MANCHESTER 1824
The University of Manchester

NHS
National Institute for Health Research

Collaboration for Leadership in Applied Health Research and Care (CLAHRC) for Greater Manchester

PWP MANUAL

Case-managing people with low mood and depression and coronary heart disease and/or diabetes

PWP MANUAL

Case-managing people with low mood and depression and coronary heart disease and/or diabetes

Karina Lovell, David Richards, Janine Archer, Clare Baguley, Carolyn Chew-Graham, Peter Coventry, Chris Dickens, Charlotte Garrett, Linda Gask

Acknowledgements

Thanks to Vicky Wilkinson, Jill Barlow, Caroline Haniak, Heena Parmar of the Primary Care Research Network (PCRN); Ms Moira Winters, hub manager, Ms Michelle Vey, Ms Deela Monji and Mrs Polly Bidwell, clinical studies officers, and Mr Amandeep Singh, e-science officer of the North West Mental Health Research Network (MHRN) for their help in recruiting for the COINCIDE trial.

COINCIDE
Collaborative Interventions for Circulation and Depression

http://www.coincidehealth.org

Contents

Introduction

Firstly we would like to thank you so much for agreeing to be part of this study by delivering the intervention, your help is invaluable.

Much of what is covered in this manual is provided in the training; however this manual is for your reference throughout the study.

This resource is for you to use in your role case-managing people with coronary heart disease and/or diabetes and depression. It is divided into the following 2 sections:

Section 1: Background and context to the intervention

Section 2: Delivering the intervention

If there is anything you do not understand or if you want to know more about the study please contact one of the team either by telephone or email.

Let me introduce you to the trial team:

Professor Linda Gask
Professor of Primary Care Psychiatry
Tel: 0161 275 1871
linda.gask@manchester.ac.uk

Professor Karina Lovell
Professor of Mental Health
Tel: 0161 306 7853
karina.lovell@manchester.ac.uk

Dr Peter Coventry
Co-Lead/Research Fellow
Tel: 0161 306 7653
peter.coventry@manchester.ac.uk

Professor Carolyn Chew-Graham
GP & Professor of Primary Care
Tel: 0161 275 1868
carolyn.chew-graham@manchester.ac.uk

Dr Charlotte Garrett
Training Manager
Tel: 0161 306 7040
Charlotte.garrett@manchester.ac.uk

Dr Waquas Waheed
Academic Consultant Psychiatrist
waquas.waheed@lancashirecare.nhs.uk

Ms. Clare Baguley
IAPT NW Programme Field Lead
clare.baguley@northwest.nhs.uk

Dr Andrea Cherrington
Trial Manager
Tel: 0161 275 7616
Andrea.cherrington@manchester.ac.uk

Kate Roughley
Research Assistant
Tel: 0161 3067039
Kate.roughley@manchester.ac.uk

Isabel Adeyemi
Research Assistant
Tel: 0161 306 7042
Isabel.Adeyemi@manchester.ac.uk

Dr Chris Gibbons
Research Associate
Tel: 0161 306 7040
Chris.gibbons@manchester.ac.uk

Kim Hunter
Programme Administrator
Tel: 0161 3067919
Kimberley.hunter@manchester.ac.uk

What is **COINCIDE**?

The Greater Manchester CLAHRC and the CLAHRC Practitioner Theme

The Greater Manchester Collaboration for Leadership in Applied Health Research and Care (GM CLAHRC) is a collaboration between the University of Manchester and NHS partner organisations, and is funded by the National Institute for Health Research (NIHR). The GM CLAHRC consists of research themes and an implementation theme. The GM CLAHRC has three main objectives:

- *Support patient-management and improve quality of care for people with chronic vascular disease* by developing and evaluating a series of interrelated interventions (the research strand).
- *Improve health care provision and reduce inequalities in access to care* by implementing these and other evidence-based interventions in the NHS across Greater Manchester (the implementation strand).
- *Build NHS capacity to plan and implement evidence-based changes to care-pathways for people with vascular disease* through close working and knowledge transfer between University staff and NHS providers and commissioners.

More information about the GMCLAHRC can be found at: http://clahrc-gm.nihr.ac.uk/

The CLAHRC Practitioner theme is one of three research themes in the GMCLAHRC, the aim of which is to test a new model of care for people with heart-disease and/or diabetes and depression to see whether it improves depression, facilitates self-management and improves physical health outcomes.

Research and policy context

Depression is two to three times more common in people with long term conditions such as heart disease and diabetes than it is in people without such conditions and is associated with poorer health outcomes, poorer self-care and poorer quality of life.

At the moment general practice is incentivised to screen for depression in people with heart disease and diabetes and there is clinical guidance from NICE *(see table on page 7)* on how depression should be treated in people with long term conditions.

Despite the presence of incentives to screen for depression and the availability of guidance on how to treat depression among these patients, we know that people with long term conditions are less likely to be treated for depression than people who don't have a long term condition.

Our previous research in the Greater Manchester CLAHRC and the CLAHRC Practitioner Theme has identified a number of barriers present in patients, healthcare professionals and in the healthcare system itself to the efficient detection and treatment of depression in the CLAHRC practitioner theme.

Current NICE Guidance *Stepped care for the treatment of depression in people with chronic physical health problems (also known as Long Term Conditions, LTCs)*

	What is the focus	Nature of the intervention
Step 4	Severe and complex depression, risk to life, severe self neglect	Medication, high intensity psychological interventions, ECT, crisis service, combined treatment, multi-professional input and in-patient care
Step 3	Persistent sub-threshold symptoms; mild to moderate to depression with inadequate response to initial interventions, and moderate depression	Medication, high intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions
Step 2	Persistent sub-threshold symptoms; mild to moderate depression	Low intensity psychological and psychosocial interventions, medication, referral for further assessment and interventions
Step 1	Recognition of depression	Assessment, referral, psycho-education, active monitoring and support, referral for further assessment and interventions

Patients for example are reluctant to admit they are having difficulty coping. Professionals are reluctant to burden the patient with yet another (stigmatising) diagnosis. These barriers may be even greater if patients belong to a different ethnic minority group to the professional, and in people with a first language other than English[1].

Psychological Wellbeing Practitioners (PWPs) are well placed to support and manage depression in people with long term conditions including coronary heart disease and diabetes but PWPs may have limited knowledge of long term conditions and limited experience undertaking psychological therapies in this group of patients.

To help PWPs to work together with primary care professionals to improve physical and psychological health and support self-management for this group of patients we have developed the following:

- A training package for PWPs including training days and a training manual. The focus of this is a collaborative care framework to enhance access to stepped care for people and liaise effectively with other primary care professionals to improve depression in people with coronary heart disease and/or diabetes. The specific psychological interventions used within this framework include behavioural activation, cognitive restructuring, problem-solving, life style changes and medication management for those patients taking an antidepressant, or those who make an informed decision to take an antidepressant.
- A training day for practice nurses/GPs to ensure effective communication between professionals involved in supporting patients.
- A self-help book to help patients with coronary heart disease and/or diabetes who are also experiencing distress and low mood.

The acceptability and feasibility of our training and training materials has been tested in a study with Psychological Wellbeing Practitioners and primary care professionals in Cumbria. In this study we are training Psychological Wellbeing Practitioners and primary care professionals across the North West and collecting data that will allow us to assess the effectiveness and cost-effectiveness of the intervention.

Further information on the CLAHRC Practitioner Theme can be found here:

http://clahrc-gm.nihr.ac.uk/projects/research/health-care-practitioners

Trial website: http://www.coincidehealth.org

[1] *If you want to learn more about these barriers, the group have published their research in a paper which can be accessed here: http://www.biomedcentral.com/1471-2296/12/10*

What is the intervention?

1. The overarching framework is **Collaborative Care** (see next section).

2. Within this framework each patient will be offered a brief psychological intervention dependent on patient preference (behavioural activation, problem-solving, cognitive restructuring and/or lifestyle changes by a PWP). Anxiety interventions (exposure, behavioural experiments) will be offered where underlying anxiety is identified as a problem.

3. Medication management will be used to ensure that patients have the necessary knowledge to make an informed choice about whether to start an antidepressant (AD). For those patients who are taking ADs information will be elicited on the AD that they are taking and whether they are taking it as prescribed. Finally medication management also involves speaking to the GP about medication if there is no improvement, so that a discussion including a medication review with the patient and GP can take place.

4. Each patient will receive up to 8 sessions with the PWP over 12 weeks. Session 1 will be approximately 45-60 minutes long and the subsequent 7 sessions 30-40 minutes long. Sessions can be delivered face to face or via the telephone dependent on patient preference.

5. After sessions 2 and 8, a 10 minute review with the patient, practice nurse or GP and case manager (PWP) to monitor progress, share the problem statement and goals, and discuss the management plan is recommended.

6. The key principles of the intervention are that it is patient centred and includes partnership working, proactive follow up and integrated communication and care between patient, mental health professional and GP and/or practice nurse. The intervention will be patient defined and goal orientated (to improve mental and physical health) outcomes and to recognise the links between physical and mental health (i.e. reducing mind-body dualism).

Overview of the intervention

COLLABORATIVE CARE

Session 1
Patient-centred assessment
Identify problem statement (shared understanding) and goals

Session 2
Collaboratively select intervention
Medication management

Team meeting
(PWP, PN & patient)
Share understanding and agree management plan

Session 3
Reviewing progress
Implementation of intervention and collaborative problem-solving of barriers

Session 4
Formal review of progress including re-rating of goals
Implementation of intervention and collaborative problem-solving of barriers

Session 5 - 7
Reviewing progress
Implementation of intervention
Collaborative problem-solving of barriers

Session 8
Staying well (include continued patient monitoring of outcomes using RAG system)

Team meeting
(PWP, PN & patient)
Review overall progress and agree next steps

What is Collaborative Care?

Collaborative care is an enhanced form of a consultation/liaison model. In most cases it involves the patient, GP/practice nurse, case manager and your clinical supervisor but may also involve hospital specialists in physical disease and/or other (e.g. 3rd sector) agencies. In this case you, the PWP, will be acting as case manager.

The key characteristics are:

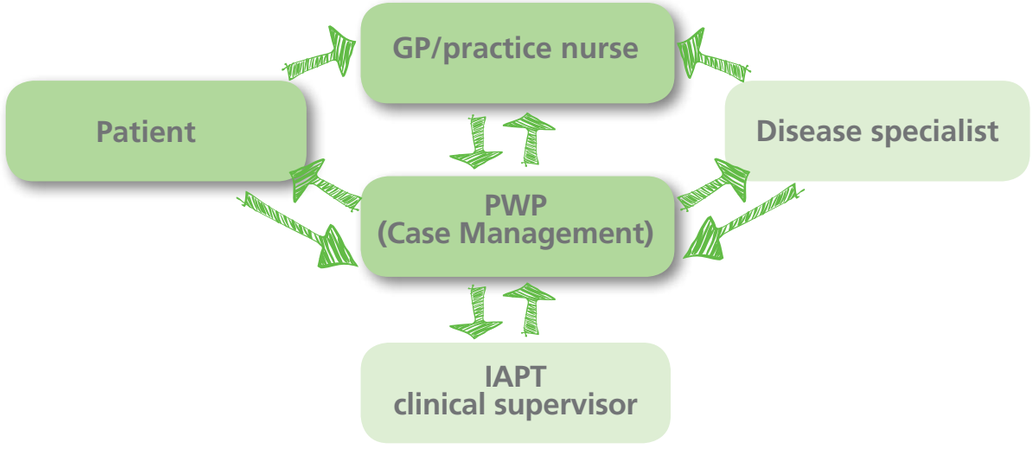
- A multi professional approach to patient care
- A structured patient management plan
- Proactive scheduled follow-up
- Enhanced inter-professional communication
- Closer co-ordination of care
- Case manager as the conduit and patient supporter offering psychological, social and medical care

Your role

Your role in delivering the intervention is to case-manage people with heart disease and/or diabetes and depression. In brief this means that you will see patients (either face to face or telephone dependent on patient preference) with heart disease and/or diabetes and depression up to 8 times over a 3 month period. Case managing means that you will be responsible for **engaging** the patient, completing a **patient centred assessment, negotiating** with the patient in selecting an optimal intervention from a menu of choices, and **supporting, motivating, monitoring and actively following** patients. In addition the role of case manager is to **pro-actively follow patients up**, i.e. if they fail to attend a session you should repeatedly try to contact them (this is because we know that the very nature of depression means that it can be difficult to attend appointments). Further key activities are **liaison, feedback** to and **discussion with** the patient's GP/practice nurse and any other parties (e.g. disease specialist or third party agencies) who are involved or become involved in the patient's case, and **discussion with** your supervisor.

Our role

Our role is to support you in your role of case manager. We will provide the training and guidance for yourselves and your supervisors.



Delivering the intervention

Session by session guide

This section contains a step by step guide to help you in delivering the intervention. Brief details of what should be included in each session are described in the 'session review box'. Below each review box there is a more detailed explanation of what should be covered during the sessions. The detail given in these types of manuals can sometimes feel patronising for experienced mental health workers. We do recognise you are skilled clinicians and the detail is only to prompt and help you to deliver the intervention as close to the protocol as you can.

Session 1
(Patient assessment and developing a shared problem statement)

Session 1 overview:

- Orientation to the session
- Initiate patient centred interview (assessing both the heart disease/diabetes and low mood and the links between these), ABC, impact, other relevant information and risk. Use enhancing change skills to ensure a positive interview.
- Introduce the book and educate briefly about heart disease and/or diabetes with depression
- Write down ABC and personal links
- Main problem statement and goal setting
- Between session work – encourage patient to read the stories in the book to help them think about the intervention which they feel would help them most.
- Feedback on session – final questions – next appointment (face to face or telephone)

Session 1 will be between 45-60 minutes and can be face to face or over the telephone depending on patient preference (though often because of the way services work it is likely that session 1 will be face to face).

We have created a tool for you which you may wish to use to guide you through Session 1. You will find this at the end of the book on page 27.

A patient centred assessment requires a host of skills – we will be discussing many of these in the training but two skills which will facilitate the interview are skills in **engagement** and **enhancing change.**

Engagement and enhancing change

When conducting a patient centred assessment, you should try to conduct the session in a relaxed and conversational manner in order to develop a good rapport with the patient.

Throughout you should remember the importance of listening attentively to what the participant is saying and adopt **a collaborative approach** to the delivery of the intervention i.e. working with the patient, ensuring that they are involved at all times in discussion, problem-solving and decision-making.

Key interviewing skills in engaging patients include rapport building, flexibility, summarising, facilitation and managing emotion (empathy, factually accurate reassurance, etc). It is important that patient expectations are explored (i.e. "what are you hoping to get out of today's session?") as this ensures that you have a shared view of the purpose of the session.

Be aware that because stigma still exists around mental illness some patients may be wary of being labeled as 'mentally ill' – be sensitive in your use of language (try to use the language the patient uses) and try to normalise the link between physical and mental well being (e.g. 'When people have problems with their physical health this often impacts on how they feel'; 'Staying positive can often be a challenge for people when they are managing physical health problems').

We all find it difficult to make changes to our life styles; change requires significant effort and such efforts need to be acknowledged. More importantly, sustaining change is even more difficult. Rather than telling the patient what to do it is important to pose questions which help the patient make their own choices i.e. 'What would help you?'; 'How can I best help you?'.

Enhancing change is more than just trying to motivate people (many people are motivated), but it also about acknowledging that there are a number of barriers that make change difficult. Discussing such barriers (physical, financial, social, time, psychological) is central to enhancing change. Collaborative problem-solving and drawing solutions from patients' past experience, effective question usage, responsiveness, positive regard and trust are skills which will help to foster change.

Orientation to the session

Introduce self, role (i.e. 'I am a Psychological Wellbeing Practitioner and my role is to work with you – which I will explain more about in a few minutes'). Confirm the patient's full name, identify the purpose of the interview, and approximate duration of the interview. Confidentially should be explained.

Orientation to the team approach (collaborative care)

It is important that you explicitly introduce the patient to this idea. State that the help we offer is a team approach:

- the patient
- you, the case manager
- the self-help booklet
- family and friends
- GP and/or practice nurse

The Patient: Emphasise that the patient is the most important part of the team; they are the expert in how they are feeling now, how they want to feel in the future and the agent of change. They also have knowledge of their LTC.

The Psychological Wellbeing Practitioner: Explain in detail your role – that your role is to work with people who have an LTC, and who are showing a level of distress, low mood, or depression. It may be useful to explain briefly that we know that people with heart disease and/or diabetes are more likely to be distressed/ depressed than people without a health condition. Thus your role is to work with the 'whole' person rather than a bit of them (i.e. avoid mind-body dualism) and help them to help themselves to manage their mood as well as their heart disease and/or diabetes.

A way of explaining this to patients might be to use an analogy of a personal fitness trainer (this is the same analogy as we have used in the book). You might introduce this by saying that a way of explaining your role is similar to a personal fitness trainer:

"If you go down the gym or play sports, fitness trainers don't do the actual physical work of getting you fit. That's up to you. However, the trainer helps you to devise a fitness plan, monitor your progress and keep encouraging you when the going gets tough. I, as your case manager, will act in the same way. I am there to support, advise, encourage and monitor your progress".

The Book: Introduce the booklet as something which can help patients manage situations which they are finding difficult. Explain that you will use the book as you go through the sessions. Also introduce the workbook which you will be working in.

Your friends and family: Emphasise that for most people friends and family are usually the people that we are closest to and that it is usually helpful to involve them in helping people to help themselves. At this point it should be asked whether the patient has somebody that they think would be involved in the team. Inform the patient that if they are willing then you would be pleased to talk to a friend or family member.

Your GP/practice nurse: State that the patient's GP/practice nurse are an essential part of the team and that you, the PWP, will have frequent contact with the GP and practice nurse for the next 12 weeks. In addition offer a 10 minute joint appointment (patient, yourself, practice nurse/ GP) at session 2 and session 8. The purpose of this meeting is to ensure continuity of care and effective communication between the team.

Initiate patient centred assessment:

Introduce the assessment with an opening statement – e.g. "Your GP has told me that you are experiencing low mood and that you also have heart disease and/or diabetes – is this your understanding? Sometimes when we are low in mood this can affect the way we manage our heart disease and diabetes but not always. What would be helpful now is for me to understand more about you, how you are feeling, and particularly the impact that this problem is having on your life now".

We know that many patients with depression or low mood use metaphors to describe their own experience and believe it important to incorporate this into the assessment. Try to elicit this by asking an open question such as "In a nutshell, tell me, how have you been feeling?"

Once you have a brief idea of the patient's problem from their perspective, briefly elicit some information about their heart disease/ diabetes or depression if they have not mentioned it – i.e. "Your GP has told me that you have heart disease and/or diabetes – can you tell me more about this?" – i.e. onset, course, current physical symptoms, current medications and side-effects, complications of LTC, how they feel they are managing it, what they have difficulty doing.

Elicit information on specific health outcomes i.e. BP, HbA1c, cholesterol etc. Don't assume that patients don't know a lot about key health outcomes as many do have good knowledge on specific health outcomes. Conversely, if they have not mentioned low mood or depression you should try to elicit some brief information about this i.e. "Your GP has told me that he/ she thinks you are bit low in your mood at

the moment – I am interested to know what you think about this and whether you think that this a problem for you at the moment".

As with any patient centred assessment – the idea is to understand their experience of the way they are feeling but also to elicit other necessary information. The tension between patients wanting to tell their story and you eliciting information can be difficult. However, to do this the following areas need to be weaved into the interview.

4 Ws, ABC, impact, other areas, and risk

- **4 Ws** – Ask the patient what they see as their main difficulty at the moment. Use the 4 Ws to elicit this information (what, where, when, with whom).
- **Triggers** – Ask the patient what they feel were the triggers for their current episode of low mood/depression. Occasionally these may not be present.
- **Ask explicitly for information about their heart disease/diabetes** (i.e. how long they have had the condition, what impact it has on their life, medications, how they feel they are managing, whether this has changed).
- **Elicit the ABC.** Try to use the language of what they feel (A) what they do (B) and what they think (C) – about both depression and heart disease/diabetes. When asking about cognitions try to elicit any unhelpful health beliefs about their heart disease/diabetes – "what are your thoughts about your heart disease/diabetes" "do you think that you manage your condition well or not" (if not why not?), "do you feel that you have any control over your condition and the impact it has on your life?"
- **Links between conditions** – When asking about the ABC it is useful to ask if they think there are any links between their heart disease/diabetes and mood: for some people there will not be any link – i.e. they are continuing to manage their heart disease/diabetes well but are depressed; for others they may feel that the heart disease/diabetes is the cause of the depression; whereas others may feel that there has been a deterioration in their self management of heart disease/diabetes because they have been depressed.
- **Impact** – How is their current difficulty impacting on their life – ask specifically about work, home, social, private leisure and relationships (weave in impact of depression and heart disease and/or diabetes)
- **Modifying factors** (is there anything that makes the problem better or worse?)
- **Onset and course** (cover both depression and heart disease/diabetes)
- **Why they want help now**/why the patient thinks it has been suggested that they come and see you
- **Past treatment**
- **Drugs** (illicit, prescribed and over the counter) and **alcohol.**

Ask specifically about antidepressant medication (including name, dose, how long they have been taking it, whether they think it is effective, any side effects, are they taking as prescribed, what are their views about medication) – ask specifically about current medication for their health condition (you should have the name and dose – ask if they are taking it as prescribed, and what are their views on taking this medication).

- **Lifestyle** – briefly ask about lifestyle – exercise, diet, smoking, stress etc.
- **Risk** (you will be using your NHS Trust protocols to assess risk but below are some questions and areas that you should ask):
  - **Intent** – Whether the individual has thoughts about self-harming, killing self, harming others
  - **Plans** – Whether the individual has planned how they intend to carry out their intentions and whether they have access to the means to self-harm/harm others
  - **Actions** – Whether the individual is currently engaged in actions that result in harm to the self or others and/or whether past actions that have resulted in harm to self/others
  - **Prevention** – What factors might militate against the individual self-harming/or can actively be called upon to do so - e.g. social network, services, key relationships etc.

A key question to ask patients is "Is there anything that we have not covered in our discussion that is relevant to your difficulties? Is there anything else that you would like to add?" Thank them for information that they have given so far.

Introduce the book and accompanying workbook and educate briefly about depression and heart disease and/or diabetes

It is at this point that you introduce the book – remind the patient about the team approach and that one part of the team is the book. Explicitly state that the book is a tool, which you will support them with.

There are a number of things which you should specifically explain:

- That the book is a tool which will help to manage situations which they are finding difficult.
- That the book is there for them to make choices about what they do rather than you/ others telling them what they should do.
- That it is divided into five sections. The first section provides more information about the booklet. The second section is about understanding the way they feel. The third section looks at ways of improving their mood/anxiety and better managing their heart disease or diabetes and the fourth section is about staying well. Explain that the fifth section contains stories which are there to illustrate how these individuals used the different techniques described. They are about ordinary people with heart disease and/or diabetes and low mood and how they have used some of the techniques in the book.
- That there are also worksheets in a seperate booklet which they will be filling in as they work through the manual. Writing on worksheets rather than in the manual itself means that if they encounter similar problems in future they can use the manual again.

Further points

It is important in the assessment to briefly discuss the possible interrelationships between physical and psychological health. It is important to discuss potential links between their mood and health condition but equally it is important not to make links if there are not any.

Using the relevant worksheets, **write down the patient's ABC and personal links**.

Explain the nature of the ABC model and with the patient complete the ABC worksheet in the workbook adding personal links (much of this will have been elicited in the assessment) e.g. "Do you remember earlier when I asked you about your thoughts, feelings and actions?"

Identify links between health condition and depression (if none then use ABC to explain either depression or health condition). If you can see clear links but the patient can't – pose these as questions but ultimately go with what the patient says. This can be gently challenged through the sessions but challenging too much at this stage may disengage the patient.

Summarise current difficulties

With the patient, devise a **shared problem statement** of the current problems/difficulties. This should include the 'What', ABC, and impact. For example:

"I get palpitations and I am frightened and think I might be having a heart attack or over straining my heart which leads me to take everything very slowly. I don't do any exercise and I check my pulse hundreds of times every day. I have stopped going out and although I could work I don't."

"Because of lots of stressful things in my life I feel low in mood which has led to poor sleep, eating the wrong foods, and I have lost interest in the things that I used to enjoy. This has caused me to put on weight and I am having problems keeping my blood sugar stable."

Get the patient to find the appropriate worksheet in the workbook ***(Worksheet 5: problem statement, page 8)***. Ask the patient if they would like to write out their problem statement or whether they would prefer you to do this.

Goal-setting

Ask the patient about specific goals that they want to achieve.

Goals should be:

- patient centred (i.e. developed by the client)
- focused on change
- specific
- stated positively
- realistic and feasible
- set within a time scale

EXAMPLES OF SPECIFIC GOALS

- to play badminton once a week and enjoy it
- to maintain my cholesterol level below 4.0mmol/l*
- to keep HbA1c within a level that indicates good control*
- to keep blood glucose levels before meals between 4-7mmol/l*
- to join a healthy living group
- to get to sleep in 30 minutes on six occasions weekly
- to go to work five days a week and concentrate while I am there
- to meet people twice a week and speak to them confidently
- to walk briskly for 30 minutes four times a week

You, as case manager, may introduce goal-setting to the patient in the following way: "Setting goals and developing action plans is a way of helping people to achieve changes in their lives that they want to make."

"Goals are like targets to work towards and, with an action plan, can be either what you want to achieve over a long period of time, such as by this time next year, or over a very short period of time."

"We would suggest your goal should be something that you want to achieve over the next 3-4 months. Having goals to work towards will make it more likely that you will succeed in making changes because it will help you to be clear about what you are trying to achieve and how you will go about it."

Explain to the patient that goals are things to aim for. Sometimes patients make very general goals such as "To feel better". Try to work with them to be more specific i.e. "Could you tell me what feeling better means to you, what things would you be doing/or doing differently if you felt better?" Try to pick out 2-3 goals, write them down on the appropriate worksheet from the patient manual and ask the patient to rate them.

Ask them "on a scale of 0-10 where 0 is not started and 10 is fully there – where would you put yourself right now?"

Patients like to feel listened to and will pick up if everything is being rushed. If you are unable to do the problem statement and goals then you could ask the patient to have a look at the section in the book and suggest that they could do them between sessions or that you can work on them together at session 2.

** The specific range or value of HbA1c will be unique to every patient.*
The patient's GP or nurse will be able to help you and the patient to work out what is realistic for them.

Ending

Tell the patient when there is 5-10 minutes of the session left.

Explain that there are different ways of helping people and that the next session will focus on ways of helping but ways of helping that they want – i.e. re-emphasise partnership working. To help the patient choose, suggest that it would be helpful if they read the five recovery stories which are linked to the ABC.

Ask the patient when they would like their next contact – i.e. one week or two weeks – and what mode of delivery they would prefer – i.e. face to face or telephone.

Remind the patient that the second and subsequent sessions will be 30-40 minutes and that at the end of the second session there will be a team meeting (patient/yourself/practice nurse or GP). If the patient prefers telephone there is no reason why this team meeting could not be completed on the telephone.

Ask the patient for feedback on the session and any final questions that they may have.

Session 2

Session 2 overview:

- Review depression, LTC, risk and helpfulness/completion of tasks in the book
- Review goals
- Review what patient thinks about stories
- Relate stories to interventions
- Encourage patient to choose intervention
- Collaboratively plan intervention (action plan) and next steps of the intervention
- Team meeting (patient/yourself/practice nurse or GP)
- **Ending:** feedback on session – final questions – next appointment (face to face or telephone)

Review mood/health condition, risk and helpfulness/completion of tasks in the book

Welcome the patient, orientate them to the purpose and duration of the session (approx 30 minutes).

Review the patient's mood (using the PHQ/GAD) and health condition using open questions; elicit any previously held risk factors or risk factors that have arisen.

Use open questions to elicit information on the book e.g. "Did you read any of the book?", "What did you think of the book?", likes /dislikes.

Ask patients if there was anything from the last session that they would like to discuss or any particular issues they have.

Ask if they have engaged any family members and offer to speak to them if the patient wishes.

Elicit information about completion of work – "In our first session we discussed…(brief recap) and we agreed that you would have a go at writing down your problem statement and goals (if not completed in session 1) and read the five stories."

Review Goals

At this point you should look at the goals the patient has completed, advise if not specific enough and ask relevant questions such as how such goals relate to improvement in functioning, mood and health condition. If the patient has had difficulty or has not completed them, use careful and non judgemental questioning to find out why: Was it that the goals were not relevant, that they did not understand, or forgot? You should try to problem solve goals with the patient and if necessary use the first part of the session to determine them.

Review what the patient thinks of the stories

Discuss with the patient what they thought of the stories.

If the patient has read them, ask them if they identified with any of the stories or the interventions. Spend a few minutes discussing why they related to this story and how it fits into their own experience/beliefs about depression/health condition.

If the patient has not read them ask why and use problem solving – it may be that the patient has been unable to for the reasons described above. You might use this session to go through the stories with the patient.

Relate stories to interventions

Discuss what the patient thought of the stories in relation to the specific interventions.

Encourage patient to choose intervention

Explicitly state that the choice of the intervention is for the patient to make. Also state that they can select more than one intervention, or they may start with one area and move onto another intervention later. If patients specifically ask you to choose then you should do this making your selection using your clinical judgement and the information that they have given you in the assessment.

Collaboratively plan next steps of the intervention

Recap problem statement, goals and devise action plan. With the patient, assist them in planning the intervention and the steps involved e.g. if they have selected behavioural activation then you will need to explain the diary sheet in step 1 (they will have one in their workbook); or if they want to work on their sleep use a plain diary; or thoughts use a thought diary.

Team meeting

This collaborative meeting can be completed face to face or via the telephone and include the patient/ yourself /practice nurse or GP – i.e. a meeting of experts (practice nurse/GP have expertise in health conditions and health conditions medications; the patient has the expertise of lived experience, you as case manager have expertise in mood and knowledge of health conditions). This 10 minute meeting should review the main problem, goals and intervention selected. Relevant health outcomes if not known by the patient or yourself should be identified by the practice nurse (i.e. BP, cholesterol, lipids or HbA1c); any medication issues should also be raised. The patient should be offered the opportunity to ask any questions or any other issues relevant to the action plan.

Ending

Recap the session, next steps of the intervention, ask them to read or listen to the intervention selected and reiterate what they have agreed to do before the next session. Ask for feedback from the session and ask if they have any final questions. Arrange next appointment (face to face or telephone).

Session 3-7

Session 3-7 overview:

- Review depression/LTC and risk
- Review progress on the intervention
- **Formal review (session 4 only)**
- Collaboratively plan next stage of intervention or new intervention
- **Ending:** feedback on session – final questions – next appointment (face to face, telephone, email)

Review depression, risk, physical symptoms/ concerns about LTC, and helpfulness/ completion of tasks in the book

Welcome patient and orientate them to the purpose and duration of session (15-20 minutes). Review the patient's mood (using the PHQ/GAD) and health condition using open questions; elicit any previously held risk factors or risk factors that have arisen. Elicit information about completing the diaries, lifestyle changes etc.

Review progress on intervention

Identify any barriers, 'stuck points' with the intervention and progress. Use the patients own experience to work with them - i.e. "you must have experienced barriers in your life before – what has worked for you to overcome them?". Perceived or actual barriers are crucial to identify – use careful questioning in a conversational style to elicit and collaboratively problem solve.

With all of the interventions the end result is to incorporate changes into their current lifestyle – so if someone has changed their diet then the key is to discuss how this can be sustained and incorporated into their daily lives to ensure it becomes a routine activity.

Formal review *(Session 4)*

Although a review is held at every session – a formal review should be held at session 4 – this is a full review including re-rating of goals, PHQ-9 or GAD-7 and any other IAPT measures, other changes in medical outcomes where relevant (i.e. BP, blood glucose etc). You as case manager and the patient should have the opportunity to produce an evaluation of progress.

Collaboratively plan next steps of the intervention, or new intervention

Continue to make specific links with the patient regarding the intervention ABC (feelings, actions and thoughts). Make specific links with the patient about their mood and health condition.

Collaboratively plan the next steps of the intervention – for some people this may require changing the intervention if something is not working well – or using a different intervention to work on a specific goal.

Ending

Recap the session, review the next steps of the intervention, ask them to read or listen to the intervention selected and reiterate what they have agreed to do before the next session. Ask for feedback from the session and ask if they have any final questions. Arrange next appointment (face to face, email or telephone).

Session 8
(Staying well)

Session 8 overview:

- Review depression, risk, physical health symptoms/ concerns
- Review progress
- Introduce the concept of 'staying well'
- Discuss individual staying well behaviours
- Team meeting (patient, yourself and practice nurse/GP)
- **Ending:** feedback on session – final questions – closure of the session – next steps

Review depression and risk

Welcome the patient, orientate them to the purpose and duration of session (30-40 minutes). Review patient's mood, (using the PHQ/GAD) health outcomes and goals, using open questions; elicit any previously held risk factors or risk factors that have arisen. Elicit information about completing the diaries, lifestyle changes etc.

Review progress on intervention

Review diaries and progress on intervention i.e. what is working well – what not so well. Elicit barriers and facilitators to incorporating changes into daily routines. An overall review of progress will be completed at the team meeting.

Introduce the concept of 'staying well' and discuss staying well behaviours

During the last few sessions it is important that you introduce the concept of 'staying well'. It is important that you are honest with people – depression can and does recur but looking at relapse prevention is important. You should review with the patient their overall progress. As with the intervention this should be a collaborative process and directed by the patient, along with a summary of their PHQ scores.

Introduce this to them by saying that this part of the session is focused on staying well – what things they need to do (you will have already discussed with the patient the importance of incorporating positive changes in their daily routine to ensure gains are maintained). You should ask the patient what aspects they think are important to monitor to help them stay well (for example this may be teaching the patient to use the PHQ9 on a monthly basis, or it may be ensuring that a patient who has previously failed to attend the practice to have regular follow-up starts to attend. Other patients may buy a blood pressure (BP) monitoring machine; a patient may decide to stick to a healthy diet, stop smoking, or do regular exercise). One of the key messages here is that to stay well we need some form of monitoring system to alert us to any early warning signs that things may not be going so well – this allows us to make changes and try to nip the problem in the bud.

Where patients have previously not monitored either their health condition, behaviours or mood try to encourage them to do so – this will usually mean copies of a scale in the case of depression, how to measure and interpret them (i.e. using a cut-off on the PHQ-9) and at what point to act, and what action to take. For some patients a RAG (Red, Amber, and Green) system works well. For depression a patient may be advised to complete a PHQ-9 once a month – they set a date in their diary (e.g. 1st of the month) on which they complete the PHQ-9.

After completing and scoring the PHQ-9 they take appropriate action: anything less than 6 is green and no action need be taken; if 7- 11 this would be considered orange and the patient needs to use their action plan for this circumstance to plan next action (i.e. if their score is 10-11 the patient might switch to weekly scoring to monitor their mood more closely); and anything over 12 would be deemed red alert and implementation of the action plan is crucial.

A similar RAG rating could be completed with any health outcome with discussion with GP or practice nurse (HbA1c, cholesterol, blood pressure etc). It is a good idea for the patient to make a record of their staying well plan and to discuss with the patient whether they might want to share this with other members of their care team. Worksheets 17, 18 and 19 in the patient workbook can be used to record the patient's early warning signs, for mood-monitoring, or to record their staying well plan.

Ask the patient if they can think of key 'take home messages'- things that they have learnt during the course of the treatment which would be useful to remember in the future if they start feeling bad again. There is space for patients to write these things down in the patient workbook as part of their staying well plan (worksheet 20).

Team meeting

The collaborative meeting can be completed face to face or by telephone and again should include the patient, yourself, practice nurse or GP. This 10-minute meeting should review the patient's progress in terms of the main problem statement, goals, intervention used and relevant health outcomes (i.e. BP, lipids and HbA1c) and any medication issues.

Next steps should be decided in partnership with the patient. If the patient's mood has improved then maintenance of gains should be discussed and monitoring of health outcomes. As part of this, the PWP and the patient should share with the 'Early warning signs and action plan' and 'Staying well plan' with the practice nurse/GP, to make them aware of these and see if there are any suggestions they wish to make. If the patient's mood has not improved then discussion should be focused on next steps. This may include a medication review with the GP (i.e. increase or change in antidepressant), and, with the agreement of the patient, referral to step up to a higher intensity intervention. The patient should be offered the opportunity to ask any questions or discuss any other issues that are relevant to the action plan.

Ending

Recap the session, particularly highlighting staying well and the team management plan. Thank patients for their time.

Monitoring and supervision

Supervision

PWPs will receive individual supervision from a senior mental-health practitioner in their team. You will be expected to briefly present each new patient – problem statement and goals, current medication, psychometric scores (PHQ 9, GAD-7), impact (including the impact of their depression on their self-management), treatment concordance, and risk issues.

You will also be expected to present all patients at session 4 for review (progress with goals, depression and CHD/diabetes outcomes e.g. HbA1c, lipids), as well as any patients not attending, at risk or who are not improving and all patients at session 8.

There will also be an opportunity for you to discuss any other patients. Individual supervision may be conducted face to face or over the phone depending on PWP and supervisor preference and availability. Duration of this supervision will be approximately 1 hour.

Normally you would also undertake 2-weekly group supervision with other PWPs involved in the study facilitated by a senior mental-health practitioner in your team.

The duration of this group supervision will be approximately 1 hour and it will involve in-depth discussion and skill-development arising from specific cases.

Monitoring and record keeping

You will be keeping your own notes for the patients you are seeing, on the IAPTus system and hopefully on the system of the GP practice you will be working with. You will need to discuss this with the practices (start with the practice manager) to get an agreement and then access to the system.

We will be asking you to keep monitoring forms for each patient. This information is very important to us as it will give us idea of how many sessions patients are attending, the delivery mode in which patients are receiving treatment (face to face or telephone), what interventions the patients chose to work with, referrals to other services (e.g. expert patient or exercise on prescription programmes), and how effective attempts were to follow-up patients when they did not attend. The CLAHRC Practitioner team will inform you of the procedure for completing and returning these monitoring sheets.

When patients do not attend (DNA)

A crucial part of collaborative care is pro-active follow-up. If a patient DNAs the health professional should actively follow them up (usually by telephone) and we would recommend that you try to contact them up to 8 -10 times (ensuring that the patient is rung at different times of the day morning, afternoon and evening) over a period of 2 weeks. You should discuss your pro active follow up plan with your supervisor. It is important to stress the role and rationale of proactive follow-up at assessment – i.e. we understand that when people are feeling low and have a long term condition they can find it difficult to attend appointments so we try to reengage people by contacting them frequently for a 2 week period - check with the patient how they would like to be contacted should they DNA. If after the planned period of proactive follow-up the patient is still unreachable a team decision should be made about the discharge strategy and route for re-referral by the PN / GP if and when appropriate.

SESSION 1: ASSESSMENT TOOL

Patient's name: .....

Session date: .....

Orientate patient to the session

Introduce self, role

Confirm patient's full name

Identify the purpose of the interview & approximate duration

Explain confidentiality

Orientate to team approach (collaborative care)

4 W's (patient's main difficulty at the moment)

What .....

.....

Where .....

.....

When .....

.....

With whom .....

.....

Triggers

.....

.....

.....

.....

ABC (physical and psychological)

Autonomic (include physical symptoms) .....

.....

Behavioural (include self-management behaviours) .....

.....

Cognitive .....

.....

+ Identify any links between physical and psychological .....

.....

SESSION 1: ASSESSMENT TOOL

Disease-specific information (include medical & patient perspective)

What?

How long?

Causes?

Impact?

Medication?

How well are they managing? Has this changed?

Drugs

Illicit

Prescribed

Over the counter

Alcohol

Onset and course – depression and heart disease/diabetes (if not already covered)

Impact

Work – paid/unpaid (e.g. caring responsibilities)

Home

Social

Private leisure activities

Significant relationships

Why help-seeking now?

Lifestyle

Exercise

Diet

Smoking

Stress

Other

SESSION 1: ASSESSMENT TOOL

Risk

Intent .....

.....

Plans .....

.....

Actions .....

.....

Prevention .....

.....

Introduce the book

Part of the team approach

Tool to manage situations they are finding difficult

Structure

Workbook

Stories

Use workbook- Draw out ABC and personal links

(may also want to fill in 'Worksheet 3: Triggers' and 'Worksheet 4: impact')

Problem statement (What, ABC, impact)

Get patient to write this in their workbook (worksheet 5).

Set goals (2-3)

Get patient to write this in their workbook (worksheet 6).

Ending

Tell the patient- 5-10 minutes left.

Explain what will happen in the next session.

Ask them to read the 5 recovery stories (if appropriate)

Ask when they want the next contact (1/2 weeks)

Remind of timings of future sessions.

Ask patient for feedback on the session and final questions.

Additional notes

Manchester Academic Health Science Centre (MAHSC)

www.mahsc.ac.uk

COINCIDE

Collaborative Interventions for Circulation and Depression

PCRN

Primary Care Research Network North West

North West Hub

Mental Health Research Network

Trial website: http://www.coincidehealth.org