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PRIMARY GAINS: REDUCTION IN GP APPOINTMENTS AFTER ATTENDING A PAIN MANAGEMENT PROGRAMME
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Background
Patients with chronic musculoskeletal pain are high users of healthcare services and have a significant impact on resources. Pain is one of the most common reasons people see their General Practitioner (GP)¹ and it is estimated that chronic non-malignant back pain alone costs the NHS £12.3bn per year². Chronic musculoskeletal pain is complex and causes significant levels of distress and disability. Multidisciplinary pain management programmes (PMPs) are recommended by NICE³ to reduce the distress and disability associated with chronic pain. However, in today’s economic climate it is not enough to be just clinically effective, services also need to be cost effective or even demonstrate reductions in cost. This effect has been demonstrated by PMPs in secondary care⁴ but there is little research on the impact of PMPs on primary care appointments. The present research aimed to examine the effect of attending a PMP on primary care pain-related appointments.

Method
The GPs of patients who had attended the Centre for Active Lifestyle Management (CALM) PMP were contacted and asked to provide information on their patient’s attendance at primary care pain-related appointments for one year before and one year after they attended the PMP. One to one consultations and telephone consultations were included in the dataset. The initial request for information was followed up by telephone and fax reminders.

In total, 27 GP practices replied to these requests and data were obtained for 49 patients who attended the PMP in eight separate groups to promote a self-management approach to their pain.

Results
Data were analysed for the 49 patients using a one sample t-test. A significant reduction in the number of primary care consultations was found 12 months post-PMP (p < .00025). This represents a 44% reduction in pain related primary care appointments. This is equivalent to a cost of £158.67 pre-PMP and £88.78 post-PMP (based on a costing of £25 per GP consultation⁵). It is estimated that the cost for the 10 week PMP including the initial assessment is £1048.

Data regarding clinical outcomes was also collected using the Beck Depression Inventory II (BDI), Pain Self Efficacy Questionnaire (PSEQ), Tampa Scale for Kinesiophobia, Pain Catastrophising Scale, Brief Pain Inventory Pain Levels (BPI Pain), Brief Pain Inventory Pain Interference and number of sit to stands in one minute. A significant improvement was seen in all clinical outcomes, except PSEQ and BPI Pain, on analysis of the data at 12 months post-PMP.

Conclusion
Attending an outpatient PMP has been associated with a significant reduction in pain-related secondary care consultations 6 months post PMP⁴. This data shows an additional reduction in the healthcare costs of pain-related primary care appointment. Information like this is essential in the current economic climate where both clinical effectiveness and cost effectiveness need to be demonstrated. This research only demonstrates an association between attending a PMP and a reduction in pain-related primary care appointments. Further research would be required to demonstrate a causal link such as the use of a randomised controlled trial comparing the effect of attending a PMP with a control group. Meanwhile, additional data will be gathered for this cohort of patients to enable more long term evaluation.

References
WE KNOW IT WORKS, BUT WHY? A QUALITATIVE STUDY OF PATIENTS’ VIEWS OF A PAIN MANAGEMENT PROGRAMME

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Background
Multi-disciplinary pain management programmes (PMPs) have been recommended as the most effective intervention for patients with chronic pain, with The British Pain Society1 stating they are “the treatment of choice” for patients experiencing significant distress and disability. Research has shown PMPs are clinically effective2, 3, 4, 5, 6 as well as cost-effective7. Whilst we know PMPs work, what aspects of the approach are important for change to occur? The present study was designed to address this question by providing a detailed insight into the experience of patients who have completed a PMP.

Method
Purposive sampling was used to identify suitable participants, and seven women chose to take part in the study after completing a ten week outpatient PMP. Semi-structured interviews were conducted by an independent interviewer and ranged from 25 to 56 minutes in length. The interview protocol was devised to guide participants in exploring their experience of chronic pain and pain management services, with participants instructed to respond as honestly and fully as possible. Interviews were recorded digitally and then transcribed before being subject to Interpretive Phenomenological Analysis (IPA). Transcripts were analysed by separate researchers and a list of super-ordinate and sub-themes were agreed upon.

Results
Four super-ordinate themes emerged from analysis: the group aspect of PMPs; importance of good communication from healthcare professionals; knowledge; past versus present self. The PMP group seemed to reduce the isolation caused by pain, with many expressing the importance of empathy. “It was nice to have other people know what you go through.” Lack of good communication skills from healthcare professionals in the past appeared to increase negative affect, with many participants feeling disbelieved or unheard, though many noted that the PMP improved their ability to communicate and self-advocate. Knowledge about pain management tools and the physiology of pain was also highlighted, “with [the PMP] it was [...] more about giving you the knowledge, just making you more empowered.” Finally, most participants commented on a change in self before and after the PMP, “just talking to them was fantastic and I started improving, going back to what I would consider my old self.”

Conclusion
As might be expected, participants valued the provision of information about pain management tools but they also talked about the importance of wider issues such as support, validation, communication and their sense of identity (previously identified as an important concern in pain research8). Consequently, this study suggests that group processes are as important as content. Information on pain management can be provided via self-help books, computerised programmes, individual sessions or group PMPs, all of which offer useful tools. In addition, the space to discuss broader psychological issues within a supportive group context is greatly valued by participants and enables them to better manage the problems pain causes.

References

DOES EARLY NON-ATTENDANCE BY PARTICIPANTS ON A PAIN MANAGEMENT PROGRAMME INFLUENCE OVERALL GROUP ATTENDANCE?

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Background
Consistent attendance is considered essential if participants are to achieve the most from a Pain Management Programme. The Back in Control Pain Management Programmes at Kings Mill Hospital are lead by a multidisciplinary team of 6 professionals, providing strategies and advice to patients using a cognitive behavioural approach for pain management, with the aim of improving quality of life. Twelve participants are invited onto each programme and participants are encouraged to attend each of the 9 full day sessions comprising their programme. There was a perception that non-attendance was high and particularly increased once one or more people did not attend.

The aim of this study was to determine if non-attendance by one person predicts subsequent non-attendance by others within the same programme.

Method
All attendance and non-attendance data were analysed from 61 Pain Management Programmes from Jan 2002 to Aug 2010. Data recorded in an Excel document with separate categories collected for size of group, number of early non-attendees and attendees, drop outs, returnees and subsequent non-attendees and drop outs. Patients who did not attend any of the program sessions were excluded from the analysis.
Attendance was counted if any part of the session is attended.

'Drop out' was defined as failure to attend both of the last 2 days of the programme. 'Early attendees' attended both of the first 2 days programme days. Data were analysed using SPSS v.15, and presented as median (interquartile range). Associations were sought using Spearman's rank correlation coefficients.

Results

Our prospectively collected data identified 5490 (88%) of actual attendances out of a possible 6256, by 688 participants. 58% of participants attended every day of their programme with a drop out rate of only 11%. Forty percent of participants showed some non-attendance, with 12% of appointments missed over the whole study (inclusive of all non-attendance by drop outs) and 7% of appointments missed by early attendees who had attended the first 2 days.

The number of participants who did not attend either or both of the first 2 sessions of a programme did not significantly predict subsequent non-attendance or drop out by other members of the group (r values 0.10 to 0.21, all p values > 0.12).

Conclusion

Programme non-attendance and drop out rates were found to be lower than anticipated based on staff impressions. Furthermore, early non-attendance by participants did not significantly predict increased non-attendance by other participants in a programme. We conclude that programmes should be made optimally accessible, and provide maximum satisfaction to participants in order to maximise appropriate attendance. However, programme facilitators and participants should be encouraged to accept non-attendance when it occurs, without fear of negative impact on other attendees.

THE PREVALENCE AND SEVERITY OF SELF-REPORTED FATIGUE BEFORE AND AFTER MDT LED PAIN MANAGEMENT PROGRAMME.

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Introduction

Fatigue is commonly present in people suffering from chronic pain and may be etiologically related to the presence of pain. Fishbain et al. (2005) have demonstrated that people with chronic low back pain (LBP) are more fatigued than controls. Strategies that specifically may improve fatigue may help with chronic pain. Not all people with LBP suffer with fatigue, and it may be that a subgroup with severe fatigue have particularly poor prognosis.

The Back Pain Unit based at King's Mill Hospital has been running multidisciplinary (MDT) Pain Management Programmes since 1998 for people with chronic LBP. Three previous Evaluation Reports have demonstrated consistently good clinical outcomes. Although sleep disturbance and fatigue are commonly reported by people attending the programmes, there has, to date, been no formal evaluation as to whether fatigue improves during participation, or whether there is a need for greater attention to fatigue within the programme.

Methods

This is a prospective observational service evaluation study.

Study participants:

Programme participants comprised patients who are diagnosed with chronic LBP in primary and secondary setting attending the specialist 'Back Pain Unit' at King's Mill Hospital that run multidisciplinary CBT based pain management programmes.

Patients referred were invited to complete questionnaires at baseline, during attendance on day 1 and again on day 10 of the programme, 5 months after baseline. Participants who did not attend day 10 of the programme were invited to complete questionnaires by post.

Measures:

The Fatigue Severity Scale (FSS) is composed of 9 items with a 7-point response format. In a validation study1, internal consistency for the Fatigue Severity Scale was high for specific illness groups and healthy controls. Scores above 36 are considered clinically severe.

Preliminary Results

In the 2 consecutive programmes evaluated to date, 14 out of 21 attendees completed the questionnaires (age of 23 to 70 years, 5 male). The median (inter-quartile range) FSS score at baseline was 46 (39 to 55) and at the follow-up was 36 (28 to 39). At baseline 13 (76 %) participants had FSS score above 36 where as only 4 (26 %) participants were above 36 at follow-up.

Preliminary Conclusions

The study highlights the importance of fatigue for people attending a multidisciplinary pain management programme for low back pain. Preliminary data suggesting improvements during the programme will be extended in the presentation with the data collected from subsequent programmes.

THE PAIN MANAGEMENT PLAN: A PILOT STUDY OF A COGNITIVE BEHAVIOURAL SELF-MANAGEMENT PROGRAMME FOR CHRONIC PAIN

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Background

Psychologically-based interventions for chronic pain delivered by a MDT are known to be effective (Eccleston et al 2009). Unfortunately such resources are limited and few of those in need take part. For some an intensive programme is not necessary, for others, group activities and regular outpatient appointments are not welcome. Similar challenges exist for cardiac rehabilitation programmes and one solution, a brief self-management programme using a manual (the Heart Manual) has been shown, in numerous RCTs, to be as effective as group outpatient programmes (Dalal et al 2010). We set out to develop a similar intervention that could increase the range of treatment options we offer and allow us to reach more patients.

Methods

The intervention consists of an initial assessment process, the use of an interactive pictorial workbook, called the Pain Management Plan, and a series of brief meetings or phone contacts delivered by a 'facilitator' who has knowledge of the cognitive behavioural methods employed. The workbook includes education and self-management advice on living with chronic pain, a goal setting diary, and a CD-based stress management programme. Teams of clinical staff
were trained in the approach in three centres (Bradford, Birmingham, and Gloucestershire and Herefordshire) in January 2011. Data was collected regarding the number/length of sessions and staff/patient feedback. Pre and post outcome measures included the Pain Self-Efficacy Questionnaire (PSEQ: Nicholas, 2007); and the Pain Disability Questionnaire (PDQ: Anagnostis et al, 2004).

Results
88 patients took part in this pilot study; 75% completed the intervention. For 48% this was their first contact with a Pain service; 19% of participants had attended a pain programme in the past. Reasons for attrition included patients’ needs being too complex and life factors. The mean age of the sample was 47.5 years (sd=13.5) with an average pain duration of 10.8 years (sd=10.0). After assessment, those who completed the intervention (N=66) received an average of 4.5 treatment sessions (sd=1.3), a mean total duration of 2.9 contact hours. Statistically significant improvements were shown in self-efficacy (PSEQ) mean pre = 28.0, sd=12.5, mean post= 37.3, sd=13.0, t(63)=-7.0, p<0.001, and disability (PDQ) mean pre= 85.0, sd=28.4, mean post 66.2, sd=32.8, z=-4.3, p<0.001. Patient feedback data (N= 63) demonstrates an overall satisfaction level of 92%. Dropout rates were no higher than those of a hospital based, outpatient group MDT chronic pain management programme.

Conclusion
The pilot has demonstrated significant value to this approach and the Pain Management Plan can be successfully implemented by trained specialist staff. Clinical outcomes and patient feedback are encouraging and the efficiency of our pain services have been enhanced; with people receiving only the level of input they require, in the manner they prefer. We are using staff and patient feedback to make some adjustments to the printed materials, develop a description of the competencies required to facilitate the intervention and provide a one-day training programme suitable to the varying needs of the different staff groups working in this area.

References

TRAINING HEALTH PROFESSIONALS TO USE THE PAIN MANAGEMENT PLAN CBT WORKBOOK
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Background
The Pain Management Plan (PP) is a cognitive behavioural, self-management support programme for people living with long-term pain, in the form of an interactive, accessible, pictorial workbook. This workbook is designed to be supported by a trained facilitator who introduces the concept of pain self-management. The facilitator acts as a guide to understanding the impact of pain on the individual and enabling them to develop a range of self management skills needed to manage pain effectively. This abstract reports on an evaluation of the facilitator training.

Method
Training took the form of a one-day interactive workshop, delivered by the clinicians who contributed to the development of the PP, and aimed at clinical staff already experienced in the management of pain. The workshops presented the rationale and evidence for the PP, an introduction to the content of the workbook, usage of an introductory Health Needs Assessment and six role-plays to practice working with the PP. Participants were asked to self-rate their own knowledge and skills in 15 domains covered in the training pre and post workshop. One week after training, all participants were also invited to complete an online survey to rate their confidence in using the programme and to comment on the workshop design and content.

Results
Data were collected from 94 participants, attending 5 workshops around England between December 2011 and December 2012. Participants (N=58) from 3 of the workshops self-rated their knowledge and skills, pre and post training, on a Likert scale ranging from 1 (no confidence) to 10 (complete confidence). They reported a mean improvement in all aspects of the training, with the greatest improvements seen in using Health Needs Assessment tools (mean pre-workshop score = 3.89, mean post-workshop score = 8.34), and in understanding the ‘5-areas’ CBT model (mean pre-workshop = 5.30, mean post-workshop = 8.19). Participants (N=68) from 4 of the workshops gave feedback online, reporting high levels of confidence in using the programme. Feedback on the training indicated that it was valued, with participants reporting most positively about the printed materials (71%), and least about the time available to practise interactive skills during the workshop (62%).

Conclusion
The results show that after attending a PP skills training workshop, participants report a greater understanding of the skills needed to deliver the programme and high levels of confidence in using it. The feedback provided highlights how the training might be improved with more time allocated to practising the interactive skills needed by the facilitators to support the people using the PP programme.

IMPROVING ACCESS TO PAIN MANAGEMENT: A PILOT EVALUATION OF A WEB-BASED PAIN MANAGEMENT PROGRAMME IN PRIMARY CARE
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Background
There is a growing body of evidence supporting the effectiveness of web-based cognitive behavioural interventions. However, the evidence for web-based treatments for chronic pain is still developing (Macea et al. 2010). An evaluation was conducted of a web-based
pain management programme (PMP) supported by a community chronic pain management service. Patients were referred by physiotherapists working in a primary care musculoskeletal service. The aim of the evaluation was to determine whether the web-based PMP provides a safe, acceptable and accessible treatment choice for patients with chronic pain in primary care. Potential future benefits may include reduced use of out-patient pain clinic appointments and procedures providing savings for the local health economy.

Methods

Referrals were screened by a Consultant Clinical Psychologist with expertise in delivery of PMPs. Where appropriate further information was obtained from referrers/GPs and telephone-based mental health risk assessments were conducted with a small number of participants. Suitable referrals which opted for treatment were given access to the programme. Participants were required to activate their account and work through a series of 24 steps comprising a number of interactive screens. An Assistant Psychologist provided email support and offered a telephone consultation after activation and upon completion to review progress. Outcome measures were administered pre and post programme including pain (numerical rating scale), disability (ODI), depression (PHQ-9), anxiety (GAD-7) and quality of life (EQ-5D). Between May-October 2012 118 patients were referred for consideration for the web-based PMP. Screening identified 113 referrals as appropriate. 52 patients opted in for treatment and were given access to the programme. 50 patients activated their accounts.

Results

Physiotherapists were able to identify potential people for web-based PMP with 96% of referrals found to be appropriate. However, a small number of referrals were identified by the screening as unsuitable mainly due to significant mental health problems or on-going medical investigations/treatments for pain. 44% of people offered treatment took up the offer. Of patients who opted for treatment 92% were female and 8% were male. Ages ranged from 20-69; mean age was 48. Mean duration of pain reported was 9.52 years. Completion rates were modest, with 40% of patients allocated to treatment completing the programme. Pre-post data was available for 21 patients who completed treatment. A series of paired samples t-tests were used for outcome analysis. Significant improvements were found for depression, perceived level of pain and disability.

Conclusion

Safe and effective provision of a web-based PMP is enhanced by clinician support for patient selection, engagement and follow up for those completing and failing to complete treatment. For patients completing the web-based PMP there was some evidence for significant health gains. A minority of patients referred entered treatment and of these a minority completed treatment. Despite this, for some patients, a web-based PMP may provide an acceptable low-intensity treatment choice. Web-based programmes could widen access for those unable to attend traditional group PMPs. Controlled trials are needed to determine whether such interventions are cost-effective and should be routinely recommended.

Declaration of interest

Funding for computer licences was provided by South Central Strategic Health Authority. A Medical Education Grant was provided by Pfizer Pharmaceutical Operations Primary Care to fund an Assistant Psychologist to administer licences and support patients using the web-based PMP.

DIFFERENCES IN PAIN MANAGEMENT PROGRESS BETWEEN PATIENTS WHO ATTEND FOR FOLLOW-UP AND THOSE THAT DNA.

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Background

Drop-out from treatment and attrition from follow-up present problems for generalizing results from pain management programmes (Coughlan et al, 1995). Previous publications looking at the efficacy of Pain Management Programme and changes in a range of psychological, physical and pain measures acknowledge drop-out rates and DNAs to follow-up appointments. To date, few studies have looked at the differences in coping of pain between patients who attend their follow-up appointments and those who do not.

Aim

To compare mood, use of coping skills and confidence managing chronic pain between patients who attend follow-up appointments and those that DNA.

Method

A questionnaire was designed to collect data regarding patients progress since attending a PMP. All patients that were invited for a follow-up appointment between July 2010 and May 2011 (retrospective) were sent a coded questionnaire (for anonymity) with a request to complete and send back the PMP team. At the same time, to maximise participant numbers the same questionnaire was given to all patients who attended a follow-up clinic throughout April 2011 to October 2011. Patients who DNAd follow-up clinic were sent the questionnaire with a request to complete and send back the PMP team.

Results

In total 318 questionnaires were issued. Of these 318 questionnaires, 104 were returned which gives a response rate of 32.7%. Of these 104 patients that returned the questionnaires, 29 (27.8%) had DNAd their follow-up appointment and 75 (72.1%) attended their appointment.

Attenders and non-attenders were compared on a number of measures. No differences were found in terms of mood state, adherence to exercise or use of pacing. Therefore, the data between the two groups was collapsed and relationships were explored amongst variables. Specified reasons for DNAs were also explored. The key finding was that mood rating was significantly correlated with pain intensity, level of activity, perceived coping ability and use of medication.

Conclusion

There was no significant difference between attenders and non-attenders on a variety of measures and non-attendance at follow-up was more likely a reflection of pragmatic issues rather than clinical ones. Of particular importance it was observed that low mood for both groups was associated with reduced programme principles adherence and increased medication use at six months. These findings are discussed in terms of implications for the timing of follow-ups and the nature of the support offered.
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THE LONG-TERM BENEFITS OF MULTIDISCIPLINARY PAIN MANAGEMENT INTERVENTIONS: IS ADHERENCE TO SELF-MANAGEMENT STRATEGIES ASSOCIATED WITH IMPROVED QUALITY OF LIFE IN THOSE WITH CHRONIC PAIN SYNDROMES?

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Background

A number of systematic reviews and meta-analyses show that multidisciplinary treatments based on cognitive behavioural therapy (CBT) produce clear short-term benefits for patients with chronic pain. These benefits include improvements in pain experience, emotional distress, disability, pain behaviour, and coping. However, the ability to demonstrate long-term benefits in patients with chronic pain remains an important consideration in evaluating the effectiveness of multidisciplinary pain treatment. Although some controlled studies have indicated that initial treatment gains are largely maintained up to two years post-treatment, the vast majority of pain management programmes (PMPs) do not follow up patients beyond this period, even if there is recognition of the need to do so. This study aimed to explore the impact of attending a PMP on the overall quality of life (QoL) of participants 10 to 15 years after programme completion and the extent to which practice of taught self-management skills affected outcomes.

Methods

A questionnaire pack was sent to 1426 chronic pain patients who attended and completed a multicomponent PMP between 1995 and 2000. Patients had been referred from all over the UK and attended a two- or four-week inpatient PMP following assessment by an anaesthetist and a psychologist. The PMP aimed to restore optimal physical function, improve mood, and reduce the use of pain-related drugs, as well as equip patients with skills and knowledge to improve their pain experience throughout their lifetime. The questionnaire pack included numerical rating scales of average pain intensity, distress and interference, and the SF-36, a generic measure of health-related QoL. A scaled questionnaire was used to assess the frequency of adherence to specific PMP-taught pain management strategies. Data from the outcome measures were compared with existing data from the same measures completed by patients when attending the PMP and at follow-up points.

Results

One hundred and fifty PMP attendees (93 females, mean age 56.8 years) responded. Respondents tended to be less affected by pain and more functional across SF-36 dimensions than non-respondents at pre-PMP, but there were no differences on sociodemographic variables or in the magnitude of treatment benefit on pain-related variables and SF-36 subscales. At 10-15 year follow-up, 96% of the respondents were still experiencing pain although average intensity had significantly fallen from pre-PMP levels. Within-subject comparisons found significant increases from pre-PMP to 10-15 year follow-up on all SF-36 subscales except Physical Function and General Health, indicating benefits on most QoL dimensions were maintained over the longer term. Effect sizes (Cohen’s d) ranged from -0.03 to 0.76 for SF-36 physical health components and from 0.34 to 0.40 for mental health components. Patients who reported practicing taught self-management strategies more frequently had improved mental health outcomes relative to those using strategies less frequently.

Conclusion

This study provides support for the long-term benefits of multidisciplinary pain management interventions for people with chronic pain conditions. Although the response rate was low, the study sample was large and representative with respect to PMP benefit. In the face of enduring pain, gains achieved on the PMP on all measured mental health components and some dimensions of physical well-being were largely maintained in the 10 years following attendance. The results are also consistent with cognitive-behavioural theories positing that frequent practice of self-management strategies taught at PMPs can positively impact on patients’ quality of life, particularly their mental health.

Conflict of interest

The authors declare that they have no competing interests.