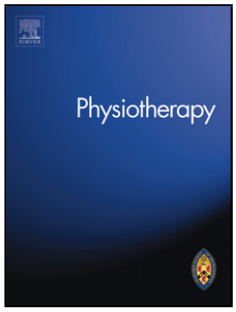
Experiences of physiotherapy in mental health

Laura, Hemmings; Soundy, Andrew

DOI:
10.1016/j.physio.2020.01.001

Document Version
Peer reviewed version

Citation for published version (Harvard):
Laura, H & Soundy, A 2020, 'Experiences of physiotherapy in mental health: an interpretative phenomenological analysis of barriers and facilitators to care', *Physiotherapy*, vol. 109, pp. 94-101.
https://doi.org/10.1016/j.physio.2020.01.001



Experiences of Physiotherapy in Mental Health: An Interpretative Phenomenological Analysis of Barriers and Facilitators to Care

Hemmings Laura, Andrew Soundy

PII: S0031-9406(20)30001-8

DOI: https://doi.org/10.1016/j.physio.2020.01.001

Reference: PHYST 1160

To appear in: *Physiotherapy*

Please cite this article as: Laura H, Soundy A, Experiences of Physiotherapy in Mental Health: An Interpretative Phenomenological Analysis of Barriers and Facilitators to Care, *Physiotherapy* (2020), doi: https://doi.org/10.1016/j.physio.2020.01.001

Experiences of Physiotherapy in Mental Health: An Interpretative Phenomenological Analysis of Barriers and Facilitators to Care

Laura Virginia Frances Hemmings, MRes; Andrew Soundy

Hemmings, Laura (MRes)

(Corresponding author)

University of Birmingham, School of Sport and Exercise Sciences, 142 Edgbaston Park Road, Birmingham, B15 2TT 07701027457

L.Hemmings@bham.ac.uk, @laurahemmingsPT

Soundy, Andrew (Dr)

University of Birmingham Lecturer in Physiotherapy School of Sport and Exercise Sciences, 142 Edgbaston Park Road, Birmingham, B15 2TT, a.a.soundy@bham.ac.uk

Abstract

Service users with severe mental illness (SMI) are at increased risk of physical health co-morbidity such as musculoskeletal pain, neurological impairment, obesity and COPD; many of which require input from Physiotherapists. Physiotherapists play a pivotal role in treatment of those with SMI but are reported to lack skills and confidence with this patient group. Furthermore, disparities in accessing healthcare are evidenced for those with SMI. This study explored experiences of Physiotherapeutic care for those with co-morbid physical and mental health complaints to identify barriers and facilitators to care.

A qualitative study using Interpretive Phenomenological Analysis was undertaken. Semi-structured interviews were completed with service users (n=8) with longstanding physiotherapeutic and psychiatric complaints. Focus groups were completed with physiotherapists working in mental health. Verbatim transcripts of interviews were analysed using Interpretive Phenomenological Analysis to obtain in depth insight into participant experiences. Study quality was enhanced through use of methodological and investigator triangulation, negative case analysis, reflexivity and secondary coding.

Data was analysed systematically following the structure: individual case analysis, emergence of themes, cross case analysis, validation of themes and ideas. This analysis produced five master themes: Communication [1], holistic care [2], benefit of physiotherapy [3], healthcare politics and service interaction [4], patient activation [5].

Results identified current service provision did not always meet the complexities of service user needs. Improved Physiotherapist awareness of mental health and how to communicate and treat this population was identified. The importance of better integration between services was also

highlighted. A positive experience of physiotherapy is vital for patient activation and engagement with Physiotherapy.

Keywords: holistic care; patient experience; musculoskeletal; patient centred care; communication; engagement

Diagnosis and Prevalence

Severe mental illness (SMI) is identified as a group of disorders causing significant disability and persisting for at least two years. Disorders include schizophrenia, bipolar disorder, and other significant psychotic diagnoses [1]. In the UK alone, mental illness makes up the largest cost to the NHS [2] and is seen globally as the leading cause of disability [3]. High prevalence of co-morbid physical health complaints are identified as a large contributor to the socio-economic burden of SMI [3]. Despite a growing awareness of the impact of comorbid physical and mental health complaints, large disparities in care provision remain [4-8]. Health and care inequalities are apparent on a global scale with individuals with SMI seen to have a decreased life expectancy of approximately 20 years compared to their age and gender matched counterparts [9].

Overcoming these disparities is a current priority within the NHS' five year forward plan for mental health [10] and integration of physical and mental health interventions identified as a global research priority [5]. The recent Lancet Commission [5] promotes development and delivery of multidisciplinary lifestyle interventions and physical health strategies to increase health outcomes within this population. Addressing the multifactorial, holistic needs of patients is seen as one strategy to ease the burden of chronic conditions and decrease premature mortality rates [8, 11].

Physiotherapy in Mental Health

Physiotherapists play a pivotal role in treatment of physical health conditions experienced by individuals with SMI. These include pain, movement disorders, respiratory illnesses such as COPD, somatisation of symptoms, extrapyramidal side effects of medications and physical symptoms of neurological origin such as stroke [11-14]. Policy documents have identified the importance of physiotherapeutic care for those with SMI [14-16]. This is supported by research identifying the importance of the role of physiotherapy for this population across inpatient and outpatient settings [14, 16, 21]. However, uncertainty exists over whether physiotherapists have the skills to address the complex needs of these patients [19, 20] and around accessibility of physiotherapy services for those with SMI [21].

There has been a recent call for a shift towards the biopsychosocial approach within physiotherapy due to evidence of improved patient outcomes [22]. However, studies suggest that physiotherapists struggle to consider the holistic needs of patients [19, 22]. Recently, qualitative research has provided rich accounts and insights into the problems faced by physiotherapists. For instance, a systematic review [19] identified how physiotherapists felt they lacked time, training and confidence to use relevant psychological skills with patients with mental health illness. Such factors can have a negative impact on service user experience of physiotherapeutic care [20].

Whilst these studies consider the use of psychological skills within physiotherapy and barriers to care, they do not explore specific experiences of service users with multi-morbidity attempting to access physiotherapy. They are therefore unable to identify factors potentially impacting upon service user experience and engagement.

Further exploration into access and experiences of physiotherapeutic care for individuals with SMI is required in order to acknowledge current provision and barriers to care for this population. The aim of this study was to 'give a voice' to participants [23] and provide in depth understanding of the participants' experiences of physiotherapeutic care. To the best of the author's knowledge, this is the first study exploring service user experiences of physiotherapy for those with SMI.

Methods

Design

An interpretive-phenomenological approach (IPA) was used for this study [23]. The study design was developed with consideration of the SPIDER acronym [24]. The COREQ checklist [25] was followed to ensure for robustness of design.

Eligibility Criteria

Methodological triangulation was utilised through collection of data from two sample populations: service users and physiotherapists. Individuals were eligible if; (a) they were diagnosed with SMI alongside a co-morbid physical health complaint requiring physiotherapeutic input, (b) the physical health complaint had been present for a minimum of one year, (c) individuals were 'adults of working age', between 18 and 65 years, (d) individuals had been referred to the physical therapies department within a mental health trust in Birmingham, UK.

Individuals were excluded if they: (a) lacked capacity to consent, (b) had additional learning difficulties, or (c) had a diagnosis of dementia. These criteria were selected due to vulnerability and potential lack of understanding [26].

Mental health physiotherapists were included if they had worked within the field of adult mental health for at least one year and were current employees at a mental health trust in Birmingham.

Reflexivity and trustworthiness

The lead author was a female physiotherapist with six years' experience treating individuals with SMI. Patients were not known to the physiotherapist prior to the study. Physiotherapists were known to the author as they worked within the same professional team. Any bias which may have resulted due to the professional stance of the researcher was decreased through use of interviewer triangulation, transparency of design and audit trail of results.

Sampling

Due to in depth exploration of experiences being central to IPA studies, emphasis was placed on obtaining rich data from a small sample size as opposed to inviting large numbers of participants into the study [27]. Convenience sampling was used to recruit patients under the care of a mental health trust in Birmingham who were also referred to the trust's physical therapies department.

Outcome measure

Semi structured interviews were used to obtain data from service users. The interview schedule was developed within the research team. The schedule was piloted with the first two patient interviews as well as by physiotherapists working in mental health to ensure apt wording for understanding.

[Please see supplementary file for interview schedule.]

Procedures

Service users were contacted by a member of the research team who approached them and discussed the study with them. Informed consent was obtained and participants made aware they could withdraw from the study at any time. Methodological triangulation was utilised through dual data collection methods: semi structured interviews and focus groups.

Setting

Interviews and focus groups took place in private rooms either on the ward or in the Physiotherapy department and were conducted by the lead author.

Ethical Considerations

Ethical approval was obtained from City and East NRES Committee London (REC number 15 LO 1661 PR). Anonymity of participants was maintained through coding. Participants were provided with information sheets and consent forms and able to withdraw from the study at any time.

Analysis

The IPA analytic process followed a traditional approach [28, 29]. Investigator triangulation [29] was employed through use of two researchers working on coding and analysis of interviews. Interviews were transcribed verbatim and read through for familiarisation of data [30].

A four stage analysis process was undertaken: (1) Individual case analysis: In keeping with the idiographic commitment central to IPA studies [28], each interview was initially thoroughly independently analysed. Transcripts were read multiple times with notes made in the margins. (2) Emergence of themes: Each transcript was further analysed to address emerging themes. Discussion between two researchers over the emergence of themes was undertaken and reported within a thematic table. (3) Cross case analysis: Themes were explored across all interviews. These themes were moved around in order to create patterns of themes and group them into wider over-arching themes as presented in table 2. (4) Validation of themes and ideas: Themes were considered alongside the transcripts from focus groups with physiotherapists to allow for interpretation of experience from multiple viewpoints. They were also considered alongside current literature in order to identify further patterns and recommendation.

Results

Demographics

Service users were recruited from inpatient and outpatient services with a variety of physiotherapeutic complaints and comorbid mental health diagnosis. There was a total of 8 individuals located (5 male, 3 female). The average age of the group was 44 years. The most common mental health diagnosis was psychosis (n=3/8) and the most common physiotherapy complaint was chronic back pain (n=3/8). No participants dropped out of the study.

[Insert table 1 here]

Themes

Five master themes were identified. Table 2 displays themes, subthemes and provides more participant quotes.

[Insert table 2 here]

Theme 1: Communication with healthcare provider.

This theme considers the importance of the therapeutic relationship and the impact this can have on attitudes, motivation and behaviour of service users. This theme had two sub-themes:

Sub-theme 1a; the need to be understood

When asked about what makes for a positive experience of physiotherapy, there was an agreement amongst participants of the importance of a good relationship with the therapist. A therapeutic relationship where the service user felt 'at ease' was a primary need. This was exemplified by the therapist displaying caring attitudes and awareness of both physical and psychiatric/emotional needs of the service user. However, this need was not consistently met within physiotherapeutic care from interpretation of patient experiences.

Patients commonly reported feeling not listened to and misunderstood. One service user stated:

'the person [Physiotherapist] doesn't seem to have listened to what's going on- the pain but the context of you know the pain exists but there are other things that are going on which may contribute to the pain' (Participant 3).

Sub-theme 1b; the physiotherapist as motivator

Participants reported that they felt the physiotherapist had an important role in education and motivation during interactions. However, that these aspects of the participant-physiotherapist interaction were lacking in practice. For instance, Participant 4 stated: 'I hope that they'd explain everything, not just give me a handout of exercises…'it don't make sense to me and I can't remember exactly how to do it properly'. This need for motivation was seen as central to treatment for those with SMI due to the multifactorial elements for decreased patient activation described below. Physiotherapists partaking in the study identified lack of time and awareness as factors impacting upon factors addressed within this theme.

Theme 2: Crossing the boundaries between physical and mental health

This theme considered the provision of person centred, holistic care which took into account the patient's physical and mental health needs. When this occurred, this was identified as acting as a significant determinant of compliance with Physiotherapy. This supports findings within the literature identifying the need for patient centred exercise provision to increase adherence [5].

Sub themes within this theme were:

Sub-theme 2a; Separation of mind and body

There was a common perception that physiotherapists focussed on physical pain and mental health services focused on the psychological complaints. Participant 2 simply stated: "They [Physiotherapists] assume they have to fix your body and someone else is there to fix your brain".

Sub-theme 2b; Awareness of mental health needs

Physiotherapists partaking in focus groups suggested that a lack of education and experience within mental health specialities was partly responsible for minimal consideration of the psychosocial aspects of care. This supports findings of previous research around lacking psychological knowledge and skills of physiotherapists [19, 20].

Theme 3: Perceived benefit of physiotherapy

This theme considered the importance of past experiences of physiotherapy care and perceived benefit of intervention. There are 2 subthemes:

Sub-theme 3a; mental health impacting upon outcomes

Previous negative experience was seen to impact upon participant motivation and therefore acted as a barrier to care. Those with negative past experiences or poor outcomes from physiotherapy identified decreased drive to attend or comply with interventions whereas those with positive experiences, spoke more highly of services. Physiotherapy was seen to have a positive effect upon pain and mental health however, due to factors relating to the patient's mental health, these effects were not always felt:

'you don't feel the benefits of the session because you're actually too stressed out' (Participant 8).

Sub-theme 3b; Positive benefit for mind and body

With the perceived benefit of physiotherapy for mind and body: 'when I come out of there not only do my legs feel better but my head feels better' (Participant 5), it would seem paramount to ensure these benefits are optimised through service provision.

Theme 4: Healthcare politics and interaction between services

One major influence on access to physiotherapy care was identified as interaction between different services. The subthemes were:

Subtheme 4a; The 'silo' effect

The 'silo' effect of physical and mental health services appeared to result in poor experience, getting lost from the system or difficulties attending multiple appointments in different locations.

Subtheme 4b; Detached Processes

Processes, such as discharge following non-attendance, were identified as barriers to care and seen to have great impact upon patient experience:

'I have physio at my GPs… like a conveyor belt… you've gotta get here for this time… we're not seeing you if you don't attend… you've gotta go through the process again' (Participant 3).

Theme 5: Patient activation

Patient activation was identified as a barrier to accessing care. These were intrinsic factors which decreased patient motivation to comply with physiotherapy and included aspects such as mood priorities:

[I struggled to attend physiotherapy] 'due to mental capacity issues and lack of motivation' (Participant 1).

If these factors were not understood by the Physiotherapist, further barriers were seen to arise, interlinking with other themes identified.

Discussion

Service User Experience

Positive experiences have been identified as key to increasing compliance with interventions and exercises [5]. This study highlights how positive experience of Physiotherapy can lead to increased drive and engagement with therapy. This should therefore be considered in practice to optimise outcomes. It became clear that certain aspects within physiotherapy sessions were of great importance to achieving this positive experience for the service user. These factors included: (1) patient-therapist interaction, (2) holistic approach to care, (3) therapist awareness and experience of mental health.

Previous literature identifies communication as pivotal for positive experiences within healthcare and physiotherapy [30]. This study supports this with emphasis placed on the importance of communication and patient-therapist rapport. Outcomes of positive interactions include greater compliance and psychological well-being.

Holistic, person centred care was highlighted as essential for optimal physiotherapist-participant rapport. This finding supports previous research [4, 7, 31]. However findings of this current study identified that service users often found this facet of care lacking. This suggests the need for greater emphasis on holistic care and positive relationship building on the part of physiotherapists working within this population. Physiotherapists should ensure active listening and work with service users to identify goals based around patient preferences as opposed to solely focussing on diagnosis-informed interventions. Such strategies have been seen to improve experience and adherence [5].

Barriers and Facilitators to Care

Multidisciplinary lifestyle interventions, provided by qualified specialists are identified as central to addressing the physical health of those with SMI [4, 5]. Such interventions require timely access to services. This study highlights barriers to this within the population. Barriers identified include; (a) negative experience of physiotherapy resulting in decreased compliance and engagement, (b) long, complex processes and lack of service integration, (c) intrinsic factors such as low mood and lack of service user motivation.

Facilitators to care were closely linked with barriers. Service users identified how improved relationships, holistic care and simplified referral processes would increase access to physiotherapy. These findings support those within current literature [5, 20] and should therefore be addressed when considering training and service design. It is of critical importance to note that many facilitators to accessing physiotherapy services were reported to be lacking by service users. The lack of such facilitators is likely to have a negative impact upon experience and therefore also upon engagement and adherence. Ways of ensuring inclusion of facilitators must be a priority for making physiotherapy services more accessible for this population.

Integration of physiotherapists into mental health services is recommended in previous literature [20] to facilitate access to services. This may simplify referral processes and enable physiotherapists with knowledge and experience of mental health to address the complex needs of service users [15, 16, 20]. This study identified physiotherapist integration onto mental health wards as beneficial for outcomes and interactions. It was identified that specialist input was lacking within outpatient clinics and integration of physiotherapists into these settings is therefore recommended. With nine out of ten service users with mental health illness treated within primary care settings [10], it appears pertinent that physiotherapists at this point of care have awareness and experience of SMI.

Limitations and Clinical Implications

This study supports current literature identifying a perceived lack of mental health awareness for physiotherapists working outside the speciality. It is recommended that all physiotherapists should have confidence to discuss mental health with service users particularly due to close links between pain, disability and mental health [14]. This identifies the importance of improved education for both undergraduate and qualified physiotherapists to ensure confidence when treating patients with mental illness. Further exploration of specific physiotherapist perceptions of working with those with SMI is highlighted in order to help direct training and provide further recommendation.

The study addresses the impact of health care 'silos' and recommends expansion of physiotherapy services within mental health care to improve access and optimise experience. The study endorses the enablement of healthcare needs, of both physical and psychiatric nature, being met within one multidisciplinary team. It is suggested that this may help overcome challenges attending appointments, improve communication lines and ensure holistic care.

One limitation of the study is a small sample size which resulted in exploration of limited SMI comorbidities. The aim of the approach was to achieve depth of data and findings were supported by literature, increasing generalisability of results.

Conclusion

Positive experience is seen to increase engagement and compliance and is therefore paramount to optimising outcomes. To ensure positive experience and improve outcomes, timely access to services is identified. However this is reported to be largely lacking. Whilst integrated mental health training within physiotherapy curricula and multidisciplinary approaches are likely to increase timely access to holistic services, an increased understanding of mental health for those in positions of management and policy makers is identified. To obtain and maintain a positive rapport and ensure consideration of holistic needs, time limits and discharge processes may benefit from consideration.

Ethical approval for this study was obtained from City and East NRES Committee London (15 LO 1661 PR) and Birmingham and Solihull Mental Health Foundation Trust.

The research study was completed as part of the author's Masters in Health Research which received funding from the NIHR. No specific funding for the study was received.

The authors declare no conflict of interest.

Contribution of the paper:

1) Key messages:

i. Access to important physiotherapeutic care must be improved for service users experiencing mental health illness through improved service interactions and streamlined processes.
ii. Physiotherapists require better education and experience of mental health illness in order to improve their ability to treat service users holistically and achieve positive patient experiences.
iii. Service users with mental illness require increased time with physiotherapists in order to build rapport and receive education and motivation which may lead to improved outcomes.

2) What the paper adds:
   i. In depth understanding of lived experiences of service users attempting to access physiotherapeutic care.
3) New knowledge:
   i. Service users with mental illness struggle to access mainstream physiotherapy services in the UK due to a variety of factors.
   ii. Holistic care in mainstream physiotherapy services believed to be largely lacking for service users with mental health diagnoses due to a poor understanding of mental health and elements relating to such diagnoses.
   iii. A lack of integration between physical and mental health services decreases patient experience of physiotherapy for service users with mental illness.

References

1 Public Health England (2018). Severe mental illness (SMI) and physical health inequalities: briefing. [Online] Available at < https://www.gov.uk/government/publications/severe-mental-illness-smi-physical-health-inequalities/severe-mental-illness-and-physical-health-inequalities-briefing>

2 Royal College of Psychiatrists. (2010). No Health Without Public Mental Health: The Case for Action. London: Royal College of Psychiatrists

3 Disease and Injury Incidence and Prevalence Collaborators (2018) Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. The Lancet; 392:1789–858.

4 Stubbs, B., Vancompfort, D., Hallgrend, M., Firth, J., Kahl, K.G. et al. (2018) EPA guidance on physical activity as a treatment for severe mental illness: a meta-review of the evidence and Position Statement from the European Psychiatric Association (EPA), supported by the International Organization of Physical Therapists in Mental Health (IOPTMH). European Psychiatry 54: 124-144.

5 Firth, J., Siddiqi, N., Koyanagi, A., Stubbs, B et al. (2019). The Lancet Psychiatry Commission: a blueprint for protecting physical health in people with mental illness. Lancet Psychiatry. 6: 675-712

6 Happell, B., Scott, D., Platania-Phung, C. (2012) Perceptions of Barriers to Physical Health Care for People with Serious Mental Illness: A Review of International Literature. Issues in Mental Health Nursing 33:752-761

7 Nankivell, J., Happell, B., Scott, D. (2013) Access to Physical Health Care for People with Serious Mental Illness: A Nursing Perspective and a Human Rights Perspective-Common Ground? Issues in Mental Health Nursing 34:442-450

8 Druss, B.G., Chwastiak, L., Kern, J., Parks, J.J., Ward, M.C., Raney, L.E. (2018) Psychiatry's Role in Improving the Physical Health of Patients With Serious Mental Illness: A Report From the American Psychiatric Association.

9 Chang, C.K., Hayes, R.D., Perera, G., Broadbent, M.T., Fernandes, A.C., Lee, W.E., Hotopf, M., Stewart, R. (2011) Life expectancy at birth for people with serious mental illness and other major disorders from a secondary mental health care case register in London. PLos One 6(5)

10 Mental Health Taskforce (2016) The Five Year Forward for Mental Health. [online] Available at: <https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf>

11 Hawker, G.A., Gignac, M.A.M., Badley, E., Davis, A.M., French, M.R., Li, Y., Perruccio, A.V., Power, D., Sale, J., Lou, W. (2011) A Longitudinal Study to Explain the Pain-Depression Link in Older Adults with Osteoarthritis. Arthritis Care & Research. 63(10): 1382-1390

12 Surah, A., Baranidharan, G., Morley, S. (2014). Chronic Pain and Depression. Continuing Education in Anaesthesia Critical Care & Pain. 14(2): 85-89

13 Filipic, I, Sartorius, N. (2018) Patterns of Chronic Physical Multimobidity in Psychiatric and General Population. Journal of Psychomatic Research

14 Arthritis and Musculoskeletal Alliance (2019) Mental Health and Musculoskeletal Conditions: Report of Roundtable. [online] Available at: <http://arma.uk.net/wp-content/uploads/2019/05/Mental-Health-Roundtable-report.pdf>

15 Chartered Society of Physiotherapists. (2008a) Commissioning Mental Health Services. London: The Chartered Society of Physiotherapists.

16 Chartered Society of Physiotherapists (2008b) Recovering Mind and Body. London: The Chartered Society of Physiotherapists.

17 Stubbs, B., Soundy, A., Probst, M., De-Hert, M. De Herdt, A., Vancompfort, D. (2014) Understanding the role of physiotherapists in schizophrenia: an international perspective from members of the International Organisation of Physical Therapists in Mental Health (IOPTMH). Journal of Mental Health: 1-5

18 Soundy, A., Stubbs, B., Roskell, C., Williams, S.E., Fox, A., Vancampfort, D. (2015) Identifying the facilitators and processes which influence recovery in individuals with schizophrenia: a systematic review and thematic synthesis. Journal of Mental Health 24(2): 103-110

19 Driver, C., Kean, B., Oprescu, F., Lovell, G.P. (2017) Knowledge, behaviors, attitudes and beliefs of physiotherapists towards the use of psychological interventions in physiotherapy practice: a systematic review. Disability and Rehabilitation. 39(22): 2237-2249

20 Lee, S., Waters, F., Briffa, K., Fary, R.E. (2017) Limited interface between physiotherapy primary care and people with severe mental illness: a qualitative study. Journal of Physiotherapy. 63(3): 168-174

21 James Lind Alliance. Physiotherapy Top 10 Priorities. (2019) Cited at http://www.jla.nihr.ac.uk/priority-setting-partnerships/physiotherapy/Physiotherapy-top-10-priorities.htm

22 Sanders, T; Foster, N.E; Bishop, A; Ong, B.N (2013) 'Biopsychosocial care and the physiotherapy encounter: physiotherapists' accounts of back pain consultations' BMC Musculoskelet Disord. 14: 65

23 Harper, D. and Thompson, A.R. (2012) Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners. John Wiley and Sons. Oxford

24 Cooke, A., Smith, D., Booth, A. (2012) Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qualitative Health Research 22(10):1435-43.

25 Tong, A., Sainsbury, P., Craig, J. (2007) Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups, International Journal for Quality in Health Care. 19(6): 349–357

26 Roberts, L., Roalfe, A., Wilson, S., Lester, H. (2007) Physical Health Care of People with Schizophrenia in Primary care: a Comparative Study. Family Practice 24:34-40

27 Fusch, P. I., & Ness, L. R. (2015). Are We There Yet? Data Saturation in Qualitative Research. The Qualitative Report, 20(9), 1408-1416. [Online] Available at: <https://nsuworks.nova.edu/tqr/vol20/iss9/3>

28 Smith, J.A., Flowers, P., Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. London: Sage.

29 Korstjens, I., Moser, A. (2018) Series: Practical Guidance to Qualitative Research. Part 4: Trustworthiness and publishing, European Journal of General Practice, 24(1) 120-124

30 Lacey, A., Luff, D. (2007) 'Qualitative Research Analysis'. The NIHR RDS for the East Midlands/Yorkshire & the Humber

31 Potter, M., Gordon, S., Hamer, P. (2003). The Physiotherapy Experience in Private Practice: The Patients' Perspective. Australian Journal of Physiotherapy. 49(3): 195-202

Table 1 Participant Demographics

ID	Role	Age	Gender	Mental health diagnosis	Physiotherapeutic complaint
Participant 1	Service user	38 years	Male	Psychosis and affective disorder	Chronic back pain
Participant 2	Service user	55 years	Male	Psychosis	Knee pain
Participant 3	Service user	47 years	Male	Anxiety/PTSD	Chronic back and leg pain
Participant 4	Service user	51 years	female	Severe anxiety and depression	Arthritic pain
Participant 5	Service user	35 years	Male	EUPD	Long term neurological complaint
Participant 6	Service user	19 years	Female	Eating disorder	Musculoskeletal injury and pain
Participant 7	Service user	56 years	Male	Psychosis	Long term musculoskeletal injury
Participant 8	Service user	53 years	Female	Borderline personality disorder	Chronic back pain
Participant 9	Physiotherapist	41 years	Female		
Participant 10	Physiotherapist	26 years	Female		

Table 2

Theme	Subtheme	Example unit
Communication with healthcare provider	The need to be understood and valued	'I feel people are not listening to me' (Patient one) 'the person doesn't seem to have listened to what's going on- the pain but the context of you know the pain exists but there are other things that are going on which may contribute to the pain' (Patient 3) 'when I've gone to see an NHS physio – and they're probably overworked whatever- they don't really ask the questions about what's really the matter and they suggest things that you just think 'oh it's pointless'' (Patient 8)
	The physiotherapist as motivator and educator	I hope that they'd explain everything- not just give me a handout of exercises…'it don't make sense to me and I can't remember exactly how to do it properly (Patient 4) 'if they give me a task to do, check that I'm doing it right 'cause I don't follow written instructions very well' (Patient 5) 'I like a treatment plan- I like to be kept updated that's what sometimes I feel like I'm getting lost with what's going on' (Patient 5)
Crossing the boundaries between physical and mental health and providing holistic care	Separating mind and body	'they assume they just have to fix your body and someone else is there to fix your brain' (Patient 2) 'to you as a physiotherapist you're only looking at one problem but to me as a patient I've got multiple problems. I'm trying to juggle things and sometimes I can't physically juggle everything on top of what's going on with me'(Patient 3)
	Physiotherapist awareness of 'the whole picture'	How can like anyone I know- a friend understand- and when you get medical staff who don't understand? (Patient 4) It's the understanding their problems that they don't necessarily get from other people [physiotherapists] sometimes (Physiotherapist 2)
The perceived benefit of physiotherapy	Mental health impact on outcome	'because of the depression and it was just too much to do' (Patient 4) 'It wasn't beneficial and I just lost heart' (Patient 4) 'you don't feel the benefits of the session because you're actually too stressed out' (Patient 8)
	Mental and physical benefits	Whenever I work out or do exercise my mind gets clearer and I feel a lot better mentally (Patient 1) felt mentally better 'cause I felt like I was taking care of myself' (Patient 5)

Healthcare politics and interaction between services	The silo effect	'due to the situation of being in a mental health hospital, restrictions and time consumptions and other like quantity of seeing patients- making sure it goes round- it was lacking. I would say there weren't enough physiotherapists to go around' (Patient 1) 'other times the GP has referred me for physiotherapy and nothing has happened' (Patient 8) I just got lost from the system (Patient 5)
	Detached processes	I have physio at my GPs… like a conveyor belt… you've gotta get here for this time… we're not seeing you if you don't attend… you've gotta go through the process again … it's quite a lengthy process… the NHS is slow now and you have to go through a lengthy timescale (Patient 3)
Patient activation-motivation to comply with treatment		'I love 1-1 because it really helps…I can be motivated but I like being accompanied' (Patient 1) 'to actually get yourself out of the house can be quite stressful' (Patient 3) 'I've always gone when they [give an appointment]' (Patient 6) 'if I've got an appointment, I'd move heaven and earth to be there' (Patient 8) Struggled to attend physiotherapy 'due to mental capacity issues and lack of motivation' Patient 1) 'you feel like you can't be bothered with this because it's another thing that adds onto the rest of it' (Patient 3) If a person can't be bothered to do it, they won't do it (Patient 2)