Therapists' experiences of delivering treatment to patients with co-morbid mental and physical health conditions within an IAPT service.

Francesca Jackson

A Thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the degree of Professional Doctorate in Health Psychology.

Faculty of Health and Social Sciences

July 2023

Contents:

The Patient:

The Therapist:

Discussion:

The Treatment Plan:

The Service:

The Patient

The Therapist:

Acknowledgements

I would like to thank my supervisors Dr James Bryon-Daniel and Miles Thompson for their support and advice throughout this process. I would also further like to thank Dr James Bryon-Daniel for his consistent and encouraging supervision, ensuring that each stage of this process was achieved to get to this final point.

I would also like to thank the Somerset Foundation Trust IAPT service, which has been so supportive throughout this process. Lastly, I would like to thank my family who have motivated, encouraged and supported me in every way possible to be able to achieve the completion of this thesis.

Abstract

The number of people who have a Long-Term Health Condition (LTC) is increasing. There is a high prevalence of those who have a LTC who are also experiencing a Mental Health Condition. There has been a recent focus on The Improving Access to Psychological Therapies programme (IAPT) role in providing psychological support for patients with LTC's. Therapists' experiences are important for providing 'on the ground' feedback into how this works in practice, and can guide future developments within services.

Aims of research:

- To explore therapists' experiences of delivering treatment to patients with co-morbid mental health and physical health conditions.
- Therapists' perceptions of the differences in treating patients with co-morbid LTC and mental health difficulties within an IAPT service, compared to working with patients presenting with only mental health difficulties.
- Therapists' opinions on what is most helpful and what is challenging to deliver in terms of treatment for these patients.
- Therapists' perceptions on barriers and facilitators to engagement for these patients.

Semi structured interviews were conducted with 16 therapists within an IAPT service. Using Thematic Analysis 4 main themes were identified, each with 3 subthemes. Themes reflected therapists' experiences of the important factors to consider when working with these patients.

1. The Treatment Plan: Flexible and adaptable treatment plans are key. However, the IAPT framework places barriers on this. Therapists described how they often focused on getting patients to re-engage with activities. However, therapists' felt they needed 'more tools' to be able to support these patients.

2. The Service: Training, supervision and CPD were all controversial areas. Therapists recognised the role of collaborative working with other healthcare professionals. However, the reality of this was a different picture.

3. The Patient: Therapists discussed the impact of where a patient is with accepting their LTC, as well as accepting that there is mental health aspect to this.

4. The Therapist: Therapists tended to take on a lot of responsibility for patients. Furthermore, there appeared to be negative pre-conceptions about working with these patients.

Conclusions: Therapists clearly want to do their best for patients with co-morbid physical and mental health conditions. However, therapists feel they need more skills to do this. The role of Health Psychology could potentially aid in filing this void especially around training, supervision and CPD. More attention needs to be given to addressing preconceptions around working with these patients, with not only IAPT services but other health care professionals all clear on the roles they are playing in a patients care. More attention should be given to how patients present in treatment and the appropriateness of receiving treatment through IAPT.

Introduction

Chapter outline

The current research focuses on therapists' experiences of working with patients with comorbid Long Term Health Conditions (LTC's) and mental health difficulties within an Improving Access to Psychological Therapies (IAPT) service. To illustrate the importance of providing research into this area the prevalence and impact of co-morbid physical and mental health conditions will be discussed, as well as why there are such strong links between mental and physical health. Treatment for people with this comorbidity is then reviewed moving onto a focus on the role of the IAPT programme in providing support for these patients. The importance of researching therapists' experiences of treating these patients is then explored. Current research specific to IAPT therapists with be discussed followed by the gaps in literature and rationale for the current study.

Physical and Mental Health Co-Morbidity

It is estimated that 30% of the UK population suffer with an LTC (Seaton et al, 2022). LTC's can be characterised as: a disease where there is currently no cure and are therefore controlled through other methods, such as drugs or other treatments. Examples of LTC's are: diabetes, chronic obstructive pulmonary disease (COPD) and arthritis (Kings Fund, 2020).

The National Collaborating Centre for Mental Health (NCCMH, 2018) report that there is a high prevalence of comorbidity between LTC’s and mental health difficulties, with two thirds of people with an LTC also experiencing poor mental health. People with diabetes, hypertension and coronary heart disease (CHD) have double the rate of mental health problems compared to those without LTC’s (The Department of Health 2012). Furthermore, people with two or more LTC’s are 7 times more likely to have depression (The Department of Health, 2012). Not only does the above highlight the increased prevalence of those who experience an LTC also suffering from a mental health condition, but this link can also be seen working in the other direction. The Department of Health (2012) highlight that people with severe mental health conditions are also more likely to develop other LTC’s such as diabetes or cardiovascular disease.

The Department of Health’s Long Term Conditions Compendium (2012) states that the two key factors for developing LTC’s are age and lifestyle. Furthermore, the number of people with multiple LTC’s is set to rise (The Department of Health, 2012). NICE Multimorbidity Guidelines (2016) highlight that multimorbidity is often associated with reduced quality of life, higher mortality, polypharmacy, high treatment burden and greater use of healthcare services. Therefore, it is important to highlight the impact of LTC’s on those who experience these and the wider impact on healthcare services.

This high prevalence of co-morbid mental and physical health difficulties contributes to an excess cost to the National Health Service. Health care costs for patients with this comorbidity have an increased cost in care by an average of 45% (Five Year Forward, 2016). An example in relation to Type 2 diabetes in England states there are £1.8 billion in additional costs, with these excess costs being attributed to poorer mental health (Five Year Forward, 2016). Most of the excess costs are accounted for by an increase in the use of physical health services (Five Year Forward, 2016). The Improving Access to Psychological Therapies Manual (2018) highlights that patients with Chronic Obstructive Pulmonary Disease (COPD) and depression have increased rehospitalisation rates. Furthermore, those with Medically Unexplained Symptoms (MUS) who were not offered Psychological Therapies were found to have a higher rates of primary care consultations (IAPT Manual, 2018).

The prevalence of those with co-morbid physical and mental health difficulties is even more prominent given the COVID-19 pandemic. Skilbeck, Spanton & Roylance (2020) have highlighted the role that infectious disease outbreaks can have on people's mental health. This research emphasises that although psychological responses to these outbreaks are normal, they can develop into mental health difficulties (Skilbeck, Spanton & Roylance, 2020). Skilbeck, Spanton & Roylance (2020) state that pathological grief, depression, anxiety and Post-Traumatic Stress Disorder (PTSD) can all be long term symptoms of these outbreaks. Furthermore, they also suggest that people with pre-existing mental health problems are prone to experiencing an exacerbation of COVID-19 symptoms (Skilbeck, Spanton & Roylance, 2020). Again, this research highlights the importance of recognising the link between physical health and mental health difficulties.

The prevalence of LTC’s is increasing across England with a higher prevalence of patients with a LTC also suffering from a mental health problem (The Department of Health, 2012). This comorbidity can impact on patients’ quality of life and also have a substantial impact on costs to the NHS. Furthermore, with the effects of the COVID-19 pandemic highlighted above, how best to support patients with these co-morbid difficulties needs to be carefully considered.

Links Between Mind and Body

Exploring the links between mental and physical health difficulties is an important area to consider. This helps to consider what areas would be important to target to ensure the most appropriate support for these patients. So why are there these strong links between experiencing both mental and physical health difficulties. Clear links can be made here to the Biopsychosocial Model of Health (Engel, 1977). This model highlights that the 3 areas of: Biological (e.g., genetics, viruses), Psychological (cognitions, emotions and behaviours), and Social (for example social values on health) factors all contribute to someone’s health (Ogden, 2012).

The Biopsychosocial model is widely recognised in terms of its theoretical and research value and provides overarching guidance to consider in the care of patients (Smith, 2021). However, the model does come with its criticisms with its scientific status being questioned. The model has been criticised as too vague in terms of how the variables interact with each other (Smith, 2021). Furthermore, critics have highlighted how there has been no guidance on how to implement the model (Bolton & Gillet, 2019).

Although the model has gained criticism more recent research has aimed to show how the variables of the model interact (Karunamuni, Imayama & Goonetilleke, 2020). Karunamuni, Imayama & Goonetilleke (2020) highlight a wealth of research to illustrate the various pathway interactions. Furthermore, Smith (2021) shows the role of specific Biopsychosocial models that are individual to patients. Therefore, although we must consider the valid criticisms of the Biopsychosocial model research is continuing to address these and highlight the important role that the model still plays in considering the link between mental and physical health.

Health Psychology recognises a holistic perspective of health by identifying how the specific functions of the body's organs both directly and indirectly impact each other (Anisman, 2016). This impact can either be through direct pathways such as: the impact of stress on a person physiologically, or through indirect pathways such as: through behaviour changes (NCCMH, 2018). This shows the potential mechanisms through which the 3 areas of the Biopsychosocial model can impact on someone's health. Furthermore, this highlights the importance of ensuring to treat the multiple dimensions of the individual including psychological aspects (Anisman, 2016). The mechanisms of physical links and lifestyle factors will now be further explored.

Research into direct links between physical and mental health:

Research into physiological changes provides some insight into why people are more likely to experience co-morbid mental and physical health conditions. Recent research suggests there may be a shared biological pathway with changes in inflammation possibly linking physical and mental health conditions (Gialluisi et al, 2020). Inflammation is part of the immune systems response to infection or injury with proinflammatory cytokines being mediators of the inflammatory response (Maydych, 2019). These cytokines have been found to communicate with the brain and disrupt neurotransmission activity (Maydych, 2019). Chronic stressors which lead to the continuing release of these cytokines has been linked to certain pathology such as depression (Maydych, 2019).

Inflammatory immune activation has been suggested to affect several different illnesses such as heart disease and diabetes (Anisman, 2016). Research has suggested a range of factors that can contribute to experiencing chronic inflammation such as obesity (Ellulu et al, 2017) and smoking (Shiels et al, 2014). Furthermore, Baumeister et al's (2016) meta-analysis suggests that inflammation can be caused by emotional distress such as childhood trauma. In terms of research into inflammation with mental health links have been identified between increased inflammatory markers and depression (Dowalti et al, 2010, Strawbridge et al, 2017, Dregan et al, 2019). Research has also suggested that treatment for depression can reduce inflammatory markers (Strawbridge et al, 2019) and anti-inflammatory drugs can improve mood (Kappelmann et al, 2018).

The pathway for this may be that certain proinflammatory cytokines (that are released as part of the inflammatory response) enter the brain and disrupt the communication between the neurons in the central nervous system (Dowalti et al, 2010), which can result in symptoms of depression and anxiety. However, caution should be given to accepting the long-held monoamine neurotransmitter theory of depression. Moncrieff et al's (2022) recent review of this body of research suggested there was no consistent evidence to support this theory.

The above research highlights how being under chronic stress can lead to certain physiological changes and increase the likelihood of also experiencing mental health problems. It’s important to highlight how addressing psychological factors can impact this physiological response. For example, increased stress levels are likely to have a physical impact on a patient’s long term health condition, due to the physiological changes in the stress response exacerbating the physical symptoms that these patients experience (Penlington, 2018, in Papworth and Marrinan, 2018). Furthermore, Penlington (2018, in Papworth and Marrinan, 2018) state that there are physical symptoms of both anxiety and depression that can exacerbate physical symptoms which already exist for these patients such as fatigue, pain and breathlessness. This highlights those links between psychological and biological links demonstrated within the Biopsychosocial model therefore emphasising the impact that addressing psychological aspects may have on a patients physical health condition.

Furthermore, inconsistent results hold questions over this field of research (Gialluisi et al, 2020). With issues including the direction of the associations and potential confounders and mediators (Gialluisi et al, 2020). The confounders here need to be carefully considered such as social and behavioural aspects. For example, people with LTC’s and mental health problems disproportionately live in deprived areas and have access to fewer resources (Kings Fund, 2020). Furthermore, Gialluisi et al (2020) suggest that lifestyle factors contribute more to the association between mental health and inflammation. Therefore, it is equally if not more important to consider the indirect links between mental health and physical health.

Research into indirect links between physical and mental health.

It is also important to consider the indirect links between physical and mental health difficulties. This can be considered by looking at the impact of behavioural changes that occur when suffering with mental health difficulties and LTC's. These behavioural changes mentioned above such as unhealthy living and poorer self-management of health can indirectly contribute to the development of LTC's. The Department of Health (2012) suggest that one of the key factors for developing an LTC is lifestyles choices. We know that people with mental health difficulties are more likely to engage in unhealthy lifestyle choices such as higher rates of smoking, alcohol usage, poor diets and lower physical activity (The NCCMH, 2018).

Linking in with how your lifestyle choices (that are impacted on by your mental health) can pre-dispose you to developing an LTC: changes in chronic inflammation is not only impacted by emotional distress but also physical stress. This physical stress can be down to lifestyle and behaviour choices. An example of this is research into obesity and smoking which has found links with chronic inflammation (Ellulu et al, 2017 and Shiels et al, 2014). Therefore, those lifestyle choices people make can pre-dispose them to developing an LTC and the lifestyle choices people make can be affected by someone's mental health.

Not only are you more likely to engage in unhealthy behaviours when you are experiencing mental health difficulties but if this is also coupled with having an LTC, then people are also less likely to manage their LTC effectively. Untreated depression and anxiety lower the likelihood of patients engaging in treatment and effectively managing their physical health condition (The NCCMH, 2018). The Department of Health (2012) state that people with at least one LTC are more likely to have risky health behaviours. Graziano et al (2014) note the negative effects depression and anxiety may have on social relationships, patient's adjustment to their illness and their adherence to treatments offered. Kanapathy & Bogle (2019) also found that depressed diabetic patients can demonstrate nonadherence to treatment regimes and self-care behaviour. Therefore, depression can have a negative impact on not only the person's mental health but can also further impact their physical health and how they relate to and manage their LTC.

Some research has suggested that the presence of mental health problems can have a greater effect on function and quality of life than the severity of the LTC (Yohannes et al, 2010, De Jonge et al, 2006). Yohannes et al (2010) found that depression and anxiety can impact more on functional status than the severity of COPD and depression was more closely correlated with poorer quality of life than lung function. Furthermore, De Jonge et al (2006) found that depressive symptoms have a greater impact on quality of life than the severity of cardiac problems. This research indicates the importance of ensuring that these people receive the appropriate support for their mental health difficulties and not just addressing their physical health.

Both the direct and indirect links are important in considering why someone may be experiencing co-morbid mental and physical health difficulties. Research highlights how having poorer physical health can increase the likelihood of mental health difficulties (Dowalti et al, 2010, Strawbridge et al, 2017, Dregan et al, 2019). For example, through the increase in inflammatory markers causing disruption in neurotransmitters (Dowalti et al, 2010). Furthermore, mental health difficulties can increase inflammatory markers therefore increasing the likelihood of poorer physical health (Baumeister et al's 2016).

It is also important to explore the role of the indirect links between physical and mental health. Research has highlighted how unhealthy lifestyle choices can be influenced by poorer mental health and the subsequent impact on a patient's physical health. Furthermore, in the case of patients already suffering with an LTC poorer mental health can result in reduced adherence to treatment and self-management of their condition. This highlights the importance of supporting patients who have an LTC with their mental health difficulty due to the significant impact mental health difficulties can pose to these patients.

Treating mental health difficulties in the context of having an LTC

The importance of the role mental health difficulties can play in patients with LTC's in terms of quality of life and self-management is highlighted above. Although the above emphasises this link between our mental and physical health less than 15% of patients with co-morbid LTC's and mental health difficulties access mental health support (Five Year Forward, 2016).

Cognitive Behavioural Therapy (CBT) in the treatment of LTC's has gathered a wide evidence base including being used in the management of asthma (Kew, 2016), diabetes (Chen, 2017), cancer (Osborn, 2006), tinnitus (Martinez, 2007) and IBS (Toner et al, 2015). Guidelines from the National Institute for Health and Care Excellence (NICE) for treatment of depression in patients with chronic health conditions (2009) recommend low intensity CBT for mild to moderate depression. This can be in the form of group work, individual CBT and computerised CBT (cCBT). For the treatment of moderate depression, the recommendation is high intensity CBT delivered in groups, individually or in couples (NICE, 2009).

However, CBT is not the only recommended psychological treatment. NICE Guidelines for depression in adults (2009) also recommend Interpersonal Therapy (IPT), counselling for depression and brief psychodynamic therapy for those with mild -moderate depression, who have not responded to low intensity CBT work and those with moderate to severe depression. We must also be aware that not everyone will respond to CBT or indeed want to engage in this. Therefore, we must also consider the alterative psychological therapies that could support patients.

The above suggests a lack of patients with co-morbid mental health and LTC’s accessing treatment for their mental health difficulties. Furthermore, the above research highlights the possible benefits of psychological treatment for these patients. However, treating mental health difficulties in the context of physical ill health does not always result in improved physical symptoms. This is highlighted by Cimpean & Drake (2011) who conducted a systematic review of care for people with co-morbid medical illness and depression and/or anxiety disorders. They found that most interventions addressed the mental health side of their comorbidity therefore showing improvements in their depression and/or anxiety but not in their co-morbid medical illness. Cimpean & Drake (2011) suggest that further research should focus on integrating mental health treatment and physical health treatment. Cimpean and Drake (2011) suggest that this would support improvements in not only mental health symptoms but also LTC symptoms and the management of these conditions.

The role for collaborative care has been found to be more effective for patients who are living with these comorbidities. This is instead of just attempting to treat one or the other difficulty. Camacho et al (2018) describe collaborative care as a model that recognises the interplay between mental and physical health. Camacho et al (2018) describe four key parts to the collaborative care model these are: 1. A multi-professional approach to patient care, 2. A structured management plan, 3. Scheduled patient follow ups and 4. Enhanced communication between healthcare professionals.

Randomised control trials of collaborative care for patients with co-morbid physical and mental health conditions have found more positive outcomes for patients than usual care approaches (Katon et al, 2010, Coventry et al, 2015, Camacho et al, 2018). Within studies the intervention group consisted of collaborative care management for example, Coventry et al (2015) provided psychological support as well as support from practice nurses. These studies found that the intervention group significantly improved patients control over their physical conditions and depression. Camacho et al (2018) also cited the cost-effectiveness of collaborative care. Furthermore, NICE guidelines for depression in adults with a chronic physical health problem (2009) also recommend considering collaborative care for patients with moderate to severe depression and a chronic physical health problem.

However, Coventry et al (2015) stated that they only experienced modest effect sizes and felt this was due to the trial being run in routine settings with a deprived population with high levels of mental and physical multimorbidity. This needs to be carefully considered as it has already been discussed that rates of multi-morbidity are increasing. Furthermore, those from more deprived social economic backgrounds have a higher chance of developing multiple LTC's (NCCMH, 2018). Therefore, this is likely to be very representative of the patients who are experiencing co-morbid mental and physical health difficulties. We also need to consider here the feasibility of collaborative care in a National Health Service that is already overstretched and under-resourced.

Research highlights the significant impact mental health difficulties have on patients' quality of life and costs to the healthcare system (Five Year Forward, 2016), yet there is a lack of patients with co-morbid LTC's and mental health difficulties accessing treatment for their mental health difficulties. NICE recommended guidelines (2009) highlight CBT as an effective psychological intervention. However, there is a need to be cautious on the appropriate support for these patients. Evidence suggests that collaborative care is of more value to a patient by addressing both the physical and psychological aspects of a patients care.

Improving Access to Psychological Therapies Programme

This section will now look at the biggest provider of mental health support in England which is the Improving Access to Psychological Therapies programme (IAPT). The IAPT programme was formed in 2008 to address the gap in services for patients suffering with mental health difficulties. IAPT offers evidence based psychological therapies predominately CBT in line with NICE guidelines (IAPT Manual, 2018). This section will explore the role that this programme has played in providing mental health support for patients with common mental health difficulties including those with co-morbid LTC's and mental health difficulties.

IAPT services are characterised by 3 key areas: 1. Evidence based psychological therapies, 2. routine outcomes measures and 3. regular and outcome focused supervision (NHS England, 2021). IAPT follows a stepped care model of treatment delivering the least intrusive but most effective treatment as the first step in treatment. IAPT suggests that most patients would be appropriate for a low intensity intervention. If patients do not then meet recovery within this treatment plan this can be reviewed and patients can be offered higher intensity treatment where appropriate (IAPT Manual, 2018). IAPT has set national targets for services. These targets include:

- Waiting times: 75% of people referred into services should start treatment within 6 weeks of referral and 95% within 18 weeks of referral.
- As of March 2021 the expected access rate into services should be 25% as a proportion of prevalence of those in the population with a mental health difficulty.
- Recovery: at least 50% of people who complete treatment should recover (NHS England, 2021).

The Psychological Therapies Reports on the use of IAPT services (2021) states how these targets are being met. As of December 2021 51.8% of eligible referrals moved to recovery and 92.6% waited less than 6 weeks for treatment. This suggests some positive patient and access outcomes from the IAPT programme. Although the statistics being presented by IAPT show a promising picture the topic of recovery rates is hotly debated. Questions have been held over the long terms effectiveness of treatment and confounding factors impacting reported recovery rates such as patients still taking medication while in treatment (Marks, 2019).

CBT is the most recommended therapy with IAPT in line with NICE recommended guidelines (IAPT Manual, 2019). It is therefore important to also explore the evidence around the use of CBT. CBT is ‘based on the theory that people’s thinking influences their emotion and behaviour’ (Beck, 2020), which ultimately leads to a cycle of symptoms (Williams & Garland, 2002). Treatment therefore targets these areas of the cycle using a variety of techniques to change thinking, mood and behaviour (Beck, 2020). By targeting one of these areas this influences other areas (Williams & Garland, 2002). Using this model allows both practitioners and patients to better understand the patients’ current difficulties and the impact on the patient. Therefore, this helps identify where to target treatment interventions (Williams & Garland, 2002).

Caution must be given here to the CBT treatment that NICE recommends (for example, NICE guidelines for depression in adults (NICE, 2009) and those for anxiety and panic disorders in adults (NICE, 2011) and the CBT treatment that is delivered through IAPT. As discussed previously IAPT is a target driven programme and in order to meet these targets there have been criticisms around the ‘quality’ of treatment being delivered. Often this is in the form of how many sessions are offered with reports of this being substantially under the recommendations by NICE (Binnie, 2015). Although this may result in more patients coming through the service patients may not be receiving the most effective ‘dose’ of treatment therefore patients ultimately having to refer back to the service after discharge (Binnie, 2015).

It has also been recognised that there may well be issues with the training therapists receive to become CBT therapists working within IAPT (Binnie, 2015). With the training programme lasting a year there are obvious omissions in the training (Binnie, 2015). Binnie (2015) highlight the complete exclusion of the third wave CBT therapies such as Acceptance and Commitment therapy (ACT) despite the fact these therapies are continuing to grow in their proven effectiveness. The varying professionals that can now apply for this training (such as those without a core profession) has also been highlighted. Liness, (2019) state that these people may require more support and guidance through the training to reach competency than those who have a core profession for example, those with a core profession of clinical psychology. However, the professionals without a core profession can meet the requirements to become therapists and this is important considering the expansion of services and the need for more therapists (Liness, 2019).

It is also important to look at research conducted into therapist competence and patient outcomes. This is important to consider given the question marks over the quality of training and treatment provided through IAPT. Studies have found competence of therapists can impact on patient outcomes, (Branson, Shafran & Myles, 2015, Liness et al, 2019). However, Firth et al (2015) highlights that patient factors such as the severity of patient's presentation, unemployment and therapy disengagement were more damaging to outcomes than therapist factors, with these only accounting for 6-7% of variance in patient outcomes. Therefore, the quality of the CBT therapy along with the training and competence of therapists are important factors to consider when looking at the effectiveness of the IAPT programme.

Although IAPT is trying to fill a void of appropriate treatment for patients with mental health difficulties there is also a body of research which highlights the limitations and constraints of IAPT. One of these key concerns is the impact on the wellbeing of therapists that work within services. Research has highlighted the high risk and prevalence of burnout for staff working within IAPT. Westwood et al (2017) suggest rates of burnout 68.6% in Psychological Wellbeing Practitioners (PWP's). Furthermore, Walklet and Percy (2014) found that 30% of staff surveyed reached criteria for minor psychiatric morbidity. Walklet and Percy (2014) highlighted stressors being around high volume of caseloads, target orientated work, constant change, resource issues, holding distress and risk and demands of high stakes in service training. The impact on staff wellbeing has also been highlighted through NHS England who have reported case studies of services that have indicated lower staff morale and wellbeing due to the focus of performance targets and management of stressful clinical situations (NHS England, 2021). Therefore, we must also recognise the pressure on staff working within this environment and highlight their experiences of working within this framework. This also shows the important value in researching therapists' experiences.

It is important to note the differences in the way IAPT services are run across the country. Carroll et al (2020) highlight that research done in IAPT services will be specific to those services. Carroll et al (2020) suggest this is due to the diversity of services, therapists and types of interventions offered. Gyani et al (2013) also highlight service level predictors of reliable recovery with IAPT services. They found that factors such as use of the stepped care model, number of sessions being offered and working within the NICE recommended guidelines affected patients’ recovery rates (Gyani et al, 2013). This research highlights the differences in services and how they are run can ultimately impact on patients recovery rates.

It could also be argued that the reality of the patients that IAPT services see is not always in line with those that the NICE guidelines are recommended for. Martin et al (2022) conducted a systematic review to investigate the clinical characteristics of patients using the IAPT services as well as whether the interventions provided within IAPT target these characteristics. Martin et al (2022) found that the patients using the IAPT services were more complex. This was in terms of serious mental illness and comorbidity presentations compared to the presentations that IAPT had been set up to support (Martin et al, 2022).

There is clearly a need for a provision such as IAPT in supporting people with mental health difficulties with positive outcomes being highlighted. However, there are also clear flaws in the system such as rigidity of policies, being target driven, the impact on therapists wellbeing, and variations in how services are run. These points are all important when considering the next point of the role IAPT can play in providing support for patients with co-morbid LTC and mental health difficulties. These are important due to patients with co-morbid mental and physical health conditions presenting with more complexity. Therefore, there may be potential further impact on therapists and discrepancies within services that may occur.

Treatment for patients with co-morbid LTC’s and mental health conditions within IAPT

Considering the role that IAPT has in providing treatment for common mental health difficulties, the next section will now look at the programmes role in providing support for those patients with co-morbid mental health difficulties and LTC’s. It should be noted here that services would have seen patients coming for treatment who have co-morbid physical and mental health difficulties for a long time. However, there is now a shift in increasing access for these patients. Furthermore, there is an increased focus on how treatment can be adapted to accommodate patients LTC’s into their psychological treatment.

IAPT has grown each year and now sees over 1 million people each year with over 600,000 of those going on to have a course of therapy (IAPT Manual, 2018). The NHS long term plan outlines the expansion of IAPT services to access 1.9 million people each year by 2024 (NHS England, 2020). To reach those patients with co-morbid LTC's the NCCMH (2018) set out guidelines for a new IAPT-LTC pathway. The IAPT-LTC pathway is designed to increase timely access to effective psychological treatment interventions (NCCMH, 2018). Alongside the common functions of existing IAPT services IAPT-LTC services should also provide:

- Case recognition methods.
- Integrated care pathways (therapist co-located with general health care teams and primary care and joint working where required).
- Revised IAPT assessment protocols – reflecting increased complexity associated with anxiety and depression in patients with LTC's.
- Revised IAPT workforce: expansion and upskilling.
- Sharing best practice with existing IAPT services.
- Close links with the wider system.
- Clinical and Health Psychology services (NCCMH, 2018).

Furthermore, in terms of treatment, clinicians should also:

- Consider the impact of the LTC on the presenting mental health problem.
- Help promote the self-management of the LTC.
- Address problematic beliefs and behaviours that may increase the impact of the LTC.
- Modify the delivery of the intervention to take into account the LTC (NCCMH, 2018).

Within the new IAPT-LTC pathway a key component of this is the integration of services. Recently there has been a focus on integrating primary care pathways between mental and physical health services (Five Year Forward, 2016). The NCCMH put together the IAPT-LTC full implementation guidance (2018). Within this guidance they have stated that integrating services should improve the availability and quality of care of mental health in physical health settings and of physical health in mental health settings.

Linking in with the research mentioned earlier with regards to the excess costs to the NHS, Toffoultti et al (2019) investigated the economic benefits of the IAPT provision. Toffoultti et al (2019) found that IAPT treatment significantly reduced healthcare utilization for patients with co-morbid depression and/or anxiety and physical health difficulties. This therefore highlights the possible economic benefits of the IAPT provision. Furthermore, this suggests that these patients are not needing to access healthcare services as much, suggesting that they are better at self-managing their conditions. However, it is important to highlight in this research that the physical conditions patients had were mainly diabetes, COPD and Cardiovascular Disease therefore, we should be cautious with generalising these findings.

The Coronavirus pandemic has also brought about a new long term condition to consider with long COVID. People who experience long COVID may also experience mental health difficulties. The NHS Long COVID plan 21/22 (NHS England and NHS Improvement, 2021) state that these people may experience depression, anxiety, PTSD and ‘brain fog’ or other cognitive impairments. In addition to this there may also be a social impact which can have a significant impact on a person’s day to day life. As part of the Long COVID NHS plan 2021/22 IAPT services are recommended to work with long COVID clinics to ensure appropriate outcome measuring. They should also provide integrated care for those suffering with long COVID and mental health difficulties. As part of this initiative long COVID training packs have been developed for IAPT therapists (NHS England and NHS Improvement, 2021). Therefore, the need to provide psychological support for those with LTC's is becoming even more prevalent through the COVID-19 pandemic.

As already discussed the most recommended form of therapy through IAPT is CBT, following NICE recommended guidelines (2009). A commonly used intervention used within CBT is Behavioural Activation. Behavioural Activation looks to gradually increase patients' activity levels without patients becoming overwhelmed (Marrinan, 2018, in Papworth and Marrinan,2018). Pacing is an adaptation that is used within Behavioural Activation to support those with LTC's. Pacing encourages patients to look at how long they can engage in an activity without exacerbating their physical health symptoms. Patients are encouraged to break tasks down and do smaller chunks of activities with regular rest periods to avoid over-activity and the worsening of physical symptoms (Royal College of Occupational Therapies, 2023).

However, we must be cautious with generalising the use of stepped care CBT to all physical health conditions. Delgadillo et al (2017) investigated the effectiveness of stepped care psychological therapies for patients with LTC's. They found that for some physical health conditions treatment actually worsened symptoms reported on the Patient Health Questionnaire and the Generalised Anxiety Disorder scale. These conditions included patients with musculoskeletal problems and COPD. Furthermore, they highlighted that these patients were more likely to access higher intensity treatment and even after this they still continued to have higher average post-treatment symptoms (Delgadillo et al, 2017).

Research into medically unexplained symptoms (MUS) by Geraghty & Scott (2020) identified major limitations to treating patients with MUS via IAPT. They identified seven core problems: unproven treatment rationale, a weak evidence base, biases in treatment promotion, exaggeration of recovery claims, under reporting of dropout rates, a risk of misdiagnosis and inappropriate treatment (Geraghty & Scott, 2020). Therefore, we must be cautious with potential differences with patients with MUS presentations to patients with the more 'standard' LTC's such as diabetes, CHD and COPD. This does raise the question of how helpful it may be to 'bunch' LTC's and MUS presentations together within IAPT's guidance for supporting these patients. There may well be quite vast differences in what is the most appropriate support for them.

Furthermore, the role of different treatment options (rather than the standard CBT approaches which IAPT favour) have been explored over recent years. Acceptance and Commitment Therapy (ACT) has gained an increasing research base supporting its use with patients with LTC’s (Dochat et al 2021). ACT has been said to have value to patients with LTC’s due to increasing psychological flexibility. This encompasses the following: acceptance, cognitive diffusion, present moment awareness, self-as context, defining life values and acting in line with those values (Dochat, 2021).

IAPT services are being commissioned to provide psychological treatment for patients with LTC’s with the NCCMH setting out guidance for the implementation of IAPT-LTC services. However, as with the ‘core’ IAPT programme there are cautions around the appropriateness of this treatment pathway for these patients. This includes the use of the preferred CBT treatment, with the growing body of evidence of perhaps more effective treatments such as ACT. Furthermore, there are cautions around the differences presented by those with MUS presentations. However, IAPT services are providing these services with the likelihood that this will continue to expand therefore, research into this area is going to be of value.

Research into therapists experiences of treating patients with co-morbid physical and mental health difficulties in IAPT

It is important to consider now the role of research exploring therapists' views of treating patients with co-morbid physical and mental health conditions with IAPT services. Hassan et al (2018) suggest that therapists' experiences of delivering treatment helps to gain an understanding of how therapy can be improved, how therapists could be best supported in services, as well as how services could be modified. However, there is a lack of research exploring therapists' experiences (Hassan et al, 2018). Therapists are the ones who are working on the ground to implement the recommendations set out by NICE and the IAPT-LTC implementation guidance. Researching therapists' experiences provides an 'on the ground' real world view of how this works in practice. This is important when therapist's' are working are currently working within an NHS which is under increasing pressures.

As discussed earlier links have been made between therapists competence and patient outcomes (Branson, Shafran & Myles, 2015, Liness et al, 2019). Hassan et al (2018) also highlight that improvements in psychotherapy outcomes are dependent on both patient and therapist. For example, flexibility in therapy and the therapist's ability to adapt to suit the individual patients are important (Hassan et al, 2018). Furthermore, Green et al (2014) state that therapists who had better recovery rates for patients had greater resilience, organisation abilities, knowledge and confidence. Heinonen & Nissen-Lie (2019) also state that factors such as therapists' experiences with challenging situations, coping strategies and attitudes towards therapeutic work were important for patient outcomes.

This is particularly important to consider when looking at the previous research around burnout for those working within IAPT settings (Westwood et al, 2017, Walklet & Percy, 2014). Delagadillo, Saxon & Barkham (2018) found that therapist burnout had a negative effect on depression and anxiety outcomes in patients who had received psychotherapy. The above suggests that therapists play an important role in treatment for patients and the development of services for patients.

Earlier research by Lewis (2013) explored the views of CBT therapists working within IAPT on their perceived competency in providing CBT to patients with MUS. Lewis (2013) identified 5 themes: Unfamiliarity with MUS, difficulties in engagement, making slower progress, utilizing skills and knowledge and therapists' emotional reactions, both positive and negative. However, this research is now 9 years old. Since this was conducted there has been substantial growth and development within IAPT as stated above. More patients with LTC's are being referred to the services and specific training and service developments in place to support practitioners.

We will now consider the research that has been conducted into specific LTC services. The first research to investigate this was Clarke et al (2018) who undertook a multi layered evaluation of early implementation sites of the IAPT-LTC pathways. Within this they gained feedback from staff on their experiences in implementing the pathway and patients experiences of receiving treatment through the pathway. They found that service users noted positive experiences, reporting impact on everyday functioning, work and family lives and their ability to manage their physical health conditions. Experiences gained from staff were put into 3 themes of: implementation process, working with new teams and systems and working with services users with LTC/MUS.

Takeaway points from this research were focused on the implementation of an IAPT-LTC pathway. The importance of teamwork, effective working relationships and access to health psychology services were highlighted. Although there was a theme around working with the service users, the focus here was around the value of quality supervision as well as concerns about the use of the minimum data set and recovery rates for these patients. Within the staff experiences in this research there is a lack of more in depth detail about what works in treatment for these patients, how patients present and what's different in providing treatment for these patients.

Pancel et al (2020) also report on the implementation of a specific IAPT-LTC service. Their research highlights 4 successful case studies on how CBT had been applied to patients with LTC's. They also identified key considerations around the development of the LTC pathway. Engagement with healthcare professionals was discussed in terms of promoting the service and working together with these professionals, identifying the key professionals involved in a patients care was also important to engage patients. Training and supervision were discussed in terms of building on the core training provided with further CPD and specialist supervision. Although this research highlights important factors to consider in the implementation of IAPT-LTC pathways, this is a case study on the effectives of adapting high intensity CBT treatment for a small number of patients.

Hassan et al (2018) reported on therapist views on delivering a specific CBT treatment for cancer patients within an IAPT service. They reported themes of flexibility, adaptability and consideration of individual needs as important. Rigidity of IAPT policies and demand on the service were reported as problematic. Key messages that were taken from this study again revolved around the psychological needs of patients being individually assessed, therapy adapted to suit them and communication with other healthcare professionals involved in patients care should be considered. Furthermore, flexibility in policies such as discharge polices and specialist support and training around delivery therapy to these patients is important. This research is very specific to a CBT programme put together for cancer patients again within a specific IAPT service. The key takeaway messages are directed again towards the practicalities of implementing the programme.

Carrol et al (2020) provide a more general view of therapists experiences of the facilitators and barriers to uptake and engagement in therapy for those with LTC's. Therapists were recruited from an IAPT service and physical health care settings. Findings suggested 4 key themes around: working flexibly within the National Health Service context, embedded vs separate care, confidence in working with LTC's and navigating implementation of online therapies. The research here is related to barriers and facilitators to accessing treatment looking at what would help get these patients into the service and engage in treatment.

Within the research discussed above the focus is more on the IAPT structures. Flexibility in the ridged policies and procedures is a prominent feature of this research along with the processes around working with other healthcare professionals involved in these patients care. Carroll et al (2020) highlight an area around therapist confidence. This is mainly in relation to therapists' finding they may not provide enough information about the treatment to patients due to lack of knowledge in this area. There is no other expansion around therapists' confidence and what impacts this.

There is less focus on how therapists feel about working with these patients given the added complexity that comes with this. There is no detail on the treatment itself as well as what are the key differences that need to be considered when providing treatment. Furthermore, we have already discussed that how the patients that present in IAPT service may be more complex (Martin et al, 2022). Therefore, there may be issues with how representative patients are compared to the patients that IAPT was intended to support.

Furthermore, with services receiving more funding and expected to continue to expand more consideration is needed around what works for these patients within these services. Therefore, instead of just focusing on the difficulties surrounding these patients it is also important to consider what therapists feel these patients do benefit from in treatment and why.

Carroll et al (2020) also highlight that this research is specific to the IAPT services that it is conducted in due to the diversity of services, therapists and types of interventions offered through IAPT. It has already been highlighted the vast differences in how services are set up. Therefore, IAPT service specific research is of value in gaining that wider picture of how services are set up, what are common themes among services and what may be more service or regional specific. This will help to consider how best to support patients with co-morbid physical and mental health difficulties.

Since the NCCMH (2018) put out the IAPT-LTC implementation guidance research has been conducted looking at the role of the IAPT programme in providing treatment with co-morbid mental and physical health difficulties. Focus has been on the IAPT processes and the implementation of these specific services. This has highlighted that certain treatment considerations and adaptations need to be considered when treating these patients. Further improvement and development is needed in certain areas around the IAPT processes, policies and procedures. Although the most recent research from Carroll et al (2020) gives more insight into aspects affecting therapists confidence working with these patients. More in-depth analysis into therapists’ experiences of working with these patients would be of value.

Links to Health Psychology Theory and Practice

Health psychology theories around illness perceptions and beliefs are of relevance when looking at physical and mental health comorbidity. Leventhal et al (1984, as cited in Ainsham, 2016) describe the common-sense model of illness. This model states that physical health symptoms promote both cognitive and emotional responses (Ainsham, 2016). The model suggests that individuals form a representation of their illness based on what they know about this, their own experiences and personal characteristics (Ainsham, 2016). This effects how an individual then copes with the illness (Ainsham, 2016). The role of illness perceptions has been suggested to play an important role in explaining the distress outcomes in individuals with physical health conditions (Dempster, Howell & McCory, 2015). Dempster, Howell & McCory's (2015) systematic review in this research field found that perceptions of the consequences of the individuals physical health conditions and their emotional representations had the strongest relationship with distress outcomes. Therefore, how a person perceives and represents their illness plays an important role in how they cope and ultimately maintain their emotional wellbeing.

Another model that is of relevance is Michie's (2011) COM-B model of behaviour change. This model suggests that 3 key factors are essential for behaviour change. These are: 1. Capability: that is the psychological understanding and physical capacity of the individual to engage in the behaviour change, 2. Opportunity encompasses all the other factors outside of this such as time, resources, support and 3: Motivation refers to how motivated the individual is to engage in the change behaviour (Michie, 2011).

This model is of particular importance to those with co-morbid physical and mental health conditions. As discussed, there are more factors to consider when working with these patients. Therefore, consideration needs to be given around the barriers that these patients may face when trying to engage in psychological treatment. These barriers can be considered within the COM-B framework. For example, within capability the therapists will need to consider the patients physical capability more for these patients. This could be in terms of how their LTC is going to impact on them being able to engage in a treatment plan. For example, this could be in relation to a treatment plan that gets them to increase their physical activity.

This model is also relevant to therapists' ability to deliver treatment to patients with co-morbid mental and physical health conditions. A therapists capability needs to be considered in relation to their understanding of how to support these individuals. A therapist's opportunity could be considered in terms of training and extra support provided. Furthermore, a therapist's motivation for treating these patients could be considered in relation to their confidence in supporting these patients. All of these are again important considerations when considering if these patients are receiving the most appropriate support.

It should also be noted that in terms of Health Psychology in practice Health Psychologists are already being embedded into the IAPT-LTC pathways. The NCCMH (2018) IAPT-LTC implementation guidance sets out the recommended workforce for these pathways. Within their recommendations are senior therapists comprising of Clinical or Health Psychologists. The NCCMH (2018) highlight that's these 'specialists' will have a role in supervision and the assessment and management of more complex presentations. Therefore, this highlights the value that Health Psychologists could bring to these services.

Rationale for current study:

Patients who have an LTC are more likely to also suffer with a mental health condition. The direct and indirect links as to why this may be has also been explored, as well as the role of providing psychological support for these patients. With the IAPT programme being the leading provider of mental health support for patients in England the services have been given guidance about how to implement IAPT-LTC pathways to support these patients. However, IAPT does come with various criticisms which also reach to the appropriateness of support that is provided for patients with comorbid mental and physical health conditions.

Gaining experiences of the therapists who are delivering psychological treatment is of value. This is due to the impact that therapists can potentially have on patient outcomes as well as the role their experiences can play in the development of services provided to patients. Therapists' experiences can highlight the potential benefits and barriers in treatment that may not be highlighted through the use of quantitative measures.

Concerns have also been raised about how these patients present in IAPT services may be more complex (Martin et al, 2022). Therefore, there may be issues with how representative patients are compared to the patients that IAPT was intended to support. As well as issues with the support that is provided within IAPT settings compared to how it was originally set up and intended to function. This coupled with the fact that there is a wide variation in the way IAPT services are run highlights the importance of collecting data across IAPT services.

Furthermore, the research into the IAPT-LTC pathways focuses more on the implementation process of IAPT-LTC pathways and the barriers around IAPT in terms of policies and procedures. More in depth research into therapists' experiences of providing treatment for these patients is lacking. Certain aspects have been raised such as training and confidence. However, more in depth analysis into this would be of value. Especially due to the burnout risk already highlighted in those working with IAPT and the impact of the extra pressures of working with this more complex patient presentation. Further areas of value to explore with therapists would be how patients present in treatment, are there any impacts on themselves as practitioners working with this patient group, what benefits patients in treatment and what is more difficult to implement. Therefore, the current research has the below aims.

Aims of the research:

- To explore therapists’ experiences of delivering treatment to patients with co-morbid mental health and physical health conditions.
- Therapists’ perceptions on the differences in treating patients with co-morbid LTC and mental health difficulties within an IAPT service, compared to working with patients presenting with only mental health difficulties.
- Therapists’ opinions on what is most helpful and what is challenging to deliver in terms of treatment for these patients.
- Therapists’ perceptions on barriers and facilitators to engagement for these patients.

Method

Context: Somerset Foundation Trust

As the above research indicates there has been specific implementer sites to work on the IAPT-LTC pathway and look at the benefits and barriers to these services. This way of working has been rolling out gradually over the country. Somerset has been in the more recent phase of this rollout. Although patients with LTC's have always accessed the service it is only recently that there has been a shift in attention to this particular patient group. There has been increased investment into getting referrals, with offering treatment for these patients and looking at adapting the current treatments. One of the main aims of integrated services would be for IAPT services to be situated in physical health settings. This has been hindered due to COVID restrictions in place and many services within the NHS moving to online options for seeing patients where possible. However, although having therapists physically located in health care settings has been set back the IAPT therapists are still working with patients being referred through the pathway.

Design justification

Qualitative methodology has been chosen in this research due to the focus being on gaining staff experiences around delivering treatment within an IAPT-LTC pathway. Qualitative methodology allows for a richer and deeper meaning of understanding (Braun & Clarke, 2013). Braun & Clarke (2013) highlight that real life practice reality, meaning and experience of people tend to be messy and contradictory and qualitative data can embrace this and can capture what else is going on.

Interviews are ideally suited to experience-type research questions (Braun & Clarke, 2013) as they allow for the researcher to engage with someone else's experience. They are also a method that participants are familiar with in society and so are generally more comfortable with this method of research (King & Hugh Jones, 2018). Semi- structured interviews offer a looser structure but provide a flexibility depending on the answers from the participants (King & Hugh-Jones, 2018). Therefore, semi- structured interviews allow the researcher to collect rich and detailed data with scope for participants to raise issues that the research had not anticipated (Braun & Clarke, 2013).

Theoretical Framework

This research took a critical realist ontological viewpoint. Within critical realism there is the assumption that peoples' perspectives, beliefs, experiences and thoughts can be accessed through listening to their account of things (Sullivan, 2018). The research looked at exploring therapists' views of working with patients with long term health conditions within an IAPT service. The research therefore assumed that how therapists talk about this situation in a particular way is more relevant than whether this is actually true or not (Sullivan, 2018).

Unlike the relativism approach which assumes that reality is dependent on the ways we come to know it (Braun & Clarke, 2013), by taking this critical realist viewpoint the research does acknowledge that a pre social reality does exist. However, unlike the realism approach which states this can be accessed through research, critical realism assumes that we can only ever partially know this (Braun & Clarke, 2013). Therefore, we can find this through researching peoples accounts of the situation. This also links with the use of interviews as these are not about fact finding but focus on the subjective interpretation of the participants experience (King & Hugh-Jones, 2018).

This research also took a contextualist epistemological viewpoint. The contextualist approach comes from the viewpoint that all knowledge is local, provisional and situation dependent (Madill, Jordan & Shirley, 2000). This approach clearly maps onto this research with the focus being therapists' experience in this particular IAPT service. The research acknowledges how this may be different from other services. Therefore, the research is viewing knowledge as emerging from contexts (Braun & Clarke, 2013). This is also in line with the ontological critical realism viewpoint as again the research is focusing on experiences in a particular setting and situation.

Furthermore, the critical realist viewpoint states that instead of evaluating knowledge in terms of how true it is we instead evaluate it in terms of how plausible, useful and compelling it is (Sullivan, 2018). This knowledge may therefore help provide a useful solution to a certain problem or help us work towards a certain outcome. (Sullivan, 2018). This clearly links to the research aims as the understanding we gain from therapists experiences will help create a positive experience for both therapists and patients within the service.

Quality:

In qualitative research it is also important to consider the quality of the research conducted. The usual criteria that may be appropriate for assessing quality in quantitative research such as statistical generalisability and replicability do not particularly apply when looking at individuals experiences (Nollaig & Bailey-Rodriguez, 2018). For this research the Eight ‘Big Tent’ criteria for excellent qualitative research (Tracy, 2010) will be used to ensure the quality of the research.

Eight ‘Big Tent’ criteria for excellent qualitative research (Tracy, 2010):

Criteria	Way to achieve the criteria:	Actions taken:
Worthy topic:	Relevant, timely, significant, interesting	Introduction has highlighted the interest in this research area. Since the implementation of national guidance in 2018 there has been increased focus, funding and resource into this area which warrants further exploration.
Rich rigor:	Study uses a sufficient, abundant, appropriate and complex: set of theoretical constructs, data and time in the field, sample, context, data collection and analysis processes	Good sample size of 16. Appropriate use of qualitative methodology. Semi-structured interviews allowed for some structure but also further exploration of topics. Use of Thematic Analysis has been justified. Ontological and Epistemological viewpoints discussed.
Sincerity:	Characterised by: self-reflexivity about subjective values, biases and inclinations of the researcher, transparency about the methods and challenges	Self-reflexivity has been highlighted with role as insider research. How this was addressed at each stage of the research has been highlighted. Reflexive journal kept.

Credibility:	Marked by: thick description, concrete detail, explication of tacit (non textual) knowledge and showing rather than telling, triangulation or crystallization, multivocality, member reflections	Results have thick description. Some areas are more semantic in nature. However, more latent themes and concepts are discussed with more interpretation of the data.
Resonance:	The research influences, impacts/moves particular readers through: aesthetic, evocative representation, naturalistic generalizations, transferable findings	The research moves readers through how findings have resonating with previous research. New areas and expansions on previous areas have been discussed. Transferrable findings for practice have been highlighted.
Significant contribution:	Conceptually, theoretically, practically, morally, methodologically, heuristically	The research contributes further ideas for practice and ideas for future research.
Ethics:	The research considers: procedural ethics, situations and culturally specific ethics, relational ethics, exiting ethics	Ethical considerations were discussed and measures put into place to minimise negative impact on participants.
Meaningful Coherence	Achieves what it purports to be about, uses methods and procedures that fit its stated goals, meaningfully interconnects	It is discussed how the aims of the research were met. Methodology has been justified and fits with goals of the research. It has been illustrated how the

	literature, research questions/foci, finding and interpretations with each other	findings fit with existing literature and further expanding on.

Reflexivity

Taking a qualitative approach means that some subjectivity will be a part of the research to a certain extent (Nollaig & Bailey-Rodriguez, 2018). Furthermore, being aware that the interview is a form of social interaction and that responses can be influenced by how you want to be seen by the interviewer is important to acknowledge and hold in mind when coming to analyse data. (King & Hugh-Jones, 2018). Reflexivity is an important quality criterion in qualitative research and indicates how my own thoughts, feelings and experiences influence the interpretations of the research (Nollaig & Bailey-Rodriguez, 2018).

As a practitioner working within the service, I would come under the term ‘insider researcher’ (Bran & Clarke, 2022). Therefore, I come with my own views and experience of working with patients with long term health conditions within this IAPT service. I already have an understanding of experiences working with these clients and the challenges that may be faced by therapists. This does aid me in the research as it allows me to be able to fully immerse myself and understand the therapists’ viewpoints and experiences. Braun & Clarke (2022) state that subjectivity should be embraced in qualitative research and should be viewed as valuable to the research process rather than problematic.

However, I also needed to take into consideration that this may have also posed some challenges to the research such as some bias or preconceived ideas that I may have formed. To practice reflexivity within the research a reflexive journal was kept (Appendix F). This acknowledged how my subjectivity may have influenced different stages of the research. I have also expanded how I have reduced and acknowledged and potential biases through the method sections set out below.

Participants and Recruitment :

Ethical approval was gained from the Research Ethics Committee Faculty level at The University of West England (Appendix A). NHS Ethics was not needed for this study due to the research focusing on Therapists' experiences and no patients were involved.

Approval to contact therapists was gained by the Somerset IAPT lead. Participants were recruited across the Somerset IAPT service and across different modalities of Psychological Wellbeing Practitioners, Cognitive Behavioural Therapists and Psychological Therapists. This was to ensure to capture data across the IAPT stepped care model. Recruiting a sample across modalities is important as patients with long term health conditions can be seen at any of these levels of treatment.

Ethical Issues:

The research involved conducting interviews with participants and discussing therapists' experiences of working with patients with mental health difficulties. This may have evoked some distress/emotional responses in participants. Participants were made aware of the aims of the research. They were made aware that if they were not comfortable answering certain questions then they had a right to not answer these. They were also advised that they could take time out or break at any point if they needed to. Participants were debriefed after the interviews and advised of the withdrawal process.

Participants were asked to discuss issues around the frameworks within the service they work in and they may have felt uncomfortable with this. However, they were advised that information would be anonymised and was being collected to advise of areas of development if these were to arise. Participants were informed in the participant information sheet that a report will be put together for the management team and wider service following completion of the research. Within this report no quotes would be used and only the themes from the analysis would be reported. Furthermore, any recommendations/considerations would be advised.

Being interviewed by myself as a colleague and practitioner within the service may have had an impact on how much participants wanted to discuss their views of the service. Participants may have withheld some of their thoughts and experiences. Or this could have meant that they felt more comfortable to speak more freely when discussing these points as I have a certain understanding of the issues. I also had to be mindful of this in the interviews. Although being a practitioner in the service meant that I was able to empathise and understand issues discussed, I was careful not to get drawn into this too much and potentially add any bias onto the interviews. However, there may be subconscious bias throughout the process which I was not aware of.

Participants:

Numbers:

Braun & Clarke (2013) recommend 10-20 participants when using interviews in a moderate sized project. They also suggest that 15-30 interviews tend to be common when the research aim is to identify patterns/themes across data. Previous research on therapist perspectives in similar settings (Carrol et al, 20, Hassan et al, 18) have recruited 15-16 therapists. By being informed from previous studies my aim was to recruit between 10-20 participants. I was able to recruit 16 participants.

Characteristics:

Psychological Wellbeing Practitioner (PWP)	7
Cognitive Behavioural Therapists (Hi CBT)	7
Psychological Therapists (PT)	2

When recruiting participants I was aware that due to working in the service that people who were in my immediate team may have been more inclined to participate. Furthermore, being a PWP myself I was aware that perhaps more PWP's would participate than Step 3 therapists. However, through the recruitment process I was able to recruit participants from across the service, with some who I had very little or no contact with whilst working within the service. I was also able to recruit a fairly split between step 2 and step 3 therapists.

Procedure

After gaining ethical approval staff from Somerset Foundation Trust IAPT service were emailed the participant information sheet (Appendix C) and the data privacy notice (Appendix D). They were informed about the aims of the study: To gain therapists experiences on delivering treatment through IAPT to patients with long term health conditions. They were informed that the study would involve participating in an interview of approximately 30 minutes. They were informed that the topics of discussions would be around their experiences of working with this patient group, looking at the benefits and barriers to delivering treatment to this patient group through IAPT. Participants were informed that their participation was voluntary and they could withdraw at any time. Furthermore, their data was confidential and confidentiality guidance was followed. Staff that were interested then contacted me and we arranged when would be the best time to complete the interview. Once this was confirmed a Teams link was sent to each participant. A link to the consent form via Qualtrics (Appendix E) was embedded into the participant information sheet. The participants were required to follow the link on the participant information sheet to Qualtrics to give their consent. This was checked before the interview took place.

<u>The interview:</u>

An interview schedule was created acting as a guide for the interview and also allowing for flexibility if the participants were to raise further areas of discussion. The interview schedule was guided by the previous literature and expanded on to embed the aims of this research. The interview schedule was then piloted on a couple of participants first to gauge if any adjustments were needed.

Interview schedule:

Interview Question	Prompts
What is your role within IAPT and working with patients with long term health conditions?	
How long have you worked in the service?	
Have you worked in any other services?	*If so what was your role working in this team and working with patients with long term health conditions?*
How do you feel about working with this patient group?	*Prompts: how confident do you feel in delivering treatment within your role? Why? What make/has helped you feel confident/not.*

	Presumptions about working with them
What changes do you feel there has been over time in delivering treatment to LTC patients	*How has this affected treatment that patients receive/the treatment that you deliver?* *Who delivers this and the content of treatment.*
What differences do you feel there are working with this client group compared to core IAPT patients?	*Prompts: considerations/Therapeutic alliance/ practically how sessions are run/content*
What components of treatment that you deliver do you feel are most helpful for patients/ challenging to deliver? Why?	
How are you supported in the delivery of treatment for these patients?	*Prompts: Supervision/training – any further support that could be beneficial to support delivering treatment to these patients.* *How is this helpful/ not helpful*
What do you feel are the barriers to/facilitators to engagement in treatment?	*Prompts: from patient level, therapist level and service level.*

How do you feel that COVID has impacted on your treatment for these patients?	*Prompts: Personal impacts, impacts from patients, impacts from service level* *Long COVID patients coming into the service – experiences of this.*
Is there anything else that you feel it would be important to discuss around your experiences of treating patients with long term health conditions?	

After piloting the interview schedule on the first couple of participants the questions appeared to be gaining a wide-ranging amount of information. On reflection I had some reservations that I did not want the interviews to just bring out the processes of working within IAPT, but try to gain more detail on therapists experiences specifically. For example, I was aware that there may have been a tendency for participants to fall into discussing the processes and procedures of working with patients with long term health conditions within IAPT, instead of gaining richer and more detailed information about their experiences as a therapist. Therefore, I focused more on this asking more follow up questions around ‘how does this impact on you as a practitioner’ to gain that further detail.

I also wanted to ensure that certain areas of discussion where emerging from the participants themselves rather than by myself asking those specific questions. I therefore adjusted my interview schedule to take out more specific questions and instead used the participants answers and experiences to guide questions around this area. For example, when a participant highlighted a point that was linked to integration of services I then used this as an opportunity to ask more around this, rather than me bringing it up specifically. This therefore ensured that I was capturing the information that was of importance to each participant.

Interview Process:

The interviews were conducted via Microsoft Teams. This method of conducting the interview was chosen due to the COVID restrictions at the time and ease for participants. Therapists were also sampled from across the Trust. As this is a rural location this covers a large geographical area. Therefore, remote interviews provided more accessibility for staff to attend. The use of Microsoft teams was also in line with the guidance from The University of West England. When participants had consented to take part in the research, they were sent a Teams link to their NHS email account. At the start of the interview's participants were asked if they had any further questions about the research and reminded that they could withdraw at any time.

The interviews were between 24 minutes and 50 minutes. Interviews were audio recorded to be able to gain the level of detail needed. Participants were allocated a number prior to their interview to be able to identify them if they wished to withdraw as the data was anonymised when interviews had been transcribed. When participants brought up a topic area before the interviewer had raised this was then explored in more detail. Then the interview was brought back to the next area of discussion. If a participant was unable to answer a question or did not understand the question the question was rephrased or repeated. The interviewer ensured that it was ok if participants were unsure of how to answer and that there was no right or wrong answer to the questions.

At the end of the interview participants were asked if they had any further comments to make or questions and then the recording was stopped. Participants were thanked for their participation in the study and reminded of the researchers contact details in case they did have any further questions.

Throughout the interview process I was aware that I may fall into not expanding on terminology and areas in as much detail, due to believing I knew what the participants meant. Therefore, I had an open conversation with the participants to explain my role as the research and that I may ask for clarification or ask them to expand on certain areas. I was also aware of the negative pre-conceptions that I had myself about working with this patient group. I therefore ensured that I didn’t just explore around the more difficult areas of working with this client group but also the more positive areas as to not disregard these.

Analysis:

The interview recording was accessed via Microsoft teams along with the transcription. This was used as a baseline and each interview was played back and amendments made to the transcription as needed. The transcriptions were stored securely on UWE One Drive account using the participants assigned number. Any quotes used were checked to ensure there was no identifiable information (see appendix B for example transcript).

As the research was interested in therapists' experiences of delivering treatment to patients with LTC's, Thematic Analysis (TA) was used to analyse the data set. TA is a method of identifying themes and patterns across data sets (Bran & Clarke, 2013). Themes allow us to classify and categorise a set of data and allows us to extract sections and examine these in more detail (Freeman & Sullivan, 2018).

TA is known for its theoretical flexibility (Braun & Clarke, 2013). Although this is helpful as TA can be applied to so many research questions, it can be argued that this theoretical flexibility can be a weakness of TA. This is because it can lack the substance of other methods of analysis which are driven by certain theoretical approaches such as Interpretative Phenomenological Analysis and Grounded Theory (Braun & Clarke, 2013). Therefore, it is important when looking at how the themes are constructed and interpreted to take into account the theoretical assumptions of the research (Willig, 2013).

Within TA the analysis of data can be bottom up therefore derived from the data itself (Braun and Clarke, 2022). Or analysis can be top down and use a theoretical idea to analyse the data (Braun & Clarke, 2022). It is also common for both bottom up and top down approaches to be combined in one analysis (Braun & Clarke, 2013). This research took an Inductive TA approach therefore analysing the data bottom up. Inductive TA analysis is not shaped by pre-existing theory. However, it does acknowledge that the analysis will always be shaped to some extent by the researcher's standpoint. It is important to note my own perspectives as a therapist who works in the setting being researched and how this may guide the research. Furthermore, the contextualist theoretical framework acknowledges that the researcher will inevitably bring their own perspective to bear on research (Madill, Jordan & Shirley, 2000) and therefore maps onto this approach of data analysis.

Other methods of analysis were considered below:

Interpretative Phenomenological Analysis (IPA) could have been used given its phenomenological framework of critical realism which has a focus on 'lived experience', however this is only the focus of IPA (Shaw, 2018). Furthermore, IPA tends to focus on a person's experience of a particular life experience and the impacts on identity (Braun & Clarke, 2013). The research interview questions were looking at therapist experiences of delivering treatment to patients with long term health conditions, but also their opinions and perceptions of delivering this treatment. Therefore, Thematic Analysis allows for this broader range.

Within Grounded Theory, the goal is to generate theory (Gordon-Finlayson, 2018). Furthermore, there is an emphasis with Grounded Theory on understanding social processes. (Braun & Clarke, 2013). Therefore, as this study was not aimed at producing theory it was not an appropriate method to analyse this data set. Discourse Analysis looks at how accounts of objects and events are constructed in certain ways and is concerned with patterns in language (Braun & Clarke, 2013). Discourse analysis holds the theoretical assumptions of social constructionism (Riley and Wiggins, 2018) and therefore is not in line with the theoretical assumptions of the current research.

Furthermore, previous research that has been conducted into IAPT services and specifically therapists' experiences have also predominately used TA (Millet et al, 2018, Carrol et al, 2020, Marwood et al, 2016, Tutani et al, 2018). Therefore, due to the considerations discussed above and TA being used for similar research, this choice of data analysis was deemed as the most appropriate.

Braun & Clarke's (2006) phases of Thematic Analysis were applied to analysis of the data as below:

1. Familiarisation with the data. This involved immersing myself in the data set by re-reading and searching for meaning and patterns.

2. Generating initial codes. This involved organising the data into meaningful groups and identifying sematic and latent codes.

3. Searching for themes. This involved sorting codes into themes and developing a thematic map.

4. Reviewing themes. This involved a 2-level approach. Level 1 was reviewing the themes at the level of coded data extracts and assessing if they are they forming a coherent pattern. Level 2 considered the validity of the themes in relation to the entire data set.

5. Refining and naming themes. This involved refining what each theme is about ensuring the story that each themes tells and why it is interesting. From this process sub themes also emerged within the overarching themes.

6. Producing the report

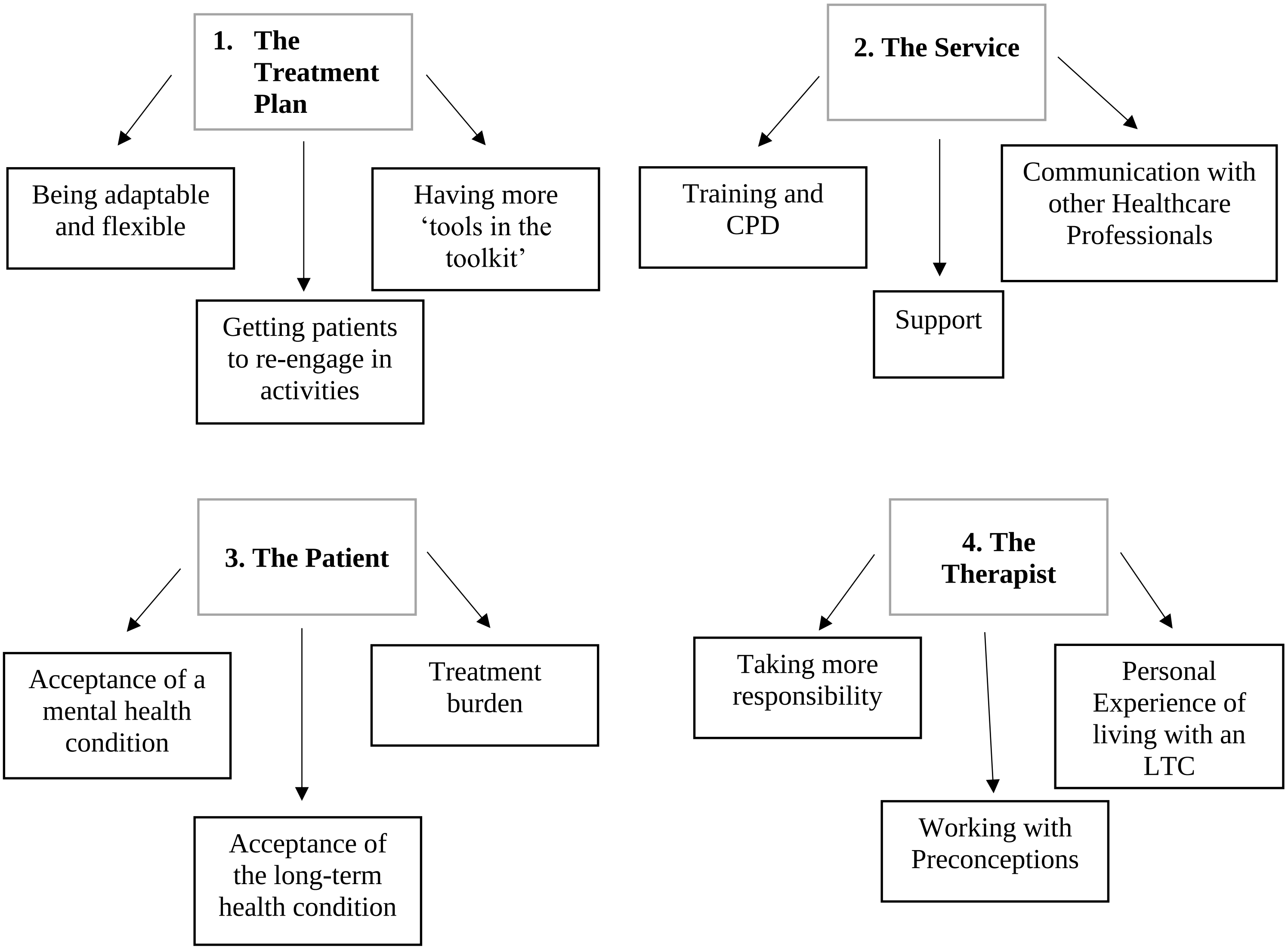
To ensure quality of the analysis stage full explanations to interpretations of the data are used. Furthermore, discussions with supervisors took place to reflect on the decisions made and explore other perspectives of the data. This links in with the rigor, creditability and meaningful coherence criteria within Tracy’s (2010) eight big tent quality criteria for qualitative research.

Being an insider researcher and having explored previous research in this area I was aware of themes that I may have been expecting to come up. Due to this I was careful not to dismiss any other data by fully immersing myself in the data reviewing and checking themes, as well as having the discussions with my supervisor as discussed above. Throughout the analysis process some areas which brought about challenges within the service did bring up some feelings of discomfort about possibly going against my workplace. However, I tried to take a step out of this as see the data from a researcher perspective as much as possible.

Results

From analysis 4 themes were identified. Each theme had associated subthemes to provide further understanding of therapists' experiences. Themes and sub themes are identified within the thematic map in Figure 1. Each theme highlights a specific area of importance around providing treatment for patients with co-morbid mental and physical health conditions. Themes also each provide a target area when considering future steps and areas for further consideration and development. Although each theme is presented distinctly each area will ultimately have some influence over another. For example, the theme of The Treatment Plan especially the sub-theme of having more tools in the toolkit will be dependant to a certain extent on the training and CPD providing with the theme of the Service.

Figure 1.


1. The Treatment Plan
Being adaptable and flexible
Getting patients to re-engage in activities
Having more 'tools in the toolkit'
2. The Service
Training and CPD
Support
Communication with other Healthcare Professionals
3. The Patient
Acceptance of a mental health condition
Acceptance of the long-term health condition
Treatment burden
4. The Therapist
Taking more responsibility
Working with Preconceptions
Personal Experience of living with an LTC

The treatment plan

The theme of the treatment plan focuses on therapists' experiences of the aspects of the treatment itself that are important to consider then working with these patients. Within this theme three subthemes were identified. Therapists identified the importance of being adaptable and flexible within treatment. Therapists focused on the importance of getting patients to re-engage with activities and the impact this can have on their illness beliefs. Therapists also discussed the benefit of having more 'tools in their toolkit' when supporting these patients and the importance of having different skill sets that provide more relevant support.

Being Adaptable and Flexible

Therapists indicated the importance of adaptations within different aspects of the treatment plan. This may be adapting the intervention itself and the material provided for patients but also taking into consideration the impact of symptoms. The impact of patients' physical symptoms such as poor concentration or brain fog were discussed. Therapists discussed making adaptations such as recording sessions so patients can look back over sessions. This indicates how flexible therapists are willing to be and thinking 'outside the box' on how to really engage this patient group.

> *‘I think over time it's been, there's a lot more now about adapting treatments rather than a kind of like a one size fits all sort of thing. Really making things more personalized to that person. However, that might be whether it's recording sessions so they've got that for, you know, the client can listen back to it. Like I said, adapting worksheets, just adapting the intervention all together or sometimes doing a different intervention that might be more suitable. So, I do think, yeh for me, it's definitely been much fresher in my mind to really adapt the way I work to suit the client’*
>
> *Cognitive Behavioural Therapist*

Flexibility was discussed in terms of how treatment is delivered to patients within the service. It was noted that during the pandemic a lot of treatment had moved online. Overall practitioners felt that this was positive. This has given patients with LTC’s the options of having their appointments online, via telephone or face to face. This meant that they were more likely to attend their appointments. For example, if someone was experiencing a flare up in their physical symptoms and couldn’t drive that day they could attend their appointment online instead. This appeared to be a positive change to evolve from the COVID-19 pandemic and appears to show that the service can be more flexible and adapt when needed.

> *‘be quite flexible in the terms of the way that you deliver it, so sometimes they might want telephone sometimes they want might want face to face. So it’s trying to be quite flexible in that sense, you know you might be seeing someone face to face but then they suddenly say ‘I'm not feeling great this week’ or you know ‘I've got an appointment before I see you next week so I want to be at home’ and then you can say well do a telephone session instead then or video’*
>
> *Cognitive Behavioural Therapist*

Flexibility was also discussed in terms of the number of sessions and being more flexible if a patient needs to cancel an appointment due to their LTC or if they do not attend an appointment. It was recognised that patients with LTC's may not be able to engage in the treatment plan at a pace that patients without LTC's can. Therefore, offering shorter sessions (and more of them) ensures patients are getting the most out of the treatment. However, although the needs for flexibility in treatment is highlighted there were varying opinions on how flexible they were able to be.

> *'with the patients who have the co-morbid difficulties, we do have to go that little bit slower sometimes, and there is thankfully a bit of flexibility and maybe offering an extra session if needed, or even having slightly longer sessions if needed. If it takes longer to go through things, but unfortunately there's limitations to that, and what the services allows us as practitioners to offer'*
>
> *Psychological Wellbeing Practitioner*

Some therapists discussed flexibility in being able to offer individualised care was dependant on discussion between the therapist and their supervisor. Interestingly, some therapists felt that they were able to have this flexibility and collaborate with their supervisor around this. Others felt that they were not able to do this and ultimately it was up to the supervisor to make the decision on how flexible the practitioner could be with appointments offered. There was also a sense of practitioners needing to justify the need for the flexibility in sessions. This suggests the importance of a practitioner being able to provide a good enough 'rationale' to get the extra support that the practitioners feel is needed for these patients.

> *'I can ask for an extension, but it has to have, like a rationale rather than 'can I have a few more because they've got an LTC'. It has to be like, this is the reason you know, this is the reason why. So it's something you have to kind of think about rather than just kind of being able to get it, when you would feel like it would be necessary'*
>
> *Psychological Wellbeing Practitioner*

This subtheme highlights the importance of adapting the treatment itself. This facilitates engagement of patients with therapists expressing the willingness and creativity to do this. However, therapists often reported that this was done ‘as much as they can’. Therefore, highlighting that although they are willing and wanting to provide this flexibility and adaptation to treatment this is restricted. This was due to the restraints of policies and procedures within the IAPT system and also how much they are able to justify this to supervisors.

Getting patients to re-engage in activities

Therapists discussed the important role of getting patients to re-engage in activities. Behavioural interventions were often seen as the predominant intervention of choice for these patients. There was often a focus on pacing as an adaptation to support engagement. Pacing is a technique that allows patients to break down tasks and provide rest periods instead of trying to complete an activity all in one go, which could then result in patients experiencing an increase of physical symptoms. The idea of breaking activities down was highlighted as particularly helpful in getting patients to realise that they can still engage in certain activities.

> *‘my main experience with LTC’s is using the behavioural activation, so I think obviously breaking things down. I would say that can be a particularly helpful part of it, 'cause I think sometimes people just saying ‘oh I just can't do that anymore, it's completely impossible, I just can't do it’. But actually when you do identify it and then you start to break things down and use like the hierarchy as well, I find that really helpful.*
>
> *Psychological Wellbeing Practitioner*

Therapists also appear to make the links here between how behavioural approaches can also impact on a patients’ illness beliefs. Therapists felt this challenged the ideas that they cannot do anything anymore or perhaps that they are ‘just being lazy’, through engaging in activities more. Therefore, patients can see that this may not necessarily be the truth and they can still engage in valued activities.

> *‘I think it's that more gentle approach and it gives that patient that permission that they don't need to act in the ways that they would have done previously. I think they come into that mindset with the idea of OK ‘well, that's laziness or that's you know, ‘I'm not making the most of my time’ and they have all these expectations and beliefs that they should be acting in certain ways, and I think pacing is just a really nice way to just work around that and give them an alternative choice’*
>
> *Psychological Wellbeing Practitioner*

Therapists felt that getting patients to re-engage with activities to get a sense of value, achievement and re-connecting was an important part of treatment. However, therapists did highlight how this can involve some ‘creativity’. If a patient is not able to do something due to their physical health then the focus is around how to get that same value from something else that they can engage in. Again, this highlights therapists skills in problem solving around these difficulties. However, this naturally does require more ‘effort’ on the therapists’ part to really encourage the patients to think about this.

> *‘I'm thinking about, you know, the values. Say someone liked to play cricket, but isn't able to at the moment …. thinking about what was it about cricket that was important? You know what were the values there? Was it about socializing? ….. So I think trying to reconnect’*
>
> *Cognitive Behavioural Therapist*

Although therapists highlighted getting patients to engage in activities as an important aspect of treatment they also discussed the difficulties with implementing these techniques. These difficulties were around not wanting to cause more harm. Therapists stated that there is the added complexity of knowing if what you are asking of the patient is going to exacerbate their physical health issues. Therefore, there was concern about potentially causing more harm.

> *‘there is things such as you know pain and fatigue involved then you know, you really have to be thinking about introducing these activities in a way that's not going to add, you know exacerbate any problem, so you know that can feel a little bit you know daunting as a practitioner, to make sure you're not asking them to do something that's going to make that physical health worse say that's always slightly more complicated’*
>
> *Psychological Wellbeing Practitioner*

Interestingly some therapists also discussed patients previous experience of using pacing within other services such as Chronic Fatigue and Pain services. Therapists who mentioned this discussed that some patients may have a not found pacing helpful. Therefore, they may hold a negative view of this as a technique to support them. Therapists reported that this could impact on their willingness to try this in their current treatment plan. Furthermore, therapists described how some patients are using the technique of pacing already. Therefore, therapists questioned how they can further support patients especially if they are already doing what the therapist would be recommending.

> *‘Coming with a very negative, ‘don't talk to me about pacing, don't talk, don't dare talk to me about pacing’*
>
> *Cognitive Behavioural Therapist*

> *‘she was already familiar with the idea of pacing and she was implementing that in her life, so it's just trying to see how we can further adapt it in anyway because the pacing wasn't really making that much difference’*
>
> *Psychological Wellbeing Practitioner*

This indicates that there needs to be caution in the way that the adaptation of pacing is approached with patients. With also clarity on how this is relevant to the treatment plan to support their mental health. This also highlights a lack of the joined up working with other healthcare professionals involved in the patients care. This shows a lack of understanding about the role that other services play and a possible ‘overlap’ of support that may consequently cause some frustration for patients.

This subtheme highlights the role of getting patients to re-engage in activities. Behavioural Activation was a prominent intervention that was discussed by therapists. Therapists recognised the value of this in getting patients to realise what they are still able to do and regain a sense of value and purpose in life again. However, therapists discussed holding caution over how much they feel able to get patients to do in terms of the physical symptoms they experience and not wanting to make patients worse. Furthermore, therapists raised caution around patients' potential previous experience of pacing and how this can then impact on a patient wanting to engage with this or how beneficial it is for them.

Having more ‘tools in the toolkit’

Therapists often discussed the need for different skills and approaches to support these patients. The need for different approaches was often discussed in relation to trying to address a patient’s negative beliefs about themselves. Therapists recognised that cognitive interventions can sometimes be more difficult to implement. This was due to the nature of the patient’s negative thoughts often being backed up with real evidence. Therefore, the thoughts are likely to be true, for example the thought that their condition is not going to get better. This means that trying to challenge these thoughts using a typical CBT based intervention of Cognitive Restructuring, where you teach the patient to be more balanced in their viewpoint may not always feel appropriate for these patients.

> *‘you know the thought that ‘I am probably not going to get better’ it is potentially quite accurate for someone, they probably maybe even have been told that’*
> *Cognitive Behavioural Therapist*

Therapists, especially high intensity step 3 CBT therapists, recognised a move towards using other third wave CBT approaches such as Acceptance and Commitment Therapy (ACT). Which they felt were more beneficial for these patients**.** Therapists felt like having these extra techniques added to their ‘toolkit’ of approaches that they could take with these patients.

> *‘sometimes I think it's appropriate to deviate from the sort of normal way we would normally work with cognitions, in the sense that we might just look at rather than challenging a thought, sort of just sitting with it and allowing it to be there, rather than getting tangled up and struggling with it’*
> *Cognitive Behavioural Therapist*

> *‘but also now having ACT as one of my treatment things I can offer I think has meant I feel like I got few more tools in my tool kit and I think that's really helped. CBT has definitely got its place, but it does but it doesn't fit for everybody, and I find that the acceptance elements that I can utilize from ACT really helpful.*
>
> *Cognitive Behavioural Therapist*

This highlights how the standard CBT approaches to treatment that IAPT focus on may not always encompass everything that could be relevant for supporting this patient group. Consideration to expanding on these techniques needs to be given more attention. It also suggests that therapists within this role want to learn more and have more treatment options they can deliver. It is important to highlight here that access to ACT training was limited. Some therapists stating that this was covered minimally in the training. Furthermore, some therapists had gone on to seek their own more in-depth training. Therefore, it appears that the upskilling in ACT techniques across therapists could be of value.

Low intensity step 2 PWP’s also discussed the role using more ‘tools’ within their guided self-help sessions. It was recognised that these sessions can involve the use of more than one intervention. Furthermore, being able to stop and switch to using a different technique when appropriate was also discussed. This may be controversial when PWP’s are taught to deliver ‘single strand’ interventions, with sessions also being shorter in length and there are generally less of them. Therefore, if therapists are saying how different techniques and approaches may be needed is this appropriate within a guided self-help framework. However, this may also show some ‘therapeutic drift’ in some PWP’s with what they have been taught. With PWP’s feeling like what they are delivering may not be enough and therefore trying to bring in more content to the treatment.

> *‘I find that sometimes the interventions are a little bit more mixed than perhaps it would do if we were doing it in the main service. I think we do try and keep it as single strand as possible, but like I said, if there is that kind of higher level of anxiety, sometimes we might just take that into account and incorporate something just to help them manage that anxiety. So, the sessions in my experience tend to be a bit more meaty, a bit more packed and it may just not be one single thing that we're doing with somebody’*
>
> *Psychological Wellbeing Practitioner*

This subtheme highlights how therapists felt more is needed, or different approaches are needed in treatment. For CBT therapists this was often discussed in the way of more ACT techniques to help address negative cognitions. They felt this helped them to address cognitions that are based in some truth rather than trying to challenge negative thinking patterns. PWP’s highlight having different skills to be able to use and not just a focus on a ‘single’ intervention. However, caution should be held over how appropriate this may be within the guided self-help approach and the way this is taught and delivered with IAPT.

The service:

The theme of the service focuses on therapists' experiences of aspects of the service that impact on how they feel about working with these patients. Within this theme there are three subthemes. The topic of training was discussed in terms of specific training that is provided and access to CPD. Differences were noted here between low intensity step 2 and high intensity step 3 views. Support was discussed in terms of specific supervision and access to support from the wider team. The role of collaboration with other healthcare professionals was also discussed looking at the importance of this and how this is feasible within the service.

Training & CPD

Vast differences in opinions of the usefulness of training delivered at low intensity step 2 and high intensity step 3 treatment were noted. Training was discussed in terms of the specific university set training days. This are offered for therapists within an IAPT setting around working with patients with co-morbid physical and mental health difficulties.

PWP's generally reflected on how helpful they had found the training. They reflected that this has been helpful in addressing negative beliefs about working with this patient group. They reported that this also provided them with more concrete ideas of what adaptations they could make to treatment. Therefore, they ultimately felt more confident in delivering treatment to these patients.

> *‘I've definitely been feeling more confident since going on the top up training though and I think that's really helpful, kind of focusing on what they can do, really exploring around you know is this a physical health barrier or is this a depression barrier, is there a way that we could adapt an activity or you know so that they could kind of work with it, and just generally kind of feeling like I've been geared with more questions to ask really to gain some more information and like relevant questions to ask that'll kind of help me kind of understand a little bit better, and the kind of, again the links between them and physical health. So I think the training has been getting quite so yeah my confidence is definitely grown sort of since then’*
>
> *Psychological Wellbeing Practitioner*

It also appeared that PWP’s felt that this extra information from the training helped them to feel ‘qualified’. This helped them to feel like they can deliver an intervention for these patients within the parameters of step 2 low intensity work. It appears that perhaps the training gave PWP’s validation that they can work with these patients. This also says something about how PWP’s may view themselves and their role within IAPT.

> *‘feeling like ‘am I qualified enough to help this person when they had seemed to have so much other stuff going on’, but I think it's been kind of, I think the training has been quite empowering in that’*
>
> *Psychological Wellbeing Practitioner*

In contrast, high intensity step 3 therapists generally reflected that the training did not give them any new information. These therapists felt that they were told that they just needed to apply the techniques they already knew. They felt this did not provide them with anything extra to support them in their treatment with these patients.

> *‘the message I got was that ‘you guys all have the skills to deal with this and now you've had this 10 days of training, so now you are even more prepared’. But I don't think we were, I think we were just kind of told that we have all the skills that we need, but then if that's the case why have the training’*
>
> *Cognitive Behavioural Therapist*

Step 3 therapists described how they felt these areas were more ‘specialist’ and how the limited training days offered did not cover enough. This ultimately led to some therapists lacking confidence and not feeling as equipped to support these patients. There were concerns about being labelled an ‘LTC practitioner’ which may mean that they are perhaps seen as more of an ‘expert’ in this area.

> *‘It feels to me like it's a really specialist area, and so I don't feel that well equipped. You know the training is like one day on this one day on that. And you know that we did like one day on pain, which you know, I'm sure you could do a whole training on just pain itself can’t you, so it all feels like it's all quite specialist areas, and we just kind of got these tiny little bits of knowledge about it. Yeah, so I guess I don’t necessarily always feel that well equipped and feel slightly fraudulent being like ‘you're the LTC one of the LTC practitioners in the service’*
>
> *Cognitive Behavioural Therapist*

Therapists also discussed the lack of continuing professional development (CPD) in this area. With this area being such a focus for IAPT and the push being towards expanding services in this area, services need to keep up with CPD in this field. Some therapists were proactive in seeking their own CPD outside of that specifically conducted in service. This perhaps is important to highlight to therapists, in terms of their own role in skills development. With IAPT being such a fast paced, high volume and target driven approach to seeing patients it could be considered how much time is being spent and committed to CPD and developing practitioners skills set.

> *‘also CPD as well is something that I don't see very often. I cant remember the last time I had any CPD related to long term health conditions. It just feels like it's kind of in the background and not really a priority so services could possibly change that and make a bit more priority’*
>
> *Cognitive Behavioural Therapist*

This subtheme highlights the difference in opinion in specific training provided for working with patients with LTC's. PWP's appeared to feel more empowered. They felt the training provided more of a structure for them and validated how they can support these patients. However, CBT therapists were expecting more from the training and felt they were being told they already have the skills they need. Therefore, they felt that there were not provided with any 'new' skills. Furthermore, the need for more CPD within the service was highlighted. This is especially important considering the drive and focus for more referrals for patients with LTC's into the service. As well as the variety in LTC's that are coming through the service and 'new' LTC's such as Long-COVID.

Support

Therapists in general felt they had a good level of support from the service to work with these patients. The conventional route of using supervision to access support was discussed with this being viewed as a supportive tool for therapists. Many therapists felt that supervision was a collaborative tool where they could share experience and seek support and further advice for these patients.

> *'You know I can do that in my supervision with other people and sort of like 'oh do you think you could have said something different there' you know and you can pick up on so much more. And having a second opinion on that session and whether they are saying 'well now I can't see anything' or 'you could have approached it this way' 'we could have said that', 'It might be helpful to go down this route', 'Have you thought about doing this route' or 'stay on the route you're on stop trying to change what you're doing'*
>
> *Cognitive Behavioural Therapist*

Therapists with more experience tended to reflect that supervision may not provide any new information but was still a useful space to talk through treatment and offer validation. For newer therapists there was more of a focus on supervision being a space to seek more 'expertise' from a supervisor who has more experience. This again raises an interesting point about the use of supervision and the role of the supervisor. Should they been seen as having more expertise or should this be more of a 'peer' supervision process. Within the field of working with LTC's this also links into the role and benefits of having more specialised supervision.

Furthermore, supervision groups at high intensity step 3 were seen as not being consistent or perhaps not well led. It was reflected that there is no sense of ‘expertise’ in the group. Therefore, it appears that therapists are wanting more structure and a ‘leader’ within these sessions to guide this and make it more of a useful tool.

> *‘supervision group has been good, although it's been kind of hit and miss when it runs, but when it does, when it's helpful umm although again, it's umm it's not necessarily people with lots of experience. It's you know, most of us are probably trained fairly recently, so it's kind of a bit of blind leading the blind, but it's still helpful to talk about it’*
>
> *Cognitive Behavioural Therapist*

Therapists discussed being able to go to other colleagues with extra training and more experience as well as their wider management team for further support and advice. Therefore, support received didn’t feel limited to just the use of clinical supervision. This shows the importance of having those good working relationships and feeling comfortable and able to reach out to others. Again, this does draw on perhaps supervision not feeling ‘enough’ if further support is being sought from different avenues.

> *‘Supervision, that's very supportive. Team Leader is supportive and duty, you know I could take anything to duty if I ever had any questions, and kind of the duty meeting, although it is a duty meeting its kind of a bit of peer supervision as well if you had any queries or discussions you can take it to any colleague and discuss that, so that’s predominately the way I’m supported’*
>
> *Psychological Therapist*

For those who had done the high intensity step 3 training some had been offered specialist supervision with a Health Psychologist and the value of this was recognised. However, this was not continued. Therapists not only reflected on how useful an expert in this area was such as a Health Psychologist. They also point out that this also provided a perspective from outside of the service. With IAPT having such structure and rigidity it appears that therapists value this alternative perspective outside of this. This also highlights how perhaps therapists can see that other perspectives and treatment approaches could be beneficial for these patients outside of the restraints of treatment offered with IAPT.

> *‘we were lucky enough to have a health psychologist who was a Gestalt practitioner but we had her for three sessions ….. that was amazing, that she was a health psychologist and completely separate from the service, completely kind of having a different approach to it and it just felt like that was really useful’*
>
> *Cognitive Behavioural Therapist*

Support within the service was sought in a variety of different avenues. The most conventional being through supervision. However, more specific and more specialist supervision appears to be needed with access to ‘experts’ who may be outside the service to provide a different perspective. Although supervision is an important part of IAPT and monitoring practice the use of this and how it is used for providing support to therapists when treating patients with LTC’s could be explored further.

Collaboration with other healthcare professionals:

Therapists recognised that patients with LTC's will have other healthcare professionals involved in their care. The majority highlighted the importance of the links that are built between the professionals involved to provide more rounded and coherent care for the patients. However, although the importance of this was highlighted by many therapists the practical considerations to being able to implement this was often discussed.

This was often reflected in having the time to be able to make these links. Therapists report not having the dedicated time for this and having to prioritise and balance their workload. It appears very clear that therapists need the time to make effective links with other healthcare professionals but there appears to be no accommodations made for this. This reinforces that some of the structure within IAPT may need to evolve if they are to provide an effective service for these patients.

> *'I'm the link person with these people but I don't have time in my diary to actually request this, you know and my meeting with (another service) the other day was in the lunch time and so you know I fit it around my schedule rather than have a space for it'*
>
> *Cognitive Behavioural Therapist*

In regards to 'integration' (being able to work within physical healthcare settings) space was often described as an issue. Not being able to physically have a room within the healthcare setting for a therapist to work from is a basic requirement. This puts into question how feasible integration is if there are barriers at this level.

> *‘I think space is something that we've you know bumped into quite a lot you know we've had I think we've just managed to get a practitioner in to start sitting in on the clinics and but that's been talked about for years but they could never find a room for us so it's the practicalities of that as well’*
>
> *Psychological Wellbeing Practitioner*

It was recognised that other healthcare services may not fully understand the role of IAPT and what can be offered, with patients have been told they will have access to certain types of treatment. This can then result in patients coming into the service with a certain expectation when this may not be available, or is not appropriate.

> *‘I think the wider services being aware of talking therapies and actually being aware of exactly how it is we can help is really important. So a lot of the time you know we might get referrals through from GP’s. And in my experience sometimes the GP’s are kind of referring sort of as a sort of almost a stopgap, and they've kind of sometimes kind of misled the patient in terms of what it is we can offer. And they're not having a full understanding that we are very much a mental health support’*
>
> *Cognitive Behavioural Therapist*

Therapists reflected on the idea of building relationships with other healthcare professionals. Within a busy NHS service trying to keep on top of and abreast of what other services are doing and offering is going to be difficult. The NHS is one service but appears to get divided up. This can lead to patients not having that sense of cohesive care. Not only can this lead patients into some confusion about what service is supporting them with what, therapists and other healthcare professionals also lack an understanding of the role of each service. This can ultimately impact on patient’s care by not receiving the right support or getting different advice or messages from different services.

> *‘so there are some that we’re going alongside one another at the same time but we rarely have links. So for example I have some patients with Long COVID, so they’re part of the long COVID clinic, and they're getting help with that service, but they're also part of our service and getting treatment from talking therapies but I have no idea how we would link and I haven't had any links with them. So we're kind of going down to we are parallel or working in terms of you know we're going at the same time but we're not on the same path together’*
>
> *Cognitive Behavioural Therapist*

The impact of the COVID-19 pandemic on work around integration was also recognised. Many links with physical health care settings that were being set up prior to this had stopped and not yet re-established. COVID-19 has had such an impact on the way services are now run. This includes the amount of face-to-face contact that patients have with a move towards more online and telephone consultations. This needs to be considered when looking at integration. This shows that the communication and collaborative working outside of just being physically co-located is important to establish and maintain these important links.

> *‘And I think in an ideal world we would like an outreach project with every area of physical health services. Especially with the local hospitals. But I know COVID’s kind of stopped a lot of those projects, so I don't know if that's realistic now’*
>
> *Psychological Wellbeing Practitioner*

The need for better links and collaborative working with other healthcare professionals is clearly important to provide more cohesive care to patients. However, there are still very basic barriers and practical restrictions that need addressing for this to be facilitated such as time and physical space to work from. Communication is a two-way mechanism which needs to be acknowledged from both the IAPT services and other healthcare professionals involved in patients care. A clear understanding of roles and responsibilities between these services should be much more explicit and defined.

The Patient:

Therapists discussed the role of the patient themselves and their experiences of patient characteristics can impact treatment. Within this theme three subthemes were discussed. Therapists acknowledged the importance of whether the patient had accepted that there was a mental health component to how they were feeling. Also, where the patient was in terms of accepting their LTC and being able to move forward with this was highlighted. Therapists frequently discussed the impact of treatment burden for these patients. With patients often having multiple appointments and discussing their ability to commit to psychological treatment on top of this.

Acceptance of a Mental Health Condition

Therapists quite frequently discussed patients not fully understanding the link between their physical health and their mental health. Therapists often described patients as 'medically modelled'. Therefore, they described patients as not seeing that there is a connection between their physical and mental health, with patients often focusing on looking for a medical answer to their difficulties.

> *'they are still trying to look for a physical issue, they're still trying to get more tests done and they're still kind of in that place where that's still going down the medical model route, or wishing to even if they have kind of been told that 'no we've done all we can there'. And so we have to get over that barrier first, so that could make it more tricky.'*
>
> *Cognitive Behavioural Therapist*

This was also highlighted more for those patients who may come under the umbrella term of ‘medically unexplained symptoms’ (MUS). For these patients there is often a long process of ruling out other conditions before they are given this diagnosis. This can be driven by trying to find a medical explanation for their symptoms. Therapists also discussed how there may still be a stigma around accepting that part of their condition may be exacerbated by mental health difficulties, which can be a barrier for engaging in treatment for these patients.

> *‘for some that are medically unexplained that actually perhaps it's a big part of it is mental health and not physical, and sometimes that's a real struggle and a barrier getting somebody to have some sort of acceptance and understand that acceptance doesn't mean giving in to a condition, and I think it's really big, so I think and yeah it's just sometimes dealing with stigma I guess maybe’*
>
> *Cognitive Behavioural Therapists*

Therapists discussed the idea of the patients having ‘understandable difficulties’. Therapists discussed how these patients would often hear ‘no wonder your depressed’. This appears to be suggesting that patients should be depressed given what’s going on for them. Therapists stated that this way of viewing their difficulties has come from GP’s, physical healthcare professionals and therapists themselves. This does raise the question of how helpful this is for patients to hear. Normalising a patient’s experience can be helpful however, when does this start to become unhelpful and ultimately supporting unhelpful beliefs about how a patient should be feeling.

> *‘whereas we definitely do see some long term health condition clients where is more of a sort of belief of this is just my condition and how I'm you know responding to it’*
>
> *Cognitive Behavioural Therapist*

Therapists also highlighted the important role of psychoeducation within the treatment to get the patients to understand this link. When patients have that understanding of the mental health aspect to how they are feeing and the connection between their physical and mental health then they are more likely to engage in the treatment plan. Therefore, it seems that this first step in treatment shouldn't be underestimated, with perhaps more time and emphasis given to this.

How much a patient has accepted that there is a mental health aspect to how they are feeling and how this impacts on their physical health condition is important to consider when assessing patients and considering the most appropriate treatment plan for them. This may be more evident for people who present with MUS presentations due to the difficulties in diagnosis and the stigma still attached to these conditions. Caution must also be given to how much patients are told that their mental health difficulties are a 'normal' reaction to living with an LTC. This may prevent a patient from getting the appropriate support and believing that they can still live well with an LTC.

Acceptance of the long-term health condition

Therapists discussed the role of how patients present in treatment in terms of accepting their health condition and the limitations that come with this. It was often discussed that patients are wanting to get back to where they were before their illness. Therapists highlighted how patients often compare themselves to how they were before their illness. Therefore, not being able to accept their limitations and move forward with this.

> *'so it's that you're having to adjust to a really significant life changing event so you have a person before the illness which you take you as better than the person that you are after the illness so it's essentially you know how do you adjust to that, so there can be a kind of an experience of loss so I've lost the person I am grieving for that life'*
>
> *Cognitive behavioural Therapist*

Links were also drawn to a person's sense of identity. Furthermore, that the acceptance of living with an LTC is also like going through a grieving process. Therefore, there are much more complicated in-depth psychological issues going on for these patients. It's important to consider the role of IAPT in supporting these patients with such complex dynamics going on.

Interestingly, therapists did speak about the impacts of a patient having a new diagnosis verses having lived with the condition for a long time, with some mixed views of this. Some therapists reported that the newly diagnosed may be more in denial. Whereas others stated this may be easier to work with as there is 'less to unpick'. However, one therapist expressed that they felt it was more about where a patient is with their acceptance rather than how long they have had the condition for.

Hopelessness was a key word that was frequently used when thinking about a patient's acceptance of their LTC. Therapists described that this patient group can have a sense of hopelessness about their condition. They described patients as being very negative in their view and not being able to see a way to move forward with living with the health condition. Therapists highlighted that this sense of hopelessness can come from the wide impact that living with a LTC can have on the patient's life including, finances, social lives and relationships.

> *'for some of the people I've worked with is just being a level of hopelessness because they've really tried over a number of years to improve the way they feel and to make life better and they just keep being thrown obstacles, in terms of maybe they're health, maybe their finances linked with their health, their relationships linked with their health'*
>
> *Cognitive Behavioural Therapist*

Interestingly, the 2 Psychological Therapists who were trained in delivering Interpersonal Therapy (IPT) reported positive experiences of providing IPT to this patient group. They discussed how patients often respond well to this work in regard to 'adjusting to their illness'. With IAPT being very CBT driven it's important to consider other evidence based treatments that are recommended for these patients.

> *'So I think role transition in IPT that component so acknowledging the changes in their identity in having an LTC I think that's a really important component that in my experience, people have said I've been really helpful*
>
> *Psychological Therapist*

Where a patient is in terms of the acceptance of their condition and how far they are in a process of ‘transition’ appear to be important components in terms of how hopeless a patient may present in treatment. This could have knock on effects on how a patient engages in a treatment plan. With IAPT using a stepped care approach these important factors of a patients presentation should be considered when making treatment pathway decisions, as well as the appropriateness of a ‘short-term’ treatment with an IAPT service. Although CBT is still very much the preferred mode of therapy within IAPT other options such as IPT may warrant further exploration and consideration for these patients. Furthermore, with the impact of living with an LTC having such an impact on all areas of a person’s life from social to financial difficulties, it is also important to consider that more ‘rounded’ sense of care for these patients. Therefore, ensuring that they have other basic support structures in place for example, the appropriate financial support.

Treatment burden

Therapists discussed the impact of these patients experiencing a lot of input from medical professionals. The impact of treatment burden was discussed on how patients perceive healthcare services. Furthermore, there were views on how much patients prioritise attending appointments for their mental health over attending appointment for their physical health.

Therapists recognised the higher amount of healthcare appointments these patients may need to attend. They discussed how the priority tends to go onto the physical healthcare appointments rather than mental health appointments. This also links with previous discussions on how patients' view their mental health as part of their physical health. If a patient is struggling to see this connection and is focused on a medical explanation then are they more likely to prioritise their physical health appointments.

> *'that particular client group will often have quite a lot of medical appointments which they need to attend as well which could clash with what we're doing and I mean they may miss some of our appointments or have to cancel things'*
>
> *Psychological Wellbeing Practitioner*

Patients' previous experiences of other healthcare professionals was a topic that was often raised by therapists. Therapists felt that these patients often had negative experiences. This was due to services being under resourced or patients not feeling they were being believed in their symptoms, as well as having to go through multiple tests and investigations. This was especially related to those patients who come under the umbrella term of medically unexplained symptoms.

> *‘I think one of the other challenges is sometimes patients can come to us and actually be quite tired at the health care system. You know if people have had long term physical health conditions for a number of years, they are likely to have had a lot of you know appointments of different people and different services over the years and that can be quite tiring, particularly having to self-advocate for your own care, and so sometimes I think that can have a knock on effect on how kind of the service is viewed’*
>
> *Psychological Wellbeing Practitioner*

The sheer volume of appointments and contact that patients have with healthcare professionals was also acknowledged, with perhaps patients being tired of this. With all this input practitioners also discussed how patients can be confused by who they are when they ring for appointments. Again, this leads back to collaboration with other healthcare professionals and the role of integration. If there were more cohesive care pathways and joint up working then perhaps patients would not be so confused around the role of the professionals involved in their care.

> *‘I often find that sometimes help a patient will have so many health care professionals working with them that they sometimes confuse me for someone else. And that's happened quite a few times, so I'm usually kind of still mindful to introduce myself and just make sure they know who I am and that they remember kind of, you know which professional I am because I've had sessions before where a patient is kind of thought that I've been someone from the ME service for a session, and that’s been a bit tricky’*
>
> *Psychological wellbeing Practitioner*

It’s also important to recognise the role the COVID-19 pandemic has had in perhaps exacerbating the negative view of healthcare professionals, with cancelled appointments and longer waiting lists. This may be worsening the experience and views of patients. There is also the reality that patients are going to have in terms of impacts on their physical healthcare appointments now due to the backlog created by the pandemic. Therefore, therapists are likely be seeing more of this and are going to have to manage this with patients in treatment.

> *‘I treated someone recently who wasn't able to see his specialist for a year you know whereas normally they would be meeting every other month because of COVID so they came in quite frustrated about that so I think you already you know and they do see you know which we are as part of the NHS so I think you already battling with some maybe existing perceptions of and it you know the NHS being stretched and not having enough resources’*
>
> *Psychological wellbeing Practitioner*

When assessing the appropriateness of psychological therapy for these patients it appears important to consider the treatment burden for patients. If they are in a stage of having lots of appointments, are they in the best place to take on more. Furthermore, with lots of involvement from different healthcare professionals’ patients may get confused about who is supporting them with what. This also indicates a lack of joint up working between professionals.

The Therapist:

The theme of the therapist focuses on the aspects of the therapists themselves that can impact on their own experience of working with these patients. Within this theme 3 subthemes were discussed. Therapists often described a sense of taking on too much responsibility. This was discussed in terms of how much they should know about the physical health conditions that the patients are experiencing. Therapists also discussed the preconceptions around working with these patients, with the vast majority highlighting some sort of concern about how to support these patients. Furthermore, an interesting subtheme emerged around therapists' personal experience of living with their own long term condition and the impact that this may have on delivering treatment to patients who are also experiencing a health condition.

Taking more responsibility

Some therapists felt that they needed to know more about the patient's LTC to feel more prepared and support the patient. Those who felt they didn't know enough recognised the impact that this may have on their confidence to treat these patients. By doing their own research on certain conditions this made them feel more competent to support the patients.

> *'I've done some research myself like I've bought books and things on certain conditions that I haven't felt very confident about and done the research and the reading myself to try and gain that confidence, so that kind of helps me feel little bit more competent in certain areas'.*
>
> *Psychological Therapist*

Other therapists appeared to have thought this themselves at one point but had moved away from this idea. They had accepted that they couldn’t know about every physical health condition. They also acknowledged that they were there to support the patient with the emotional aspect of this, not the condition itself which an important distinction to make. Although the LTC and the mental health difficulties will be closely linked some therapists appear to get ‘caught up’ in the LTC itself. This appears to cause some difficulties in the confidence of the therapist in supporting the patients. However, those who report being more confident discuss focusing on the role they have been trained to do in supporting the patient’s psychological wellbeing.

> *‘I don't know enough’ you know ‘I must know about all the conditions’, and actually you know you can't know about all of the conditions because there are so many … but you're treating that person for how it's impacting their emotional well-being, so you're just doing the job that you been trained to do’.*
>
> *Psychological Wellbeing Practitioner*

Therapists felt that it was important to be open with the patient that they are not the expert in their condition. Therapists stated it was important to get this information from the patient and explain the boundaries of their role as a therapist. When therapists acknowledged the patient’s expertise and what their role was, this appeared to take that pressure off of them.

> *‘kind of realizing you don't need to be the expert in every condition you know you can do your best and try and find out a bit more about it, but it's much more important to find out the patients experience of that condition which is actually going to be different for everyone, so that's an approach that I've been trying to take, which is sort of lessened the pressure a little bit’*
>
> *Psychological Wellbeing Practitioner*

It was not just researching a specific condition but also feeling like they needed to prepare more for the treatment sessions. Some therapists described needing more time to prepare beforehand. Interesting, this came from PWP’s rather than CBT therapists. This may well indicate less confidence in PWP’s own abilities to manage more complex situations when the arise. Also, there may be less confidence in being able to say to a patient that they don’t know about a certain area or a certain question.

> *‘kind of prepare myself each session so if I had been told what to do with my supervisor or through clinical skills kind of like do mini script for myself you know what I need to say how I need to get it across so it's just more time off my day having to make sure I am prepared for it and I do know exactly what to say and obviously if the patient has questions I need to be able to know how to answer it so it might take me some time research literature online so it's just making sure that I have prepared fully for each session’*
>
> *Psychological Wellbeing Practitioner*

This highlights the importance of collaboration with the patient. The therapist is not there to be the expert on patients’ conditions. The focus should be on empowering patients in their treatment plan, with this being a collaborative process between the therapist and patient. The above quotes highlight how therapists may feel the pressure to know everything about a condition but is this necessary to build a therapeutic alliance and be able to support the patient. Due to the impact that therapists can have on patient outcomes it is important for therapists to be clear on their role and how much responsibility they need to take on in treatment.

Working with preconceptions

Many therapists recognised negative preconceptions around working with these patients. These preconceptions were often around feeling like working with these patients is going to be difficult, more complex and with more to ‘unpick’ within the treatment. With these preconceptions therapists realised how these impact on how helpful they may think treatment is going to be, with this ultimately having a knock on effect of therapists confidence. Some therapists showed insight into recognising how this may impact on the treatment and being more mindful of this. This often came with the more experience therapists had.

> ‘*there was a quite a lot of sort of negative beliefs of you know ‘is this going to help this person,’ ‘Is this sort of worth doing’ ‘Are we going to get anywhere’ and I think when you're going into treatment already feeling like that, it's just quite a negative outcome and something that I think need to be quite mindful of’*
>
> *Psychological Wellbeing Practitioner*

These preconceptions seem to be at odds with therapists’ ability to be flexible and adaptable. Recognising the value of this with this patient group has already been highlighted. Therapists would benefit from receiving feedback about the work being done with these patients and highlighting what’s working well to try and dislodge some of these beliefs.

Feeding into the role of experience often therapists who had been working in the service longer and had worked with this client group more felt more confident. This appeared to be because they had some positive experiences to draw upon. Therefore, it appears those who are newer to their roles and newer to working specifically with these patients or have perhaps less experience in this may hold more negative preconceptions. The role of sharing experiences and learning from each other is important to draw upon here. This shows further the role of having more specialised supervision, more specific CPD and clinical skills to draw more on those positives to boost therapists' confidence.

> *'I feel a lot more confident mainly because I've seen that for the majority of people I work with CBT is either helpful or it can actually help them to reach recovery'.*
> *Cognitive Behavioural Therapist*

It should also be mentioned that many therapists highlighted that difficulties with these patients were often no different to working with patients without LTC's. Therapists acknowledged that there are always going to be patients who are a bit more complex, have more things going on, or take more time. It appeared that many therapists didn't want to appear to 'single out' patients who have LTC's. Therefore, recognising that these emotional responses can also happen with patients without these difficulties.

The mention of the Minimum Data Set (MDS) and whether patients reach recovery was also often discussed. Many therapists had views that these often didn't feel relevant for these patients. They discussed a lot of cross-over with the symptoms of their LTC and the mental health condition. Therefore, feeling like this is not a true reflection of a patient's mental health symptoms. Therapists often discussed feeling like these patients wouldn't reach 'recovery'. This was reported to be de-moralising for therapists who are supporting these patients.

> *'specifically for IAPT where we use the MDS … this particular client group will often score quite high, especially for depression but with the answers relating to their pain .. and obviously there is such cross over of symptoms with a lot of long term health conditions and with depression and anxiety …. it can be a little bit demoralising as the therapist when the scores don't necessarily change throughout treatment'*
>
> *Psychological Wellbeing Practitioner*

Interestingly, a therapist raised the issue around what recovery may mean for these patients. For these patients it may not be about getting those questionnaire scores into a below clinical threshold. Instead, this may be more about them feeling better than when they first came to the service. This raises issues around whether the MDS used within IAPT and the concept of 'recovery' is relevant and appropriate for these patients. Or is this more about therapists' experiences and preconceptions about how relevant the MDS is.

> *'and so you know the way our service works and it's all about recovery but for these patients recovery is something that's in context they're not going to recover to the point where you know they might be depression or anxiety free in the same way that they're not going to be you know umm symptom free so it's about 'am I feeling better than I was before' 'am I functioning better than I was before' not 'am I recovered per say'*
>
> *Cognitive Behavioural Therapist*

It is important for therapists to acknowledge any preconceptions that they may have about working with patients with LTC's. It was acknowledged that those preconceptions are often negative in a viewpoint of whether treatment is going to be helpful, due to the complexity these patients may present with. However, although it is likely there will be more complexity therapists have already showed how flexible and adaptable they are willing to be. Perhaps more focus should be given to more positive experiences especially the sharing of those between therapists to dislodge some of these beliefs. The role of the MDS is much debated area in terms of therapists preconceptions about its relevance. Perhaps more focus needs to be given to what recovery means for these patients rather than what recovery means 'generically' for those who do not have LTC's.

Personal Experience: of living with an LTC

Interestingly, 4 therapists drew on the role of personal experiences of living with an LTC. They discussed the impact that this can have when working with patients who also have LTC's. This is not necessarily an area that was expected to come up within the research, but with a quarter of the participants reflecting on this it was important to highlight this area. Some therapists who were also living with a long-term condition reflected on how this has helped them in working with their patients. It appeared that for some this gave them a relatable experience to draw upon and giving them more of an understanding of what the patient was experiencing.

> *'I think 'cause I've had personal experiences of long term conditions and kind of feeling restricted and limited by things, I think that's kind of giving me a better insight into why someone might feel as exhausted with it as they are, or frustrated with it. So I think I've learned not to take those traits personally, if the patient is presenting like that and in that I know it's not necessarily me that they're frustrated at, I know it's because of the wider situation. So I think in a way I haven't had that difficulty myself. It is helpful'*
>
> *Psychological Wellbeing Practitioner*

However, although this may provide some sense of being able to relate and understand a patients experience more, it is also important to hold caution as to how much a therapist relates to a patient and the impact this may have on treatment. A therapist did highlight this mentioning that it is something they needed to be aware of and the importance of using the avenues of support available to discuss those issues.

> *'I think looking at like the impact of LTC clients on me and especially 'cause I have a tendency to like over relate to patients with LTC's, usually my line management really helpful for that. Especially if I feel like you know I'm getting quite attached to a patient or I feel really feel for them and their situation'.*
>
> *Psychological Wellbeing Practitioner*

The negative impacts of personal experience of living with an LTC and working with patients with LTC's was also recognised. Therapists discussed feeling frustrated. This was in relation to the therapist experiencing a similar LTC, with the therapist perhaps managing this well and struggling to relate to the barriers and resistance a patient was putting up in treatment. This was especially felt when they were able to overcome these problems themselves. Another therapist reflected on how working with these patients could be triggering for them when they are going through similar experiences.

> *'I have heard of a situation where a member of staff had the same long term health condition as the patient that they were working with, and the patient was basically saying I can't ever live a normal life, and what you're telling me to do is not possible … then the therapist was feeling like 'well actually like I have a job and I you know do lots of different things and I have that condition' so I have therapists say that sometimes they can feel a frustration when working with patients'*
>
> *Psychological Wellbeing Practitioner*

> *'because I do find it personally challenging to work with this group patient group, and I would much prefer to work with patients who I don't find as activating for myself'*
>
> *Cognitive Behavioural Therapist*

This is a particularly interesting area for therapists to reflect on. Approximately 30% of the UK population suffering with a long-term condition (Seaton et al, 2022). Therefore, there are going to be therapists who do have long term health conditions themselves and are treating patients with long term conditions that may be the same or similar. As mentioned in the quote above therapists who perhaps manage others have recognised the importance of therapists raising these concerns in supervision and with managers. This was important to recognise in terms of the emotional impact that this is having on them and the knock-on impact this could also be having on treatment for these patients.

Discussion

This study looked at the experiences of therapists providing psychological treatment to patients with long term health conditions within an IAPT service. Participants consisted of 16 therapists, 7 Hi Intensity Cognitive Behavioural Therapists, 7 low intensity Psychological Wellbeing Practitioners and 2 Psychological Therapists. Participants took part in semi-structured interviews via Microsoft teams. Interviews lasted between 24 and 50 minutes. Interviews were then transcribed and analysed using Inductive Thematic Analysis. 4 key themes were identified: The Treatment Plan, The Service, The Patient and The Therapist. Each theme had 3 subsequent sub themes to provide further detail. The main takeaways and implications of these findings are discussed in further detail.

The Treatment Plan

The theme of the treatment plan highlighted therapists' experiences of important factors of the treatment plan itself in providing support for patients with LTC's. Three subthemes provided further detail on these factors and included being flexible and adaptable, getting patients to re-engage with activities, and having more 'tools in the toolkit'. The implications of the findings from these are discussed further below.

How flexible can you be in IAPT?

The need for flexibility and being adaptable with the treatment plan was discussed in terms of getting patients to engage in the treatment plan. Importantly, therapists showed a willingness and need to be more flexible for patients. Therapists described the 'creativity' that this takes to problem solve the barriers. Flexibility and being adaptable related to the mode of delivery in treatment. Being able to have options of face to face, telephone, online sessions and moving between these to suit the patient's needs were important. Therapists discussed providing adaptations to promote engagement. For example, recording sessions to aid memory problems, so patients can listen back on sessions when needed. The topic of the number of sessions provided and the cancellation policies were also discussed. Therapists had varying experiences on how flexible they have been able to be around this.

Flexibility and being adaptable are important aspects of treatment to consider when providing treatment for patients with LTC's due to the varying needs of the patients. NICE guidelines for treating multimorbidity (NICE, 2017) suggest that these patients require a personalised assessment and the development of an individualised management plan. Furthermore, these individualised management plans must take into account a person's individual needs and preferences for treatment. Individualised care is also raised by Muth (2014) who cited the Ariadne principles. These are guiding principles to support decision making in primary care consultations. Within these are the sharing of realistic treatment goals and an individualised management plan. Therefore, therapists appear to have these guiding principles in mind and try to work collaboratively and use a person-centred approach with these patients.

Although the importance of this was highlighted there were varying experiences on how much policies and procedures could be flexible within the IAPT framework. Furthermore, therapists highlighted internal differences depending on their supervisor. Some therapists reported that their supervisors were open to flexibility in the treatment plan, whereas others reported that this was more difficult and a clear rationale was needed to get this flexibility. This is important in terms of thinking about the structure and guidelines for interventions recommended when working with this patient group. IAPT is known for its structure and rigidity but what therapists are saying here is that this is not always possible.

Furthermore, there appears to be a need for more consistency internally to what therapists are being advised from their supervisors. The need to ‘justify’ themselves and battle with the IAPT policies and procedures could also be having an effect on therapists’ confidence. This can then have effect the treatment that they are providing. If a therapist is consistently being met with barriers to providing the most appropriate treatment for their patients this is bound to feel quite de-moralising.

The role of illness beliefs

The role of illness beliefs appeared to be very relevant when looking at getting patients to re-engage with activities. Therapists identified that behavioural interventions could help in addressing these. This is through patients recognising that they can still in engage in certain activities when they thought they wouldn't be able to. This highlights the value of Leventhal et al (1984, as cited in Ainsham, 2016) common sense model of illness, with patients forming their own representation of what they can and cannot do based on the emotional and cognitive response to their illness. With illness beliefs being such a strong area that was discussed it would be beneficial for therapists to have more support and guidance on this specific area.

Many therapists found the idea of trying to challenge negative thoughts difficult. This was due to some of the thoughts being true. Therefore, therapists were seeking alternative and more appropriate ways to address this such as through the use of certain ACT principles. However, it should also be noted that perhaps with a lack of confidence in working with these patients' cognitions there could be a tendency for therapists to lean more of behavioural approaches to treatment. This should be explored when there is potentially more therapists could be directly supporting the patient with in treatment.

Research has highlighted the important role illness beliefs have in terms of patient wellbeing. Hampson et al (2000) state that Illness beliefs are more consistent and a stronger determinant of quality of life and self-management of the long-term health condition than depression. This also links in with the previous research discussed by Dempster, Howell & McCory's (2015) who's systematic review found that perceptions of the consequences of the individuals physical health conditions and their emotional representations had the strongest relationship with distress outcomes.

However, the role of Health Psychology within IAPT is still minimal. It's clear here that therapists are identifying illness beliefs and stating that these are important to work with for these patients. Having more guidance from a Health Psychology perspective would be extremely helpful here. This would likely increase therapists' confidence supporting these patients and could be incorporated more into the avenues of training, CPD and supervision.

Being able to use ‘more tools’ within IAPT

Therapists discussed a need for more ‘tools’ to be able to support these patients with the use of ACT and values-based work discussed. Therapists felt that this gave them something ‘extra’ that they could provide and felt particularly relevant for these patients. Although therapists are highlighting how these different approaches can be helpful, this is not reflected in the feedback around the training given which is mentioned later. Therapists often felt that techniques like ACT were only lightly touched on, with some therapists going on to do find further training themselves around this. Research by Dennison, Moss-Morris & Chalder (2009) also highlight the role of third wave CBT approaches in those with chronic illness. They suggest that ACT can be more helpful in terms of accepting thoughts that are indeed true and therefore not appropriate to challenge using traditional CBT approaches. Furthermore, Gloster et al (2020) found that across 20 meta-analyses, 133 studies and 12,477 participants that ACT was effective and showed positive outcomes across a broad range of target conditions including both mental and physical health conditions.

It is important to acknowledge the NICE recommended evidence-based treatment for patients with depression and co-morbid physical health conditions is CBT based treatment (NICE, 2009). Carrol et al (2022) put forward the use of a Transdiagnostic model of adjustment to long term health conditions to guide clinical practice. Carroll et al (2022) highlight that following a CBT protocol for treating depression as the primary problem does not apply well with those with LTC's. Carroll et al (2022) suggest that this fails to address the context and challenges associated with living with an LTC. Carroll et al (2022) set out a transdiagnostic model to adjustment which can support therapists to tailor treatment. Examples of how to tailor CBT treatment where: identifying that concerns about health are likely to be real concerns so challenging these is likely not helpful. Instead, they propose to explore the helplessness of these thoughts in the context of the patient's life now. Furthermore, Carrol et al (2022) highlight how it is important to challenging unhelpful illness representations as well as identify areas the patient has control over and validating accurate beliefs. This research is important as it highlights how CBT can be tailored and the importance of exploring the context of a patients LTC to help guide this. Therefore, it appears that therapists need more guidance and belief in these techniques and better understanding of how to tailor these.

However, NICE guidance for the treatment of depression (2022) also recommends Interpersonal therapy (IPT). This guidance highlights how this form of therapy may be helpful for people with associated interpersonal difficulties related to adjusting to transitions in relationships, loss, or changing interpersonal roles (NICE, 2022). Poleshuck et al (2010) highlight that IPT requires minimal adaptation to support different patient populations, including those with chronic illness. Poleshuck et al (2010) suggest that with chronic pain the focal areas of transition and role disputes can be clearly identified in these patients due to the impact that living with chronic pain can have e.g., job loss and changes in relationships. Positive outcomes have also been noted in patients with Coronary Heart Disease (Koszycki et al, 2004), Medically Unexplained Symptoms (Sattel et al, 2012), IBS (Hyphantis, 2009) and patients with Cancer (Blanco et al, 2019, Badger et al, 2004

Therapists that delivered IPT based treatment also gave more positive feedback about how this tended to fit well with these patients. This was due to the focus on transitions and adjustment that this type of treatment allows for. Therefore, further exploration could be warranted to explore the role other forms of psychotherapy such as IPT can play for this patient group. The need for IAPT to evolve with the research has also been discussed by Martin et al (2022) who suggest that the selected evidence-based treatments favoured by IAPT do not necessarily meet the complex needs of those patients coming through the service.

We know there is a large evidence base using CBT interventions with patients with LTC’s. It’s worth considering whether therapists perspectives on working with these patients could be being impacted by their lack of confidence and knowledge in this area. This research suggests that there are still a lot of preconceptions about working with this patient group. These included patients being more complex, sessions will be more difficult and questioning whether treatment will help. These clearly still need to be addressed.

There have been success stories in terms of patients going through the IAPT services with these difficulties (Pancel et al, 2020, Clarke et al, 2018). Perhaps more weight on the positive work therapists are doing with these patients and more robust training, supervision and CPD would enhance confidence and dislodge/change these beliefs. Not all patients coming through the service will reach recovery or benefit from treatment. However, that can be said about patients without LTC's remembering that the recovery target for IAPT is 50%. For those who do not benefit emphasis should be given on why this is. Issues that were raised in this research highlighted areas of importance such as have the patients accepted their LTC and whether patients are going to be able to commit to treatment if they are in a stage of having a lot of input from other professionals.

With the complexity and suggestion for differing approaches discussed the role of low intensity CBT treatment provided by PWP's could be questioned here. It appears that these patients often present with co-morbid symptoms of depression and anxiety. Some PWP's reported that trying to only focus on one area doesn't always feel appropriate. With patients possibly benefitting from multiple interventions and techniques. This goes against the training of PWP's to provide 'single strand' treatments. This does also raise the question of if these patients may need a multi-strand approach to treatment should they be considered more for higher intensity step 3 work rather than being offered low intensity treatment.

Again, linking in with the NICE multimorbidity (2017) guidelines treatment should be offered on an individualised approach. Therefore, for some patients' low intensity work may appear more appropriate for them. However, Farrand and Woodford (2015) conclude in their systematic review a small effect size and limited evidence supporting the use of CBT self-help for these patients therefore, questioning the effectiveness of using this treatment approach for this patient group. Should the role of low intensity work be expanded to include these different tools? Research by Dochat (2021) found evidence for the use of single session ACT interventions. However, Dochat (2021) does highlight the need for further research into the role of this within a 'stepped care' model of treatment.

The Service

The theme of the service encompassed therapists' experiences of working with patients with LTC's that were impacted by service factors. The role of training was heavily discussed with varying opinions of the usefulness of this. There was a consensus on the need for more CPD in this area. It appeared that more specialised supervision from 'experts' in this field would be helpful. Therapists discussed the important role of linking with other healthcare professionals who are involved in the patients care to provide the more 'integrated' care. However, barriers were discussed in terms of having the time to do this, the lack of effective communication and understanding of the role of differing healthcare professionals.

Supervision/CPD/Training:

An area where Health Psychology could have more input was highlighted in therapists wanting ‘expert’ led supervision, more CPD and issues around the training received. Therapists, especially high intensity step 3 therapists discussed how helpful it would be having an expert (in particular a Health Psychologist) providing supervision around working with these patients. Although IAPT does have clear guidance on supervision that should be received within the service, therapists felt that supervision from an expert such as a Health Psychologist adds another valued perspective. Health Psychologists would offer particular knowledge on areas such as illness beliefs, adapting to chronic illness, the role of lifestyle, and impact on self-management of physical health conditions, along with the evidence base around these areas.

However, I must acknowledge the bias of my viewpoint here. I am looking at this from the role a Health Psychologist could provide. This could indeed also be supported through other Psychologists with insight into these areas. However, it is clear that a multidisciplinary and integrated approach of care for these patients is of more benefit. Therefore, Health Psychology could well add another layer and perspective fir the patients care, on top of the other psychological disciplines already involved.

In terms of specific training for CBT practitioners the research indicated that perhaps the training needs to be addressed, especially looking into what therapists feel it would be helpful to learn more about. It comes across that this is a specialist area, more complex and in need of more support. These therapists reported that they were told that they already have the skill set to work with these patients. However, it appears these therapists felt that they should be doing something more or something different. It's also worth considering if therapists are getting too involved in the detail of a patient's long term conditions, feeling like they need to know every detail about a condition. It may be that they are getting lost in what they are there to support the patient with, which is supporting them in managing their mental health in the context of living with this condition.

The difference of opinion in training was also highlighted by Clarke et al (2018). However, the same pattern in terms of step 2 low intensity and step 3 high intensity training was not necessarily noted. It is important to acknowledge here that only 3 of the 8 step 3 therapists and 3 of the low intensity therapists had received the specific 'top up' training recommended for working with these patients. This may not give a clear representation of the value of the training. However, it does appear that the training provided in this area needs to be reviewed as to whether this is indeed fit for purpose.

CPD was also highlighted as lacking in this area. CPD is of equal importance as specific training to ensure ongoing development of skills. Perhaps more emphasis should be placed on the therapists ongoing CPD in this area and having adequate supervision. Pancel et al (2020) noted that ongoing CPD and supervision were important on top of the training provided to provide an effective service in this area. However, it was also recognised that some therapists appeared more proactive in going on to find their own CPD rather than relying on the service to offer this. The responsibility of therapists engaging in their own CPD is equally as important and should be encouraged within the service for therapists to continue to build on knowledge and develop skills. This also comes back to the structure of IAPT and how much time they dedicate to CPD for therapists within the service. It would be of benefit to improving therapists' confidence, knowledge and skills set if there was a clear focus on CPD in this area.

What about Integration?

There is a heavy focus on integration between physical and mental health services (IAPT-LTC full implementation guidance, 2018). Although it was highlighted that this would be beneficial for patients lots of practical considerations were discussed. The key considerations were being able to find a room to be co-located and having the time for collaborative working. Clearly these basic requirements still need to be addressed as they have been raised previously (Carroll et al, 2020 and Clarke et al, 2018). Having the time for collaborative working can have such an impact on the patients care with these positive impacts have been noted by Clarke et al (2018) and Carroll et al (2020).

It appears here that IAPT seems ‘outside’ of the more standard care for patients with LTC’s. Therefore, more work needs to be done to ensure that this is seen as part of the patients NHS care. This also links in with the stigma that we still face around mental health. By physical health care professionals having more awareness, training and joint up working with mental health professionals, the more cohesive care patients will receive.

Other healthcare professionals and NHS departments having a clear understanding of how IAPT can support these patients and the treatment provided is an important area for improvement. Carroll et al (2020) highlighted the role that these professionals can play in these patients engaging in treatment. If the services are not clear on what they are recommending for patients then patients are going to be more sceptical of services. The impact of the COVID-19 pandemic was also heavily acknowledged here. Links that were built with other healthcare services were stopped during the pandemic and are only starting to be re-established again.

However, the way in which services work has changed because of this with an emphasis still on remote appointments for patients where possible. This needs to be considered moving forward with integration. A heavy focus on communication between healthcare professionals is needed if being physically co-located is not always possible. Communication is a key element highlighted in this research that is difficult to achieve and maintain and further consideration needs to be given to this.

It’s important to highlight that IAPT services do operate differently across the country. Some services have a specific LTC service that is set up to only see these patients. While other services do not separate out these services, with therapists seeing a mix of patients with and without LTC’s. With some IAPT services offering LTC specific services there must be some consideration here as to what is more beneficial for the patients going through these different pathways. It’s important to ensure that there isn’t a ‘postcode lottery’ depending on where you live to have access to these services. Therefore, more research should be considered into the most appropriate way for IAPT services to be set up to see these patients.

The Patient

The theme of the patient looked at therapists’ experiences of aspects around the patient that can impact on treatment. There were many discussions around whether a patient has accepted their LTC. With the impact of this in terms of adjustments they need to make to their lives. Furthermore, patients needed to acknowledge and accept the mental health aspect to their condition to commit to engaging in treatment. The role of treatment burden was also discussed and the impact this can have on patients and their ability to engage.

The role of acceptance work:

There were some very interesting and key findings from discussions around how these patients may present within treatment. The subthemes around acceptance of having a mental health condition and acceptance of the LTC itself provided important information that needs to be considered when patients are being put forward for treatment within an IAPT service. Previous research has discussed how treatment in IAPT can benefit patients (Clarke et al 2018, Pancel et al, 2020) and there have been discussions around flexibility and adaptations (Carrol et, 2020, Hassan et al, 2018). This area however brings some new light on other factors that should be being considered when thinking about offering treatment within a very ridged service such as IAPT.

Therapists discussed how the role of acceptance and adjustment to living with a LTC is an important part of a patient engaging in treatment. There are key links here with illness beliefs as discussed above. Patients with LTC's experience difficulties accepting their diagnosis and symptoms especially when this conflicts with their need to have independence and control over their lives (Budge et al, 2021). This also ties in with Carrol et al's (2022) proposed transdiagnostic model of adjustment to LTC's as discussed above. Carrol et al suggest that the experiences around ongoing illness stressors, symptom management and threat to mortality disrupt the persons state of equilibrium. Carrol et al (2022) suggest that the process of adjustment involves the person regaining this state of equilibrium.

Furthermore, the role of acceptance work has gained a lot of recent attention. With positive outcomes for a variety of LTC's such as pain (Craner et al, 2017, Hughes et al, 2017), chronic fatigue syndrome (Jonsjo et al, 2019, Roche et al, 2017), and neurological disorders (Robinson, Russell & Dysch, 2019). Therefore, where a patient is on their journey of acceptance is an important factor to consider when looking at appropriate treatment options.

Psychological flexibility has been described as being able to accept both unwanted and wanted experiences, using this to choose whether to persist in certain behaviours or change behaviours depending on whether they are in line with living a meaningful life (Densham et al, 2016). The importance of the process of psychological flexibility has been noted in LTC research such as in pain research (McCracken and Morley, 2014) and Chronic Fatigue Syndrome (Densham et al, 2016). Psychological flexibility is a key process within ACT principles in terms of focusing on acceptance and values (McCracken and Morley, 2014), again supporting the use of these techniques with this patient group. It is clear how important the ability of a patient to accept and be psychologically flexible is. This is in response to the experiences that they come across, and how their behaviour changes in response to this. More weight should be given to exploring this with patients to ensure that individualised care is provided and patients are able to engage in the treatment offered.

Importance of psychoeducation

Another heavily discussed area was whether patients were able to see the psychological link to their difficulties. The role of psychoeducation appears to be very important in terms of ensuring that patients can make these links. If they do not understand these links, then they are less likely to want to engage in a psychological treatment as they don't believe that this is a contributing factor to their physical health and vis versa.

It was recognised that treatment sessions may just be about getting a patient to a stage where they can engage in treatment. However, within a service that is limited on the number of sessions provided it could be questioned whether this is the best use of these sessions. Rather than IAPT services attempting to do this when they just don't have the capacity or perhaps the skill set, it may be that more work needs to be done in terms of getting a patient to a stage where they can engage in a service like IAPT. Where this work would sit within the patients care providers would need to be considered.

Another key point to consider here is how much patients are being told that their mental health difficulties are 'understandable'. It has previously been discussed that normalising these symptoms for patients means that further assessment and treatment for mental health difficulties is not sought (Coventry et al, 2011, Carrol et al, 2020). Therapists identified that this is reinforced by other healthcare professionals but also by themselves. This highlights the importance of educating other healthcare professionals of what may be a 'normal' reaction to living with an LTC, versus presentations that would require further psychological support.

Medically Unexplained Symptoms:

Therapists tended to use examples of patient's with LTC's consistent with MUS presentations such as Chronic Fatigue Syndrome/ME and Fibromyalgia. This was rather than the more 'standard' LTC's such as Diabetes and COPD. This may highlight an important consideration in terms of the actual presentations of patients that are coming through IAPT. The IAPT positive practice guide for MUS (2014) states that patients often do not perceive symptoms to be related to psychological factors, which again was recognised in this research as a barrier to engaging in treatment. The Talking Therapies: A four-year action plan (2011) also state that MUS symptoms are complex and need careful consideration. However, they acknowledge the role that Talking Therapies can have on improving outcomes for these patients.

The IAPT positive practice guide (2014) states that the most effective treatment approaches for people with MUS are especially formulated for these conditions thus, highlighting the importance of incorporating the conditions into the psychological formulation. Therefore, not trying to treat anxiety/depression symptoms separately. It should be recognised here how unrealistic this is. As it has been discussed, IAPT works within strict protocols in terms of the number of sessions and treatment options available. It has been presented here that more flexibility is needed around these patients and more time may be needed to gain that psychoeducation around links between their mental and physical health. Furthermore, therapists need to feel skilled up and confident in working with these patients through receiving appropriate training and support.

Therapists highlighted the role of other services such as CFS services and pain services. It was acknowledged that patients may well have been taught some similar techniques such as pacing. Patients' previous experiences of this can impact on their willingness to engage in the treatment. This can cause confusion and frustration for patients. This also highlights a potential overlap of treatment for these patients. Consideration should be given to who is best placed to support them. Is this appropriate for an IAPT service or should there be more focus on psychological treatment within these specific services. However, again services may differ in what is offered depending on location. Therefore, this may be more of an issue for the region in this research and would need to be looked into across other regions.

The Therapist

The theme of the therapist looked at aspects of the therapists themselves that impact on working with patients with LTC's. It was noted that therapists tended to take on a lot of responsibility in terms of understanding the patients LTC. With some doing extra research and feeling 'under prepared' if they didn't know about a patient's condition. However, others felt that it was more important to use the patient's own experience and work more in collaboration, being open and honest with the patient that they may not know everything about their condition. Instead, focusing on working together and how best to move forward with treatment.

Therapists highlighted the role of preconceptions about working with these patients and the importance of being self-aware of these. Preconceptions appeared to be centred around whether they felt treatment was going to be helpful due to patients being more complex and need more ‘unpicking’. 4 therapists also described personal experiences of living with an LTC themselves and discussed the positive and negative impacts of this.

Addressing Misconceptions:

These patients were often thought of as being more ‘complex’ or where things needed ‘unpicking’ more. Therapists felt that this is difficult to achieve when working within the restrictions of an IAPT service. This Included certain protocols in place around the number of sessions available and content and structure of sessions. Previous research has shown that patients can benefit from treatment within an IAPT service (Clarke et al, 2018, Pancel et al, 2020), but therapists still appear to hold the assumptions that due to the rigidity of the service that this is more difficult. It appears that a lot of these presumptions still need addressing and real clarity on the role of IAPT in supporting this patient group.

Another preconception is around the use of the Minimal Data Set used within IAPT, to collect quantitative data used to measure recovery. Therapists often felt that this didn't feel relevant to these patients and had concerns about patients reaching 'recovery' on these measures. Previous research has also raised therapists concerns about the MDS (Lewis et al, Clarke et al, 2018). The topic of recovery appears to be contested with some research suggesting that there is no difference in recovery to those patients without LTC's (Clarke et al, 2018). Others suggest these patients are less likely to reach recovery (Kellet el al, 2016). Further research and data are needed in this area to provide a better understanding of recovery for these patients.

Furthermore, the idea of 'what does recovery mean' for these patients was also an important point that was highlighted. For these patients' certain symptoms are not going to reduce. Recovery could be viewed more in terms of the difference they feel to when they started treatment. Hudson and Moss-Morris (2019) highlight the lack of immediate positive reinforcement when treating illness self-management. They suggest that successful self-management may require patients to understand that this may not always lead to an immediate or observable gain in outcomes. Therefore, the use of alternative evaluation by providing more objective assessment of the illness management rather than relying on subjective and non-specific symptoms cues may need to be considered (Hudson and Moss-Morris, 2019).

Furthermore, Gerskowitch et al (2015) found that although patients with medically unexplained symptoms report improvements in being able to cope with symptoms, this did not necessarily result in change on the Routine Outcome Measures (PHQ9, GAD7 and WASAS). This highlights that further considerations need to be given to qualitative feedback into treatments for this patient group. As well as therapists' experiences of working within the framework of needing to collect these measures for all patients they work with and how this may differ to those with LTC's.

The impact of COVID

With the impact that the COVID-19 pandemic has had in the past couple of years it is equally important to acknowledge this here, especially due to the prevalence of those experiencing mental health conditions likely to increase. With the impact on wait times for physical health appointments having been well documented it's reasonable to suggest that this is going to have an impact on these patients' mental health. This is going to be important for mental health services to consider in terms of how patients perceive the NHS and their experience. This research has highlighted how patients previous experience can impact on their willingness to engage in treatment and therefore this may need further consideration on how to manage this.

Although the negative impact of the COVID-19 pandemic is well documented, it is also important to highlight the positives that perhaps have come out of this. Therapists highlighted the increase in flexibility for patients due to the pandemic. This was evident in more delivery methods in treatment such as, face to face, online, video and telephone appointments, with patients being able to switch between these. Therefore, services having to adapt to home working and a reduction in face-to-face contact appears to have meant that more thought and consideration has gone into ensuring treatment can be accessed via different methods. This also shows a move away from the conventional face to face therapy. This is particularly relevant as it appears there is a move to looking into the role online treatment may play in supporting these patients (Carrol et al, 2020, Van Beurgen et al, 2014, Burnham et al, 2015).

Furthermore, therapists discussed working with patients with long COVID. It was widely acknowledged that there is still very little known about the condition. This naturally can cause some anxiety around the right support for these patients. However, even in the short space of time that these patients have started to come through the service therapists were recognising the need to treat this like any other LTC. This was in terms of what adaptations and consideration for treatment would be needed. Therapists showed flexibility and willingness to work with these patients. This is particularly important considering the increasing numbers of those suffering with long COVID and the likelihood of these patients coming through mental health services (NHS England and NHS Improvement, 2021).

Strengths & Limitations:

This research was conducted within a specific IAPT service. It has already been discussed that IAPT services can operate very differently across the country. Therefore, some of the findings from this research may not be generalisable across the whole of the IAPT services. However, previous research (Carroll et al, 2020) have also highlighted this issue and emphasised the importance of ensuring that research is conducted across different services. Interestingly, similar themes were highlighted, which have been recognised in research conducted across different services. But more research needs to be conducted across different services to draw on the similarities and differences in findings to access the wider change needed within IAPT, rather than just in specific localities.

It is important to acknowledge that as the researcher I work within the service. Therefore, the therapists being interviewed were colleagues. Some therapists may not have wanted to discuss certain topics fully, particularly around service level issues, or may have answered in a way that they thought I would want to hear. Furthermore, as much as I attempted to keep an objective viewpoint when analysing and interpreting data, having worked in this field I acknowledge that I am going to be interpreting the data with my viewpoints.

A reflexive journal was kept throughout the research process to check on where any of these biases may have been evident (Appendix F). It should be recognised that my own subjectivity also adds value to the research. As discussed by Braun & Clarke (2022) the researcher’s subjectivity is a resource for analysis on qualitative data. By working within the service, I have a deeper understanding on the difficulties around working with these patients. This could offer deeper and more meaningful interpretation of the data as well as the practical applications that this research has.

This research was also conducted across the different modalities of treatments within the service (PWP’s, CBT therapists and PT therapists). It could be argued here that perspectives will be different depending on the treatment that the therapists are offering, and the level of intensity that they are working at. It has been identified where these differences have been highlighted. But it may also be worth considering further research focusing on each specific treatment pathway to understand in more depth the experiences of what works well in each treatment modality offered.

Furthermore, although there was an even spread of PWPs and CBT therapists interviewed only 2 PT therapists were interviewed. Given the feedback highlighted from these therapists around the role of IPT in particular it would appear helpful for further research to look at experiences from this particular modality in more detail.

Future Research

As discussed, the role of the MDS to provide a way to measure recovery for these patients appears to be hotly debated. More data is needed identify the recovery rates for these patients. It would also be useful to get more detail on specific conditions and recovery rates such as, the recovery rates of those with MUS presentations vs. those with more standard LTC's such as diabetes. This will help give a better picture to presentations that may seem to benefit more from IAPT treatment and those who may not. It would also be helpful to get more qualitative feedback from therapists and patients on their view on the MDS to gain more contextual detail.

Health psychologists are already starting to play a role in IAPT services and are a recommended part of the workforce within IAPT-LTC pathways (NCCMH, 2018). With the continuing commissioning and development of IAPT-LTC services it would be helpful to review the role of these Health Psychologists with the services. This would help understand more what their role has been and how this is received within services. Furthermore, the current research highlights therapists' views of needing more tools and using different therapy approaches for these patients. More research should be conducted into the application of ACT techniques for these patients, as well as the use of different treatments such as IPT.

The role of low intensity step 2 work for these patients could also be explored further. More research is needed into the effectiveness of guided self-help interventions for these patients due to lacking empirical research in this area. Furthermore, it could also be helpful to look at how PWPs could be taught different self-help techniques to bolster their offering to patients, but still working within the parameters that they are trained for.

The IAPT-LTC pathways are still being commissioned and developing nationally across England. More research needs to be conducted across these services. The more research that is conducted into the implementation and running of these services the more this helps to look at common themes across services and potential developments that could be made to improve patient care.

Implications for Clinical Practice

The research highlights that clearly more needs to be done in terms of achieving the integration of physical and mental health services. Collaborative care and joint up working between healthcare professionals is of clear value to patients’ health and well-being. However, the practical considerations around this cannot be ignored. With a national health system that is under-resourced, overstretched and still dealing with the ramifications from the COVID-19 pandemic how feasible is it going to be to achieve this. There clearly needs to be some fundamental changes in how healthcare professionals work to have the space, time and motivation themselves to achieve this.

The role of appropriate supervision, training and CPD also needs reviewing. This research as well as others stated previously (Pancel et al, 2020, Clarke et al, 2018) recognises the importance of effective training for therapists. With such mixed opinions and feedback on the training provided to IAPT therapists, this clearly should be reviewed to assess if this is indeed fit for purpose. Supervision is a key part of effective IAPT provision. However, it appears that therapists are calling out for more specialist supervision and CPD in this area. It is important that therapists get the access to specialist supervision to ensure they are adapting and meeting the needs of this more complex patient group. Furthermore, services should be providing, if not opportunities for CPD, then the time for therapists to be able to find and engage in CPD that they have found themselves.

Therapists appear open and willing to adapt their practice and support patients with co-morbid mental and physical health conditions. However, even with the willingness to do this it appears that more considering needs to be given to the complexity of the patients coming through the service. Therapists highlight how they feel they need more tools to be able to support these patients. It appears that either this needs to be given some further consideration and more training and skill development provided to help meet these needs. Or there needs to be clear direction and parameters in place for therapists understanding of what they should be doing within in treatment for these patients and what are the expectations.

More consideration needs to be given to patients' presentation when they come into services. Therapists need to consider where patients are in terms of their acceptance of the LTC and the mental health component to this. COM-B (Michie, 2011) could have relevance here. This could certainly be explored more when considering whether patients are going to be able to engage and benefit from treatment within an IAPT service. More consideration needs to be given to the following: patients physical capacity and whether this can be managed in the rigid framework of IAPT, whether patients have the psychological understanding of the interaction between their mental and physical health conditions, whether these patients have the opportunity to engage. For example, considering their wider social circumstances: support networks, living situation, and financial situation, all that could be impacted by living with an LTC.

Conclusions

This research highlights the role that IAPT can play in supporting patients with LTC's. Considering what therapists find to be most beneficial to patients as well as what helps with their own confidence to support these patients. The research also highlights important factors to consider when looking at appropriate support for patients. With not only factors around the IAPT framework itself but how patients may present in treatment impacting on their ability to engage.

It appeared that therapists perceived they need something ‘extra’ in terms of therapeutic skills to use with these patients such as the use of ACT and IPT. New research is constantly developing in this area and IAPT needs to consider the diversity in the treatment offered for these patients. This may help therapists feel more equipped in providing treatment for these patients as well as ultimately meeting the needs of a patient group.

Addressing the misconceptions of how therapists can support these patients is also a takeaway message from this research. Therapists can have an impact on patient outcomes. More work needs to be done to ensure that therapists believe they can help and know the benefits of the support they are able to give patients. Therapists also need to be clear on the role that they have. This being in terms of the consideration they need to give to a patient’s physical health condition within treatment and the importance incorporating this into treatment.

The progress of integration also needs to be considered. Again, there are basic requirements such as space and time that need to be considered. But it’s also important to highlight the role of the physical healthcare services in achieving integration as equal with mental health services. Responsibility is also on the physical healthcare professionals to be aware of mental health difficulties and be educated in what support is available for their patients. More consideration should be given to where a person is at with their illness and are they ready for change. Furthermore, how may they be supported with this before entering treatment to ensure they get the most out of this. Therefore, a lot more work needs to be done in terms of this collaborative care, communication between healthcare professionals and joint up working to ensure the most effective support for patients.

This research highlights how Health Psychology can offer an important role within IAPT services. This has been evident across training needs, CPD, and clinical supervision as well as the role of Health Psychology in the treatment itself, such as the important role of illness beliefs when working with these patients. Further consideration should be given to the knowledge, support and skill set that Health Psychology can bring to this area of clinical work.

References:

Adult Improving Access to Psychological Therapies programme. (2021). NHS England. Retrieved from: https://www.england.nhs.uk/mental-health/adults/iapt/.

Anisman, H. (2016). Health Psychology. Sage: London.

Badger, T., Segrin, C., Meek, P., Lopez, A.M., Bonham, E. & Sieger, A. (2005). Telephone Interpersonal Counseling with women with breast cancer: symptom management and quality of life. *Oncology Nursing Forum,* 32(2): 273-279.

Baldwin, S.A., Wampold, B.E., & Imel, Z.E. (2007). Untangling the Alliance-Outcome Correlation: Exploring the relative importance of therapist and patient variability in the alliance. *Journal of Consulting and Clinical Psychology*, 75(6), 842-852.

Baumeister, D., Akhtar, S., Ciufolini, S., Pariante, C.M. & Mondelli, V. (2016). Childhood trauma and adulthood inflammation: a meta-analysis of peripheral C-reactive protein, interleukin-6 and tumour necrosis. *Molecular Psychiatry*, 21(5). 642-649.

Bechtold Kortte, K. & Wegener, S.T. (2003). Anosognosia and Denial: Their relationship to coping and depression in acquired brain injury. *Rehabilitation Psychology*, 48 (3), 131-136.

Beck, J.S. (2020) Cognitive Behaviour Therapy: basics and beyond. 3rd ed. The Guilford Press: London.

Binnie , J. (2015). Do you want therapy with that? A critical account of working within IAPT. *Mental Health Review Journal*, 20 (2), 79-83.

Blanco, C., Markowitz, J.C., Hellerstein, D.J., Nezu, A.M., Wall, M., Olfson, M., Chen, Y., Levenson, J., Onishi, M., Varona, C., Okuda, M., & Herhman, D.L. (2019). A randomized trial of interpersonal psychotherapy, problem solving therapy, and supportive therapy for major depressive disorder in women with breast cancer. *Breast Cancer research and treatment*, 173, 353-364.

Bolton, D., & Gillet, G. The Biopsychosocial model of health and disease: new philosophical and scientific developments. Palgrave macmillian: London.

Branson, A., Shafran, R. & Myles, P. (2015). Investigating the relationship between competence and patient outcome with CBT. *Behaviour Research and Therapy*, 68, 19-26.

Braun, V., & Clarke, V. (2013). Successful Qualitative Research: a practical guide for beginners. Sage: London.

Braun, A. & Clarke, V. (2022). Thematic analysis: a practical guide to understanding and doing. Sage: Los Angeles.

Braun.V., & Clarke. V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.

Brown, R.J. (2006) Medically unexplained symptoms in: Tarrier, N.Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases. London: Routledge.

Budge, C., & Taylor, M. (2021). Support for living well with long term conditions: how people manage. *Journal of Clinical Nursing*, 30. https://doi.org/10.1111/jocn.15560

Burnham, M., Martin, S., Olle, B., Terry, H., Torsten, G., & Gerhard, A. (2015). Individualized guided internet delivered cognitive behaviour therapy for chronic pain patients with comorbid depression and anxiety. *The clinical journal of pain*, 31(6), https://doi.org/10.1097/AJP.0000000000000176

Carroll, S., Moon, Z., Hudson, J., Hulme, K., & Moss-Morris, R. (2022). An Evidence Based-Theory of Psychological Adjustment to Long-Term Physical Health Conditions: Applications in Clinical Practice. *Psychosomatic Medicine*, 84, 547-559.

Carroll, S., Moss-Morris, R., Kulme, K., & Hudson, J. (2020). Therapists perceptions of barriers and facilitators to uptake and engagement with therapy in long term health conditions. *British journal of health psychology,* https://doi-org.ezproxy.uwe.ac.uk/10.1111/bjhp.12475

Chen, L. (2017). A systematic review and meta analysis of randomized controlled trials of cognitive behavior therapy for patients with diabetes and depression. *Journal of psychosomatic research, 95,* 44-54.

Cimpean, D. & Drake, R.E. (2011). Treating co-morbid medical conditions and anxiety/depression. *Epidemiology and psychiatric sciences*, 20 (2), 141-150.

Clarke, K., Furmaniak, K., & Pilling, S. (2018). IAPT-LTC Early Implementers Programme: Report on the implementation and process evaluation of Wave 1 early implementer sites. The National Collaborating Centre for Mental Health at the Royal College of Psychiatrists and the Centre for Outcomes Research and Effectiveness at University College London.

Comacho, E.M., Davies, L.M., Hann, M., Small, N., Bower, P., Chew-Graham, C., Baguely, C., Gask, L., Dickens, C., Lovell, K., Waheed, C., Gibbons, C.J. & Coventry, P. (2018). Long-term clinical cost-effectiveness of collaborative care (versus usual care) for people with mental-physical multimorbidity: Cluster-randomised trial. *The British journal of psychiatry*. 213, 456-463.

Coventry, P.A., Hays, R., Dickens, C., Bundy, C., Garrett, C., Cherrington, A., & Chew-Graham, C. (2011). Talking about depression: a qualitative study of barriers to managing depression in people with long term conditions in primary care. *BMC Family Practice*, 12:10.

Coventry, P.A, Hudson, J.L., Kontopantelis, E., Archer, J., Richards, D.A., Gilbody, S., Lovell, K., Dickens, C., Gask, C., Waheed, W., & Bower, P. (2014). Characteristics of effective collaborative care for treatment of depression: A systematic review and meta analysis of 74 randomised controlled trials. *Public library of science*, 9(9).

Coventry, P., Lovell, K., Dickens, C., Bower, P., Chew-Graham, C., McElvenny, D., Hann, M., Cherrington, A., Garrett, C., Gibbons, C., Baguley, C., Roughley, K., Adeyemi, I., Reeves, D., Waheed, W. & Gask, L. (2015). Integrated primary care for patients with mental and physical multi-morbidity: cluster randomised controlled trial of collaborative care for patients with depression comorbid with diabetes or cardiovascular disease. *BMJ,* doi: 10.1136/bmj.h638 .

Craner, J. R., Sperry, J.A., Koball, A.M., Morrison, E.J. & Gilliam, W.P. (2017). Unique contributions of acceptance and catastrophizing on chronic pain adaptation. *International Journal of Behavioural Medicine*, 24, 542-551.

De Jonge, P., Van de Brink, R.H., & Spijkerman, T.A. (2006). Only incident depressive episodes after myocardial infraction are associated with new cardiovascular events. *Journal of the American college of cardiology*, 48 (11), 2204-2208.

Delgadillo, J., Dawson, A., Gilbody, S. & Bohnke, J.R. (2017). Impact of long term medical conditions on the outcomes of psychological therapy for depression and anxiety. *The British Journal of Psychiatry,* 210, 47-53.

Delgadillo, J., Saxon, D., & Barkham, M. (2018). Associations between therapists' occupational burnout and their patients' depression and anxiety outcomes. *Depression and anxiety*, 35(9), 844-850.

Dempster, M., Howell, D., & McCory N.K. (2015). Illness perceptions and coping in physical health conditions: A meta-analysis. *Journal of Psychosomatic Research*. DOI:10.1016/j.jpsychores.2015.10.006

Dennison, L., Moss-Morris, R. & Chalder, T. (2009). A review of psychological correlates of adjustment in patients with multiple sclerosis. *Clinical Psychology Review*, 29, 141-153.

Densham, S., Williams, D., Johnson, A. & Turner-Cobb, J.M. (2016). Enhanced psychological flexibility and improved quality of life in chronic fatigue syndrome/myalgic encephalomyelitis. *Journal of Psychosomatic Research*, 88, 42-47.

Department of Health. (2012). Long Term Conditions Compendium of Information. Third Edition.

Department of Health. (2011). Talking Therapies: a four year plan of action.

Dochat, C., Wooldridge, J.S., Herbert, M., Lee. M. W., & Niloofar, A. (2021). Single-session acceptance and commitment therapy (ACT) interventions for patients with chronic health conditions: A systematic review and meta-analysis. *Journal of Contextual Behavioral Science,* 20, 52-69.

Dowalti, Y., Herrmann, N., Sawrdfager, W., Lui, H., Sham, L., Reim, E.K., & Lanctot, L. (2010). A Meta-Analysis of Cytokines in Major Depression. *Biological Psychiatry*, 67(5), 446-457.

Dregan, A., matcham, F., harber-Aschan, L., Rayner, L., Brailean, A., Davis, K., Hatch, S., Pariante, A., Armstrong, D., Stewart, R., & Hotopf, M. (2019). Common mental disorders within chronic inflammatory disorders: a primary care database prospective investigation. *Annals of rheumatic diseases*, 78(5), 688-695.

Durate, P.S., Miyazaki, C.M., Blay, S.L., & Sesso, R. (2009). Cognitive-behavioural group therapy is an effective treatment for major depression in hemodialysis. *Kidney International, 76*, 414-421.

Ellulu, M., Patimah, I., Khaza'ai, Rahmat, A. & Abed. (2017). Obesity and inflammation: the linking mechanism and the complications. *Archives of medical science*: https://doi.org/10.5114/aoms.2016.58928

Engel, G.L. (1977). The need for a new medical model: a challenge for biomedicine. *Science*, 196, 129-136

Farrand, P. & Woodford, J. (2015). Effectiveness of Cognitive Behavioural Self Help for the Treatment of Depression and Anxiety in People with Long Term Physical Health Conditions: a Systematic review and Meta Analysis of Randomised Controlled Trials. *Annals of behavioural medicine*, 49(4), 579-593.

Firth, N., Barkham, M., Kellet, S., & Saxon, D. (2015). Therapist effects and moderators of effectiveness and efficiency in psychological wellbeing practitioners: A multilevel modelling analysis. *Behaviour Research and Therapy*, 69, 54-62.

Freeman, L. & Sullivan, C. (2018). Thematic analysis in: Sullivan, C. and Forrester, A. Doing Qualitative Research: a practical guide. 2nd edition. Sage: London

Geraghty, K. & Scott, M.J. (2020). Treating medically unexplained symptoms via improving access to psychological therapy (IAPT): major limitations identified. *BMC Psychology*, 8(13), https://doi.org/10.1186/s40359-020-0380-2 .

Gerskowitch, C., Norman, I., & Rimes, A. (2015). Patients with medically unexplained physical symptoms experience of receiving treatment in a primary-care psychological therapies service: a qualitative study.

Gibson, S., & Riley, S. (2018). Data Collection in Qualitative Research, in: Sullivan, C. and Forrester, A. Doing Qualitative Research: a practical guide. 2nd edition. Sage: London

Gloster, A.T., Walder, N., Levin, M.E., Twohig, M.P., & Karekla, M. (2020). The empirical status of acceptance and commitment therapy: A review of meta-analyses. *Journal of Contextual Behavioural Science*, 18, 181-192.

Gordon-Finlayson, A. (2018). in: Sullivan, C. and Forrester, A. (2018). Doing Qualitative Research: a practical guide. 2nd edition. Sage: London

Graziano, F., Calandri, E., Borghi, M., & Bonino, S. (2014). The effects of a group-based cognitive behavioral therapy on people with multiple sclerosis: A randomized controlled trial. *Clinical Rehabilitation, 28*(3), 264-274. doi:10.1177/0269215513501525

Green, H., Barkham, M., Kellett, S. & Saxon, D. (2014). Therapist effects and IAPT Psychological Wellbeing Practitioners (PWP's): A multilevel modelling and mixed methods analysis. *Behaviour Research and Therapy*, 63, 43-54.

Gialluisi, A., Bonaccio, M., Di Castenlnuovo, A., Costanzo, S., De Curtis, A., Sarchiapone, M., Cerletti, C., Donati, M.B., de Gaetano, G., & Iacoviello, L. Lifestyle and biological factors influence the relationship between mental health and low-grade inflammation. *Brain, Behaviour, and Immunity,* 85, 4-13.

Gyani, A., Shafran, R. Richard, L. & Clarke. M. (2013), Enhancing recovery rates: Lessons from year one of IAPT. *Behaviour research and therapy*, 51(9), 597-606.

Hampson, S.E., Russel, E., & Strycker, L.A. (2000). Beliefs versus feelings: A comparison of personal models and depression for predicting multiple outcomes in diabetes. *British journal of health psychology,* 5(1), 27-40.

Hassan, S., Bennet, K., & Serfaty, M. (2018). Delivering Cognitive behavioural therapy to advanced cancer patients: A qualitative exploration into therapist experiences within UK psychological service. *Clinical Psychology and Psychotherapy*, 25(4), 565-574.

Heinonen, E., & Nissen-Lie, H.A. (2020). The professional and personal characteristics of effective psychotherapists: a systematic review. *Psychotherapy Research*, 30:4, 417-432.

Hudson, J.L. & Moss-Morris, R. (2019). Treating illness distress in Chronic illness: integrating mental health approaches with illness self management. *European Psychologist*, 24(1), 26-37.

Hughes, L.S., Clark, J., Colcough, A., Dale, E., & McMillian, D. (2017). Acceptance and Commitment Therapy (ACT) for Chronic Pain: A systematic review and meta-analysis. *Clinical Journal of Pain*. 33(6). DOI: 10.1097/AJP.0000000000000425

Hyphantis, T., Guthrie, Tomenson, B., & Creed, F. Psychodynamic interpersonal therapy and improvement in interpersonal difficulties in people with severe irritable bowel syndrome. *Pain,* 145, 196-203.

Improving Access to Psychological Therapies: Medically unexplained symptoms/functional symptoms, Positive Practice Guide. (2014).

Jonsjo, M.A., Wicksell, R.K., Holmstrom, L., Andreasson, A. & Olsson, G.L. (2019). Acceptance and Commitment Therapy for ME/CFS (Chronic Fatigue Syndrome)- A feasibility study. *Journal of contextual behavioural science*, 12, 89-97.

Kanapathy, J. & Bogle.V. (2019). The effectiveness of cognitive behavioural therapy for depressed patients with diabetes: a systematic review. *Journal of Health Psychology* ,24(1), 137-149.

Kappelmann, N., Lewis, G., Dantzer, R., Jones, P.B., & Khandaker, G.M. (2018). Anti-depressant activity of anti-cytokine activity: a systematic review and meta-analysis of clinical trials of chronic inflammation conditions. *Molecular Psychiatry,* 23(2), 335-343.

Katon, W.J, Lin, E.H.B., Von Korff, M., Ciechanowski, P., Ludman, E.J., Young, B., Peterson, D., Rutter, C.M., McGregor, M., & McCulloch, D. (2010). Collaborative care for patients with depression and chronic illnesses. *The New England journal of medicine*, 363, 2611-2620.

Karademas, E.C., Tsagaraki, A., & Lambrou, N. (2009). Illness acceptance, hospitalization stress and subjective health in a sample of chronic patients admitted to hospital. *Journal of Health Psychology*, 14 (8), 1243-1250.

Karunamuni, N., Imayama, I., & Goonetilleke, D. (2021). Pathways to well-being: Untangling the causal relationships among biopsychosocial variables. Social Science and Medicine, 272, https://doi.org/10.1016/j.socscimed.2020.112846

Kellett, S., Webb, K., Wilkinson, N., Bliss, P., Ayres, T., & Hardy, G. (2016). Developing services for patients with depression or anxiety in the context of long-term physical health conditions and medically unexplained symptoms: Evaluation of an IAPT pathfinder site. *Behavioural and Cognitive Psychotherapy*, 44, 553-567.

Kemp, S., Spilling, C., Hughes, C. & de Pauw, K. (2013). Medically unexplained symptoms (MUS): What do current trainee Psychologists, Neurologists and Psychiatrists believe. *Open Journal of Medical Psychology*, 2 (1), 12-20.

Kew, K.M. (2016). Cognitive behavioural therapy (CBT) for adults and adolescents with asthma. *Cochrane database of systematic reviews, 9*, CD011818.

King, N., & Hugh-Jones, S. (2018). The interview in qualitative research, in: Sullivan, C. and Forrester, A. (2018). Doing Qualitative Research: a practical guide. 2nd edition. Sage: London

Koszycki, D., Lafontaine, S., Frasure-Smith, N., Swenson, R. & Lesperance, F. (2004). An Open-Label Trail of interpersonal Psychotherapy in Depressed Patients With Coronary Disease. *Psychosomatics*, 45, 319-324

Lewis. H. (2013). An explortatory study of primary-care therapists perceived competence in providing cognitive behavioural therapy to people with medically unexplained symptoms. *The cognitive Behaviour Therapist*, 6(e16): doi:10.1017/S1754470X13000202

Leventhal,H. (1984) cited in: Anisman, H. (2016). Health Psychology. Sage: London.

Liness, S., Beale, S., Lea, S., Byrne, S., Hirsch, C.R. & Clarke, D.M. (2019). Multi-professional IAPT CBT training: clinical competence and patient outcomes. *Behavioural and Cognitive Psychotherapy*, 47, 672-685.

Liness, S., Beale, S., Lea, S., Byrne, S., Hirsch, C.R. & Clarke, D.M. (2019b).The sustained effects of cbt training on therapist competence and patient outcomes. *Cognitive Therapy and Research,* 43 (3), 631-641.

Long-term conditions and mutli-morbidity. (2020). The Kings Fund. Retrieved from: https://www.kingsfund.org.uk/projects/time-think-differently/trends-disease-and-disability-long-term-conditions-multi-morbidity.

Madill, A., Jordan, A. & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *The British Journal of psychology*, 91(1), 1-20.

Marks, D.F. (2019). IAPT under the microscope. Journal of Health Psychology. 23(9), https://doi.org/10.1177/1359105318781872

Marrinan.T. (2018). Working with long-term conditions, in Papworth, M. & Marrinan.T. (2018). Low Intensity Cognitive Behaviour Therapy: A Practitioner's Guide. Sage: London.

Martin, C., Iqbal, Z., Airey, N. & Marks, L. (2022). Improving access to Psychological Therapies (IAPT) has potential but is not sufficient: How can it better meet the range of primary care mental health needs? *British Journal of Clinical Psychology*, 61(1), 157-174.

Martinez, D.P. Cognitive behavioural therapy for tinnitus. (2007). *Cochrane database of systematic reviews, 1,* CD005233.

Marwood, H., Chinn, D., Gannon, K. & Scior, K. (2017). The experiences of high intensity therapists delivering cognitive behavioural therapy to people with intellectual disabilities. *Journal of Applied Research in Intellectual Disabilities*, 31(1), 76-86.

Maydych, V. (2019). The interplay between stress, inflammation and emotional attention: relevance to depression. *Frontiers in Neuroscience*. doi: 10.3389/fnins.2019.00384.

McCracken, L.M. & Morley, S. (2014). The psychological flexibility model: a basis for integration and progress in psychological approaches to chronic pain management. *The Journal of Pain*, 15 (3), 221-234.

Michie, S. (2011). The behavior change wheel: A new method for characterising and designing behavior change interventions. *Implementation Science*. doi: 10.1186/1748-5908-6-42

Millet, L., Taylor, B.L., Howards, L.M., D, B., Stanley, N., & Johnson, S. (2018). Experiences of improving access to psychological therapy services for perinatal mental health difficulties: A qualitative study of women's and therapists views. *Behavioural and Cognitive Psychotherapy*, 46(4), 421-436.

Moncrieff, J., Cooper, R.E., Stockman, T., Amendola, S., & Horowitz, M.A. (2022). The serotonin theory of depression: a systematic umbrella review of the evidence. *Molecular Psychiatry:* https://doi.org/10.1038/s41380-022-01661-0

National Collaborating Centre for Mental Health.(2018). The Improving Access to Psychological Therapies (IAPT) Pathway for People with Long-term Physical health Conditions and Medically Unexplained Symptoms. Full implementation guidance. London: National Collaborating Centre for Mental Health.

National Collaborating Centre for Mental Health. (2019). The improving Access to Psychological Therapies Manual.

NHS England and NHS improvement, (2021). Long COVID: The NHS plan for 2021/2022.

NHS digital: Psychological Therapies, Reports on the use of IAPT service (2021). Retrieved from: https://digital.nhs.uk/data-and-information/publications/statistical/psychological-therapies-report-on-the-use-of-iapt-services/january-2021-final-including-a-report-on-the-iapt-employment-advisors-pilot/outcomes

NICE guidelines .(2009). Depression in adults: recognition and management. Retrieved from: https://www.nice.org.uk/guidance/cg90

NICE guidelines .(2009). Depression in adults with a chronic physical health problem: recognition and management. Retrieved from: https://www.nice.org.uk/guidance/cg91

NICE guidelines .(2011).Generalised anxiety disorder and panic disorder in adults: management. Retrieved from: https://www.nice.org.uk/guidance/cg113

Nice guidelines (2016). Multimorbidity: Clinical assessment and management. Retrieved from: https://www.nice.org.uk/guidance/ng56

Nollaig, F. & Bailey-Rodriguez, D. (2018). Quality in Qualitative Research in: Sullivan, C. and Forrester, A. (2018). Doing Qualitative Research: a practical guide. 2nd edition. Sage: London.

Ogden, J. (2012). Heath Psychology: A Textbook (5th ed). Open University Press: Berkshire.

Osborn, R.L. (2006). Psychosocial interventions for depression, anxiety and quality of life in cancer survivors: meta-analyses. *International journal of psychiatry in medicine, 36(1),* 13-34.

Owen, J., & Hilsenroth, M.J. (2014). Therapist Adherence: The importance of Therapist Flexibility in Relation to Therapy outcomes. *Journal of Counselling Psychology*, 61 (2), 280-288.

Pancel, R., Rich, B., Rowland, C., Ryan, T., & Watts, S. (2019). The successful impact of adapting CBT in IAPT for people with complex long term physical health conditions. *The cognitive Behavioural Therapist*, 13, 1-8.

Penlington, C. (2018). Working with long-term conditions, in Papworth, M. & Marrinan.T. (2018). Low Intensity Cognitive Behaviour Therapy: A Practitioner's Guide. Sage: London.

Poleshuck, E.L., Gamble, S.A., Cort, N., Hoffman-King, D., Cerrito, B., Rosario-McCabe, L.A. & Giles, D.E. (2010). Interpersonal Psychotherapy for Co-occurring Depression and Chronic Pain. *Professional psychology, research and practice*, 41(4), 312-318.

Robinson, P.L., Russell, A., & Dysch.L. (2019). Third-wave therapies for long term neurological conditions: A systematic review to evaluate the status and quality of evidence. *Brain Impairment,* 20(1). doi:10.1017/BrImp.2019.2

Roche, L., Dawson, L., Moghaddam, N.G. & Abey, A. (2017). An acceptance and commitment therapy intervention for chronic fatigue syndrome: A case series approach. *Journal of contextual behavioural science*, 6(2), 178-186.

Royal College of Occupational Therapists. (2023). How to conserve your energy. Retrieved from: www.rcot.co.uk/conserving-energy

Riley, S. & Wiggins, S. (2018). Discourse Analysis in: Sullivan, C. and Forrester, A. (2018). Doing Qualitative Research: a practical guide. 2nd edition. Sage: London

Sattel, H., Lahmann, H., Gundel, H., Gurthie, J., Kruse, M., Noll-Hussong, M., Ohman, C., Ronel, M., Sack, N., Sauer, G., Schneider, G., & Henningsen, P. (2012). Brief psychodynamic interpersonal psychotherapy for patients with multisomatoform disorder: randomized controlled trial. *The British Journal of Psychiatry,* doi: 10.1192/bjp.bp.111.093526

Seaton, N., Moss-Morris, R., Norton, S., Hulme, K. & Hudson, J. (2022). Mental health outcomes in patients with a long term condition: analysis of an Improving Access to psychological therapies service. *BJPsych Open*: doi: 10.1192/bjo.2022.59

Shaw, R. (2018). Interpretative phenomenological analysis, in: Sullivan, C. and Forrester, A. (2018). Doing Qualitative Research: a practical guide. 2nd edition. Sage: London

Shiels, M.S, Katki, H.A., Freedman, N.D., Purdue, M.P., Wentzensen, N., Trabert, B., Kitahara, C.M., Furr, M., Li, Y., Kemp, T.J., Goedert, J.J., Chang, C.M., Engels, E.A., Caporaso, N.E., Pinto, L.A., Hildesheim, A., & Chaturvedi, A.K. Cigarette smoking and variations in systemic immune and inflammatory markers. *JNCI*: doi:10.1093/jnci/dju294

Skilbeck, L. Spanton, C. & Roylance, I. (2020). Beyond the COVID-19 pandemic: 'Learning the hard way' – Adapting long-term IAPT service provision using lessons from past outbreaks. The Cognitive Behaviour Therapist, doi:10.1017/S1754470X20000379.

Smith, R.C. Making the biopsychosocial model more scientific – its general and specific models. Social Science & Medicine, 272, https://doi.org/10.1016/j.socscimed.2020.113568

Staff Wellbeing at Back on Track IAPT service. (2021) NHS England. Retrieved from: https://www.england.nhs.uk/mental-health/case-studies/back-on-track-iapt-service-hammersmith-and-fulham-nhs/

Strawbridge, R., Hodsoll, J., Powell, T.R., Hotopf, M., Hatch, S., Breen, G., & Cleare, A.J. (2018). Inflammatory profiles of severe treatment resistant depression. Journal of Affective Disorders: doi:https://doi.org/10.1016/j.jad.2018.12.037

Stawbridge, R., Young, A.H., & Cleare, A.J. (2017). Biomarkers for depression: recent insights, current challenges and future prospects. *Neuropsychiatry Disease and treatment*: https://doi.org/10.2147/NDT.S114542.

Sullivan, C. (2018). Theory and Method in qualitative psychology, in: Sullivan, C. & Forrester, A. (2018). Doing Qualitative Research: A practical guide. 2nd edition. Sage: London

The five year forward view for Mental Health. (2016). NHS England. Retrieved from: https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf.

Toffolutii, M., McKee, M., Clark, D.M., & Stuckler, D. (2019). The Economic and Mental Health Impact of IAPT: Pragmatic Trial in Three English Regions. European Journal of Public Health, 29 (4), https://doi.org/10.1093/eurpub/ckz185.047

Toner, B.B., Segal, Z.V., Emmott, S., Myran, D., Ali, A., Disgasbarro, I., & Stuckless, N. (2015). Cognitive behavioural group therapy for patients with irritable bowel syndrome. *International journal of group psychotherapy, 48(2),* 215-243.

Tracy, S.J. (2010). Qualitative Quality: Eight “Big-Tent” Criteria for Excellent Qualitative Research. *Qualitative Inquiry*, 16(10), 837-851.

Tutani, L., Eldred, C., and Sykes, C. (2018). Practitioners experiences of working collaboratively with interpreters to provide CBT and guided self help (GSH) in IAPT; a thematic analysis. *The Cognitive Behaviour Therapist,* doi:10.1017/S1754470X17000204

Van Beugen, S., Ferwerda, M., Hoeve, D., Rovers, M.M., Spillekom-van Koulil, S., van Middendrop, H., & Evers, A.W.M. (2014). Internet-based cognitive behavioural therapy for patients with chronic somatic conditions: A meta-analytic review. *Journal of medical internet research.* http://www.jmir.org/2014/3/e88/

Walklet, E. & Percy, C. (2014). Stress and Coping in IAPT staff: A Mixed Methods Study. *Applied Psychological Research Journal*. 2, 19-28.

Westwood, S., Morison, L., Allt, J., and Holmes, N. (2017). Predictors of emotional exhaustion, disengagement and burnout amoung Improving Access to Psychological Therapies (IAPT) practitioners. *Journal of Mental Health*, 26(2), 172-179.

Williams, C. & Garland, A. (2002). A cognitive-behavioural therapy assessment model for use in everyday clinical practice. *Advances in Psychiatric Treatment,* vol 8, 172-179.

Willig, C. (2013). Introducing qualitative research in psychology. 3rd edition. Open University Press: Berkshire.

Wroe, A.L (2015). IAPT and Long Term Medical Conditions: What can we offer?. *Behavioural and Cognitive Psychotherapy*, 43, 412-425.

Yohannes, A.M., Willgoss, T.G., Baldwin, R.C., & Connolly, M.J. (2010). Depression and anxiety in chronic heart failure and chronic pulmonary disease: prevalence, relevance, clinical implications and management principles, *International Journal of Geriatric Psychiatry,* **https://doi.org/10.1002/gps.2463**