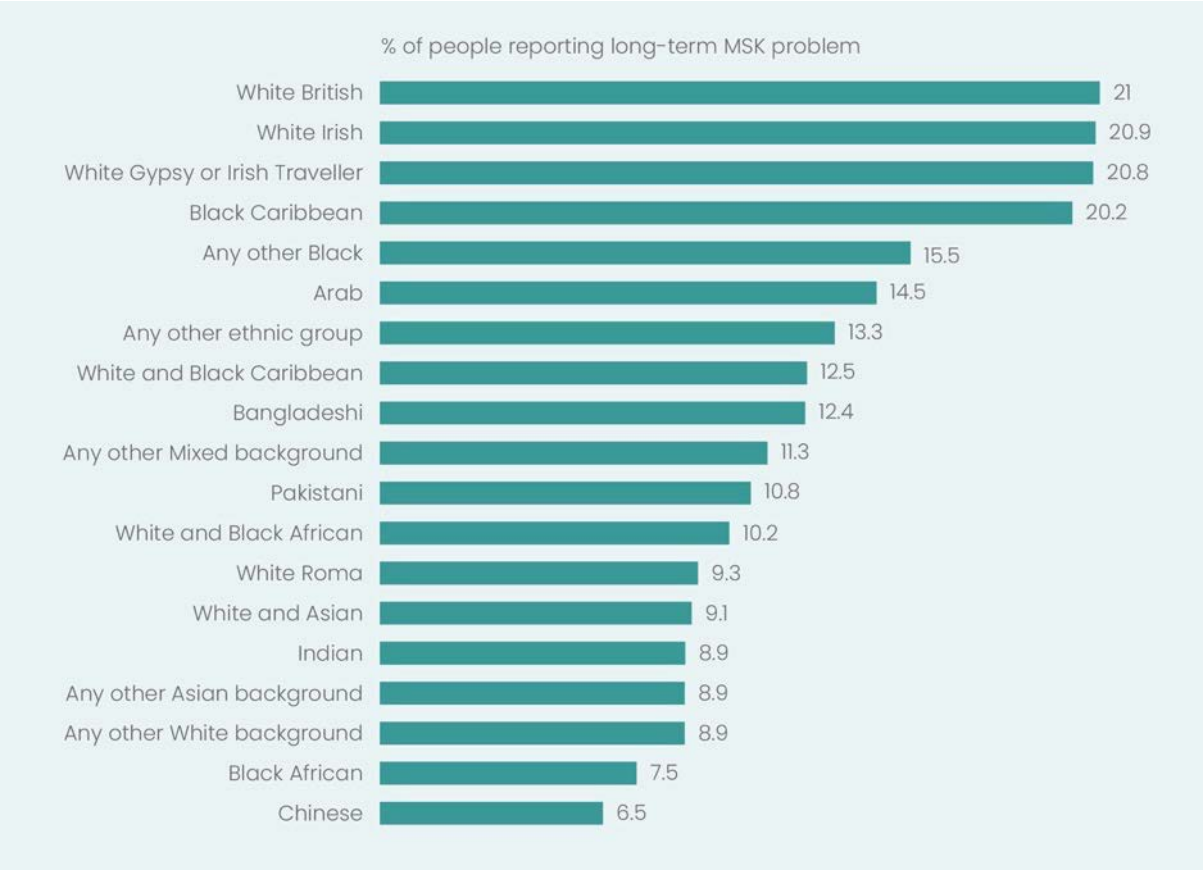
Figure 3. Socioeconomic gradient in self-reported long-term MSK problems and electronic record documentation of chronic pain or anxiety and depression



Sources: MSK data, Fingertips, Office for Health Improvement and Disparities based on 2024 GP Patient Survey self-reporting data (29)

Chronic pain and anxiety and depression data, Health Foundation report Health Inequalities in 2040 based on analysis of CPRD data (26)

Figure 4. Reporting of long-term MSK problems by ethnicity in England



Source: Fingertips, Office for Health Improvement and Disparities based on 2024 GP Patient Survey Data (29)

Chronic pain is strongly associated with unemployment and economic inactivity, reinforcing cycles of disadvantage (30). Limited access to physiotherapy and vocational rehabilitation, long waits for psychological therapy and regional variation in service provision further worsen the economic impact of this inequality. Patients with comorbid chronic pain and common MH problems have higher levels of sickness absence than those with MH problems alone (31). There is also an impact on family members and informal carers.

Feeling heard and navigating services: Lived experience perspective

A strong theme across our community discussions was the importance of feeling heard and believed. Patients described getting lost in the system, not meeting inclusion criteria for services, and not being aware of what support is available. The phrase "not what's the matter with you, but what matters to you" captured a widely shared aspiration for care that starts from the patient's own experience and goals, rather than fitting them into pre-defined pathways (32).

For people living with chronic pain, navigating the healthcare system often means moving between unfamiliar services, retelling their story at each stop, and encountering well-meaning professionals who may lack the specific skills or understanding to support them beyond their own speciality. People living with chronic pain wanted to be met by practitioners who understand their story, who know the personal demands of chronic pain and can see beyond the boundaries of their own discipline.

Inequalities in chronic pain and anxiety and depression are projected to worsen over the next 15 years (data on projections of MSK inequalities are not available). Prevalence of chronic pain and anxiety and depression are predicted to increase at a faster rate in the most deprived than least deprived areas by 2040, widening inequalities. This is partly due to increased population growth of ages 20-69, but this also means a greater impact on work outcomes (26).

Existing evidence on integrated approaches

Previous reviews have looked at several components of care relevant to chronic pain and MH comorbidity. These include multidisciplinary team (MDT) pain rehabilitation (33), collaborative care approaches across organisations in primary care (33), and multicomponent interventions that incorporate psychological approaches such as cognitive behavioural therapy (CBT) for chronic pain and depression (34). These reviews suggest that approaches addressing both physical and psychological needs may improve selected outcomes, particularly depression, coping strategies and quality of life. However, the evidence remains dispersed across different intervention types, populations and care settings.

Existing literature tends to examine discrete components of care, such as psychological therapies or MDT rehabilitation programmes. It does not synthesise how primary care and community services are organised to deliver integrated support for these comorbid patients. Consequently, there remains uncertainty regarding the optimal integrated models, their impact on clinical services and outcomes, and their potential to address inequalities in access and provision. Furthermore, many evaluations emphasise short-term symptom reduction rather than broader system-level outcomes, including continuity, access and inequality.

Policy context and health system reform

Recent national policy has increasingly emphasised integration to support people with MSK problems, chronic pain and mental health conditions. In 2019, the NHS Long Term Plan highlighted the development of integrated care systems and multidisciplinary primary care networks to improve coordination and continuity (35). Initiatives such as Getting It Right First Time (GIRFT) have focused on pathway redesign to improve outcomes and reduce unwarranted variation (36). The GIRFT handbook for commissioned Community MSK services highlights integration with local talking therapies as good practice for anyone experiencing anxiety or depression in the context of their MSK condition, highlighting the need to support patients' mental health within MSK services (37). The 10-Year Health Plan for England emphasises a shift from hospital-centred care towards community-based care delivered

closer to home. It promotes a shift towards neighbourhood-based care, emphasising prevention, community services and coordinated management of long-term conditions (38). These reforms recognise that fragmented models are insufficient for complex long-term conditions. However, policy ambition does not automatically translate into effective implementation. There is limited clarity regarding which integrated models produce meaningful improvements in outcomes.

Rationale for the review

People with MSK problems, chronic pain and MH conditions have substantial unmet health and care needs. We need to improve our understanding of how to manage these conditions when presenting comorbidly in primary and community care settings, in the context of structural reforms in the NHS. Despite the policy emphasis on integration, there remains limited synthesis of evidence examining how primary and community services organise care for individuals experiencing both chronic MSK pain and MH conditions. This evidence review, with complementary workshops, examines evidence on how integrated primary and community care is organised for adults living with chronic MSK pain alongside coexisting MH conditions.

How this review was undertaken

We used a mixed methods approach to gather and synthesise evidence. We aimed to review the most relevant and robust evidence to inform decision-making and achieve thematic sufficiency rather than attempt to review every study. As such, we focused on identifying the best available evidence to inform decision-making. We prioritised studies according to relevance in the UK and comparable settings, recency, and methodological robustness (e.g. prioritising systematic reviews of randomised controlled trials).

We conducted a rapid evidence review of integrated care models for the co-occurrence of chronic pain, MSK problems and MH conditions in primary care (39). We searched MEDLINE, Embase and PsycINFO using terms covering MSK conditions, chronic pain, MH, integrated care and primary/community care settings. We excluded pre-2010 studies, LMIC (low- and middle-income country) settings, non-English papers, conference abstracts and preprints. We supplemented the evidence with snowball searching. Studies were categorised using a prioritisation framework. This framework ranked evidence according to relevance and robustness as follows: (1) UK-relevant, up-to-date literature reviews (past 5 years), (2) older UK-relevant reviews (5-10 years), (3) recent UK primary studies (past five years), (4) older UK primary studies (5-15 years), and (5) wider international literature. A grey literature search was also conducted using focused Google searches.

We started synthesising priority 1 studies and sequentially reviewed each prioritisation category, reviewing the literature until no new themes emerged. Where a substantial body of high-quality review evidence existed, additional primary studies were not included. Where necessary, topic-specific findings were complemented with transferable evidence from the Health Equity Evidence Centre's existing catalogue on health inequalities.

In parallel with the literature review, we undertook two community engagement workshops to capture lived experience, community and health care perspectives. One took place in East London, supported by Bromley by Bow Health Partnership. One took place in North East England (Durham), supported by Live Well with Pain and Durham University. These diverse geographical settings enabled us to capture insights from a post-industrial area with a high prevalence of chronic pain and opiate prescribing, and an inner-city area with a more ethnically diverse population mix. These two-day events brought together community members with lived experience of pain, researchers, service managers and practitioners. Through structured discussions and activities, we shared experiences, evidence, and practical insights (such as the realities of working and seeking care in resource-limited settings). We engaged and built trust within the group. Central to this was acknowledging the reality of individuals' pain stories and the trauma they may have faced along their journey. Online and telephone individual and group discussions were also held with clinicians who were unable to make the workshops.

Evidence from both the literature and community engagement workshops was integrated by first synthesising the evidence and then supplementing it with narratives and case studies from the workshops.

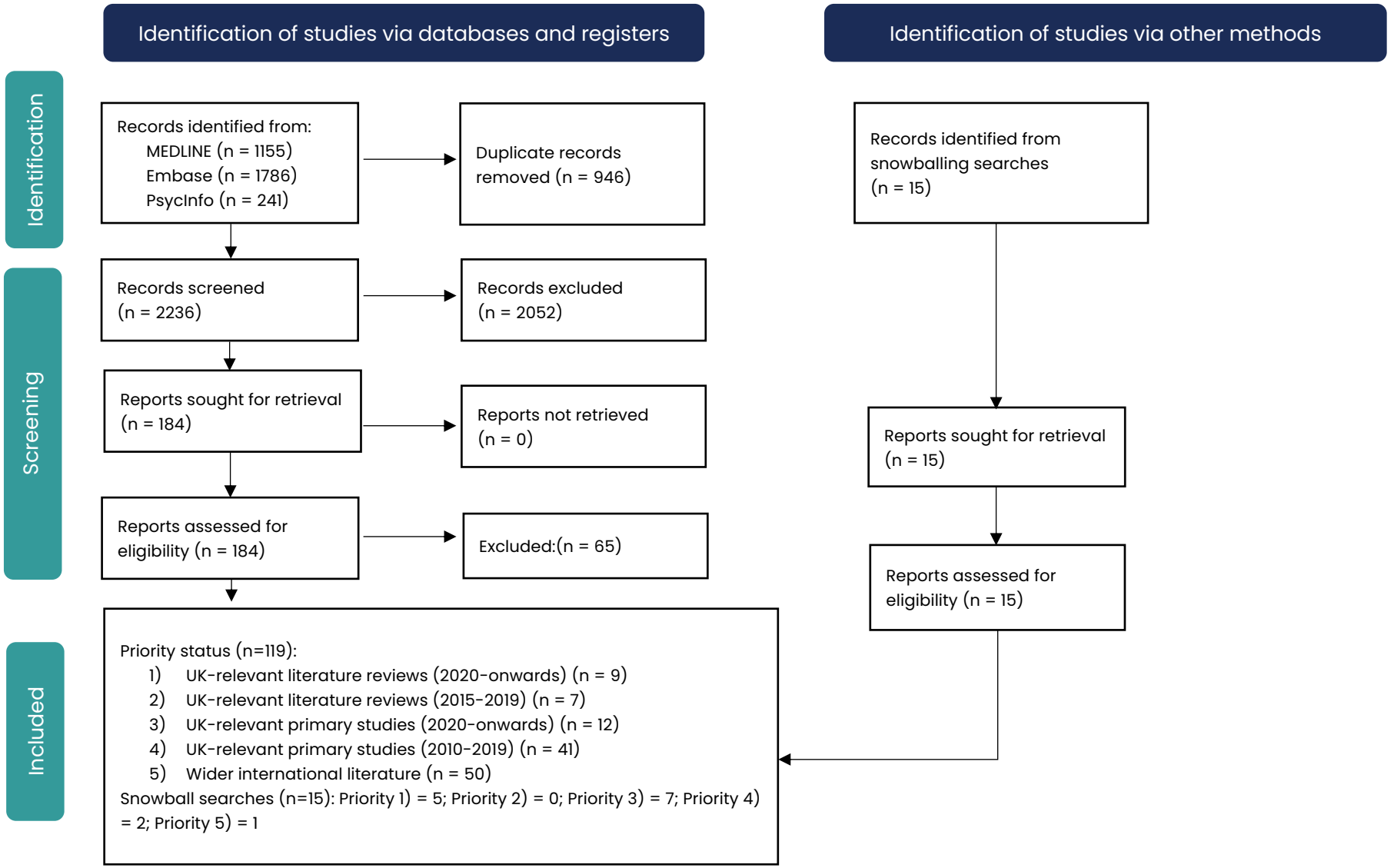
Findings

We identified 3,182 records, with 184 articles reviewed at full-text stage (see PRISMA diagram Figure 5). Following eligibility assessment, 134 studies were included and then organised using the prioritisation framework.

Overall, the evidence base is growing but remains heterogeneous. There is substantial variation in terms of: study populations (for example, adults with differing combinations of MSK conditions, chronic pain and MH needs, or broader chronic pain populations), intervention components (such as psychological therapies, exercise, education, medication management or care coordination), delivery models (including MDT programmes, collaborative care, and community-based approaches), follow-up periods (from end-of-treatment only through to 12 months or longer) and outcome measures (including pain, function, MH, quality of life and service use). In several reviews, this heterogeneity limited the extent to which findings could be pooled or compared and meant that firm conclusions about the most effective components or models could not always be drawn. Reviews that applied narrower inclusion criteria to improve comparability ended up with a smaller number of eligible studies (34,40).

This review drew mostly on reviews, supplemented by primary studies where these addressed gaps in the review evidence. Included reviews varied in size, ranging from 7 to 30 primary studies. The reviews consisted mainly of RCTs, along with rapid reviews, mixed-methods evaluations and cohort studies. Sample sizes varied considerably, from around 25-30 participants to over 9000 participants. The majority included 200-500 participants. Most studies focused on adults with chronic MSK pain or chronic non-cancer pain (CNCP) in primary care or community settings. The majority evaluated multimodal, multidisciplinary or collaborative care approaches, often combining physical, psychological and pharmacological elements. Some examined single-modality interventions such as CBT, or ACT, or mindfulness or body-based approaches like yoga or exercise. The evidence base was dominated by studies from North America, with a smaller number from the UK and other European settings. Notably, relatively few studies addressed the combined overlap of MSK conditions, chronic pain and MH problems as a single target group — most focused on one or two of these conditions.

Figure 5. Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) flow chart of the rapid evidence review (41)



We have organised the data into three key themes that characterise what works in integrated care for people with chronic pain, MSK conditions and co-occurring MH problems. These key themes emerged from integrating findings from the research literature and the themes emerging from the stakeholder workshops. Each key theme is interconnected; effective care models tend to address multiple themes simultaneously rather than in isolation.

Designing integrated, person-centred care with supported self-management

1. Integrative biopsychosocial care

Evidence consistently supports integrated, team-based approaches that bring together multidisciplinary teams to coordinate care around the patient. The biopsychosocial model provides a framework for understanding interventions addressing all three dimensions, which tend to produce better outcomes.

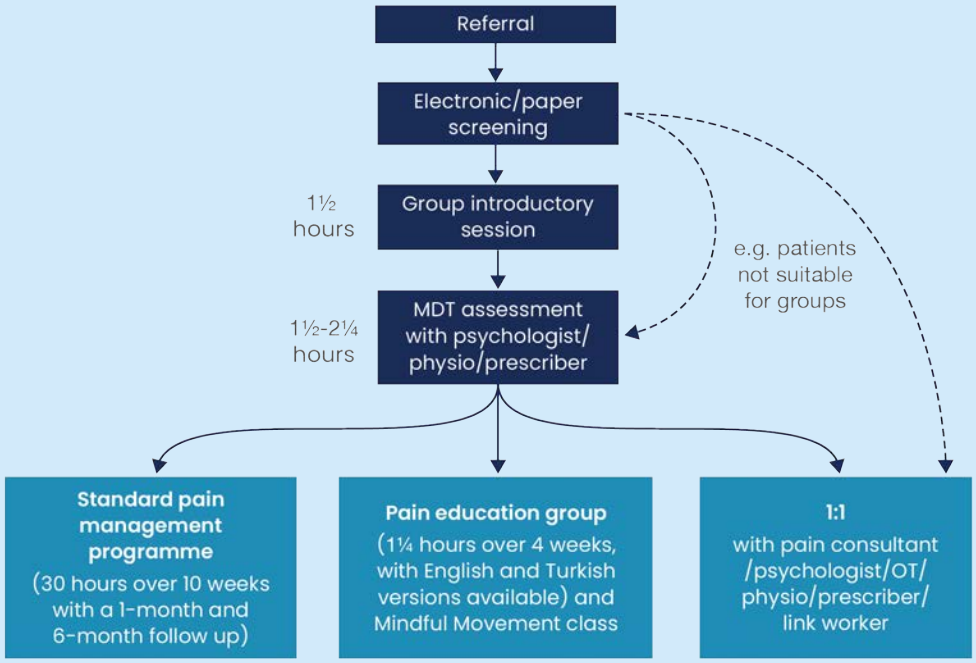
Physical treatments such as exercise, physiotherapy and pharmacotherapy remain important components of pain management, but they are rarely sufficient on their own. In a rapid evidence review of nine studies examining multimodal care models for chronic MSK pain (42), the least comprehensive model — in which pharmacists and physiotherapists focused only on medication optimisation, exercise and self-management — produced no clinically important improvement at 12 months (43).

Psychological factors play a central role in how chronic pain is experienced, maintained and managed. These factors include beliefs about pain, fear of movement, catastrophising and avoidance behaviours. Effective care requires clinicians to move beyond dualistic thinking that separates 'mental' and 'physical' presentations. In a systematic review of 18 RCTs examining collaborative care for chronic pain, findings across several trials showed that patients with co-occurring pain and depression were unlikely to achieve the same treatment outcomes as those with either condition alone (33). When pain significantly interferes with daily life, depression treatment tends to be less effective. Equally, when someone has significant depression, their pain treatment tends to work less well. In one large trial within this systematic review, nearly half of those with no or low pain interference achieved improved depression scores, compared with just over a third of those with high pain. In another, only 36% of patients with pain saw reductions in anxiety compared with 63% without pain. In a third trial, a depression-focused intervention meaningfully improved depression scores (39.6% vs 20.7%) but had no effect on any pain outcome. The evidence for psychological therapies is discussed later (see ‘Psychological therapies as a component of integrated care’).

The social side of the biopsychosocial model is less clearly defined and less well studied than the physical and psychological aspects, even though it is widely recognised as important (45). In stakeholder workshops, participants consistently highlighted how social isolation, loss of employment and limited access to community support shape people's experience of chronic pain. They called for a greater role for voluntary and community organisations. Emerging models such as Bradford's Rethinking Pain programme illustrate what a more socially connected approach can look like in practice. The programme combined health coaching, peer support and community signposting alongside clinical care provision (46,47).

Case study: City and Hackney Locomotor Pain Service

The City and Hackney Pain Management Service is a community-based, therapy-led, Locomotor Pain Service, run by Homerton Healthcare NHS Foundation Trust.



Following referral and screening, the service begins with an introductory group session, delivered in person or virtually. This covers the impact and common experiences of people living with pain, persistent pain education, and a brief introduction to the treatment options and self-management approaches offered. At the end, patients are asked to opt in or out. Those who opt in are offered an individual, MDT assessment with two clinicians — typically a pain physiotherapist and a pain psychologist.

Patients with childcare requirements, those who cannot tolerate a group setting, or those who do not speak English are screened straight to MDT. As the service serves a large Turkish community in Hackney, there is additional provision of a Turkish introductory session.

Care plans, collaboratively designed in MDTs, include individual sessions or one of the group programmes: the Pain Management Programme, a 10-week programme with occupational therapists, physiotherapists, and clinical psychologists; a 4-week physiotherapy-run Pain Education Group (available in both English and Turkish); and a Mindful Movement Class.

Inclusion Criteria: over 16 years old; pain present for more than 6 months that is significantly impacting daily life and/or mood; pain has been fully investigated as appropriate; patient consents to the referral.

Exclusion Criteria: patients with urgent red flags or current active suicidal intent; patients with ongoing assessment or treatment in other services for their pain presentation; patients experiencing severe psychological distress not related to pain.

2. Person-centred care

Effective management of chronic pain requires person-centred care. This means validating the patient's physical symptoms from the outset, understanding their priorities and preferences, and involving them in treatment decisions. The evidence highlights the importance of continuity and shared understanding for effective care. A mixed-methods review (48) of 59 RCTs involving behavioural interventions for patients with 'medically unexplained symptoms', which included unexplained chronic pain, found that the success of behavioural interventions depended heavily on who delivered them and how. Interventions delivered by trained therapists or as part of structured multimodal programmes showed beneficial effects, but when GPs attempted to deliver similar approaches within routine consultations, no beneficial effects were found for any outcome measured. The review concluded that the quality of the therapeutic relationship — including the practitioner's ability to build trust, communicate effectively, and develop a shared understanding of the problem with the patient — was a key factor in determining whether an intervention worked.

How patients understand and relate to their pain also matters. In an umbrella review covering a decade of evidence on the management of functional somatic syndromes, pain-related beliefs and expectations (such as fear that activity will worsen pain, or strong convictions about biomedical causation) were found to contribute to the persistence of symptoms and poorer outcomes (49). The review emphasised that good management requires clinicians to validate physical symptoms from the outset and to work towards a shared understanding, shifting the focus from cure to care and coping. Importantly, this reframing is needed not only from patients but also from the clinicians working with them.

Part of person-centred care means care planning and getting help at an early stage (12). Recognising the needs of patients with chronic pain and co-occurring mental health problems early on is therefore important. In a systematic mapping review of guidance for physiotherapists, all included articles recommended the use of clinical interviews or screening tools to identify psychological distress as part of routine MSK assessment (50). This assessment can be embedded at the point of presentation, as part of a person-centred approach.

The role for creative arts: Unmasking pain project

The Balbir Singh Dance Company employs dancers with chronic pain and works with groups with long-term conditions including chronic pain. In collaboration with Live Well with Pain, Durham University, Pain Challenge Academy, and Leeds Beckett University, they undertook a creative project to help people with chronic pain to tell their story, called Unmasking Pain.

The collaboration brought together artists, people living with chronic pain and pain management specialists. It aimed to understand, process, listen to and promote patient stories. Ultimately, it hoped to help patients have a healthier relationship with pain and reduce reliance on painkillers. Artistic methods used included music therapy, co-production of artworks, use of dance, drawing, painting, sculpturing, poetry to express pain experiences and connections with nature. The initial project included 12 people with lived experience of chronic pain who all reported either a decrease or stabilisation of pain medication usage, with 100% of participants having a reduction in pain catastrophising scores and an increase in confidence scores, reduced resting heart rate (5 units), and 2-hour increase in restful sleep (51).

3. Supported self-management

Supporting people to actively manage their own pain is a recurring theme of effective interventions. For many people living with chronic pain, a shift in expectations (from seeking a cure to learning to live well despite pain) is fundamental to improving quality of life. This shift can be particularly difficult for people with co-occurring mental health conditions, which may reduce a person's ability to engage with self-management. Therapeutic approaches such as ACT specifically address this by helping people commit to activities that matter to them, even in the presence of ongoing discomfort. This approach is recommended by the National Institute for Health and Care Excellence (NICE) for adults with chronic pain and long-term conditions, based on evidence that it can improve functioning, quality of life, and reduce psychological distress (14).

Evidence suggests that this shift from seeking a cure to learning to live with pain does not happen automatically; it requires structured support, accessible resources, and practitioners who feel confident in guiding it. In a US-based scoping review of 10 studies examining multidisciplinary pain programmes in settings among socioeconomically disadvantaged and underserved populations, most quantitative studies showed significant improvements in pain related outcomes post-intervention, however results were mixed. The strongest qualitative finding across these studies was an increased recognition among patients of the importance of actively self-managing their pain (52). This is consistent with broader evidence that treatments that engage people in understanding their own pain, are more effective at improving functioning and MH outcomes than passive approaches (49).

It is important to consider the potential to widen health inequalities with self-management programmes as underserved communities tend to benefit less due to socioeconomic, cultural, environmental and educational barriers that make adherence challenging (24).

Delivering coordinated, multidisciplinary services

A consistent theme across all studies is the need for multi-component care. Several studies have found that models of care that incorporate multiple components perform better than single-component interventions. For example, programmes that include both physical and psychological components result in better outcomes than interventions that address only one dimension.

1. Multidisciplinary team-based models

Approaches that bring together practitioners from different disciplines around the patient are supported by the strongest evidence. Effective models have someone responsible for coordinating care across services. The Canadian Agency for Drugs and Technologies in Health undertook a review of multidisciplinary treatment programmes for people with chronic pain in 2019. Based on two reviews, two RCTs and an economic evaluation, the authors found that MDT programmes were associated with reduced pain intensity and improved function (44).

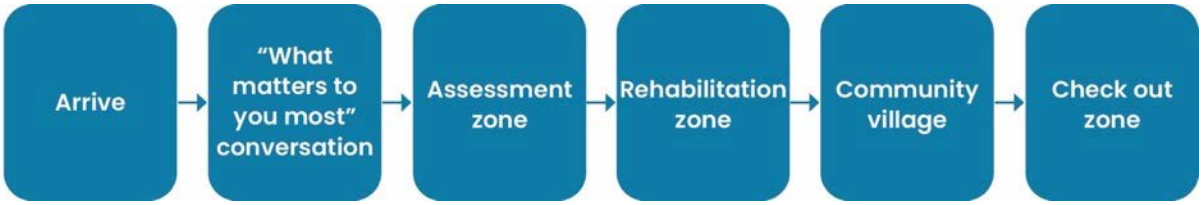
Collaborative care management (CCM) has shown promise for improving pain severity, pain-related disability, and MH outcomes in primary care. The approach involves a designated care manager coordinating care between patients, their GP and specialists. In a systematic review of 18 RCTs examining collaborative care for chronic pain, several trials reported meaningful improvement (33). In one trial of patients receiving CCM, pain-related disability improved by 1.4 points compared with 0.2 points in usual care, and pain intensity improved by 4.7 points compared with 0.6 points. In another trial in the same systematic review, average pain scores were lower in the CCM group (3.57 vs 4.59 on a 10-point scale), with improvements also observed in pain severity (3.80 vs 4.80) and pain interference (3.34 vs 4.38).

Within team-based approaches, there are some CCM interventions that include a pharmacist or a medication review. In one trial, the intervention included a pharmacist working alongside a nurse care manager. The intervention increased guideline-concordant opioid prescribing (65.9% vs 37.8%), meaning patients were more likely to have their opioid dose reduced (33). Interventions with nurse care managers or specialist addiction and pain support have also shown promising effects for preventing opioid dependence in patients with CNCP, though the evidence base remains small and further adequately powered trials are needed (53).

Community appointment days (CAD) have been piloted in Sussex. CAD are community-based, full-day events that allow patients access to clinical expertise, community organisations and voluntary sector services. A mixed methods evaluation of 130 patients found that the majority of patients (95/97 completing the survey) were likely or extremely likely to recommend CAD to friends and family. Only 28% of patients required follow-up in the local MSK service (54). Another pilot in NHS Lanarkshire with 1271 patients attending CAD found that 52% of those attending did not need any MSK follow-up. Partner organisations that contributed to the non-

medical component were leisure facilities, followed by charities, such as Versus Arthritis, and podiatry services (55).

Figure 6: Community appointment day model



Source: Ingram 2025 Acceptability of Musculoskeletal Community Appointment Days: A Mixed-Methods Service Evaluation (54)

2. Group consultations

Evidence for group consultations, also known as Shared Medical Appointments (SMA), is limited to small studies and tends to arise from wider multi-component pain programmes. Most of the evidence for group consultations comes from diabetes care, and there are only two published RCTs that consider chronic pain and/or MH (56).

Sheffield and colleagues (2022) reviewed multidisciplinary chronic pain programmes (52). The authors found four studies (two quantitative and two qualitative) that looked at Integrative Medical Group Visits (IMGV). IMGVs combine mindfulness, integrative medicine and peer support. Proponents argue that group visits offer an opportunity for diverse underserved patients who have limited access to non-pharmacological therapies to access care. The largest of the included studies was an RCT by Gardiner and colleagues (2019) (57). The study recruited 159 predominantly low-income, ethnically diverse adults with non-specific chronic pain and depressive symptoms for a nine-week IMGV, compared with standard primary care. There were no differences in pain or depression scores, but the IMGV group had fewer emergency department visits at 9 weeks compared to controls. At 21 weeks, the IMGV group reported a reduction in pain medication use.

Evidence for group consultations may not be published. For example, a group consultation intervention for patients with fibromyalgia was implemented in East London in Nov-Dec 2023 (personal correspondence from Claire Rees, more information available on request). Group consultations were delivered in a GP surgery and supported by a local fibromyalgia peer-support group, with talks over 6 weeks by a health and wellbeing coach, social prescriber, and physiotherapist from the pain management programme. 26 patients attended at least one session. There was no significant difference in quantitative markers of fibromyalgia severity and pain self-efficacy, however a post-participation evaluation survey showed that over half felt more confident in managing their condition, and most would recommend group consultations. Feedback included "attending the group makes you feel less isolated regarding your condition" and "it is always good to hear from others who are in the same position as you. Sometimes you feel alone."

3. Peer support

While group consultations provide peer support as part of a broader programme, there are also studies that focus primarily on peer support. This may include involving peer mentors/ volunteers who have the same condition. Peer support may be provided in a range of formats including: 1:1, group, face-to-face, online, phone, hybrid, or part of a multicomponent intervention.

Wilson and colleagues (2024) reviewed trials for peer support for chronic MSK pain but did not include MH outcomes. The authors included 24 small trials ranging from 50 to 800 participants. The authors combined the studies using a meta-analysis and found small statistically significant improvements in pain, self-efficacy and function compared to usual care but none were clinically significant. The authors concluded that peer support interventions demonstrated sufficient effectiveness to be part of a broader programme (58).

Stenberg and colleagues (2022) undertook a review to look at peer support to help self-management through psychological support. The authors included a range of interventions including group meetings and other peer-led activities delivered within support groups (n=3); peer-led self-management programmes/courses (n=3); peer coaching/mentoring (n=2); and online communities (n=3). The authors proposed a conceptual framework to improve the effectiveness of peer support programmes which focus on 1) enhancing autonomy, 2) building competence and 3) increasing motivation. Overall, the authors argue that peer support helps individuals to feel more in control and more connected (59).

Durham Pain Café

Durham Haven Pain Cafe is a community group set up by Su Madden in 2017 for people with chronic pain including fibromyalgia. Attendees get support to understand their long-term pain, learn a range of self-care skills and engage in social and physical fitness activities and improve mental well-being. The group (now over 250 members) holds weekly three-hour meetings featuring a mix of arts and crafts, guest speakers on topics such as pain self-management and mindfulness, and physical activities like indoor curling. Sessions also include group learning on core self-care skills based on the Ten Footsteps programme, led by members with lived experience.

Pain cafés are community-based peer support groups where people with chronic pain come together to learn self-management skills, share experiences and reduce isolation. The model was formalised as a named approach in Plymouth in 2023 and has since grown to over 150 cafés across the UK and abroad, supported by Live Well with Pain. Early evidence suggests they can help reduce opioid use, improve people's sense of control over their condition and decrease reliance on GP visits (60).

4. Psychological therapies as a component of integrated care

Approaches that actively engage patients in addressing pain-related beliefs and expectations tend to produce better outcomes than passive treatments (49). Addressing these factors through structured psychological therapies is a key component of effective integrated care.

CBT has the largest evidence base for chronic pain, with Ma and colleagues (2024) finding preliminary evidence of a positive effect on pain for patients with depression, with a small to medium effect size (40). ACT, recommended by NICE for chronic primary pain (14), offers a complementary approach: rather than focusing solely on symptom reduction, it helps people engage in meaningful activities despite ongoing discomfort, which is relevant to supported self-management (discussed earlier). ACT is transdiagnostic, meaning it can address multiple conditions simultaneously, and has been delivered flexibly, including through brief group workshops (61).

For people with co-occurring chronic pain and substance use disorders, a narrative review of 30 studies similarly suggests that psychotherapies (including CBT, ACT and mindfulness-oriented recovery enhancement (MORE)) may improve pain and substance use outcomes when delivered together (62). They assessed a range of delivery mechanisms, such as primary-care-based, telephone, online or group settings. CBT had the largest evidence base across 11 trials, with several studies reporting reductions in opioid misuse and modest pain improvements, though results were mixed.

5. Medicines optimisation

Evidence suggests that people with MSK conditions, chronic pain and MH problems are best supported by care models that include structured medicines reviews in the context of supported self-management, ongoing monitoring and multidisciplinary input. A single drug or prescribing regimen alone is insufficient. For example, Peterson and colleagues found most of the evidence for models that couple a decision-support component, e.g. algorithm-guided treatment and/or stepped care, alongside proactive, ongoing treatment monitoring (42).

The management of opioid use in the context of chronic pain is a critical challenge. Evidence supports moving away from opioid-first approaches and towards non-pharmacological alternatives, ensuring that patients who do require opioids receive support and are monitored for signs of dependence. It should be noted that clinical practice guidelines consistently recommend non-pharmacological strategies, for example, exercise or CBT/ACT. For example, NICE guidance for chronic primary pain (NG193, 2021) does not support the initiation of opioids (14).

Collaborative care approaches have evolved in response to what researchers have described as “fractured medical care” designed around medical sub-specialities. The model has been developed in North America and uses protocol-based strategies with a care manager in primary care to coordinate services. A recent review found several trials that demonstrate how collaborative care can both reduce pain intensity and reduce opioid prescribing (33). Key to improvements were the multicomponent nature, which may include nurse care management, medication review, algorithm-guided management, psychological input, electronic health record review and opioid-prescribing tools.

French and colleagues (2024) specifically reviewed primary care interventions to prevent opioid dependence in people with CNCP (53). Based on 18 studies, 8 of which were trials, they found mixed evidence with the strongest evidence for a nurse care manager (or similar dedicated staff member) to support people who were already prescribed opioids.

GOTT (Gabapentinoids and Opioids Tapering Toolbox) approach in North East England

This approach was developed in 2019 and trialled in a large primary care practice in County Durham with the highest strong opioid prescribing in Tees Valley Clinical Commissioning Group. The intervention included education for clinicians (using the Live Well with Pain 10 Footsteps programme) and creation of an annual health check for patients on opioids. Training started in June 2020; high-dose opioid prescribing fell to well below the national average and then to zero. There was also around a 50% reduction in gabapentinoid prescribing by December 2022, with an estimated cost saving of £130,000 in one year. Clinician confidence improved in behaviour change support, self-care support, and difficult consultations (63). The lead GP from the programme told us about a bed-bound patient who was experiencing significant side effects from opioid use and polypharmacy. Following the intervention the patient was able to re-develop relationships with family members and leave the house.

6. Community-based models

For people living with chronic pain, community-based models complement clinical services. For this group of patients, long-term support, social connection, and ease of access to care may be just as important as the clinical treatment itself. Community-based support delivered through Voluntary, Community, Faith and Social Enterprises (VCFSEs), social prescribing and local groups can help people with ongoing management of their pain and address dimensions of care outside clinical practice (64). The evidence base is limited with respect to community-led approaches that target the intersection of chronic pain, MSK and MH. There are several examples of voluntary and community sector organisations delivering services as part of a broader partnership, for example, as part of community appointment days described above (54).

Non-pharmacological interventions such as yoga, Tai Chi and mindfulness can be delivered in clinical, community or home settings. In a scoping review, these interventions show evidence of benefit for either MSK symptoms or MH outcomes when studied separately, but only one systematic review looked at co-morbid patients (65). In a network meta-analysis of 29 RCTs comparing community-based, non-pharmacological interventions for fibromyalgia, aquatic exercise ranked the highest in significantly improving both anxiety and depression. Other interventions that included CBT, Qigong, and hydrotherapy also showed improvement in anxiety and/or depression (66).

Community-led approaches to pain management

Bradford's VCFSE-led pain management programme, Rethinking Pain, is an innovative community-led pain management initiative. It is commissioned by Bradford District & Craven Health and Care Partnership to lead and deliver pain services in the community, in partnership with the clinical sector. The initiative uses a two-tiered system: Tier 1) GPs or MSK services refer to health coaches with patient education, peer support and signposting, Tier 2) includes pain social prescribers and 10-module education programme.

Crucially, the programme is delivered by VCFSE organisations, led by Keighley Healthy Living, and was co-produced with service users, community members, and healthcare professionals, ensuring it is rooted in the communities it serves. It is delivered in accessible community spaces, and in multiple languages, and uses storytelling, creative arts, and approaches that work with a person's faith, beliefs, and cultural context to ensure relevance and resonance. Reviews of this service have highlighted how it builds on the principles of de-medicalising pain, including "pain language", reducing burden on health services, providing personalised care, and reducing health inequalities. There is explicit recognition that chronic pain and multimorbidity are linked to broader social determinants of health (46,47).

Developing workforce capability for integrated care

Designing the optimum MDT is key to providing integrated care. Here we focus on roles that may not be part of a traditional health care model, acknowledging the important role for GPs, pain specialists, nurses, pharmacists, physiotherapists, voluntary and community sector staff and peer support workers.

1. Care co-ordinators and care managers

Several studies assess the role of health and care staff who coordinate care and help patients navigate services. These staff members may be nurses, allied health professionals or dedicated care navigators. The Collaborative Care Management approach, described above, relies on a care manager to support patients, with positive outcomes in pain and opioid measures (33). French and colleagues (2024) found the most evidence for nurse care managers (53). Similarly, Peterson and colleagues (2018) found that most models of care that were included in their review used designated case managers. Case managers had diverse professional backgrounds and delivered the treatment-monitoring component, usually via phone, ranging from weekly contact to every 2 months. This monitoring component, combined with clinical decision support, was a key feature of models that achieved clinically significant improvement — four out of five studies included in the review achieved 30% or greater improvement in pain at 12 months (42)

2. Physiotherapists skilled to support psychological wellbeing

Physiotherapists need to be prepared to support people with anxiety, depression, anger, fear, disappointment and loss in their clinical practice (67). There is an increasing number of physiotherapists who are trained to identify, assess, and manage pain-related distress, including the incorporation of screening for MH conditions. McGrath and colleagues (2024) reviewed 40 articles on the role of physiotherapists in supporting psychological distress (50). Rather than evaluating outcomes, the authors identified approaches for detecting and assessing psychological distress (brief depression screening, integrated suicide/self-harm and depression screening, and multidimensional screening with health-related distress assessment) and four approaches for managing it (education and reassurance, CBT approaches, mindfulness, and case management including referral).

3. Health and wellbeing coaches and social prescribers

Health and wellbeing coaching that supports self-management through goal setting and behaviour change may be beneficial. In a systematic review and meta-analysis of 30 randomised trials examining health and wellbeing coaching for adults with chronic conditions (only five studies were MSK and chronic pain related), one MSK/chronic pain-related study showed a moderate improvement in self-efficacy. In contrast, the other MSK/chronic pain-related studies showed little to no clear improvement in other outcomes like quality of life, depression, and anxiety (68).

The evidence for social prescribers remains mixed. Kiely and colleagues (2022) did a review of social prescribing link workers. Based on the eight studies, five RCTs and three before-and-after studies, the authors concluded that there was an absence of evidence. Four studies that included participants with multimorbidity and social deprivation reported no impact on health-related quality of life, and of four studies that reported MH outcomes, three reported no impact (69). However, two US studies found improvements in health care satisfaction and reduced hospitalisations. Similarly, Cooper and colleagues (2022) explored social prescribers specifically for people with MH conditions. Based on the 17 included studies, the authors reported that robust conclusions on the effectiveness of social prescribers could not be made (70). Spanos and colleagues (2025) reviewed 30 studies examining social prescribers for MH, wellbeing and psychosocial improvement, and found more positive results, with the caveat that the studies reporting positive findings were more likely to be smaller and/or uncontrolled (71).

Community perspectives

Our discussions with health professionals and community groups revealed enthusiasm for social prescribers and health and wellbeing coaches. These staff members often act as community activators, helping with gaps in voluntary and community sector provision, as well as helping peer support groups. People with lived experience emphasised the importance of promoting community and non-pharmacological approaches, rather than medication-centred consultations.

Our community engagement suggested that patients often received outdated and incorrect information on managing chronic pain. People with lived experience often felt stereotyped, unheard or dismissed. This group emphasised the importance of professional education that includes cultural competency and a move away from medication-focused consultations. This training should be delivered to a range of primary care staff, including GP receptionists, GPs, primary care nurses, social prescribers and health and wellbeing coaches working in chronic pain and MSK pathways

4. Staff training

Evaluating the impact of staff training is difficult. Studies that evaluate only training tend to find positive short-term impacts on staff or student confidence and knowledge, but struggle to demonstrate impacts on patient outcomes (72). Staff training was included in several broader models of pain management, such as the GOTT evaluation (63), or physiotherapist training in psychological distress (50), but in these studies it is difficult to isolate the impact of training.

Corline and colleagues (2023) undertook a mixed-methods study examining training for social prescribers to provide self-management support for people with chronic pain in North East England using the 10 Footsteps Pain Programme. 48 people attended training and 25 completed the follow-up questionnaire, with follow-up impacted by the COVID-19 pandemic. Staff confidence in supported self-management statistically improved after training and continued at 3-month follow-up (73).

Staff education

Live Well with Pain is an organisation run by health professionals with an interest in chronic pain management. They deliver co-produced resources for practitioners and patients. Their flagship 10 Footsteps Pain Programme is endorsed by the Personalised Care Institute and focuses on providing resources to patients and health care professionals to better support patients experiencing chronic pain. The 10 footsteps are modules in the following topics: Pain and the brain; Acceptance; Pacing; Setting goals and getting active; Relaxation and mindfulness; Sleep; Communication; Managing moods; Medicines and Nutrition; and Managing Setbacks (74).

Discussion

Chronic pain, MSK conditions and coexisting MH problems represent a substantial and growing burden of disability and economic inactivity. We found consistent evidence across both the academic literature and throughout our stakeholder engagement that effective care for people living with chronic MSK pain and coexisting MH conditions requires integrated, biopsychosocial, and person-centred approaches delivered through coordinated primary and community care systems. While this conclusion is not new, the challenge is how to design and deliver care to meet these aims.

Existing research suggests that effective care is characterised by multi-component models. These models combine physical, psychological and social elements and are supported by MDTs, group-based approaches, peer support, medicines optimisation and engagement with communities. These multi-component models should facilitate supported self-management to help people shift from seeking a cure to living well with their health conditions.

Rethinking evidence for complex service models

The evidence for effective models of care is limited when traditional hierarchies of evidence prioritise randomised controlled trials. The complexity and context-dependent nature of integrated care models mean that there is unlikely ever to be sufficient trial-level evidence to directly inform the design of new models of care. We found that the most promising models involve multiple interacting components built around dynamic MDTs that benefit from partnerships with local community organisations. These models are difficult or impossible to evaluate within a trial.

Undoubtedly, more research is needed to understand optimum models of care. Rather than relying on trial-level evidence, a shift towards quality improvement approaches is needed. This could take the form of learning health systems where services are continuously improved through iterative feedback, real-world data, and collaborative learning. This requires high-trust partnerships between health commissioners and providers, academia and communities. Knowledge brokers, who link between knowledge producers and users, alongside shared learning infrastructures, may be more effective in driving improvement than isolated evaluations of tightly defined interventions. Such approaches also require psychological safety within and across organisations to liberate staff to test, adapt and refine models.

The implementation gap: policy ambition versus service reality

The findings also highlight a persistent gap between national policy ambition and the realities of service delivery. Current NHS policy strongly emphasises integration, neighbourhood-based care and multidisciplinary working, all of which are supported by the evidence. However, insights from community workshops suggest that the realities of care are different from what is described in national policy. These include limited interoperability of electronic patient records, organisational silos, lack of trust between services, and rigid referral pathways that place the burden of coordination on patients and their carers. As a result, individuals with complex needs often experience fragmented care, multiple appointments and uncertainty.

The role of community and peer-led support remains underdeveloped within formal service models. Our review did not find many studies examining community-based or peer-led models of care, however community perspectives suggest that these approaches are both valued by patients and relatively low-cost. In this context, there is a strong argument for incorporating community assets into care models, such as through the provision of grants to support the sustainability of VCFSE-provided services without requiring the same level of evidence as high-cost clinical interventions.

Workforce: capability, roles and new models of care

Delivering integrated, biopsychosocial care requires not only changes to service configuration but also rethinking workforce capability and roles. The evidence supports expanded and more flexible roles within MDTs, including physiotherapists trained in psychologically-informed care, health and wellbeing coaches, and MH professionals embedded within MSK and pain pathways.

However, current workforce models do not consistently support this level of integration. Staff often lack the training, confidence or capacity to deliver psychologically-informed, trauma-aware care, and professional boundaries can reinforce fragmentation. The views of people with lived experience we heard in our community workshops highlighted the lack of knowledge and skills that health and care professionals have in supporting people with chronic pain and MH conditions. Increasing the capacity and capability of the workforce requires both training and supporting the evolution of these roles that cross traditional disciplinary boundaries.

Opportunities within system reform

The ongoing development of newly forming integrated neighbourhood teams (INTs) presents a significant opportunity to redesign care for this population. However, there is a risk that without clear national guidance and support, Integrated Care Boards (ICBs) may struggle to design and implement effective models at scale. The complexity of these conditions, combined with existing service fragmentation, means that local systems may default to incremental changes rather than the more fundamental redesign required. National frameworks that articulate core principles, supported by shared learning across systems, could help accelerate progress.

Chronic pain, MSK conditions and MH problems all compound inequalities through the bidirectional link between health, wellbeing and economic activity. Current service models often exacerbate these inequalities by relying on patients to navigate complex systems. There is an expectation that patients possess a level of digital literacy, meet rigid referral criteria, or engage with services that are not culturally appropriate. There is an opportunity to design and deliver integrated, biopsychosocial services for patients, which not only improve outcomes but also support the most underserved individuals and communities.

Future research priorities

This evidence review has highlighted significant gaps in the research. While there is a large volume of research studies focusing on medication, there is much less on models of integrated

biopsychosocial care in real world settings. Future studies should focus on identifying the key components needed for a holistic multidisciplinary approach. Pragmatic methods are needed which acknowledge the importance of population and organisational contextual factors, such as realist evaluations, mixed methods studies and natural experiments. To support these multidisciplinary approaches, more research is needed on workforce roles and how existing workforce skills could be extended.

Research to understand the effectiveness of community-led approaches to chronic pain is needed, including creative and arts-based programmes. Longitudinal and implementation-focused studies are needed to examine how integrated care models affect inequalities over time and how they can be adapted to better meet the needs of underserved communities.

There remains a lack of consensus on the best outcomes for this group. Development of a core outcome set for people with MSK conditions, chronic pain and mental health comorbidity, combining clinical outcomes, patient-reported outcomes and experience measures, is needed. Furthermore, there remains a lack of economic evaluation to understand long-term costs and benefits across health and care systems. Economic models, such as system dynamic modelling and microsimulation, are needed to take a systems approach and understand the future impacts of service changes.

Recommendations

Recommendations for national organisations: Support commissioning of integrated, person-centred care with supported self-management

1. **Prioritise a national strategy to ensure the provision of integrated chronic pain, MSK conditions and MH care.**

   A national strategy or Modern Service Framework, with an ambitious "moonshot" would give ICBs the support they need to design integrated, biopsychosocial services. This should describe a core offer that includes multidisciplinary assessment, care coordination, shared care planning, supported self-management, medicines optimisation, and access to community or peer support.

2. **Prioritise a service specification template on how to commission integrated pain, MSK and MH services with single points of access to multidisciplinary care.**

   ICBs should be supported to commission integrated services with national support that enables triage by an MDT through a single point of access and have a range of support options, including group consultations, coaching and peer support.

3. **Prioritise an interoperable electronic health record with agreed minimum summary-level clinical information for this cohort across GP, community, MH and social care interfaces to allow sharing of information.**

   Provision of integrated care relies on health and care professionals being able to share information seamlessly using an interoperable electronic patient record. Agreeing a minimum data set to be shared may require further work to build consensus.

Recommendations for local decision-makers: Deliver coordinated, multidisciplinary services

4. **Prioritise people with chronic pain, MSK conditions and MH problems for neighbourhood health and care planning, and use local population health management capabilities to generate insights.**

   Integrated neighbourhood teams (INT) have been asked to focus on high-priority cohorts and to base plans on Joint Strategic Needs Assessments. There is a need to highlight this cohort as a priority in INT planning, given their high levels of disability and correlation with socioeconomic deprivation, with support from local data insights team to help commissioners, such as local authority public health teams.

5. **Commission Voluntary, Community and Faith Sector Enterprises and provide grants for peer support groups as part of integrated care.**

   Voluntary, Community and Faith Sector Enterprises (VCFSE) should be commissioned with simple grants available for peer support groups, such as pain cafés. Local commissioners should consider co-commissioning services with VCFSE organisations and groups.

6. **Ensure medicines optimisation is part of the integrated multidisciplinary model, with a specific focus on reducing avoidable long-term opioid and gabapentinoid dependence.**

   Medicines optimisation is needed as part of a holistic approach and should focus on reducing the medication burden on patients.

Recommendations for workforce planning: Developing workforce capability for integrated care

7. **Workforce planning should focus on innovative skills and roles, rather than traditional professional boundaries.**

   There is a need for existing staff to work differently, with a focus on expanding the skill set of the current workforce, particularly physiotherapists trained in psychological therapies and roles such as social prescribers and health and wellbeing coaches who specialise in chronic pain and mental health conditions.

8. **Existing staff should be upskilled to support a biopsychosocial approach to caring for people with chronic pain, mental health problems and MSK conditions.**

   Health and care staff need to move away from a medication-dominated approach to managing chronic pain and mental health problems to the provision of psychological and social support, acknowledging that medication will have a role to support patients to benefit from psychological and social support.

Recommendations for national and local system planners: Continually build and share evidence of the most effective models of care

9. **Agree and publish a basket of outcomes for this cohort.**

   A lack of agreed outcomes continues to limit evaluation and monitoring at a local and regional level. There is unlikely to be a single set of outcomes, but agreement on a national basket of outcomes will help local commissioners and providers to understand what works. These should include patient-reported outcomes and experience metrics, in addition to existing clinical metrics.

10. **Build the evidence base through a learning health system approach which incorporates real-time evaluation, monitoring and feedback.**

    There is unlikely to be sufficient trial-level evidence to conclusively inform decision making in relation to models of care, therefore a learning health system approach with shared learning and knowledge brokers should be used to capture emerging evidence, optimise services and share insights.

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