Abstract THU0647 – Table 1. Odds Ratios (95% CI) for Effect of Poverty Status between 2003 and 2009 on Prevalent and Incident Persistent Depression. CESD Score ≥ 24 in 3 or More Years), between 2009 and 2015, with and without Adjustment

Outcome	Poor Every Year	Exited Poverty	Never Poor
Prevalent Persistent Depression (n=535)			
Unadjusted	3.9 (2.1, 7.2) *	1.0 (0.4, 2.2)	Ref.
Adjusted†	2.9 (1.4, 6.1) *	0.8 (0.3, 1.8)	Ref.
Incident Persistent Depression (n=312)‡			
Unadjusted	4.5 (1.3, 15.4) *	0.9 (0.2, 3.9)	Ref.
Adjusted†	4.1 (0.9, 19.1)	0.7 (0.1, 3.7)	Ref.

* $p < .01$

† Adjusted for gender, age, marital status, race/ethnicity, education, disease duration, extent of accumulated damage in 2009, smoking status, and BMI

‡ Excludes persons with high levels of depressive symptoms 2006–2009

Conclusions: Public policy to help persons with SLE stay out of poverty or to exit poverty may lower their rates of prevalent and incident persistent depression. Attention to the economic status of persons with SLE should be part of an overall treatment strategy including treatment for depression since such attention may help reduce accumulation of damage as well as reduce the prevalence and incidence of persistent depression.

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THU0648

“AS A PRACTITIONER I FEEL ENRICHED”: RHEUMATOLOGY TUTORS' EXPERIENCES OF DELIVERING A MANUALISED GROUP COGNITIVE-BEHAVIOURAL FATIGUE PROGRAMME TO PATIENTS WITH RHEUMATOID ARTHRITIS (RA)

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Background: Reducing Arthritis Fatigue by clinical Teams using cognitive-behavioural approaches (RAFT) is a 7-centre RCT of a manualised group cognitive-behavioural (CB) programme to reduce fatigue impact.¹ After four days training plus a delivery observed by clinical supervisors, tutor pairs (rheumatology nurses and occupational therapists (OTs)) delivered the programme four times to patients with RA. Quality assurance observations confirmed tutors used CB approaches and RAFT results show the programme reduced patients' fatigue impact at 26 weeks.²

Objectives: The aim of the current study was to understand tutors' experiences of RAFT training and delivery to inform future programme roll out.

Methods: 14 RAFT tutors (9 nurses; 5 OTs) participated in one-to-one interviews, which were audio-recorded and transcribed. Data were analysed by ED, SH, and AH using inductive thematic analysis.

Results: Four main themes were identified.

Theme 1: “It's quite daunting” - Delivering a complex programme that was “quite different to what any of us had done before” required time and effort (“I couldn't really make sense of it without actually doing a lot of work around it”). Initially, training with clinical supervisors (“experts”) who are “so good at what they do” challenged tutors' confidence (“the anxiety is are we going to deliver it the way they did?”).

Theme 2: “Most useful was actually getting to practice the sessions” - Tutors valued watching clinical supervisors demonstrate programme sessions during training (“professionals who have shown us how to do it”) plus the opportunity to practice themselves (“role playing the sessions was really helpful”).

Theme 3: “Putting it in a way that was still true to the message” - The RAFT manual was “very valuable” and “it had to be adhered to”; however, tutors wrote individual crib notes (“our own manual in our own words”) to consolidate information, deepen understanding, and gain confidence. The process was supported by “positive and constructive criticism” in the observed delivery (“the supervisor kept putting us back on track”).

Theme 4: “As a practitioner I feel enriched” - CB skills acquired during RAFT impacted tutors' wider work (“making a massive difference to my clinical practice”), and enhanced the self-management support they offered patients, including

“the particular ability to draw things out from people” and “learning when to listen and stand back and try and get the patients to find the answers”.

Conclusions: Initially, RAFT training and delivery were a challenge for tutors because the CB approach was a new way of working. Individually adapting RAFT manual wording plus feedback from supervisors increased tutors' confidence. Tutors believed the CB skills acquired during RAFT enhanced their wider clinical practice and the self-management support they offered patients. Future training should include RAFT session demonstrations and skills practice for tutors, with feedback from clinical supervisors.

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THU0649

UNDERSTANDING ETHNIC DIFFERENCES IN THE UTILISATION OF EXERCISE FOR OSTEOARTHRITIS

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Background: According to a US survey, the prevalence of arthritis-attributable activity limitation, work limitation and severe pain are all significantly higher among Hispanics than among non-Hispanics (NHs). Ethnic differences in osteoarthritis (OA) patients' experience of pain may be related to marked disparities in the use of OA treatments. According to EULAR OA guidelines, exercise should be an integral part of the management of knee and hip OA. Whether or not exercise is underutilised and why it may be underutilised by Hispanics to treat OA is unclear.

Objectives: The objective of this study was to determine if there are ethnic differences in the history and current use of exercise as therapy for patients with knee or hip OA. The secondary objective was to compare Hispanic and NH patients with lower extremity OA with respect to their familiarity and perceptions of the efficacy and risk of exercise as treatment for OA.

Methods: Research participants ≥ 50 years of age with chronic and frequent pain due to knee or hip OA were recruited from a university medical centre. Structured interviews were conducted to determine patient sociodemographic characteristics, clinical information, self-reported actual use/prescription receipt of exercise for OA treatment (currently, last 5 years), and familiarity with exercise (3 items, yes/no response). Perceptions of the benefits (4 items) and risks (3 items) of exercise, and willingness to exercise to treat OA were also evaluated; each question in these measures has a five-category ordinal response scale. Fisher's exact or Wilcoxon-Mann-Whitney tests were conducted to determine if knowledge and perceptions about exercise were associated with ethnicity (Hispanic vs NH).

Results: In our cohort of patients with knee or hip OA, Hispanics (n=119), in comparison to NHs (n=201), were younger (mean age 61.5 vs. 65.3) and less likely to have an annual income of $\geq \$50,000$ (13.5% vs. 39.1%). A lower proportion of Hispanics than NHs reported using exercise to treat OA at present (51% vs. 66%, $p=0.0165$) and in the last five years (68% vs. 84%, $p=0.0010$) or receiving a prescription for exercise in the last five years (45% vs. 67%, $p<0.0001$) (figure 1). Hispanics, compared to NHs, were also less likely to report ever hearing about exercise to treat OA (71.43% vs. 91.83%, $p<0.0001$), having family/friends that received it for treatment (33.33% vs. 51.20%, $p=0.0023$), or having a good understanding of it as a treatment for OA (66.96% vs. 79.33%, $p=0.0161$). A lower proportion of Hispanics than NHs believe that exercise is beneficial (or very beneficial) for arthritis (49.12% vs. 69.09%, $p<0.0001$) and that exercise is helpful (or very helpful) for them (60.52% vs. 75.61%, $p=0.0056$). No ethnic differences in the perceptions of risk of exercise were observed. Hispanics were also less willing to exercise to treat OA than NHs (67.83% vs. 82.61%, $p=0.0018$).

Abstract THU0649 – Figure 1 Proportion, who reported use of or prescription receipt for exercise to treat OA by ethnicity **Conclusions:** Among patients with knee or hip OA, Hispanics were less likely than NHs to utilise exercise as treatment for arthritis.