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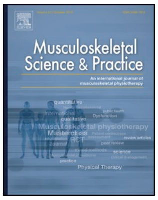

Psychosocial assessment in musculoskeletal care: A survey of UK physiotherapists

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ABSTRACT

Background: Psychosocial factors strongly influence musculoskeletal (MSK) outcomes, yet their systematic assessment remains inconsistent in physiotherapy practice. Although validated psychosocial assessment tools exist, little is known about how UK MSK physiotherapists use them.

Objective: To explore UK physiotherapists' perceptions, practices, and confidence regarding psychosocial assessment, and to identify key challenges and facilitators.

Design: Cross-sectional online survey.

Methods: An anonymous online questionnaire was distributed via professional networks and social media to qualified UK-based MSK physiotherapists. Questions focused on demographics, perceptions, practices, and challenges/facilitators regarding psychosocial assessment. Quantitative data were analysed descriptively and using non-parametric statistics; free-text responses were examined narratively.

Results: 373 physiotherapists responded, from a range of roles and experience levels. Most rated psychosocial factors as highly important and reported they often influenced treatment planning. Assessment relied mainly on clinical judgement and explicit questioning, while formal tool use was uncommon. Confidence in identifying and interpreting psychosocial factors showed moderate positive associations with screening tool use and weak or no associations with years of clinical experience. The most cited challenges to use of validated tools were time constraints, and training, whereas concise tools, electronic integration, and evidence of patient benefit were viewed as key facilitators.

Conclusions: UK MSK physiotherapists recognise the importance of psychosocial assessment, but its application in routine practice remains inconsistent and largely informal. Confidence appears to be more closely related to exposure to psychosocial screening tools than to years of clinical experience. These findings highlight the need for approaches that support consistent psychosocial assessment within routine MSK care.

1. Introduction

Musculoskeletal (MSK) conditions, including disorders of muscles, bones, joints, and connective tissues, are a leading cause of pain and disability worldwide (Guan et al., 2023). In the United Kingdom (UK), around one in three people live with an MSK condition, representing the third largest area of NHS expenditure, estimated at over £6.3 billion in 2022–2023 alone (Versus Arthritis, 2024). Common conditions such as low back pain, neck pain, and arthritis often affect patients' ability to participate in work, physical activity, and daily life, and contribute to a significant proportion of disability-adjusted life years globally (World Health Organization, 2022).

While the physical dimensions of MSK conditions have traditionally dominated diagnostic and treatment models, increasing evidence has highlighted the critical influence of psychosocial factors in the onset, persistence, and recovery from MSK pain (Dunn et al., 2024; Martinez-Calderon et al., 2020). These factors include psychological elements such as fear-avoidance, catastrophising, anxiety, as well as broader social influences such as poor social support and work-related stress (Keyaerts et al., 2022; Vargas-Prada and Coggon, 2015; Wertli et al., 2014). Given their overlap and combined prognostic relevance, this study uses the term 'psychosocial' to encompass both psychological and

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social domains.

Unaddressed or poorly managed psychosocial factors are associated with worse outcomes, prolonged disability, and increased healthcare use (Giusti et al., 2021; Vargas-Prada and Coggon, 2015). Accordingly, best-practice guidelines emphasise the need to assess, identify, and address psychosocial factors as part of the comprehensive management of MSK conditions (Andrade et al., 2020; NICE, 2016; Oliveira et al., 2018; Willy et al., 2019). A range of validated psychosocial assessment tools have been developed to support clinicians. Some focus on specific constructs, such as the Tampa Scale for Kinesiophobia (Dupuis et al., 2023), while others are multidimensional screening tools, like the STarT Back Screening Tool (Hill et al., 2008) and Örebro Musculoskeletal Pain Screening Questionnaire (ÖMPSQ) (Linton et al., 2011). These instruments can help stratify patients based on prognostic risk and support personalised interventions, yet international research shows that physiotherapists instead often rely on informal questioning or clinical judgement alone, which may under-identify at-risk patients (O'Neill et al., 2024; Klem et al., 2024; Man et al., 2019; Östhols et al., 2019; Otero-Ketterer et al., 2023).

Barriers to the use of formal tools include time constraints, limited training, uncertainty about which tools to select, and lack of integration with electronic health records (Hill et al., 2020; Klem et al., 2024). Facilitators to their use include access to concise, user-friendly tools, appropriate training, integration into clinical pathways, and organisational support (Meerhoff et al., 2021; Östhols et al., 2019). Whilst these factors have been explored internationally, there is limited UK-specific evidence on current MSK physiotherapy practice in this area. Previous research also suggests that clinical experience, training, and job role may influence both confidence in identifying psychosocial factors and the likelihood of using formal tools (Beales et al., 2016; Henning and Smith, 2023; Otero-Ketterer et al., 2023).

Understanding how UK physiotherapists perceive, assess, and manage psychosocial factors is essential for identifying training needs, informing service design, and supporting guideline implementation. Given international evidence of low uptake of validated questionnaires, we conducted a national survey to examine current practice in the UK, with particular attention to clinicians' perceptions, assessment approaches, and the role of formal screening tools in routine MSK care. The survey explored confidence in using psychosocial assessments, the extent and context of screening-tool use, and perceived challenges and facilitators to implementation. The aim of this study was to investigate the perceptions, practices, and attitudes of UK physiotherapists regarding the assessment of psychosocial factors in the management of musculoskeletal conditions.

2. Methods

2.1. Study design

A cross-sectional online survey.

2.2. Participants

Eligible participants were Health and Care Professions Council (HCPC)-registered physiotherapists based in the UK who were actively working in MSK care in a patient-facing clinical role. Physiotherapists were excluded if they were not currently working in MSK practice, held non-clinical positions, or were unable to complete the online survey.

2.3. Recruitment

The survey was promoted using convenience and snowball sampling methods. Recruitment was via professional networks, social media, and organisational email lists. Survey links were shared via professional forums, including the interactive Chartered Society of Physiotherapy (iCSP) discussion boards; an online platform for UK physiotherapists to exchange clinical and professional information. The survey was also circulated through MSK interest groups and social media platforms, including Facebook, X, and LinkedIn. In addition, the authors shared the survey directly with professional and personal contacts working in MSK physiotherapy, who were encouraged to forward it to colleagues to maximise reach. Two reminder posts were issued on social media during the recruitment window. No incentives were offered.

2.4. Sample size

No formal sample size calculation was undertaken. The size of the UK musculoskeletal physiotherapy workforce is not precisely known, so the intention was to maximise reach and obtain as many responses as possible during the six-week recruitment window. This pragmatic approach has been used in previous national surveys of UK MSK physiotherapists (Chesterton and Skidmore, 2023).

2.5. Survey instrument and variables

The anonymous survey was hosted on Qualtrics XM (Qualtrics, 2025), a secure web-based platform for designing and administering online questionnaires. Questionnaire content was informed by findings from a recent scoping review on physiotherapists' ability to identify psychosocial factors (Henning and Smith, 2023) and by previously published international surveys exploring psychosocial assessment practices in MSK care (Hill et al., 2020; O'Neill et al., 2024; Man et al., 2019; Otero-Ketterer et al., 2023). The survey was piloted with eight UK MSK physiotherapists to assess clarity, face validity, and usability. Pilot participants provided feedback on item wording, response options and time to complete. As a result of this review, two questions were reworded to improve clarity, and minor formatting and layout changes were made to enhance ease of completion. The survey included the following variable domains:

- **Demographics:** experience, qualifications, sector, clinical role, gender, UK region.
- **Perceptions:** confidence, perceived value and importance of psychosocial factors.
- **Practices:** how psychosocial factors are assessed (e.g. observation, tools), frequency and consistency of tool use, clinical reasoning.
- **Attitudes:** challenges (e.g., time, training), facilitators (e.g., support, integrated tools), and impact on clinical management.

The questionnaire comprised 28 items, including Likert-scale, multiple-choice and free-text questions. Challenge and facilitator response-options were informed by a synthesis of the published literature (Hill et al., 2020; O'Neill et al., 2024; Singh et al., 2023; Brunner et al., 2018; Henning and Smith, 2023; Klem et al., 2024; Östhols et al., 2019; Amini et al., 2021; Man et al., 2019; Meerhoff et al., 2021). The full questionnaire, including the exact question wording, is provided in the supplementary material.

2.6. Data collection

Data were collected between 2 June 2025 and 4 July 2025. To preserve anonymity, no IP addresses or other identifiers were collected. The survey link was publicly accessible and therefore multiple submissions could not be completely excluded, but close examination of demographic information and response patterns did not identify obvious duplicates. The survey was closed after a marked slowing in responses. Only fully completed surveys were included in the analysis ($n = 373$); partially completed responses were excluded ($n = 68$).

2.7. Data analysis

Quantitative survey data were analysed descriptively in Microsoft

Excel, with results summarised using counts and percentages. To explore relationships between variables, non-parametric correlation analyses (Spearman's ρ) were conducted to examine associations between confidence, experience, and screening tool use. Correlation coefficients were interpreted using commonly applied thresholds, with values < 0.1 considered negligible, 0.1–0.39 weak, 0.4–0.69 moderate, 0.7–0.89 strong, and ≥ 0.9 very strong (Schober et al., 2021). In addition, a Mann–Whitney *U* test (IBM SPSS Statistics, 2025) was used to compare confidence in identifying psychosocial factors between respondents reporting regular use of psychosocial screening tools (defined as “Often” or “Always”) and those reporting non-regular use (“Rarely”, or “Never”).

All demographic and quantitative items required a response before progression through the survey, whereas free-text items used to expand on answers, were non-compulsory. Only fully completed surveys were included in the main analyses (n = 373), so there were no missing data for compulsory items in the analysed sample. All hypothesis tests were two-sided and a p-value <0.05 was considered statistically significant.

Free-text comments were examined using a narrative descriptive approach. Responses were read in full, and common patterns or recurring ideas were summarised to illustrate key perspectives. Example quotations are included in the results to give context to these patterns.

2.8. *Protocol registration*

The survey protocol was prospectively registered on the Open Science Framework (OSF) and is publicly available (Henning et al., 2025).

3. Ethical considerations

This study received a favourable ethical opinion from the host institution's Research Ethics Committee (Ethics Reference 14,261,994). Participation was entirely voluntary. Before beginning the survey, participants reviewed an online information sheet detailing the study's purpose, procedures, potential risks and benefits, data management, and their rights. Informed consent was obtained through a required checkbox before proceeding. Survey responses were fully anonymous.

4. Reporting guidelines

This survey was reported in accordance with the Consensus-Based Checklist for Reporting of Survey Studies (CROSS) (Sharma et al., 2021) (See Appendix 1).

5. Results

5.1. *Participant characteristics*

A total of 441 UK-based MSK physiotherapists took part in the survey, of whom n = 373 provided a complete response suitable for analysis. Partially completed responses (n = 68) were excluded in line with the study protocol (Henning et al., 2025). The survey was shared openly, so the total number of recipients is unknown, and a response rate could not be determined. The sample included a range of clinical backgrounds, with the majority employed in NHS settings, and a spread of experience levels (see Table 1). All participants were actively working in patient-facing MSK roles within the NHS, and most held postgraduate qualifications.

5.2. *Perceptions of psychosocial assessment*

The majority of respondents (96.0 %) rated psychosocial factors as “very” or “extremely” important (see Table 2). In free-text explanations, clinicians commonly referred to research and guidelines, the influence of psychosocial factors on pain and recovery, their modifiability, and the need for holistic care. For example, one respondent noted that *“best practice guidelines recommend screening for these because we know they impact outcome and they are modifiable too.”* In addition, 77.4 % of respondents reported that psychosocial factors “always” or “often” influence their clinical decision-making (see Table 3).

Table 1
Participant characteristics (Total n = 373).

Characteristic	Category	n (%)
Gender		
	Male	186 (49.9 %)
	Female	183 (49.1 %)
	Prefer not to say	2 (0.5 %)
	Non-binary	2 (0.5 %)
Qualification		
	Bachelor's degree (e.g., Bachelor of Science, BSc)	140 (37.5 %)
	Master's degree (e.g., Master of Science, MSc)	134 (35.9 %)
	Postgraduate certificate (Postgraduate Certificate, PgCert)	47 (12.6 %)
	Postgraduate diploma (Postgraduate Diploma, PgDip)	35 (9.4 %)
	Doctorate (e.g., Doctor of Philosophy, PhD)	12 (3.2 %)
	Other (please specify)	3 (0.8 %)
	Graduate Diploma in Physiotherapy (GDipPhys)	2 (0.5 %)
Years of Experience		
	Less than 1 year	5 (1.3 %)
	1–5 years	60 (16.1 %)
	6–10 years	90 (24.1 %)
	11–20 years	130 (34.9 %)
	More than 20 years	88 (23.6 %)
Workplace Setting		
	Public sector (including National Health Service and Ministry of Defence)	303 (81.2 %)
	Private sector	64 (17.2 %)
	Other (please specify)	6 (1.6 %)
Current Role		
	MSK Outpatient Physiotherapist	156 (41.8 %)
	First Contact Practitioner (FCP)	104 (27.9 %)
	Advanced Practice Physiotherapist (APP) in Rehab/MSK Outpatients	43 (11.5 %)
	APP in Secondary Care/Orthopaedic Interface	42 (11.2 %)
	Other roles (e.g., Persistent pain team) and combination/mixed roles	28 (7.5 %)

Table 2
Importance of considering psychosocial factors (total n = 373).
Survey item: “How important do you believe it is to consider psychosocial factors in musculoskeletal patient care?”

Response option	n (%)
Not important at all	0 (0)
Slightly important	2 (0.5)
Moderately important	13 (3.5)
Very important	141 (37.8)
Extremely important	217 (58.2)

5.3. *Assessment practices*

Most respondents stated that they rely on their clinical assessment and many reported using explicit questioning, to identify psychosocial factors. In contrast, far fewer described using structured or standardised questions (see Table 4).

Table 3
Influence of psychosocial factors and perceived impact on outcomes (total n = 373).
Survey items:
"How often do psychosocial factors influence your treatment planning?"
"Do you believe that identifying psychosocial factors impacts clinical outcomes?"

Response option	Treatment planning n (%)	Clinical outcomes n (%)
Never	0 (0)	0 (0)
Rarely	2 (0.5)	1 (0.3)
Sometimes	82 (22.0)	72 (19.3)
Often	187 (50.1)	175 (46.9)
Always	102 (27.3)	125 (33.5)

Table 4
Methods of identifying psychosocial factors
Survey items:
"I identify psychosocial factors through clinical assessment"
"I identify psychosocial factors through explicit questions".

Response option	Clinical Assessment n (%)	Explicit questions n (%)
Strongly disagree	1 (0.3)	6 (1.6)
Disagree	7 (1.9)	30 (8.0)
Neutral	27 (7.2)	91 (24.4)
Agree	172 (46.1)	189 (50.7)
Strongly agree	166 (44.5)	57 (15.3)

When asked specifically about psychosocial screening tools, use was much less common. Only 7.2 % reported "always" using tools, while 32.4 % stated they "never" used them and 33.0 % said they "rarely" did, indicating relatively low uptake of formal questionnaires in routine practice (see Fig. 1).

Among respondents who reported using psychosocial screening tools (n = 252), the context of usage varied (see Table 5). The most common scenario selected was "Other" (n = 88, 34.9 %). The accompanying free-text identified several recurring influences.

Table 5
Contexts in which tools are used (total n = 252).
Survey item:
"When do you typically use psychosocial screening tools/questionnaires in your practice?"

Scenario	Number of participants (%)
Other	88 (34.9 %)
Only when psychosocial factors are suspected	50 (19.8 %)
Routinely for all MSK patients	49 (19.4 %)
Only in complex or persistent cases	40 (15.9 %)
Only when required by guidelines or policies	25 (9.9 %)

Time and workload constraints were frequently described. For example, one respondent noted, *"When I feel I have time and (am) organised enough to hand one out before the patient comes into the appointment/in waiting room."* System and process barriers also shaped practice. One clinician explained, *"… in FCP, I don't have the tools embedded on the EPR [electronic patient record], and less time so I never do it there. In MSK outpatients, it is at least on our EPR, though not sent to all patients automatically like I'd like. So doesn't always get done."* Another highlighted how integration could support use: *"… ours works well as built into our notes system - we tick at triage which questionnaires to pre-fill by the patient before first appt and discharge."* Condition-specific use was also reported, particularly for back pain, as illustrated by one respondent: *"With back pain use STarT Back tool routinely."*

Other influences included clinical judgement triggers (e.g. administering a questionnaire when risk factors were suspected), role or setting differences (e.g. FCP versus outpatient practice), and patient-driven factors (e.g. willingness to complete questionnaires).

5.4. Prioritising psychosocial factors

In response to the free-text question about how they determine which psychosocial factor is the most important to address in a given patient, respondents described drawing mainly on clinical reasoning and professional judgement. Many explained that they would focus on the factor that appeared most prominent or most relevant to the patient's current problem; for example, one respondent noted, *"Contextualise information, open questioning."*

Several participants highlighted the relevance of a factor to recovery or engagement, with decisions shaped by what seemed to be having the greatest impact on symptoms, progress, or participation. For instance, one comment stated, *"Depends on the problem and relevance to the patient."*

Finally, modifiability was another consideration, with some

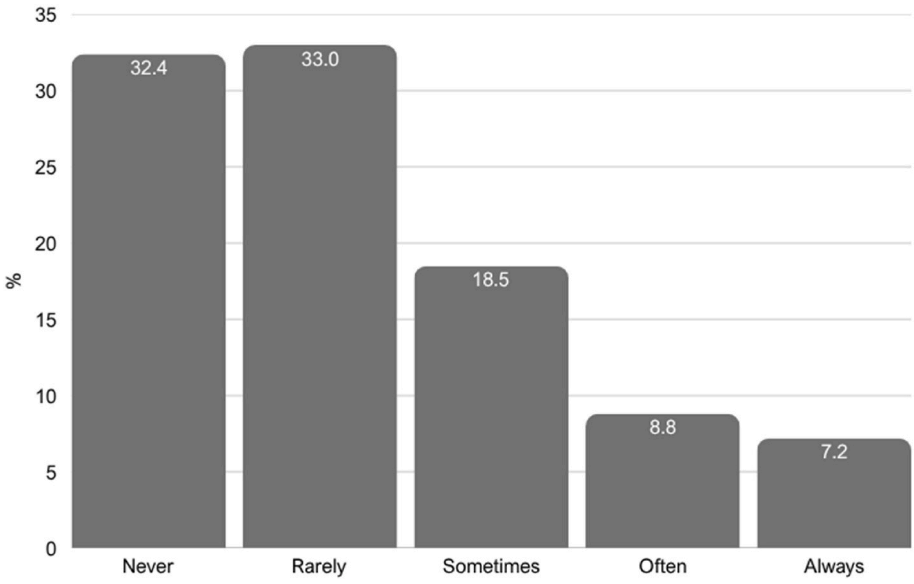

Fig. 1. Frequency of psychosocial screening tool use (total n = 373).
Survey item:
"How often do you use psychosocial screening questionnaires/tools in your practice?"

preferring to target issues they felt were amenable to change. One respondent explained, *"Try to decide which is going to be modifiable …."*

5.5. Confidence in psychosocial assessment

Participants were asked to rate how confident they felt across four domains of psychosocial assessment: identifying relevant factors, prioritising which to focus on, selecting appropriate tools, and interpreting information from psychosocial assessments. The most common response across all domains was "moderately confident," suggesting a general sense of partial but not strong confidence. Lower levels were particularly evident for tool-related skills, with many respondents reporting limited confidence in selecting or interpreting screening tools (see Table 6).

5.6. Associations between confidence, tool use and experience

Correlation analyses showed a moderate positive association between confidence in identifying psychosocial factors and use of psychosocial screening tools ($\rho = 0.54$, $p < 0.001$, $n = 373$). Confidence in interpreting information obtained from psychosocial assessments was also moderately positively associated with tool use ($\rho = 0.43$, $p < 0.001$). In contrast, years of clinical experience demonstrated only a weak association with confidence ($\rho = 0.16$, $p = 0.002$) and was not significantly associated with tool use ($\rho = 0.09$, $p = 0.074$).

To further examine the relationship between tool use and confidence, respondents were grouped according to regular tool use (defined as selecting "Often" or "Always") versus non-regular use ("Rarely" or "Never"). Regular users reported significantly higher confidence in identifying psychosocial factors than non-regular users (median = 4 [very confident] vs 2 [slightly confident]; Mann–Whitney U = 12,922.0, $p < 0.001$), as illustrated in Fig. 2. A similar pattern was observed for confidence in interpreting psychosocial information, with higher confidence among regular users compared with non-regular users (median = 4 vs 2; Mann–Whitney U = 11,911.0, $p < 0.001$).

5.7. Attitudes toward screening tools challenges to use

Respondents identified several barriers to using psychosocial screening tools (Fig. 2). The most frequent were time constraints (71.5 %), lack of training (58.9 %), and uncertainty about which tool to use (54.3 %), while nearly half (47.0 %) cited poor integration with electronic health records. Free-text comments reinforced these themes, noting that existing tools are often lengthy, poorly aligned with patient presentations, and difficult to fit into short appointments.

Table 6
Self-rated confidence in psychosocial domains
Survey items:
"How confident are you that you accurately identify psychosocial factors in your patients?“
- "How confident are you in your ability to determine which psychosocial factors are most important to address in patient care?“
- "How confident are you in selecting the appropriate questionnaire/tool for psychosocial assessments?“
- "How confident are you in interpreting the information obtained from psychosocial assessments to inform your clinical decisions?"

Response option	Identify n (%)	Prioritise n (%)	Select tools n (%)	Interpret information n (%)
Not confident at all	65 (17.4)	30 (8.0)	112 (30.0)	58 (15.5)
Slightly confident	70 (18.8)	97 (26.0)	85 (22.8)	99 (26.5)
Moderately confident	137 (36.7)	156 (41.8)	120 (32.2)	125 (33.5)
Very confident	79 (21.2)	81 (21.7)	46 (12.3)	81 (21.7)
Extremely confident	22 (5.9)	9 (2.4)	10 (2.7)	10 (2.7)

5.8. Facilitators

Respondents also identified factors that might support more consistent tool use. The most frequently selected facilitators were access to appropriate training (77.8 %) and the availability of simple, easy-to-use tools (64.8 %). Integration into electronic records (58.9 %) and clear evidence of benefit to patient care (53.4 %) were also commonly selected, as illustrated in Fig. 3.

Some respondents commented through free-text answers, on the importance of tool simplicity and the benefits of embedding tools into clinical practice.

6. Discussion

This survey provides new insights into how UK physiotherapists perceive and approach psychosocial assessment in musculoskeletal (MSK) care. The findings demonstrate widespread recognition of the importance of psychosocial factors, but also reveal that assessment is often informal, confidence in using validated tools is limited, and tool uptake remains low. These results align with international studies suggesting that the translation of guideline recommendations into clinical practice remains inconsistent (Hill et al., 2020; Klem et al., 2024; Man et al., 2019; Östhols et al., 2019).

6.1. Recognition of importance but variable influence on practice

Most respondents recognised the importance of psychosocial factors and referenced evidence and guidelines. Many noted that these factors affect outcomes and are modifiable when identified early. However, fewer clinicians reported that these factors always shape their treatment planning. This suggests that although MSK physiotherapists appreciate the role of psychosocial factors, they struggle to apply them in everyday clinical decisions, which aligns with international research (Hill et al., 2020; Klem et al., 2024; Man et al., 2019).

6.2. Reliance on informal approaches

Assessment was typically based on clinical judgement and unstructured questioning rather than validated tools. Relying on informal approaches can mean some patients at risk of a poorer outcome are missed, particularly when psychosocial issues are subtle or less visible, as highlighted in previous work (Henning and Smith, 2023). Similar patterns have been reported internationally, where physiotherapists have been shown to favour informal questioning over formal screening (Hill et al., 2020; Man et al., 2019). In this survey, only a small proportion reported using psychosocial questionnaires routinely, with most using tools selectively, in complex cases, or when required by their services. Challenges described in free-text responses in this survey, such as time pressure, lack of integration with electronic health records, and variable patient engagement, also align with international findings (Amini et al., 2021; Hill et al., 2020; Klem et al., 2024). Overall, the tendency towards situational or pragmatic use highlights the lack of a consistent national approach in UK MSK care.

6.3. Confidence and its relationship to tool use

Overall confidence in psychosocial assessment was moderately associated with tool use, rather than experience. This reflects previous international findings, where confidence was linked more closely to training and familiarity with psychosocial tools, rather than time in practice or seniority (Beales et al., 2016; Brunner et al., 2018; Hill et al., 2020; Klem et al., 2024). Correlation and group-comparison analyses supported this pattern, with frequent tool users demonstrating significantly higher confidence in both identifying and interpreting

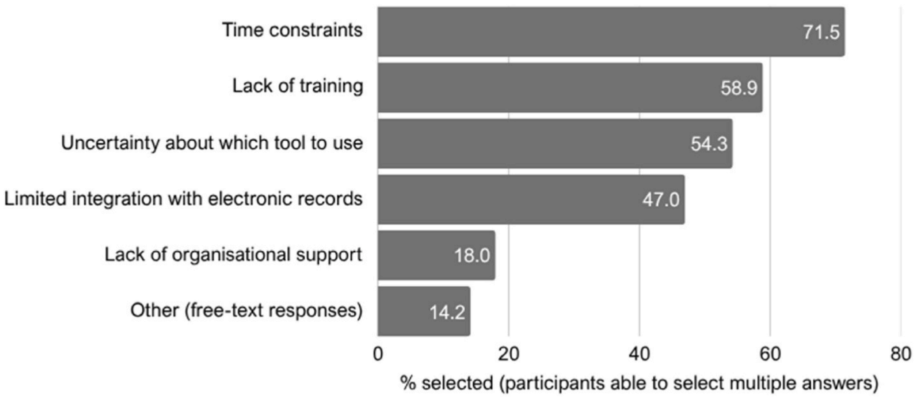

Fig. 2. Challenges to using psychosocial screening tools
Survey item:
What challenges do you encounter when considering or using psychosocial screening tools/questionnaires in practice.?.

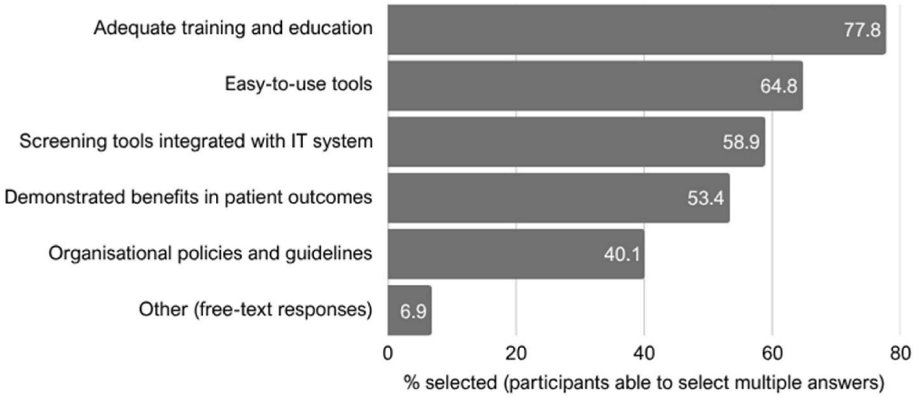

Fig. 3. Facilitators to using psychosocial screening tools.

psychosocial factors. These findings suggest that structured training and integration of psychosocial tools into everyday practice may be more effective for building confidence than experience alone.

6.4. *Challenges and facilitators to implementation*

The challenges reported in this survey included time constraints, limited training, uncertainty about which tool to use, and lack of integration with electronic systems. These have been consistently identified in previous research (Hill et al., 2020; Klem et al., 2024; Östhols et al., 2019). Facilitators such as access to concise, user-friendly tools, integration into records, and evidence of patient benefit were also recurrent themes. The consistency of these findings with international research suggests that structural and organisational factors, rather than clinician motivation, largely shape the use of psychosocial tools. Addressing these challenges through service design, training, and digital integration will be important for improving consistency in psychosocial assessment.

6.5. *Implications for practice and research*

Taken together, these findings highlight both opportunities and challenges for improving psychosocial assessment in MSK care. While clinicians widely recognise the importance of psychosocial factors, there is a reliance on informal assessment methods, in the absence of accessible and integrated tools.

Future research should focus on understanding how psychosocial information is gathered, interpreted, and used within routine MSK consultations, including how clinicians integrate information from both informal questioning and validated screening tools. Such work may help inform the design of training, tools, and clinical pathways that support consistent and feasible psychosocial assessment in practice.

6.6. *Strengths and limitations*

To our knowledge, this is the first national survey to examine UK physiotherapists' practices and attitudes toward psychosocial assessment across MSK care. The large sample included a breadth of roles and experience levels, strengthening the relevance of the findings. However, the use of convenience and snowball sampling may limit representativeness, and responses may be influenced by self-selection bias. Self-reported practices may not reflect actual behaviour, and correlation analyses cannot establish causation. Nonetheless, the alignment with international findings enhances confidence in the validity of the results.

7. Conclusion

This survey highlights a gap between UK physiotherapists' recognition of psychosocial factors in MSK care and their consistent assessment in routine practice. Although the biopsychosocial model is widely accepted, psychosocial assessment remains largely informal, with limited use of validated screening tools.

Addressing structural barriers such as time constraints, uncertainty around tool selection, and poor system integration may be key to improving consistency in psychosocial assessments. Further research should explore how psychosocial information is identified, interpreted, and integrated into clinical reasoning during MSK consultations.

CRediT authorship contribution statement

Michael Henning: Writing – review & editing, Writing – original draft, Visualization, Validation, Software, Resources, Project administration, Methodology, Formal analysis, Data curation, Conceptualization. **Shea Palmer:** Writing – review & editing, Supervision, Conceptualization. **Nicola Walsh:** Writing – review & editing, Validation, Supervision, Project administration, Methodology, Conceptualization.

Ethical approval

Ethical approval obtained from [insert approving body name and reference number].

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Conflict of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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The views expressed are those of the author(s) and not necessarily those of the NIHR or the Department of Health and Social Care.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.msksp.2025.103485.

Appendix 1

Section/Item	Checklist Item	Where Addressed in Manuscript
Title & Abstract	1. Indicate that the study is a survey in the title or abstract.	Title, p.1; Abstract, p.1
	2. Provide a structured abstract with background, objectives, methods, results, and conclusions.	Abstract, pp.1-2
Introduction	3. Explain the scientific background and rationale for the survey.	Introduction, pp.3-4
	4. State specific objectives or research questions.	Aims and Objectives, p.4
Methods	5. Describe study design (e.g., cross-sectional).	Methods – Study Design, p.5
	6. Specify eligibility criteria and settings.	Methods – Participants, p.5
	7. Describe sampling methods (probability/non-probability; recruitment strategies).	Methods – Recruitment, p.5
	8. Report whether a sample size calculation was performed.	Methods – Sample size, p.5
	9. Describe the survey instrument, its development, piloting, and domains covered.	Methods – Survey Instrument and Variables, pp.5-6
	10. Specify the mode of administration (e.g., online, postal).	Methods – Data Collection, p.6
	11. Report how many items the survey had, response formats (Likert, free-text).	Methods – Survey Instrument and Variables, pp.5-6
	12. Describe steps to increase response rate (reminders, incentives, etc.).	Methods – Recruitment, p.5
	13. Explain how missing data and incomplete responses were handled.	Methods – Data Collection, p.6
	14. State data protection, anonymity, and ethical approval details.	Methods – Ethical Considerations, p.7
Results	15. Provide number of respondents, response rate, and flow of participants.	Results – Participant Characteristics, pp.7-8
	16. Present demographic data of respondents.	Results – Participant Characteristics, pp.7-8
	17. Present descriptive results for main survey items.	Results – Perceptions, Practices, Confidence, Tool Use, pp.9–16
	18. Report subgroup analyses, correlations, or statistical tests used.	Results – Associations between Confidence, Tool Use and Experience, p.14
	19. Provide illustrative quotes from free-text responses where relevant.	Results – Assessment Practices, Challenges & Facilitators, pp.11–15
Discussion	20. Summarise key findings in relation to objectives.	Discussion – opening paragraphs, p.16
	21. Compare findings with previous literature.	Discussion, pp.16–19
	22. Discuss strengths and limitations of the survey.	Strengths and Limitations, p.18
	23. Comment on generalisability and implications for practice/policy.	Discussion & Conclusion, pp.16-19
Other	24. Provide details of funding sources and potential conflicts of interest.	Acknowledgements, Conflict of Interest, Funding, p.19

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