Personality disorder co-morbidity in primary care 'Improving Access to Psychological Therapy' (IAPT) Services: A qualitative study exploring professionals' perspectives.

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A high prevalence of people present to 'Improving access to Psychological Therapies' (IAPT) in England with common mental health disorders and co-morbid personality disorder. This group have sub optimal treatment outcomes in IAPT. Whilst new short-term treatment approaches are advocated, no solutions or guidance have been provided. This qualitative study explored IAPT healthcare professional (N=28) perspectives of working with people who present to IAPT with co-morbid personality disorder. Individual semi-structured interviews were digitally recorded, transcribed verbatim and analyzed using a framework analysis approach. Results identified a lack of skills and confidence in working with this patient group, restrictive service constraints and a treatment gap between the interface of primary and secondary services. Insight into acceptable adaptions to practice are identified which have transferable utility to a wider international audience who can identify people outside of specialist mental health services with common mental health disorders and co-morbid personality disorder traits.

Introduction

Primary care 'Improving Access to Psychological Therapies' (IAPT) services were established in 2008 (1) and are one of the most ambitious English initiatives to increase access to evidence based psychological therapies to a general population, established predominately to treat anxiety and depression (2). Primary care IAPT

services provide psychological interventions using a stepped care model, using 3 steps. Treatment is commenced at the lowest possible dose of psychological intervention to achieve a health benefit (3). Step 1 is described as General Practitioner (GP) support and treatment. Step 2 is described as an IAPT short term treatment where directed self-help Cognitive Behavioral Therapy (CBT) informed treatment are provided over 6-8, ½ hour sessions. This intervention is delivered by a Psychological Wellbeing Practitioner (PWP) and is referred to as a 'low intensity intervention'. Step 3 is focused on CBT and is provided over a longer period of 12-20-hour long sessions, delivered by CBT therapist or clinical psychologist and is referred to as 'high intensity intervention' (4). Treatment outcomes are variable in IAPT with some groups responding less well to routine IAPT treatment, particularly those identified as having co-morbid personality disorder (5). A four-year plan of action has outlined the need to expand the IAPT programme to people with complex mental health difficulties, including personality disorder (6).

Specialist secondary service treatments are usually delivered at Step 4 or 5 with a range of interventions dependent on the configuration of the service, following National Institute for Clinical Excellent (NICE) guidance (7). However, service provision and access to evidence-based therapies even in specialist secondary mental health services for personality disorder can be patchy (8). People who are eligible for a diagnosis of personality disorder are often undetected and will present across a range of medical and multi-agency settings including primary care IAPT services (9). Due to this lack of detection, they are often treated ineffectively, and in some cases an iatrogenic effect can occur (10).

A high prevalence of personality disorder has been identified in primary care populations (11) and more recently in IAPT populations. A naturalistic cohort study

of 147 people explored the impact of co-morbidity in IAPT and found 18% met the criteria for borderline personality disorder and 69% as being at high risk of personality disorder (12). Evidence suggests that ineffective treatments are currently offered in IAPT to patients who present with common mental health disorders (such as anxiety and depression) and co-morbid personality disorder (5) as identified by the Standardised Assessment of Personality – Abbreviated Scale (SAPAS) (13). Often in undiagnosed populations the term 'personality disorder traits' is used to describe the identified characteristics that are observed, with 'traits' delineating the disorder (14). To date, there is limited research into primary care treatment of patients with personality disorder (15). Research is therefore required to explore the impact of shorter term psychological interventions for personality disorder in primary care IAPT services (6), as currently there is no evidence to support short term interventions being effective (16). A whole system approach to care of people with personality disorder is long awaited (17).

Aims

This study examines IAPT healthcare professional views and experiences of working with people who present to IAPT primary care services with common mental health disorders and co-morbid personality disorder.

2. Methods

Study Design

This was a qualitative study using individual semi structured interviews. A framework analysis (18) approach was used to interpret the data. All data was managed and inputted into the data analysis software package QSR NVivo10 ©, including, digital recordings, verbatim transcripts, written field notes and the

'framework function' was used to develop the framework matrix. The NVivo software allows for data to be coded into the framework matrix via a copy and paste process that can also be linked back to its original place within the verbatim transcript. This is particularly useful within research teams to support agreement being reached on coding and theme development (19). An inter-related study exploring the perspectives, needs and treatment experiences was also carried out and results will be reported separately (20). A favourable ethical opinion was received in May 2015 by NRES Committees North of Scotland (Rec Reference: 15/NS/0043).

Study Sample

A Patient and Public (PPI) advisory group of individuals with lived experience of personality disorder developed recruitment flyers which were emailed to all clinical and leadership staff working in the service. IAPT healthcare professional and managers were recruited from two localities in a North West NHS Trust IAPT service. Participants were trained and trainee psychological wellbeing practitioners (PWP's) working at Step 2, high intensity cognitive behavioural therapist (HIT's), clinical psychologists, clinical leaders and IAPT clinical service managers (Table 1). Recruitment was discontinued once no new themes were emerging and we had a team consensus that saturation had been reached.

Data Collection

Face to face individual interviews were conducted in the workplace by (GL) and were digitally recorded on an encrypted device. Topic guides were developed by the PPI advisory group. Topic guides covered 5 areas of enquiry including: 1) An exploration of clinical experience, 2) Mapping out of current practices in IAPT and treatment provision 3) An exploration of what the workforce needs to work more effectively with

people with co-morbid personality disorder 4) An exploration of current services responses to people who present with co-morbid personality disorder 5) Exploration of next steps.

Data Analysis

Recorded interviews were transcribed verbatim. Data was analysed using a framework analysis approach (18). Framework analysis is increasingly the method of choice in qualitative health service research (21). It provides researchers with a systematic approach to analysis, that allows for 'within-case analysis' and 'cross-case analysis' (18). The analysed data was initially coded by a lone researcher (GL) however a sample of transcripts were reviewed by co-authors (KL; JB; TD) to explore interpretations of the data and reach a team consensus on themes. Team reflexivity played an important role in ensuring that the reported areas were accurate and balanced in line with the original data set. The rigorous methods employed enhanced the trustworthiness, credibility and auditability of the study (22) and the team approach strengthened the findings (19).

Results

Twenty-eight IAPT healthcare professional were interviewed out of the fifty-four team members approached. Recruitment was closed once saturation was achieved (duration 51 minutes to 1h:40 minutes, mean duration was 1h:25m). Characteristics of the sample are given in Table 1. Most participants described themselves as 'White British', most were female (N= 17) and a majority were employed as workers at Step 3 (N= 17).

Findings

The analysis identified four key themes: 1) The bread and butter of an IAPT caseload 2) Call it traits and send it to IAPT 3) Therapy experience; chaos and control, and 4) This is our business.

The Bread and Butter of an IAPT Caseload

Most participants acknowledged that this patient group presents in routine IAPT services and described them as 'the bread and butter of an IAPT caseload' illustrated below:

"I think it needs to be acknowledged in [the] IAPT world that these people exist and they will be, I think, your bread and butter of your caseload, you are having these people come in on your caseload. So, it needs to be acknowledged in IAPT" (HP3, Step 3).

Participants described using 'gut instinct' as the primary method of identification of patients with co-morbid personality disorder traits and that there was a lack of any clear clinical tools to guide this. This gut instinct method was however criticised for its reliability due to the varied levels of personality disorder knowledge amongst the workforce.

"…somebody else might sit there and go, oh, definite traits, whereas I'm just maybe not aware of it" (HP8, Step 3).

Some participants opposed identification and felt that even if traits were identified, no treatment would be offered, thus detection and identification was perceived as a futile exercise.

"When you tell somebody that they're diabetic then usually you treat them for diabetes and you monitor them or they get put on medication, otherwise what's the point in putting that label on?" (HP11, Step 3).

Participants were also concerned about the label of personality disorder and the stigma attached to it.

"There's quite a big stigma against personality disorders, to kind of give them that label" (HP23, Step 2).

Participants acknowledged the importance of having a descriptor (such as personality disorder traits / co-morbidity) for this patient group that could be used to develop a common language and understanding amongst the workforce. Whilst this descriptor was deemed appropriate for use amongst the workforce a more descriptive approach highlighting the traits as 'presenting difficulties' was advocated as being more useful when working clinically with patients in primary care, than attaching a diagnostic label. Attaching labels without a clear pathway of evidence-based treatment options was met with disapproval.

"I really focus on the problem. I wouldn't go into categorising them into a box. I'd just say it seems to me that you're having these difficulties, so what we'll do is look at interpersonal effects and so on, and discuss tolerance or whatever" (HP23, Step 2).

<u>Call it traits and send it to IAPT</u>

This theme 'call it traits and send it to IAPT' developed from the exploration of service provision and a strong feeling that people who would have historically entered specialist secondary services were now being supported in IAPT. There was a feeling also that specialist secondary services were now less inclined to diagnosis personality disorder through a fear that IAPT may not take them on.

"It wasn't helpful for clients because what was happening in assessment teams was, they were saying, well, don't give them the diagnosis or IAPT won't take them. And I've heard numerous times, "Call it traits and send it to IAPT" (HP22, Leadership).

The lack of diagnosis or reluctance to diagnose and instead use the term 'traits' in the current system was described by participants as a barrier to meeting patients' needs. A lack of available evidence-based treatments and clinical guidance in IAPT services for this patient group, frustrated participants. Service reforms and downsizing of services are reported and participants described specialist secondary mental health services as becoming increasingly difficult to access, hence people with more complex difficulties were being referred to IAPT.

"There have been big reforms, they had to downsize in secondary services, that might sound controversial. So, you find in secondary services that people who have had established treatment plans there, suddenly find themselves discharged, with a revised diagnosis, and we can often because of a lack of resources for them, what else is there? But what the general public generally feed into, which is IAPT" (HP5, Step 2).

Participants described this patient group as being passed back and forth in what is termed by one participant as *"a tennis ball effect"* (HP5, Step 3) which negatively impacts on therapeutic relationships and trust of services. Another participant described it as *"a battle between us and them"* (HP10, Step 3). A treatment gap was identified between the interface of secondary services and primary care services. Many participants felt that IAPT was being coerced to fill this gap, but without any clear guidance or support:

"That's a whole new challenge, because you're getting people, that's in the middle. They're in that gap, it's like a vacuum, if you like… And I've come across that a lot in the job, definitely. But I think there's an expectation were it does filter back into IAPT. IAPT seems to be this bubble, this base, this floor of seeing these people, if you like, because nobody knows what to do with them" (HP9, Step 2).

A skills and knowledge deficit was acknowledged amongst all participants. The intervention patients receive was felt to be a lottery, owing to the diversity of skill mix amongst an IAPT workforce. A strong consensus was shared on the need for personality disorder training to become part of the IAPT core curriculum training.

"From a national point of view, first of all, there needs to be something in the training curriculum. There's virtually nothing at the minute in any IAPT training that looks at personality traits" (HP22, Leadership)

Further clinical skills training for working more effectively were also highlighted which should be available periodically due to the ongoing changes in evidence and understanding of personality disorder.

IAPT was described as becoming increasingly business like and driven by national targets and participants deemed IAPT to be more focussed on quantity (numbers of patients seen) over quality (impact / patient experience of the intervention). This led to many reporting being constrained by the demands of the service and deskilled.

"The major constraints within this service is because it's not really about quality, it's about quantity, it's about prevalence rates, it's about recovery rates, it's about bums on seats. In a nutshell that's IAPT" (HP5, Step 3).

<u>Therapy Experience; Chaos and Control</u>

This theme ‘the therapy experience; chaos and control’ emerged as a theme which focussed on the therapist/ patient dynamics, that occurs during treatment. The main challenges reported when working with this patient group was a perceived ‘chaos in the room’ and ‘the lack of therapist control over the treatment’. Whilst many participants described the challenge of maintaining control over the session, others who adopted a more flexible approach, that allowed some movement away from therapy manuals and structure, were less likely to report this. A continuum of severity and complexity was referred to, with acknowledgement that those who were deemed less complex could respond well to routine IAPT treatment but people with what was deemed to be more severe presentations would struggle with routine treatment as they could oscillate from one problem to the next on a weekly basis making adherence to the IAPT model and protocol delivered therapies very challenging to deliver. Participant frustration at the lack of treatment options and the constraints of time limited therapy was commonly reported.

“I suppose it just makes you think that there’s only a limited amount you can do and then you just think when that’s been done, this person needs more. And it’s just about whether there’s actually any services out there that could do that and would be able…without them waiting, say, like for a year or so” (HP30, Step 2).

Many of the participants described being overwhelmed by working with patients who presented with personality disorder co-morbidity and highlighted the challenges they had keeping focussed and on track in therapy sessions. This often led to a negative appraisal of self and own skills as illustrated below:

“It’s very hard because you feel like you’re not doing them any good because you don’t know what their needs are and you want to help them. So, you feel like you’re

trying to give this bit, and this bit, and this bit, but then you feel like, what have I actually done" (HP20, Step 3).

This patient group clearly stimulated a multitude of emotional responses in the participants interviewed. A need to develop an inner strength to manage their own emotional responses and resilience as therapists was described.

"It's learning how to manage how I feel when I'm in front of these people. That's what it is for me. Not bothered about time and knowledge, it's about how I manage a person that's boiling in front of me, because that sets me off" (HP9, Step 2).

Patient needs were largely described as being unmet for this patient group. Emotional regulation skills, the time to offload and the need to work on social and relationship difficulties were all identified as what participants perceived were unmet needs and areas for improvement

"I think an ability to manage their emotions better, because they usually come into our service because, on a day to day basis, their emotions are causing them all sorts of difficulties in their personal life, with regard to employment, education, leisure activities, and they're perhaps just going from one crisis or problem, to another, and no wonder they're anxious and depressed, which obviously brings them into our world" (HP5, Step 3).

A cognitive behavioural therapy 'here and now' focussed approach was described as the most common treatment approach used in the IAPT service, this was criticised by many as being ineffective in meeting patient's needs with longstanding difficulties.

"It's like putting a plaster over it. It's going to keep falling off, isn't it?" (HP12, Step 3).

Most participants were unclear on what the needs of this patient group actually are instead suggesting that there is a need for more research to understand from the patients, what their needs are. An inter-related research study that carried out a qualitative investigation into the need and treatment experiences of this patient group was carried out parallel to this study and is reported (20).

This is our business

An overwhelming majority of participants held strong opinions that working with personality disorder co-morbidity was their business, due to the high prevalence of personality disorder co-morbidity that presents to IAPT services for treatment.

"Yeah, it has to be because of the amount of people that come through, it's very high volume. You can't ignore these traits. It's about keeping it in the conversation, keeping it in mind and making sure we're meeting these people's needs. We can't just say, well, people who are coming through with personality disorder traits, we can't work with them, it's impossible, it's just the nature of the business" (HP9, Step 2).

How and what the focus of treatment should be however was more difficult to ascertain. A split opinion of what should be adopted was encountered with half of the participants seeing it as their business to work specifically with adapted interventions directed on the presenting personality disorder traits.

"Well I think I should work with it because that's, you know, the core of the problem really. Anxiety/depression is probably a by-product to this" (HP13, Step 3).

Others advocated that whilst it was their business to work with the patient group, the focus should be on the treatment of anxiety and depression with adaptions or reasonable adjustments made to the treatment plan in order to work with the added

complexity of personality disorder co-morbid traits. Those who described adaptions to treatment generally focussed on treatment enhancement by adding something new using a more integrative approach to the treatment. This approach is focussed on working directly with the traits to enhance the potential effectiveness alongside standard evidence-based IAPT treatment approaches.

"I think if someone's actually diagnosed with personality disorder then maybe they go to somebody who's got that sort of training. But obviously alongside depression and anxiety and whatever else, we're going to get the traits of PD which…don't necessarily need those sorts of therapies, because they're not a full-blown complex traits, but if we had more understanding and more training in that area, we would be able to treat them better at Step 3" (HP21, Step 3).

Several however identified that they could only support this patient group as they would any other patient in IAPT, hence focussing on the presenting common mental health disorder. It is from this viewpoint that the reasonable adjustments approach was suggested. Reasonable adjustments are adaptions that are not focussed directly at treating personality disorder traits. Instead reasonable adjustments were described as approaches employed to navigate around the traits and provide added flexibility, so that standard IAPT evidence-based NICE guideline-based treatments for common mental health disorders can be more effectively delivered.

"The reasonable adjustments all that is, is not letting the traits get in the way of the anxiety and depression treatment, rather than actually doing something about the traits" (HP22, Leadership).

Specialist standalone approaches to treatment received very little support. Whilst many felt a specialist treatment approach would be beneficial, most also felt in the current climate that this was not feasible within the IAPT service remit.

"I think you look across the board, I think we can incorporate bits of treatment to make it a bit more tailored, but I don't think that we need the standalone thing, like a separate department for the PDs, for example" (HP17, Step 2).

The need for evidence-based models that can be applied within the context of IAPT treatment for this patient group was frequently raised. The most commonly advocated approach was to allow for adaptions to treatment. However a need for IAPT healthcare professionals to further develop the skills, knowledge and have guidance to enable them to make adaptions to their treatments was highlighted. A large majority of participants were keen to learn more about personality disorder and displayed a willingness to engage in such opportunities if it received service support. Participants were in favour of the adoption of formulation driven approaches to ensure individualised treatment plans are employed.

"You formulate the person, you don't formulate the disorder, and I think that's what they should do with IAPT, that people have been taught to treat disorders, and they've been given a protocol that looks at a disorder, as if every person that walks in the door with OCD, is a carbon copy of the last one. And it's obviously not the case" (HP15, Leadership).

Mixed views about what step would be best placed to meet the needs of the patient group were encountered. With a majority of participants feeling all patients should go through the steps starting at Step 2 when further explored the contradictorily

described Step 3 as being a more effective intervention level, due to the increased time and flexibility that can be afforded within a Step 3 intervention.

Some newer third wave CBT approaches such as mindfulness, acceptance and commitment therapy (ACT) and interpersonal psychotherapy (IPT) were described as already being practised in the service amongst some practitioners. Other specific personality disorder evidence-based approaches were also discussed including mentalisation based therapy (MBT) (23), dialectic behavioural therapy (DBT) (24), structured clinical management (SCM) (25) and psychodynamic therapy but these were described largely from limited knowledge perspective and were described based on participant knowledge and treatment interests, creating a very mixed selection of opinions and personal preferences. Mentalisation based therapy and dialectic behavioural therapy approaches were most commonly described as having potential utility for adaption and simplification for use in IAPT services.

Other subtle changes to service provision were recommended such as increased flexibility of approach and time to work with patients who present with complexity by extending treatment duration. A need for more psycho-social treatments that is inclusive of meeting the social needs of the patient group, children and families was also discussed.

Discussion

There is a high prevalence of personality disorder in primary care (11), however until recently the provision of treatment in primary care to this patient group has been overlooked. Personality disorder co-morbidity is highly prevalent in IAPT populations (12) and impacts negatively on treatment outcomes (5). Recommendations have been made to develop new approaches to working with the patient group in IAPT (5;

6) but no preliminary work to explore what new interventions, may look like has been complete. This study provides insight from the current IAPT workforce that can be used to augment current practices and inform the development of service provision, interventions and future research.

Educating the workforce

One of the key findings in this study is the identification of a skills deficit and lack of confidence amongst the IAPT healthcare professionals when working with personality disorder co-morbidity. The data suggests a need for IAPT healthcare professionals to receive personality disorder training to address an inconsistency in knowledge and skill, so that a more consistent approach is adopted for working with personality disorder co-morbidity. Increased understanding and knowledge may impact on outcomes and patient experience but can also facilitate and guide more timely and appropriate stepping up to more advanced treatments for those who do not make progress. Our findings also indicated that more attention is required in supporting the workforce to develop their clinical skills relating to emotional resilience and relational difficulties that this patient group often experience. There is a growing focus on the use of short term interventions and the utilisation of a stepped care approach for people who present with personality disorder (15). A stepped care programme specifically for people with personality disorder in Canada, reported effective clinical outcomes when short term adapted treatments that were informed by evidence-based treatments such as DBT and MBT were used (26). This indicates that personality disorder treatments can be adapted and delivered as a short term treatments and whilst more research is required, the adaptions outlined do support to the idea, that short term treatments can have a positive clinical impact. Therefore, if IAPT workers are supported to develop such skills to make these

adaptions, this could have transferable benefits to IAPT patients who present with co-morbid personality disorder. The results of this research also suggest that IAPT core curriculum training programmes should integrate personality disorder training in the context of primary care presentations.

Screening

If during triage it is suspected that the patient has an underlying co-morbid personality disorder that requires attention via adapted interventions, a screening may be beneficial using SAPAS (13). Routine personality disorder screening in IAPT has also been recommended by others (5).

Level of intervention

Results indicated that interventions delivered at Step 2 are unlikely to allow patients with the necessary time and flexibility, that participants identified as being required to address complex difficulties. Therefore, an earlier referral to Step 3 should be considered for those not making progress or with complex difficulties relating to identified co-morbid personality disorder traits.

Furthermore, the gap between the primary care IAPT services and the specialist secondary mental health care interface requires attention. In the current system patients with co-morbid personality disorder receive a routine IAPT treatment for anxiety or depression. Only those who are deemed to have high risk and complexity are likely in the current system to receive an evidence-based psychological therapy for personality disorder in specialist secondary mental health services (9; 27). This analysis highlights the need to address service deficits and enhance treatment provision within IAPT services due to the high prevalence of personality disorder co-morbidity and reduced outcomes. Further research is required to develop these

adaptions and to evaluate their efficacy. Primary care IAPT services should provide the first line of treatment for adults with comorbid personality disorder and form part of a whole system stepped care model (17). A clear pathway to treatment at various stages of mental health provision for this patient group is long awaited (15). However, it is acknowledged that for some patient's adaptions to treatment at a primary care level still may not be sufficient to address their needs hence a further step up requires consideration. Hence a standalone personality disorder specific therapy is additionally recommended and will require further research to evaluate effectiveness of interventions over a shorter duration and lower level than what is currently offered within secondary services. This could be offered as a low intensity intervention in secondary mental health services as provided in the pilot randomised controlled trial entitled 'Assessing a Low Intensity Treatment for Enduring personality-related problems' '(ALITE study) (28) or could alternatively be provided as an IAPTplus model as outlined in the Somerset NHS Trust demonstration site (29).

Service level support

Our findings identified a need for services to support IAPT Healthcare professional flexibility in approach, hence ensuring that treatments provided to this patient group are: developmental formulation driven and individualised to meet the needs of this patient group. An increased duration of therapy (when required) should be encouraged and time allotted to sessions to allow for the patients offloading their emotional concerns. This would allow for the development of therapeutic relationships and understanding of the patient's individual difficulties. However, it is accepted that IAPT services are becoming increasingly constrained due to high

demand and increased complexity, resulting in less time being available to focus on adapted or integrated approaches (30).

Analysis of the data revealed that there is a real tension in the IAPT service pertaining to the business-like model that is adopted and driven by outcome monitoring, which conflicts with the professional values of the workforce. The debate regarding quantity verses quality was frequently encountered as a constraint that makes working particularly with this patient group difficult. Participants were constrained to move away from manualised and prescriptive treatments due to both a lack of evidence-based approaches made available to them and the time and performance pressures they felt from the service. This has resulted in frustration amongst the workforce, some of whom described feeling de-skilled and not able to provide the best treatment or experience for patients.

Personality Disorder 'The label'

Our analysis revealed that IAPT healthcare professionals were sensitive to the use of the label 'personality disorder' with patients in receipt of their service, were the use of less stigmatising diagnostic labels such as 'depression' are often replaced with 'low mood', for example. The attribution of the label 'personality disorder' is a contentious issue, redolent with stigma and exclusion for many (27). Our results indicated, however, that the participants felt it was important to use a common language to describe this patient group such as 'personality disorder traits / co-morbidity' to ensure consistency of knowledge and clinical response. Use of labels with patients in treatment was however strongly opposed. Instead more descriptive approaches that describe the patient's problems should be adopted, such as relationship difficulties, emotional regulation problems, this can then be used to

guide patient friendly adaptions to clinical interventions alongside their treatment for common mental health disorders.

Limitations

One of the main limitations was that it was conducted across two localities in a single NHS trust and therefore the results may not be consistent with experiences in other IAPT sites. There was a lack of ethnic diversity in the included participants. The sample was not a balanced representation of the IAPT workforce in this study we interviewed a disproportionate number of Step 3 participants compared to the service composition which employed more Step 2 healthcare professionals. Nationally available and bespoke models of personality disorder awareness training had been made available in the study site and this may have skewed some of the experiences and reports from the participants (31; 32; 33). Additionally, the researcher's knowledge of personality disorder may have increased bias in some of the questioning approaches and interpretation of data.

Conclusion

Based on the findings of this research we suggest that the IAPT workforce require additional knowledge and education to enable them to more consistently and effectively support this patient group, something which encouragingly IAPT healthcare professionals are willing to embrace if service level support is provided. Additionally, new novel approaches to treatment at a primary care level need to be developed and evaluated for effectiveness in order to provide a whole system stepped care approach to treatment.

The research generates new knowledge and a unique insight into the experiences and views of IAPT healthcare professionals in relation to provision of psychological

therapies for people with common mental health disorders and co-morbid personality disorder and highlights deficits in service provision. This provides a useful foundation that should augment how we enhance clinical work through adaptions to treatment with this patient group. Whilst focused on an England specific initiative (IAPT), the findings provide transferable utility to a wider international audience who are able to identify people outside of specialist mental health services who present with common mental health disorders and co-morbid personality disorder traits.

Word Count (5215)

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