However, further research is required to determine the long-term effectiveness of a supervised exercise and education programme for NSLBP. Moreover, the written component to patient education was not investigated in the case controlled study and future studies would clarify the potential effectiveness of this adjunct.

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References

From research to practice: Adapting low intensity (LI) interventions for individuals with common mental health problems and a co-morbid physical health long-term condition (LTC)

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Abstract
People with a long term physical health condition (LTC) are two to three times more likely to experience a common mental health problem such as anxiety or depression. This pilot study investigated a collaborative care approach to delivering a low intensity psychological intervention to this population. Six Psychological Wellbeing Practitioners (PWP) received referrals for 161 people, of whom 81 people engaged in between two to seven sessions of guided self-help and achieved a recovery rate of 59%. A case study is presented to illustrate how the collaborative approach worked in practice. The study demonstrated that low intensity psychological intervention with additional practitioner training can be effective with this population.

Keywords:
collaborative care; Improving Access to Psychological Therapies (IAPT); guided self-help; Long Term Conditions (LTC)
Introduction

Long Term Conditions (LTCs) such as diabetes, chronic obstructive pulmonary disease (COPD) and coronary heart disease (CHD) are the leading cause of death and disability throughout the world (WHO, 2005). Currently in England, over one third of the population are living with at least one LTC and with the ageing population these statistics are expected to increase (Department of Health, 2008a). Individuals in this significant proportion of England’s population are often frequent and intensive users of health services, accounting for 52% of all GP appointments, 65% of all outpatient appointments and 72% of inpatient bed days; thereby generating a significant challenge for health services (Department of Health, 2008b). Effective self-management of an LTC is crucial to the achievement of a healthy and satisfying life and may require the patient to accept the illness; adjust their expectations and change their behaviour (e.g. adhere to treatment regimes, attend medical appointments) (National Health Service Confederation, 2012).

According to the Department of Health (2005), around 70-80% of people with LTCs can be supported to self-manage their condition. However, people with long-term physical health conditions will often have additional psychological needs resulting from the burden of illness-related symptoms and associated disability (NHS Confederation, 2012). Consequently, the prevalence of anxiety and depression is disproportionately higher for those living with an LTC, two to three times higher than in the healthy population (NICE, 2009a). Co-morbid LTCs and common mental health disorders are also associated with higher use of healthcare resources, unnecessary investigations, and increased admissions with longer lengths of stay, and wider costs of sickness absence and lack of employment (NHS Confederation, 2012). Naylor, Parsonage, McDaid, Knapp, Fossey & Galea (2012) calculated that at least £1 in every £8 of NHS spending on LTCs is attributable to the consequences of co-morbid mental health problems alongside LTCs.

The interactions between LTCs and mental health are well documented (Lustman & Clouse 2005, Wroe, Rennie, Gibbon, Hassy & Chapman, 2014), however, many individuals do not receive care that addresses both their physical and psychological needs (NICE, 2009a). There is a growing body of economic evidence to support investment in clinical services which address this co-morbidity (NICE, 2009b, Wroe et al, 2014).

Collaborative care typically involves a multi-professional approach to care, structured management plans, scheduled follow-ups, and enhanced inter-professional communication (Katon et al., 1996). There is a growing body of evidence which demonstrates the efficacy of collaborative care over standard care in the treatment of depression. One of the largest treatment trials for depression in the USA demonstrated that at 12 months about half of the patients receiving a collaborative care approach to the treatment of their depression reported at least a 50% reduction in depressive symptoms, compared with only 19% of those in usual care (Unutzer et al., 2002). Furthermore, the benefits of this intervention persisted one year after the intervention had been completed (Hunkeler et al., 2006). Moreover, in a recent randomised control trial (Katon et al., 2010) a collaborative care intervention demonstrated improved outcomes for both depression and the LTC.

The pilot study reported on in this paper proposes that a collaborative care approach could be implemented within primary care for people with long term conditions and co-morbid common mental health problems. It also proposes that, with some additional practitioner training, outcomes on standard measures for depression and anxiety for this client group would be achieved that were comparable to outcomes across the general population who engage with a low intensity psychological interventions.

The Intervention

Thirteen GP practices signed up to the pilot (serving 81,000 people across both urban and rural areas). Low-intensity psychological interventions were delivered by Psychological Wellbeing Practitioners (PWPs). PWPs are trained to identify and assess common mental health disorders, then devise shared treatment plans with patients. The main focus of the treatment is on supporting the patients to work through self-help material based on cognitive behavioural therapy (CBT) to overcome their problems and achieve their goals (IAPT, 2010). This approach is known as ‘guided self-help’ (GSH), which research evidence has suggested is more effective than the provision of information alone (Gellaty, Bower, Hennessy, Richards, Gilbody & Lovell, 2007).

The six PWPs recruited attended five additional days of training covering the background and principles of collaborative care, condition-specific information, adaptation of low intensity PWP approaches to this patient group, and use of LTC-specific self-help materials. It was decided that in contrast to the Katon et al., (2010) trial the PWPs would not act as case managers as this was viewed as unsustainable in their standard role. Several of the PWP supervisors also attended one day of this training and an additional Practice Nurse training day. This day included explanation of the aims of the pilot study, an understanding of the role of PWPs and detail on how to identify appropriate referrals for the pilot.

PWPs were assigned to two or three practices. Referrals were accepted from pilot practice Nurses and GPs, and an initial patient discussion between referrer and PWP were encouraged to ensure that
referrals were appropriate for the pilot and to start the collaborative process. Practice Nurses and PWPs explained the pilot nature of the project and consent for treatment was gained from each patient. Ethical approval for the pilot was not required as this was an evaluation of a service development rather than research. The LTC pilot training included the use of a protocol for collaborative practice whereby the Practice Nurse would join the PWP and patient as part of their second session to help with goal planning and then again in the final session as part of a review and planning for ongoing care (Figure 1).

The PWPs received one hour clinical case management supervision per week and two hours of monthly skills-based group supervision as is standard with PWPs. Supervisors had no specific experience or knowledge of working with LTCs other than having attended the training days. Supervision was augmented with an additional one hour a month for operational planning and ‘troubleshooting’.

The PWPs used a range of CBT-based self-help materials for depression and anxiety disorder. A self-help manual specifically written for people with diabetes or heart disease who also had depression (Greater Manchester Collaboration for Leadership in Applied Health Research and Care (CLAHRC), 2011) was expanded by the CLAHRC team to include COPD and to include interventions for anxiety (Spitzer, Kroenke, Williams, and Lowe, 2006). Although the PWPs were encouraged to discuss physical health markers with patients and with Practice Nurses these were not routinely recorded for the purposes of this pilot.

A follow up day for PWPs, supervisors and Practice Nurses was held to review progress of the pilot and give an opportunity to gather feedback and problem solve any difficulties.

Results

Overall Findings

The flow of patients through the pilot is illustrated in Figure 2. A total of 161 patients were referred into the pilot with 81 attending at least two treatment sessions. Two deemed inappropriate for low intensity interventions at assessment, were referred on and a further 12 entered treatment in the pilot but were subsequently stepped up to high intensity CBT or secondary care. Twenty-seven patients only attended the initial session and either declined or disengaged from treatment.

The age range of the 161 patients referred was from 21 to 88 (median age 63, mean age 61); 89 were female, 72 male. Of the 161, 9 patients who failed to engage did not have a LTC recorded, of the rest 108 had diabetes, 40 had CHD and 26 had COPD. 20 had two LTCS and one had three.

Measures

The study used standard IAPT outcome measures at every session e.g. PHQ-9 for depression (Spitzer, Kroenke, Williams, and Lowe, 1999) and GAD-7 as a proxy for anxiety (Spitzer, Kroenke, Williams, and Lowe, 2006). Although the PWPs were encouraged to discuss physical health markers with patients and with Practice Nurses these were not routinely recorded for the purposes of this pilot.

A follow up day for PWPs, supervisors and Practice Nurses was held to review progress of the pilot and give an opportunity to gather feedback and problem solve any difficulties.

Figure 1: Pilot protocol for LI collaborative care

Figure 2: Flow of patients through the pilot

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1 At this time, recovery was defined within IAPT services when a patient enters treatment above ‘caseness’ on either the PHQ-9 or GAD-7 and leaves treatment after at least two treatment sessions with both final measures below ‘caseness’. Caseness is defined as scoring ten or above on the PHQ-9 and eight or above on the GAD-7. A recovery rate is calculated as those who achieve recovery as a percentage of the total entering treatment above caseness (IAPT, 2012).
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Severity of anxiety and depression was measured; GAD-7 scored 14/27 and PHQ-9 scored 24/27, indicating moderate anxiety and severe depression. Joan's difficulties were characterised by worry over her family and being asked about her family if she ventured out into public. Her worries about negative outcomes of being in public became more generalised and she began to fear experiencing the emotional and physical symptoms of anxiety. In turn, Joan was avoiding such situations and had become low in mood.

Interventions
At the beginning of Joan's eight sessions she set the goals of increasing her activity level and speaking to people more. The referring Practice Nurse, Joan and her PWP were not able to meet altogether at the start but her Nurse suggested to her PWP the additional goal of increasing the amount of walking Joan was doing. She was amenable to this but less so to the suggestion of achieving it by attending a pulmonary rehabilitation course due to concerns about the anxiety she might experience in a group setting. Joan and her PWP summarised their shared understanding of her difficulties through the creation of a problem statement. Following this, via psychological education they explored the maintenance role of avoidance behaviour. This led to a rationale for Joan experimenting with situations she was fearful of in order to see whether the negative predictions she made were accurate. Through such experimentation Joan then began to reduce avoidance; starting to go shopping to the supermarket again then progressing to joining a local quiz team. She learned that she could do these things without the perceived assistance of safety behaviours such as avoiding making eye contact. She also learned that feeling anxious did not signify that something very bad would happen to her.

Table 1: Means and standard deviations for first and final measures

<table>
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<tr>
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<th>PHQ-9: mean and standard deviation</th>
<th>GAD-7 mean and standard deviation</th>
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<tbody>
<tr>
<td></td>
<td>(n=81)</td>
<td>(n=81)</td>
</tr>
<tr>
<td>First measure</td>
<td>12.3 (SD = 5.9)</td>
<td>9.05 (SD = 5.1)</td>
</tr>
<tr>
<td>Final measure</td>
<td>6.6 (SD = 5.5)</td>
<td>4.88 (SD = 5.1)</td>
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Among the 81 patients treated within the pilot the recovery rate was 59% (n=36). The pre and post-treatment data for this group are shown in table 1. The paired t-test analysis of first and last scores on both PHQ-9 and GAD-7 for these 81 patients derived a p-value in each case of less than 0.0001. This would indicate that the reduction in scores for depression and anxiety was clearly statistically significant. This figure (n = 81) includes patients who disengaged during therapy but excludes those who were stepped up. Twenty-one patients entered therapy below caseness and so were not included in the recovery calculation but were included in the p value calculation.

A Case Study
As in routine clinical practice, not all of these cases led to fully successful outcomes. Here we include an anonymised illustrative case study from the pilot to illustrate the interventions used, problems encountered and lessons learned.

Background and Diagnoses
Joan (64 years) was retired. Two years earlier she had a Myocardial Infarction (MI), was diagnosed with CHD and had subsequently been encouraged by family members to reduce her activity level. In the same year she found that she was becoming breathless when walking and was diagnosed with COPD. This compounded her decreased engagement in both personal and social activity. Family members moving away from the local area had further reduced positive aspects of Joan’s daily routine and constituted the final trigger for the onset of symptoms of depression, for which she was prescribed antidepressant medication. Her Practice Nurse referred her into the LTC pilot requesting treatment for depression but assessment revealed this to be a secondary problem to anxiety.
Whilst guided self-help interventions would typically draw on self-help materials to support learning, Joan's inclination was not to read or use these and her PWP accepted this choice. Her Practice Nurse joined Joan's final session when her problem statement, goals and progress were reviewed. Joan had increased her activity level, which included spending time walking. She was also talking more to other people. The intervention was concluded with discussion around maintaining progress.

Outcomes
Anxiety and depression severity measures (GAD-7 scored 0/21 and PHQ-9 scored 0/27), were consistent with the absence of symptoms of either problem. In addition to this Joan’s Practice Nurse had carried out a spirometry test, which showed an improvement in her lung capacity. Figure 3 shows the pattern of GAD-7 and PHQ-9 scores over the course of Joan's treatment.

Reflections on Case Study
In this example, as in many others it became evident that a Practice Nurse’s knowledge and use of screening measures for anxiety and depression was beneficial. Their use of them helped aid identification of patients suitable for the pilot and outline specific symptoms in referral discussions.

A second crucial learning point came from the types of referrals received. Many patients presented with more than one LTC and it was common for them to be experiencing difficult social and financial circumstances. However, exploring the presenting clinical problem using the Five Areas Model (Richards and Whyte, 2011) enabled practitioner and patient to agree a focus to sessions and develop realistic goals, irrespective of the complex presentation.

Discussion
This paper has presented outcome data from a project that has implemented Low Intensity interventions for people with Long-Term Conditions through an IAPT service. The recovery rate achieved of 59% compares favourably with the recovery rate of all low intensity interventions within the host IAPT service which was 54% (n = 5604) for the same time period as the pilot.

In this pilot 56% of patients who were referred actually entered treatment (defined as attending at least two treatment sessions). This compares with a national figure for IAPT services of 60% (Department of Health, 2012). This is perhaps understandable given the potential difficulties engaging people with LTCs in psychological therapy. Further research into lack of engagement with this client group would be beneficial.

In working in this pilot project, the PWPs found that the first thing LTC patients may have to accept is that their life will continue to be significantly affected by the LTC. The PWPs also found that they needed to socialise patients to the collaborative way of working that is integral in the guided self-help approach.

Setbacks and short-term hospitalisations in this patient group were common. Supervision particularly addressed the management of non-attendance: achieving the fine balance between accommodation
for the management of an LTC and deciding when a patient is not benefitting from therapy due to irregular attendance. The PWPs particularly emphasised offering telephone appointments to patients when they were finding it difficult to attend an appointment but were well enough to engage in a therapy session, e.g. cold weather for somebody with COPD. They also offered every opportunity to discuss difficulties in attending by making multiple attempts to contact patients by telephone. The knowledge that this client group may have difficulties attending sessions could lead to a more proactive, collaborative and problem solving management of this, and perhaps this could be better addressed as one of the tasks of contracting at the start of treatment.

The pilot required that practices involved offered a room for PWP LTC clinics, ideally located near to the Practice Nurse’s clinic room and on the same days they were working. PWPs working in practices that were not able to offer these conditions found it much more difficult to establish a working relationship with their Practice Nurse(s). However, even in cases where all three parties, i.e. the patient, Practice Nurse and PWP were willing, sometimes it was simply not possible for the collaborative team meeting to take place at the times recommended by the model. Being flexible in the timing of the first team meeting worked well for responding to patient readiness for treatment, however this could delay goal setting.

Where the first team meeting could not take place, the PWPs adapted the model by liaising with Practice Nurses between sessions. This is less ideal because it moves away from the philosophy of collaborative care working. Such working is closer to the ethos of collaborative care but may be less efficient.

This paper illustrates how collaborative care can potentially be implemented within an IAPT service. It highlights the differences physical and mental healthcare professionals may take in their approaches to delivering care and where these differences can be met through enhanced inter-professional communication to augment care.

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References


From research to practice: Adapting low intensity (LI) interventions


REVIEW
Exercising during dialysis: A reflection on environmental barriers

Leighan Meddick

Abstract
Research has demonstrated that exercise provides several physical and psychological benefits for hemodialysis patients, which include increasing their quality of life. However, implementing intra-dialytic exercise into the patients’ care schemes often proves to be a difficult task for dialysis providers, and they often run into barriers. Some of the environmental barriers that are often experienced are discussed herein, in order to raise awareness and provide recommendations which may result in the process of exercise integration running more effectively.

Keywords
barriers; hemodialysis; intra-dialytic exercise; kidney disease; physical functioning; quality of life

Introduction
Patients with end-stage renal disease (ESRD) are placed on dialysis when kidney function is reduced by approximately 85-90% of normal function, and as a result of the disease, their life expectancy is reduced considerably (NHS, 2013). There are estimated to be beyond 60,000 ESRD patients receiving hemodialysis treatment in the UK, with typically 5,000-10,000 new patients beginning treatment annually (Gilg, Pruthi and Fogarty, 2015).

NHS Kidney Care reported that the cost of incorporating dialysis treatment and kidney transplantation for ESRD costs the NHS in England £1.4 billion per year, more than the combined cost of £1.37 billion that is spent on breast, lung, colon and skin cancer (HMRC, 2011). The ideal situation