Mental Health
and
Musculoskeletal Conditions

Report of Roundtable

19 March 2019

May 2019

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Paul Farmer of Mind for chairing the event
Our speakers Shantel Irwin, CEO Arthritis Action; Kevin Mullins, Head of Mental Health, NHS England; Leigh Walmsley, patient speaker and Harry O'Hayon, Clinical & Operational Lead, Haringey IAPT.
Everyone who attended the event for their input.
Arthritis Action for sponsoring the event.

ARMA is the umbrella organisation for the UK musculoskeletal community. Our member organisations are:

Arthritis Action
BackCare
British Association of Sport Rehabilitators and Trainers (BASRat)
British Chiropractic Association (BCA)
British Orthopaedic Association (BOA)
British Society of Rehabilitation Medicine (BSRM)
Chartered Society of Physiotherapy (CSP)
Royal College of Occupational Therapists (CoT)
Ehlers-Danlos Support UK (EDS UK)
Faculty of Sport & Exercise Medicine (FSEM)
Fibromyalgia Action UK (FMA UK)
Hypermobility Syndromes Association (HMSA) UK
Institute of Osteopathy (iO)
Musculoskeletal Association of Chartered Physiotherapists (MACP)
Myositis UK
National Ankylosing Spondylitis Society (NASS)
Podiatry Rheumatic Care Association (PRCA)
Polymyalgia Rheumatica & Giant Cell Arteritis UK (PMRGCA UK)
Primary Care Rheumatology Society (PCRS)
Royal College of Chiropractors (RCC)
Royal College of Nursing (RCN) Rheumatology Forum
Scleroderma & Raynaud's UK (SRUK)
The Society of Musculoskeletal Medicine (SOMM)
UK Gout Society
Versus Arthritis

The contents of this document and further resources including contact details for our member organisations and further information about our work are available on the ARMA website at www.arma.uk.net.

About musculoskeletal conditions

The term musculoskeletal (MSK) conditions includes a broad range of health conditions affecting the bones, joints, muscles and spine, as well as rarer autoimmune conditions such as lupus. Common symptoms include pain, stiffness and a loss of mobility and dexterity.

An estimated 17.8 million people live with a musculoskeletal condition in the UK[i]. This compares to 4.7 million with diabetes[ii], 7 million with heart disease[iii] and 1.2 million with COPD[iv].

MSK conditions fall into three broad categories:

- Inflammatory conditions: rheumatoid arthritis, axial spondyloarthritis including ankylosing spondylitis, gout, juvenile idiopathic arthritis
- Conditions of musculoskeletal pain: osteoarthritis, back pain, fibromyalgia
- Osteoporosis and fragility fractures: e.g. fracture after standing fall from standing height

MSK and mental health

Pain, mental health and disability are strongly linked, so not recognising or treating one can impact the others greatly.

- Anxiety and depression are major comorbidities when living with arthritis.
- Depression is four times more common among people in persistent pain compared to those without pain.
- Around one in six people (16.8%) with rheumatoid arthritis have major depressive disorder.
- Around 20% of people with osteoarthritis experience symptoms of depression and anxiety.
- The odds of back pain in people with symptoms of depression have been shown to be 50% higher than those without symptoms of depression. [V vi vii]

Treating emotional and mental health conditions should be a fundamental part of managing arthritis from point of diagnosis. Indeed, NICE guidelines on management of rheumatoid arthritis in adults state that all patients should be checked for the development of co-morbidities, including depression. A recent survey by the National Rheumatoid Arthritis Society found that two in five respondents had never been asked by a healthcare professional about their emotional or psychological wellbeing. In fact, one in five had never been asked about this by anyone. [viii]

Patient experience

As noted, depression and anxiety are common comorbidities amongst people with MSK conditions. There is a complex interrelationship, with MSK conditions causing anxiety and depression, whilst depression and anxiety make pain feel worse.

Many people with MSK conditions will have experienced long delays in getting a diagnosis (average 8 years for Ankylosing Spondyloarthritis, 14 for Ehlers Danlos Syndrome). In the interim people are sometimes not believed by clinicians. In addition, some MSK symptoms do not have a clear physical cause. Lack of support and understanding from family and medical professionals makes both physical and mental health worse.

People often feel that they are the only ones experiencing this. Contact with patient support organisations, either through helplines or support groups, can help people understand that their experiences are common. It is often only when talking to a peer, for instance in a patient support group, that people open up about their mental distress. A review of the evidence for peer support found that it can have the potential to improve experience, psycho-social outcomes, behaviour, health outcomes and service use among people with long-term physical and mental health conditions and potentially also for carers. [ix]

People with long term MSK conditions will experience a series of "transitions". Diagnosis will be the first. For those who are initially mis-diagnosed, there may be a series of diagnosis transitions. Others will include flares, changes in medication, stopping or starting work. Stabilising the condition and managing the pain can bring another transition. Initially the pain can dominate. If pain is relieved, people can then realise how much of a loss of function they have, which can increase depression. Support is needed at every transition point in a person's journey.

Services for physical and mental health are often commissioned and delivered separately. Transitions between these services can lead to fragmented and unhelpful care.

Case Study: Leigh Walmsley, London Paralympic GB Archer

I developed osteoarthritis after a serious cycling accident aged 11, but noticed the first signs of inflammatory arthritis in my 20s.

To manage the pain, I was advised to take high doses of ibuprofen at the time, but progressed to a variety of pain medications over the years. I must admit to being in pain every day, to some extent - and it can be very severe at times, as I also have neuropathy and fibromyalgia.

Impact on mental health

The impact arthritis had on my life was very significant. I couldn't run in PE with my classmates, walk too far, stand for too long and as my inflammatory arthritis began to rear its head, there were times I almost couldn't walk home after work.

I don't go out to socialise very often as my walking can be limited, and at times, my shoulders are so restricted that I'm unable to do archery. The fatigue of chronic pain is debilitating, which causes depression.

Fighting the pain and loss of function is difficult, but trying to get family, friends and employers to understand that a young person can have arthritis was absolutely exhausting. "But you don't look sick" is a comment I hear often, but in my experience, arthritis can be isolating and lonely.

Through the years I have learnt that certainly taking up a sport has helped my arthritis, but I must pace myself or it backfires on me. I have always been a glass-half-empty person, for as long as I could remember, but I worked with a psychologist when I was on the archery team who showed me how much better positive thinking is.

Arthritis Action

Arthritis Action appeared in my life when I was at a low point. It was like coming home to family. It was a huge comfort to know there were other people like me, that have the same ideals as me and most importantly, they allow me to help other people with arthritis.

It's wonderful being part of a community that wants to help people live the fullest lives they can. I was so inspired, I decided to start a support group in the North West. Just knowing there are people out there who understand what we're going through is enough to raise your spirits. Being able to get stuck in and start an Arthritis Action Group in my area was not only be a boost for me, but for my local community. Groups are a great way of bringing people together, helping them feel less isolated or alone, which is really beneficial for our mental health.

It is difficult putting a happy face on, but I don't want arthritis to rob me of everything, so I push through it for better or worse. When things get tough Arthritis Action is always at the end of the phone, email or social media.

Case study: Patient support groups

Arthritis Action Groups offer people a platform to meet others, share experiences and tips on living with arthritis and learn more about local services to help them better manage their condition.

Each Group is different and will organise activities that are relevant to the Members who attend. Groups could:

- Hold ‘coffee and chat’ events where Members can share their experiences and tips
- Invite local health professionals to give talks
- Arrange for complementary therapists to give taster sessions
- Organise walking sessions
- Arrange for a local chef to offer cooking tips
- Organise fundraising activities e.g. walks, music and/or singing nights, balls and dances; and
- Work together to influence local arthritis provision by being the local patient voice in the area

In the safety of a local group, people will often open up about their emotional reaction to their condition and receive reassurance that their reaction is not uncommon. The groups also support carers. Family members can find it hard to understand how their relative has changed. Inviting them to attend a group and meet others in the same situation can help them better understand how to support their relative.

Improving Access to Psychological Therapies (IAPT)

IAPT has existed for ten years, providing evidence-based treatments that work for anxiety and depression. Evidence shows there is a recovery rate of more than 50% and reliable improvements in excess of 60%[x]. Most IAPT services are now part of wider wellbeing services and provide other support such as employment support or debt advice.

The Five Year Forward View for Mental Health provided funding to extend IAPT services to people with long term conditions. Additional competencies were developed and evaluated. The evaluation shows there is good evidence of benefits including increased health related quality of life and a dramatic drop in healthcare utilisation rates.

Two waves of early implementation sites were supported to develop this. The majority of these sites chose to work on diabetes, heart disease and respiratory conditions. Four chose to cover patients experiencing MSK pain, including Haringey (see case study).

The process evaluation has identified what works best, including the importance of relationships, integrated multidisciplinary working and the exchange of skills sets and knowledge. Formal evaluation of outcomes is in progress.

Case study: Haringey IAPT for patients with MSK Pain

Haringey IAPT was one of the wave 2 sites. The service includes psychologists, cognitive behavioural psychotherapists, and psychological wellbeing practitioners, working closely with MSK/chronic pain physical health teams. IAPT is not intended to replace health psychology where this is required.

The service has been providing specialist support for people with long term conditions since September 2017 when people with diabetes and COPD were included. In September 2018 people with MSK/chronic pain were also included, so this aspect of the service is still developing.

The service operates a step model:

Step 1 – educational materials, very basic psycho-educational material
Step 2 – simple behavioural activation and specific strategies used as homework e.g. Haringey & Islington pain group is led at step 2
Step 3 – mostly 1:1, focuses on behavioural change and cognitive restructuring
Step 4 – health psychology directly from the hospital.

After an initial telephone assessment, the service may offer:

- Individual Cognitive Behavioural Therapy (CBT)
- Guided Self Help (GSH) – there is a module on chronic pain
- Groups
- Computerised CBT
- Self-management courses
- Advice on other services

Physical health colleagues find it hard to complete the full mental health assessment so two questions have been developed which can be asked by therapists and provide a good indication of which patients may benefit from the IAPT service.

- Do you often feel anxious or low in mood because of your joint or muscle pain?
- Do you feel confident in managing your joint or muscle pain?

The service also has a partnership with the Shaw Trust, providing employment support.

If recovery is not happening for an external reason, e.g. debt, the service can signpost to other sources of support. They can also refer for more intensive therapy where needed.

The role of IAPT

Currently, in most areas there is no integration of IAPT and other pain/MSK services. The Haringey model is ideal but is currently an exception. IAPT for long term conditions (IAPT-LTC) is now being rolled out with all 195 CCGs commissioning. Each CCG will select which conditions they intend to cover.

IAPT, in the absence of support to address pain, is unlikely to be successful. The NHS England IAPT-LTC pathway states that IAPT-LTC services should be developed alongside existing services, with clear arrangements for joint working[xi].

Eighty percent of STPs have MSK as a priority area, but there is still an issue of mental health and the main life-threatening conditions getting the priority. We can see this in the numbers of IAPT-LTC sites choosing MSK/pain despite the high prevalence compared to other conditions.

The MSK-HQ is a recognised standard assessment tool in use in MSK. This could be used in IAPT-MSK services to measure patient outcomes. Evidence of positive outcomes will help to make the case for including MSK/pain in IAPT-LTC services.

Holistic support

The need to take a holistic approach and address the things which matter to the patient is now well recognised. It is important to open up the conversation with the patient and ask: “how are you feeling?” in every appointment. There are many opportunities to raise this with patients with chronic conditions, but as the NRAS survey cited above demonstrates, this is not happening in many cases. Reasons for this include pressure of time. It is hard to cover in a short GP appointment, so there is a role for therapists, nurses, Occupational Therapists, etc. who may have more time. There is also an important role for patient groups, as noted above.

It is everyone’s job to raise this and ensure that patients have access to someone with the time to listen and explore.

Training

Another reason health care professionals may not raise mental health issues is the lack of training for physical health professionals in mental health. This can lead to people being afraid to ask about mental health. Professionals can be particularly sensitive about raising or addressing thoughts of suicide. There is a need to empower professionals by ensuring they have the knowledge and skills to raise mental health with confidence. Occupational Therapists training includes mental health, and their role is currently under used. Similar mental health content should be included in basic training for professionals working with people with long term conditions. Integration of mental health professionals into MDTs for long term conditions can also make staff more confident.

Case study: Integrated persistent pain pathway in Oldham

Overview

This clinically led integrated persistent pain pathway in Oldham started 2015 and bases the assessment and treatment of pain on the biopsychosocial model. The pathway is commissioned by Oldham Clinical Commissioning Group (CCG) and delivered jointly by the Pennine Acute Hospitals NHS Trust, the Psychological Medicine Service and Improving Access to Psychological Therapies (IAPT) service both at Pennine Care NHS Foundation Trust, and Pennine MSK Partnership Ltd. The latter organisation takes the lead role for ‘Tier 2’ of the pathway and Pennine Acute for ‘Tier 3’. This community-based pathway supports people to make informed decisions to manage their care and have an improved quality of life.

Service description

People who are suffering with persistent pain that is hard to manage despite community interventions including physiotherapy and IAPT (Tier 1) are referred by GPs to a single point of entry. The referral is supported by 3 questionnaires: the Pain Self Efficacy Questionnaire (PSEQ), Health Needs Assessment and the PHQ4+2. People are assessed using a jointly developed biopsychosocial assessment during a 1 hour appointment by pain specialist nurses or physiotherapists. This includes questions about mental health problems, including suicidal thoughts.

Depending on the outcome of the assessment people can access a range of interventions in Tier 2 including talking therapy, physiotherapy, pain nurse advice, pain management groups and/ or review by a GP with a special interest. If needed they can be stepped up to Tier 3 to see a liaison psychiatrist or pain consultant. Interventions include one-to-one appointments and group work. The pain management group is jointly delivered by IAPT and pain nurses/ physiotherapists.

Weekly multidisciplinary meetings to discuss patients support staff in Tier 2 and 3 deliver integrated care and a regular case discussion group supports continuing professional development. Psychologists from the Psychological Medicine Service provide training and supervision to the IAPT therapists. People at high risk of self-harm, with complex mental health presentations and/ or polypharmacy can easily access a psychiatric assessment, supporting high quality risk management.

Staff from the three providers report this model allows for a more holistic approach to treating chronic pain and reduces the prescription of strong pain-killing medications, such as opiate-based drugs or epidural injections. The evidence base for these interventions is poor and in some cases medication and injections can have harmful side-effects. There has been significant interdisciplinary learning, supported by a variety of training.

Before the pathway began, people with medically unexplained symptoms, MSK problems and chronic pain were often managed inappropriately and services were not following evidence-based care. Patients were on inappropriate medication and on a merry-go-round between the pain clinic, rheumatology service and orthopaedic services, accumulating unnecessary treatments and experiencing variable quality of care. There was limited access to mental health expertise.

This care pathway represents a significant shift for the entire local health care system and for patients with chronic pain who can now access a wider range of support for their psychological and social support needs. It stops people falling through the gaps in services, between physical and mental health, and primary and secondary care. The pathway has been developed and adapted by the neighbouring Bury Clinical Commissioning Group who commenced the Bury Integrated Pain pathway in 2018.

Outcomes

Since the service started 850-1000 people per year have been treated by the service. A survey of 102 initial assessment forms showed 41% reported past or current mental health difficulties, 24% had recent thoughts of self-harm or suicide and 2/3 were on prescribed opioids.

Fifty three percent of those completing the PSEQ at discharge showed a clinically significant improvement and about 50% were much or very much improved on the Clinician's Global Impression Scale. Efficiencies of £750,000 per year have been made primarily through a reduction in interventional procedures. The service has been cited as an example of good practice in the King's Fund report 'Bringing together physical and mental health: a new frontier for integrated care' (2016)[xii].

Employment

Quality work is strongly linked to better health outcomes for individuals[xiii]. The Taylor Review noted that good work not only enables people to support themselves and their families financially, but with the right kind of support, from employers and others, work has a positive impact on health and well-being. This is equally true for MSK health, where keeping moving is generally beneficial, and for mental health where social interaction and making a contribution are important. For those with MSK conditions and mental health problems, employment support is therefore an important part of improving health.

Keeping people in work is as important as getting them into work. The longer a person remains out of work, the less likely it is that they will ever return to employment. The current Department for Work and Pensions (DWP) work and health programme identifies MSK and mental health as priority issues. It is important that this includes work to address these in an integrated way, rather than in two separate silos.

The DWP have funded employment advisors in IAPT services. Haringey IAPT works with the Shaw Trust to enable individual work placements with support and to deliver employment workshops. Supporting employers to manage staff with long term conditions is also important. A survey in 2017 found that one in four people with rheumatoid arthritis found lack of support from their employer or line manager was a serious barrier to remaining in employment.[xiv] Haringey IAPT will be delivering mental health first aid to employers so that they are more confident managing staff with mental health problems. It is equally important to train managers in good practice in managing staff with physical health conditions. Business in the Community have developed employers' toolkits, including one on managing staff with musculoskeletal conditions[xv] and another on mental health problems[xvi].

Social prescribing

IAPT services deliver an evidence-based intervention. For people with long term conditions it is also important that the service is linked to other support available in the community. In the Haringey service, a big difference for IAPT-LTC is the wide range of interventions and support needed to deliver and the need to tailor this for each person. For this reason, the targets for clinicians are lower for people with long term conditions.

This is also important for the forthcoming Green Paper on prevention as rapid access to psychological support for those who need it will enable improved self-management and prevent further deterioration of both physical and mental health conditions.

Inequalities

People who live in the most deprived areas are much more likely to report arthritis or back pain than people in equivalent age groups who live in less deprived areas. Forty percent of men and 44% of women in the poorest households report chronic pain, compared to 24% of men and 30% of women in the richest households[xvii].

Among people aged 45–64, the prevalence of arthritis is more than double in the most deprived areas (21.5%) compared to the least deprived areas (10.6%). Further, people of working age (45–64 years) are almost twice as likely to report back pain (17.7%) as those from least deprived areas (9.1%). Physical inactivity and obesity are strongly associated with deprivation and are risk factors for MSK conditions.

There are pockets of very high deprivation and areas where significant numbers of patients don't speak English. In addition, some of the tools don't work for some groups e.g. people may have a cultural resistance to scoring their symptoms and prefer to give a narrative account of their pain. Tools are also required in different languages.

Solutions

Given the prevalence and impact of MSK and mental health and the effectiveness of appropriate support and interventions, identifying and putting in place measures to address the issues discussed in this report should be a priority for every CCG. This section looks at the solutions for three different patient groups:

- Managing
- Struggling
- Unwell

The starting point for all should be a bio-psychosocial assessment- this can then help identify what the persons goals are and what areas they may need help with, to produce the best outcome. Having appropriate levels of support, for example the four-step approach of Haringey, will enable referral for support at the appropriate level.

Unwell

An effective MDT including psychology should be available, allowing time to examine the person holistically. This could significantly reduce time to diagnosis for complex syndromes such as EDS. Not having a diagnosis is stressful, especially if you feel you are not believed.

Basic principles of patient centred and personalised care should apply. Focussing on what matters to the patient and empowering them. Offering support at the right time is important. For example, diagnosis can be devastating, and people may need time to digest this before they can engage with psychological or self-management support.

Liaison Psychiatry/ Psychological Medicine Services can provide expertise for people with complex mental health problems and long term conditions and medically unexplained symptoms, linking in with and supporting primary and secondary care, mental health services, social care, third sector services and IAPT.

Struggling

Identifying people who need some extra support would make a significant difference in preventing more significant problems in future. At every opportunity people should be asked how they are and how they can be helped. This is about emotional interviewing, rather than mental health awareness. A person-centred approach will ensure that clinicians are aware of the impact of transition points in a patient’s journey.

Managing

Where people with long-term MSK conditions are self-managing their condition well, they need to be provided with enough support to help them continue doing so. Clinicians also need to be aware of the risk of transition points.

Patient organisations should be a key part of the support available. Encouraging patients to contact the organisations for the relevant to conditions will ensure they have access to the helplines, websites and newsletters which can provide the information required to manage their own condition well.

The outreach function of the Haringey IAPT service also serves this group, as well as public health campaigns and Five Ways to Wellbeing[xviii].

Recommendations

Services and commissioning

- Integrated physical and mental health support for people with MSK conditions should be available in different levels from basic educational materials to mental health support integrated in pain clinics and rheumatology. These need to be part of an integrated pathway so that patients can easily step up and step down as needed.
- IAPT-LTC in every CCG should include MSK/chronic pain.

Health care professionals

- Every healthcare professional with a patient with a chronic MSK condition should ask about emotional/psychological well-being at every appointment. The snapshot questions developed by Haringey IAPT could be used.
- Every healthcare professional should ensure that patients are aware of the patient support groups, both local support groups and national websites and helplines.
- Training and CPD for all MSK professionals should include understanding and assessment of mental health, including risk assessment and knowledge of referral pathways.

Roundtable attendees

This report is based on discussions at a roundtable held on 19 March 2019 chaired by Paul Farmer of Mind and attended by:

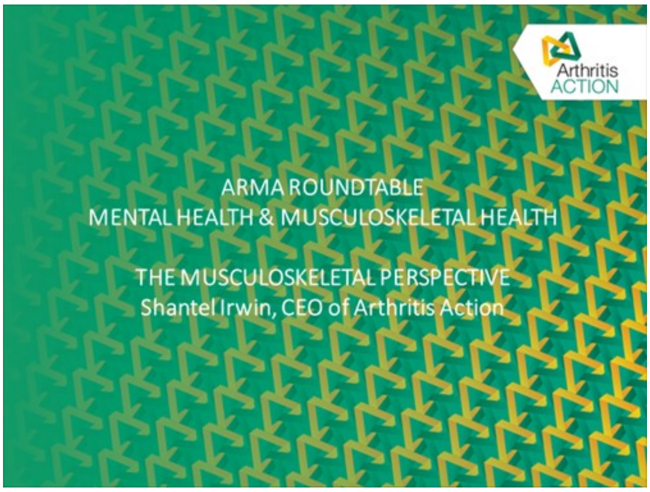
- Prof Carolyn Chew Graham, Professor of General Practice Research, Director of Clinical Academic Training, Keele University
- Clare Lait, Council member, Chartered Society of Physiotherapy
- Emma Reinhold, Primary Care Advisor to EDS UK, Ehlers Danlos Syndrome UK
- Harry O'Hayon,,, Clinical & Operational Lead, Haringey IAPT
- Heather Baumohl-Johnson, Member Services and Operations, Arthritis Action
- Ian Bernstein, GP
- Karen Dawes, 2gether NHS Foundation Trust, Head of Physiotherapy
- Kevin Mullins, Head of Mental Health, NHS England
- Laura Boothman, Policy Officer, Versus Arthritis
- Leigh Walmsley, Patient speaker
- Libby Keck, Programme Manager, Q Improvement Lab
- Lucy Thorpe, Head of Policy, Mental Health Foundation
- Matt Bezzant, Policy & Public Affairs Manager, National Rheumatoid Arthritis Society
- Nita Parmar, Policy and communications manager, ARMA
- Paul Cooper, Professional Advisor, College of Occupational Therapy

- Paul Farmer, CEO, Mind
- Peter Kay, National Clinical Director MSK, NHS England
- Sabrina Kamayah, Senior Policy Officer, British Psychological Society
- Sally Dickenson, Head of Information & Support Services, National Ankylosing Spondylitis Society
- Samir Qadery, Programme Support Manager – Musculoskeletal Health, Public Health England
- Sarah Gudgin, Membership and Office Administrator, Arthritis Action
- Shantel Irwin, CEO, Arthritis Action
- Sridevi Sira Mahalingappa, Consultant Psychiatrist, Derbyshire Healthcare NHS Foundation Trust, Royal College of Psychiatrists
- Sue Brown, CEO, ARMA

Agenda

Chair: Paul Farmer, CEO Mind
The Musculoskeletal perspective: Shantel Irwin, CEO Arthritis Action
The Mental Health perspective:
Kevin Mullins, Head of Mental Health, NHS England
The patient perspective: Leigh Walmsley
IAPT for MSK conditions: Harry O'Hayon, Clinical & Operational Lead, Haringey IAPT
Discussion

Presentations



Arthritis ACTION

ARMA ROUNDTABLE
MENTAL HEALTH & MUSCULOSKELETAL HEALTH

THE MUSCULOSKELETAL PERSPECTIVE
Shantel Irwin, CEO of Arthritis Action

Arthritis ACTION

Background on Musculoskeletal Health

Musculoskeletal Health

The term 'musculoskeletal conditions' is often used to include a broad range of health conditions affecting the **bones, joints, muscles and spine**, as well as rarer autoimmune conditions such as lupus.

Common symptoms include **pain, stiffness and a loss of mobility and dexterity.**

Musculoskeletal conditions comprise **over 100 different diseases and syndromes** that interfere with people's ability to carry out their normal daily activities.

Largest cause of disability in UK (+ lower back pain – almost half).

1 in 5 GP appointments.

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Broadly speaking there are three groups of musculoskeletal conditions

Inflammatory Conditions:
rheumatoid arthritis, axial spondyloarthritis including ankylosing spondylitis, gout, juvenile idiopathic arthritis

Around one in six people (16.8%) with rheumatoid arthritis have **major depressive disorder.**

Conditions of musculoskeletal pain:
osteoarthritis, back pain, fibromyalgia

Around 20% of people with osteoarthritis experience symptoms of **depression and anxiety.**

The odds of back pain in people with symptoms of depression have been shown to be **50% higher** than those without symptoms of depression.

Osteoporosis and fragility fractures: e.g. fracture after standing fall from standing height

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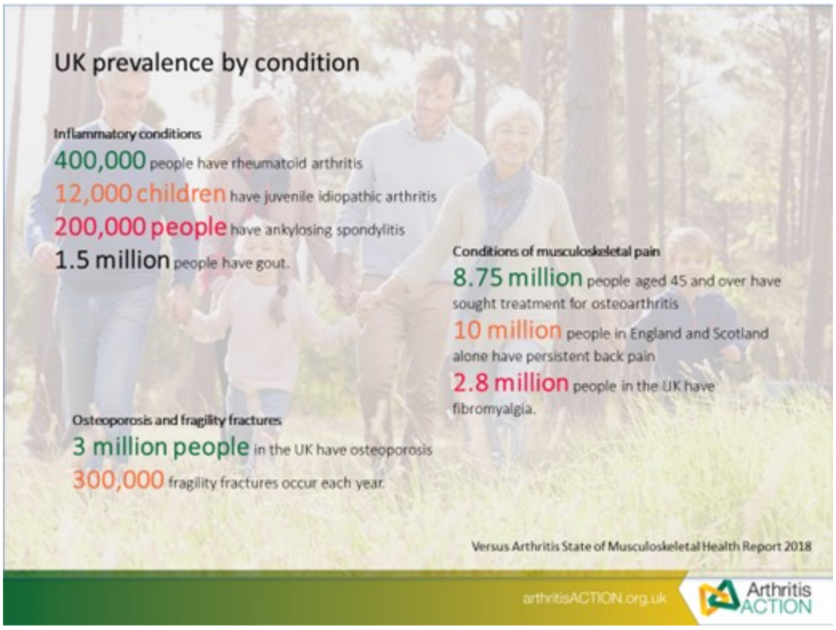

UK prevalence by condition

Inflammatory conditions
400,000 people have rheumatoid arthritis
12,000 children have juvenile idiopathic arthritis
200,000 people have ankylosing spondylitis
1.5 million people have gout.

Conditions of musculoskeletal pain
8.75 million people aged 45 and over have sought treatment for osteoarthritis
10 million people in England and Scotland alone have persistent back pain
2.8 million people in the UK have fibromyalgia.

Osteoporosis and fragility fractures
3 million people in the UK have osteoporosis
300,000 fragility fractures occur each year.

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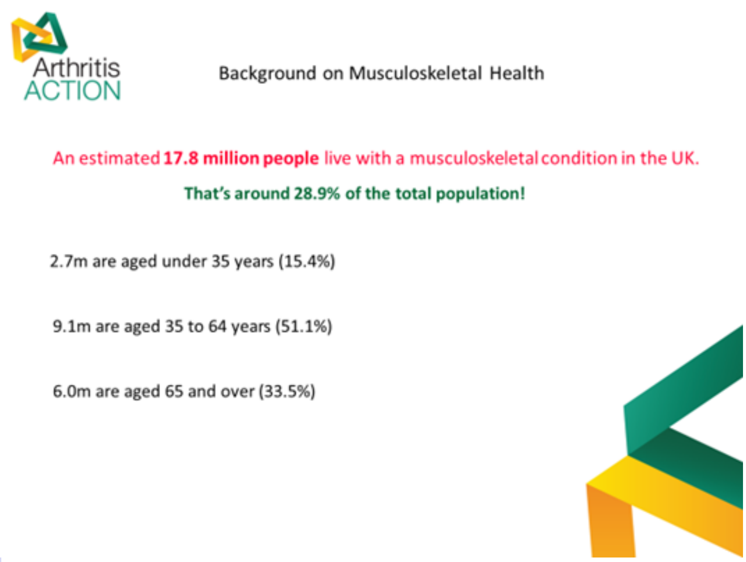

Background on Musculoskeletal Health

An estimated **17.8 million people** live with a musculoskeletal condition in the UK.

That's around 28.9% of the total population!

2.7m are aged under 35 years (15.4%)

9.1m are aged 35 to 64 years (51.1%)

6.0m are aged 65 and over (33.5%)

Impact of Pain

Anxiety & depression major comorbidities

Pain, mental health and disability are strongly linked, so not recognising or treating one can impact the others greatly.

Anxiety and depression are one of the **major comorbidities** when living with arthritis.

Treating emotional and mental health conditions should be a **fundamental part** of managing arthritis from point of diagnosis.

Emotional Health & Well-being Matters Survey 2018, NRAS

The pain and disability caused by arthritis and other musculoskeletal conditions **result in a substantial loss in quality of life.**

Depression is four times more common among people in persistent pain compared to those without pain.

78% of people with arthritis experience pain most days.

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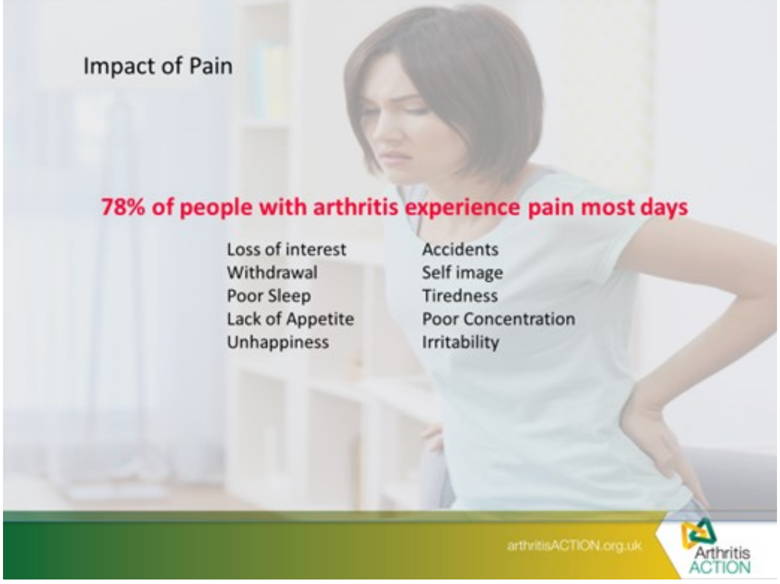

Impact of Pain

78% of people with arthritis experience pain most days

- Loss of interest
- Withdrawal
- Poor Sleep
- Lack of Appetite
- Unhappiness
- Accidents
- Self image
- Tiredness
- Poor Concentration
- Irritability

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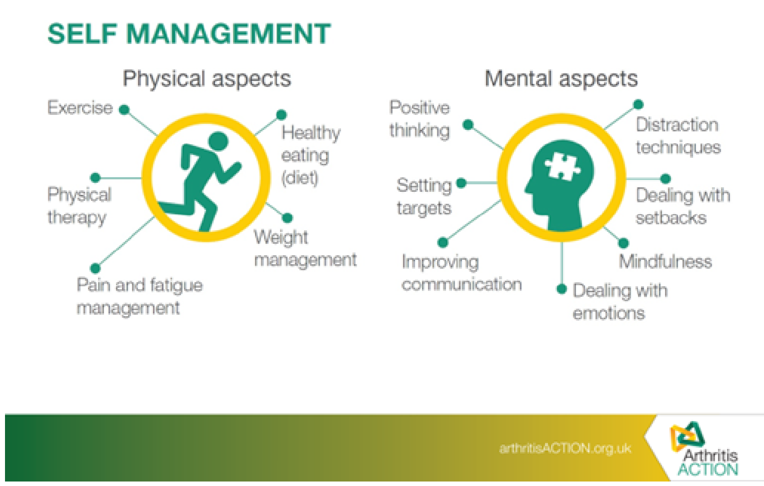

SELF MANAGEMENT

Physical aspects

- Exercise
- Healthy eating (diet)
- Physical therapy
- Weight management
- Pain and fatigue management

Mental aspects

- Positive thinking
- Distraction techniques
- Setting targets
- Dealing with setbacks
- Improving communication
- Mindfulness
- Dealing with emotions

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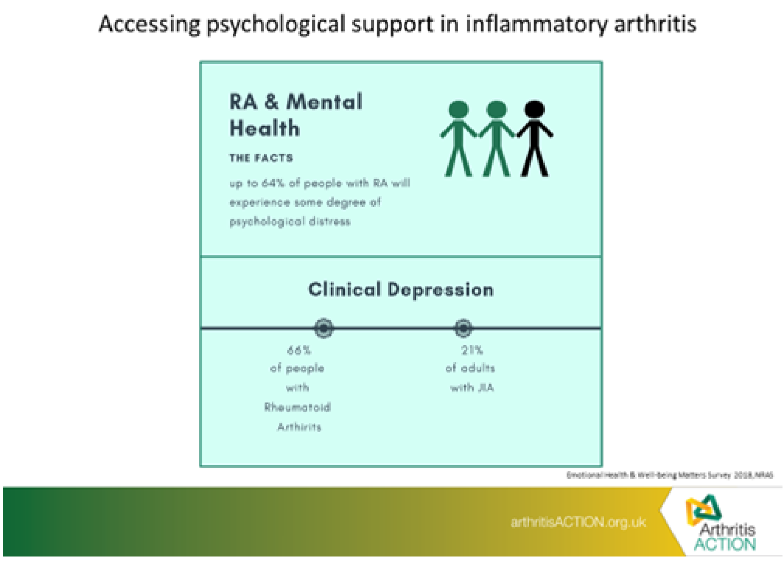
Mental Health Impact



Accessing psychological support in inflammatory arthritis

RA & Mental Health

THE FACTS

up to 64% of people with RA will experience some degree of psychological distress

Clinical Depression

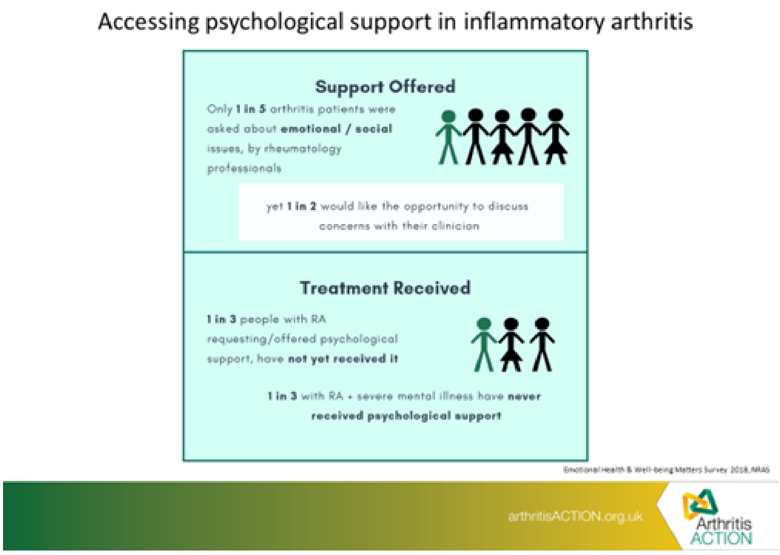
66%
of people
with
Rheumatoid
Arthirits

21%
of adults
with JIA

Emotional Health & Well-being Matters Survey 2018, NRAS

arthritisACTION.org.uk

Arthritis ACTION



Accessing psychological support in inflammatory arthritis

Support Offered

Only **1 in 5** arthritis patients were asked about **emotional / social** issues, by rheumatology professionals

yet **1 in 2** would like the opportunity to discuss concerns with their clinician

Treatment Received

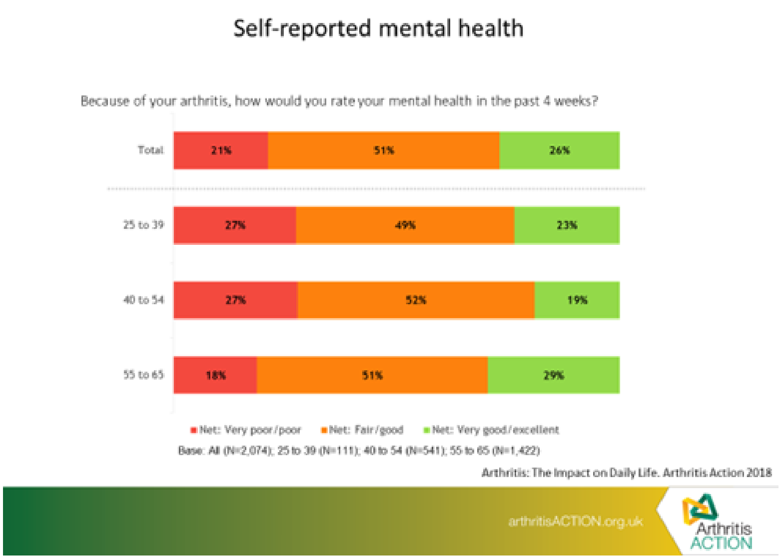
1 in 3 people with RA requesting/offered psychological support, have **not yet received it**

1 in 3 with RA + severe mental illness have **never received psychological support**

Emotional Health & Well-being Matters Survey 2018, NRAS

arthritisACTION.org.uk

Arthritis ACTION



Self-reported mental health

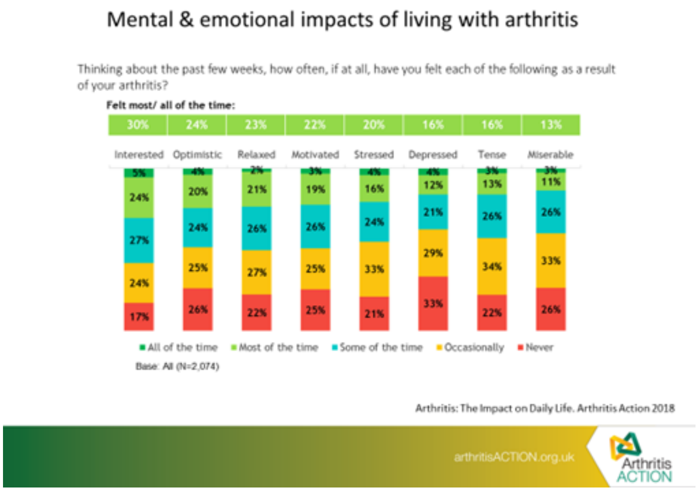
Because of your arthritis, how would you rate your mental health in the past 4 weeks?

Base: All (N=2,074); 25 to 39 (N=111); 40 to 54 (N=541); 55 to 65 (N=1,422)

Arthritis: The Impact on Daily Life. Arthritis Action 2018

arthritisACTION.org.uk

Arthritis ACTION



Mental & emotional impacts of living with arthritis

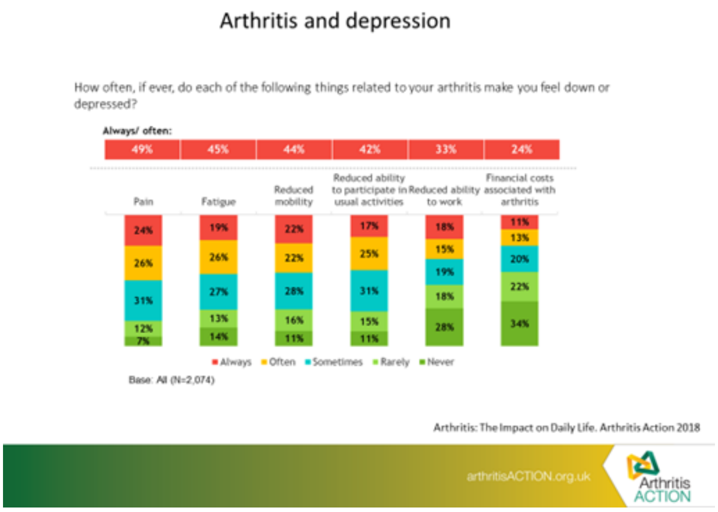
Thinking about the past few weeks, how often, if at all, have you felt each of the following as a result of your arthritis?

Base: All (N=2,074)

Arthritis: The Impact on Daily Life. Arthritis Action 2018

arthritisACTION.org.uk

Arthritis ACTION



Arthritis and depression

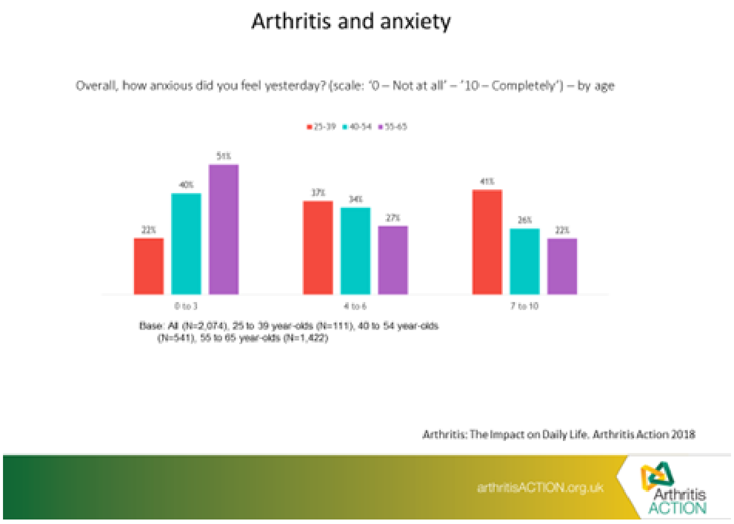
How often, if ever, do each of the following things related to your arthritis make you feel down or depressed?

Base: All (N=2,074)

Arthritis: The Impact on Daily Life. Arthritis Action 2018

arthritisACTION.org.uk

Arthritis ACTION



Arthritis and anxiety

Overall, how anxious did you feel yesterday? (scale: '0 – Not at all' – '10 – Completely') – by age

Base: All (N=2,074), 25 to 39 year-olds (N=111), 40 to 54 year-olds (N=541), 55 to 65 year-olds (N=1,422)

Arthritis: The Impact on Daily Life. Arthritis Action 2018

arthritisACTION.org.uk

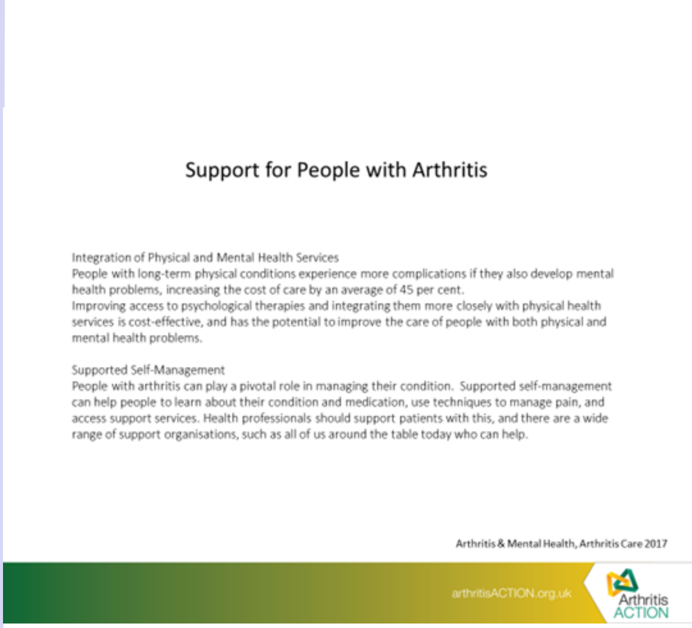
Arthritis ACTION

Life satisfaction

Overall, how satisfied are you with your life nowadays? (scale: '0 – Not at all' – '10 – Completely') – by usual level of pain

Base: All (N=2,074), those with no pain/mild pain (N=741); in moderate pain (N=869); in severe/extreme pain (N=446)

Arthritis: The Impact on Daily Life. Arthritis Action 2018

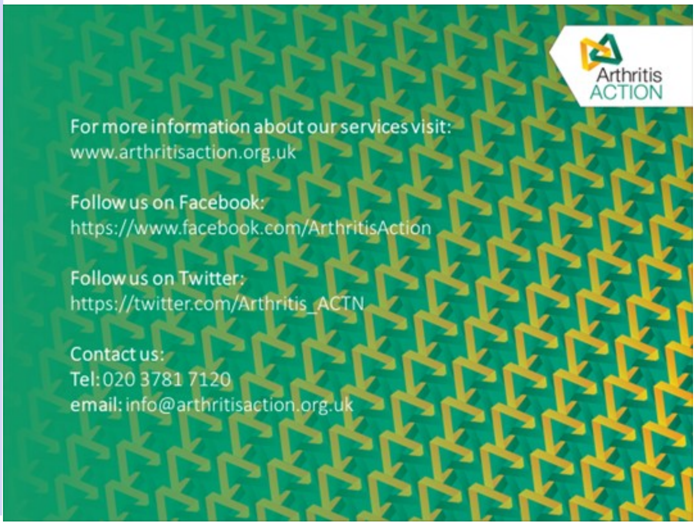


Support for People with Arthritis

Integration of Physical and Mental Health Services
People with long-term physical conditions experience more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent.
Improving access to psychological therapies and integrating them more closely with physical health services is cost-effective, and has the potential to improve the care of people with both physical and mental health problems.

Supported Self-Management
People with arthritis can play a pivotal role in managing their condition. Supported self-management can help people to learn about their condition and medication, use techniques to manage pain, and access support services. Health professionals should support patients with this, and there are a wide range of support organisations, such as all of us around the table today who can help.

Arthritis & Mental Health, Arthritis Care 2017



For more information about our services visit:
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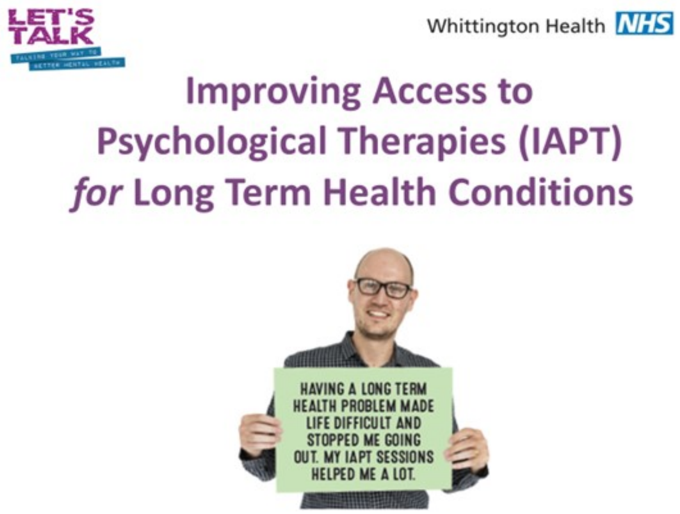
email: info@arthritisaction.org.uk

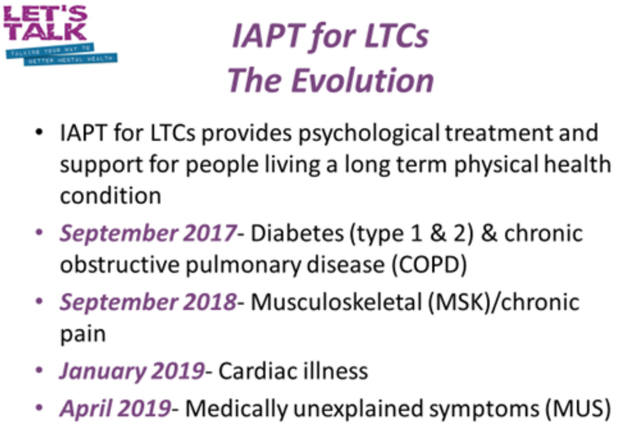


LET'S TALK
TALKING YOUR WAY TO BETTER MENTAL HEALTH

Whittington Health NHS

Improving Access to Psychological Therapies (IAPT) *for* Long Term Health Conditions

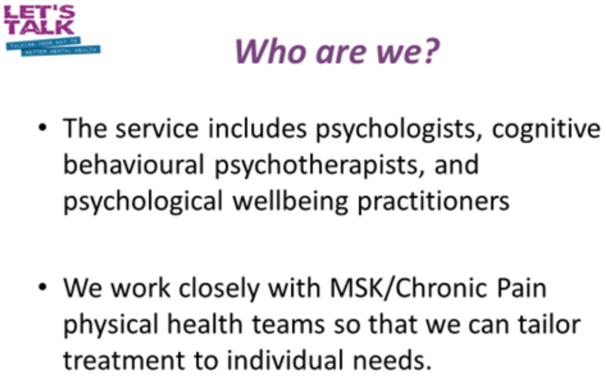
HAVING A LONG TERM HEALTH PROBLEM MADE LIFE DIFFICULT AND STOPPED ME GOING OUT. MY IAPT SESSIONS HELPED ME A LOT.



LET'S TALK
TALKING YOUR WAY TO BETTER MENTAL HEALTH

IAPT for LTCs
The Evolution

- IAPT for LTCs provides psychological treatment and support for people living a long term physical health condition
- *September 2017*- Diabetes (type 1 & 2) & chronic obstructive pulmonary disease (COPD)
- *September 2018*- Musculoskeletal (MSK)/chronic pain
- *January 2019*- Cardiac illness
- *April 2019*- Medically unexplained symptoms (MUS)

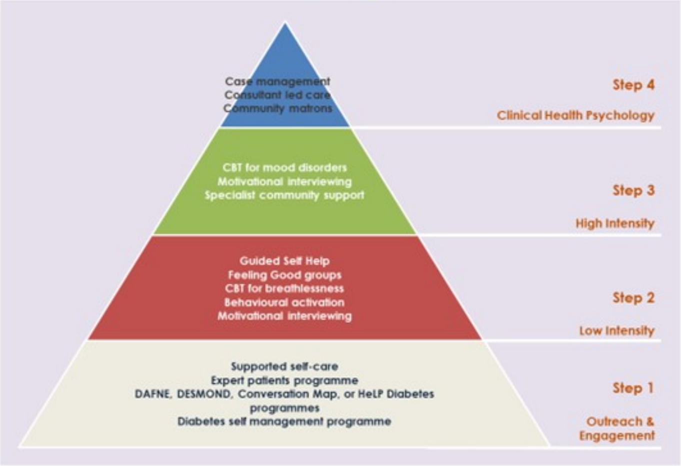


LET'S TALK
TALKING YOUR WAY TO BETTER MENTAL HEALTH

Who are we?

- The service includes psychologists, cognitive behavioural psychotherapists, and psychological wellbeing practitioners
- We work closely with MSK/Chronic Pain physical health teams so that we can tailor treatment to individual needs.

Treatment



Case management
Consultant led care
Community matrons

Step 4

Clinical Health Psychology

CBT for mood disorders
Motivational interviewing
Specialist community support

Step 3

High Intensity

Guided Self Help
Feeling Good groups
CBT for breathlessness
Behavioural activation
Motivational interviewing

Step 2

Low Intensity

Supported self-care
Expert patients programme
DAFNE, DESMOND, Conversation Map, or HeLP Diabetes programmes
Diabetes self management programme

Step 1

Outreach & Engagement

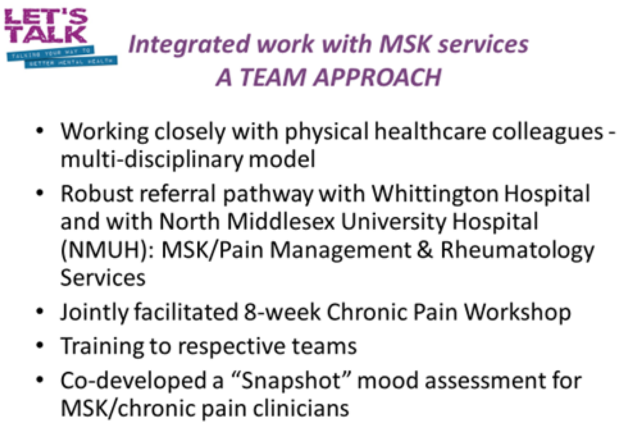
Why access Psychological Support

- Living with chronic pain can be stressful, complicated, and frustrating that can leave someone feeling angry, depressed, and anxious
- Everyone deals with it differently
- The diagnosis can cause grieving for lost good health, loss of full mobility, and create worries (“What Ifs”).

What support is offered?

After an initial telephone assessment, we may offer:

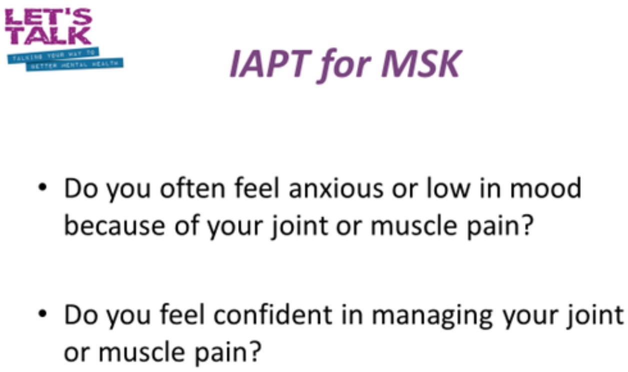
- Individual Cognitive Behavioural Therapy (CBT)
- Guided Self Help (GSH)
- Groups
- Computerised CBT
- Advice on other services



LET'S TALK
TALKING YOUR WAY TO BETTER MENTAL HEALTH

Integrated work with MSK services
A TEAM APPROACH

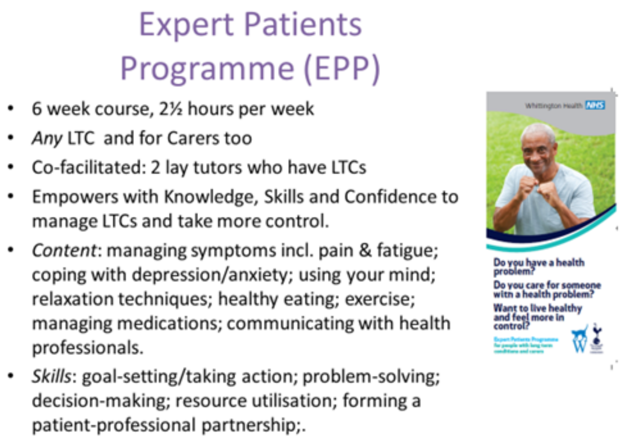
- Working closely with physical healthcare colleagues - multi-disciplinary model
- Robust referral pathway with Whittington Hospital and with North Middlesex University Hospital (NMUH): MSK/Pain Management & Rheumatology Services
- Jointly facilitated 8-week Chronic Pain Workshop
- Training to respective teams
- Co-developed a "Snapshot" mood assessment for MSK/chronic pain clinicians



LET'S TALK
TALKING YOUR WAY TO BETTER MENTAL HEALTH

IAPT for MSK

- Do you often feel anxious or low in mood because of your joint or muscle pain?
- Do you feel confident in managing your joint or muscle pain?



Expert Patients Programme (EPP)

- 6 week course, 2½ hours per week
- *Any* LTC and for Carers too
- Co-facilitated: 2 lay tutors who have LTCs
- Empowers with Knowledge, Skills and Confidence to manage LTCs and take more control.
- *Content*: managing symptoms incl. pain & fatigue; coping with depression/anxiety; using your mind; relaxation techniques; healthy eating; exercise; managing medications; communicating with health professionals.
- *Skills*: goal-setting/taking action; problem-solving; decision-making; resource utilisation; forming a patient-professional partnership;.

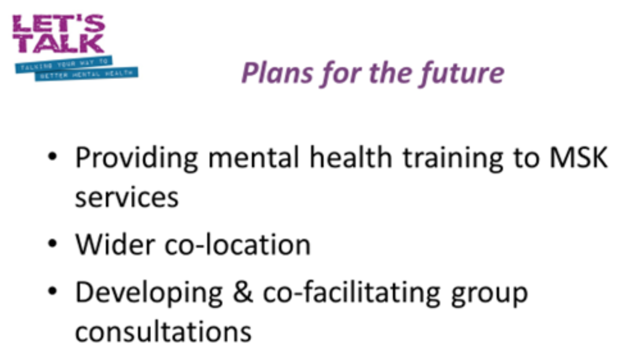
Whittington Health NHS

Do you have a health problem?

Do you care for someone with a health problem?

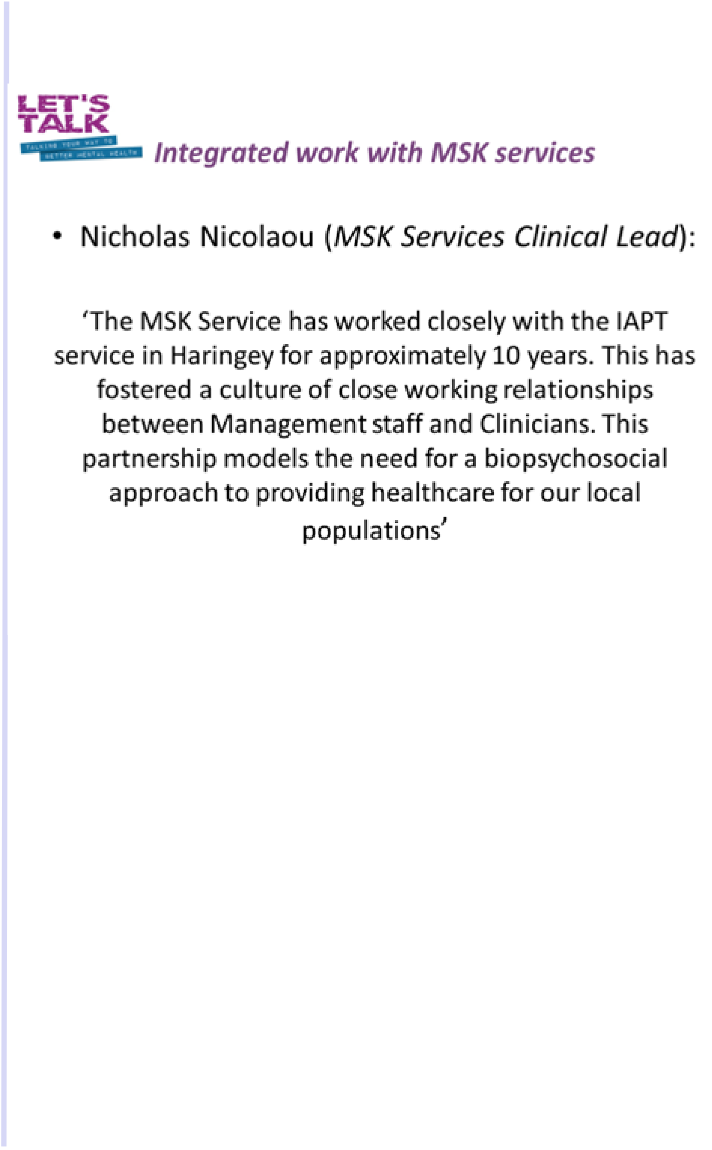
Want to live healthy and feel more in control?

Expert Patients Programme for people with long term conditions and carers



Plans for the future

- Providing mental health training to MSK services
- Wider co-location
- Developing & co-facilitating group consultations



Integrated work with MSK services

- Nicholas Nicolaou (*MSK Services Clinical Lead*):

‘The MSK Service has worked closely with the IAPT service in Haringey for approximately 10 years. This has fostered a culture of close working relationships between Management staff and Clinicians. This partnership models the need for a biopsychosocial approach to providing healthcare for our local populations’

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