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# Psychological support within tier 2 adult weight management services, are we doing enough for people with mental health needs? A mixed-methods survey

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## Summary

Depression and obesity are two of the most highly prevalent global public health concerns. Obesity and poor mental health are strongly associated, and it is likely that mental health needs are common in people seeking weight management services. The aim was to identify what psychological support is provided and required in tier 2 adult weight management services (T2 WMS). Online survey was conducted: quantitative data were summarized, and open-ended free-text questions were coded and thematically analysed. Participants were current or recent service users with self-reported mental health needs ($n = 27$), commissioners ($n = 9$) or providers ($n = 17$). Over half of service users did not feel their mental health needs were met and 60% said they would like additional psychological support within T2 WMS. Findings highlight the lack of psychological and emotional support. Psychological support and behaviour change techniques are conflated, with a lack of clear understanding or definition of what psychological support is, either between or within service users, providers, and commissioners. Moving towards more person-centred care, better identification and triaging of those living with mental health issues, together with improved resources and training of providers, is crucial to improve outcomes for people living with obesity and poor mental health.

KEYWORDS
mental health, psychological support, weight management

### What is already known about this subject?

- There is a bidirectional relationship between obesity and mental health.
- Psychological support within weight management is a recognized need.
- There is a dearth of evidence on psychological support within adult tier 2 behaviour change weight management services in the UK.

### What this study adds

- There is a lack of clear understanding or definition of what psychological support is, either between or within service users, providers, and commissioners. There is a need

to clarify the differences between psychological support and generalized behaviour change support.
- Participants emphasized the need for person-centred care and the lack of psychological and emotional support within tier 2 weight management services.

## 1 | INTRODUCTION

Obesity prevention and mental health are both public health priorities in the UK and internationally, with depression and obesity two of the most highly prevalent global public health concerns,[1,2] that co-occur in a significant proportion of people. People living with obesity have a 55% increased risk of developing depression, and people living with depression have a 58% increased risk of developing obesity.[3] A further UK study[4] suggests that the risk of depression is proportionately higher for each added 5 kg/m$^2$ in body mass index (BMI) above 30 kg/m$^2$. There are also high levels of subclinical mental health difficulties within the general population that may progress to more severe illness.[5] Given the well-established association between obesity and poor mental health, it is likely that these subclinical issues are prevalent in those seeking weight management services. However, there remains limited research on effective services for people living with obesity and poor mental health, who need psychological support. The internationally recognized Canadian 5As Team Research Program (5AsT) framework (ask, assess, advise, agree, and assist), used in conjunction with a toolkit to address barriers to implementation, can enable person-centred care which recognizes the need for psychological support.[6,7,8] Anecdotal feedback from patient groups indicates inequity in current service provision, which often fails to meet the needs of this population group. The impact of the COVID-19 pandemic is likely to have further elevated the prevalence of adult obesity and mental illness.[9] UK studies have reported reduced access to services and a deterioration in the mental health and health-related behaviours of people living with obesity, with those living with obesity and poor mental health most severely impacted.[10]

Tier 2 weight management services (T2 WMS) are behaviour change weight management services that are usually time-limited and usually commissioned* by local authorities in England and in some instances the NHS. T2 WMS are usually community-based, providing diet, physical activity, lifestyle, and behaviour change advice, often provided within a group setting for 12 weeks. As defined in the National Institute for Health and Care Excellence (NICE) guideline PH53,[11] tier 2 WMS are for people living with obesity (with a BMI over 30 kg/m,$^2$ or lower from black and minority ethnic groups 27.5 kg/m$^2$) or with other risk factors (comorbidities such as type two diabetes). Also, and where there is capacity, for people living with overweight (BMI of between 25 and 30 kg/m$^2$, or lower for those from black and minority ethnic groups) or with other risk factors (comorbidities, such as type two diabetes). Integrating psychological support into T2 WMS has the potential to alleviate psychological distress (including disordered eating, low self-esteem, and body image distress), improve emotional well-being, health-related quality of life, weight, and risk factors for related co-morbidities, and could help prevent progression to more serious mental health conditions.[12,13] The NICE guideline PH53[11] recommended further research into psychological issues, such as body confidence or attitude, depression, anxiety, and self-esteem in the tier 2 weight management setting. Evidence from an expert paper used to underpin the NICE guideline PH53 refers to a range of emotional experiences from 'mild to severe stress/depression/anxiety, low self-esteem, social anxiety, and low self-efficacy.[14] This expert paper[14] refers to common psychological models being used across weight management services that include cognitive behavioural therapy (CBT), transactional analysis,[15] compassion-focused therapy (CFT),[16] interpersonal psychotherapy, acceptance and commitment therapy.[17] Nevertheless, little is known about the psychological support available within T2 WMS.

To establish the background evidence on psychological support within the UK weight management support we carried out a scoping review of the published literature (https://osf.io/jzh6w/). Despite an extensive search and screening of 2454 references, only five studies met the eligibility criteria. Settings and providers included commercial weight loss providers, primary care surgeries, community-based leisure centres and other local authority settings. All five studies reported they delivered psychological support; however, this varied greatly within and across the studies. Some studies provided psychological support within the service, including CBT and CFT, whereas others offered an initial assessment and triaged to external psychological support services.

Main findings emerging from the scoping review were: (1) a lack of published evidence regarding the provision of psychological support within weight management; (2) psychological support focussed on eating behaviours and weight management, rather than standalone support for wider mental health needs; (3) samples were majority female and white, meaning there is currently no evidence about the need for/use of psychological support within male and Black, Asian and minority ethnic communities.

These findings lead us to recommend that improvement in the identification of mental health needs in weight management services is required.

There is consequently an urgent need to understand the experiences and priorities of people living with obesity and issues, such as emotional, addictive or binge eating, or common mental illness, such as mild forms of anxiety and depression. The aim of this mixed-methods survey was to identify what psychological support is provided in T2 WMS by asking weight management, commissioners, providers, and service users who self-identified as having mental health difficulties that impact their weight management,

their views on the use of, and need for, psychological support. The objectives were to answer the following questions:

1. What psychological support is currently provided in tier 2 Weight Management Services in the UK?
2. What are service user, commissioner and provider views on the use of and need for psychological support in tier 2 weight management services?

## 2 | MATERIALS AND METHODS

Reporting was guided by the Standards for Reporting Qualitative Research[18] (Data S1).

### 2.1 | Design

Three cross-sectional surveys were employed for each of the participant groups with the aim of capturing views regarding current provision and psychological support needs within T2 WMS. A mixed-methods approach was used, including open- and closed-ended questions. Questions were originally written by the authors, and these were discussed, refined, and agreed upon with Obesity UK, Office for Health Improvement and Disparities (OHID), a local authority commissioner, and a weight management provider. Service users were recruited through the Obesity UK support group Facebook pages, and via Leeds Beckett University Obesity Institute using Twitter (tweets from @ObesityInst) and through service provider networks. Commissioners and providers were recruited through the OHID and Local Authority networks. Researchers are experienced in mixed-methods obesity research and worked closely with colleagues from Obesity UK and the Physical Activity and Healthy Weight Leads from OHID in designing the surveys. Ethical approval for the study was granted by Leeds Beckett University Local Ethics Committee (Ref: 95611, February 22). Full versions of each survey can be found in the Data S1 and each survey is described below.

### 2.2 | Service user survey

The survey included 14 questions and the average response time was 10 min. Service users answered four initial demographic questions. Participants were asked if they are current or past user of T2 WMS and were given the option to name their provider. Because we were interested in capturing the views of people with self-identified mental health needs, we asked participants to disclose if they felt that they experienced depression, anxiety, low mood, or stress and how they felt that their mental health difficulties impacted their ability to manage their weight. Service users were asked whether they received any psychological support within their current or more recent T2 WMS, and how they would like their mental health needs to be addressed in future (closed questions). Finally, participants were asked two open-ended questions about the way that mental health difficulties impact their ability to manage their weight and any further experiences about weight management and mental health that they wished to share.

### 2.3 | Commissioners

Participants answered a maximum of 10 questions, and the average response time was 9.5 min. Questions focused on whether commissioned T2 WMS include provision for psychological or general mental health support, the type of support where this is present, and whether they planned to commission this type of support in future. Commissioners were further asked to elaborate on the main barriers and facilitators for commissioning these services, what support or guidance would help them to deliver an effective obesity care pathway, and if they had any other comments to add.

### 2.4 | Providers

Participants answered a maximum of 11 questions, and the average response time was 12 min. Providers were asked if they currently include or plan to include psychological or general mental health support in their T2 WMS, and what the content of such delivery would be. As with the commissioners, providers were asked to elaborate on the main barriers and facilitators for providing these sorts of services, whether they think providing such support would enhance their commissioned service, and if they had any other comments to add.

### 2.5 | Participants

Participants were individuals who were current or recent (last 5 years) users of T2 WMS with self-reported mental health needs ($n = 27$), commissioners ($n = 9$), and providers of T2 WMS ($n = 17$). We were interested in capturing the views of service users who self-identified as having mental health needs and so we screened out service users without mental health needs. We asked people with severe mental illness (e.g. psychosis), a substance use disorder, or an eating disorder to self-exclude from the study.

### 2.6 | Data collection and analysis

This was a time-limited convenience sample, where data were collected online using Qualtrics survey software[19] (Qualtrics XM, Provo, UT), over a period of 6 weeks (February–April 2022). All participants provided informed consent prior to completing the survey. Participants were able to withdraw from the study at any time by closing the web browser, and partial responses were not analysed. All data were collected anonymously, and any identifying information was redacted from quotations during analysis. Demographics were collected for service users only. Quantitative data were summarized and presented as frequencies and percentages.

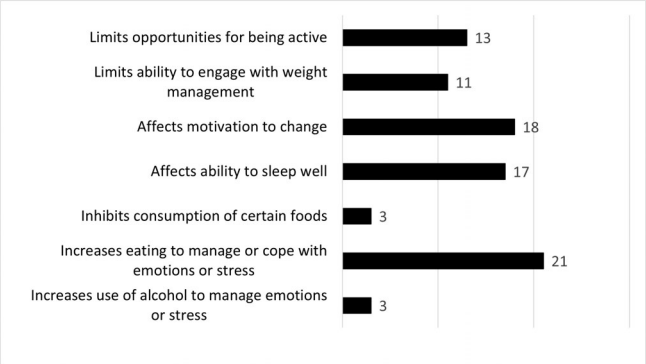


**FIGURE 1** Service users with self-reported mental health needs: their perceptions on the link between mental health and weight management


**FIGURE 2** Number of service users with self-reported mental health needs who felt their mental health needs were met in T2 WMS

Data from open-ended free-text questions was independently coded by JM and TB before data were thematically analysed, following the steps set out by Braun and Clarke.[20]

## 3 | RESULTS

### 3.1 | Completion rates

Of the 162 participants who accessed the survey, $n = 80$ participants did not give consent so could not progress to survey questions, $n = 24$ were partial completions, and $n = 9$ participants said they were not current T2 WMS or had not used such services in the past 5 years. Of the remaining 49 participants $n = 22$ reported that they did not have any mental health needs and were therefore screened out of the study, resulting in a final sample of $n = 27$. The provider survey was accessed 44 times; $n = 11$ participants did not provide consent and $n = 16$ were partial completions, giving a final sample of $n = 17$. The commissioner survey was accessed 41 times; $n = 11$ participants did not provide consent and there were $n = 21$ partial completions, resulting in a sample of $n = 9$.

### 3.2 | Participant characteristics

Service users were asked basic demographic questions; the majority were women ($n = 26$) between 25 and 64 years of age ($n = 23$). Participants identified their ethnicity as White British/Irish ($n = 22$), any other White background ($n = 2$), Black African (n = 2), and Caribbean ($n = 1$). Fifteen were current service users, while 12 had used T2 WMS in the past 5 years.

### 3.3 | Commissioners and providers

Eight out of nine commissioners reported that they do not include psychological support in their specification for T2 WMS. The commissioner who indicated that psychological support was included stated that a psychologist attends one of the 12 sessions and uses CBT-informed emotional eating support. Of the eight respondents who did not currently include psychological support, seven reported that they have no plans, or were unsure whether to commission this sort of support in the future. One respondent stated they were planning to commission this sort of support, but they had not yet developed the specification.

Comparatively, 10 of the 17 providers reported that they currently provided psychological or general mental health support within their T2 services. Most of those who did not provide this type of support had no plans to or were unsure about providing it in the future ($n = 6$).

### 3.4 | Service users with self-reported mental health needs

Participants were asked to reflect on the ways in which their mental health impacts their ability to manage their weight. Figure 1 demonstrates that for this question, the most common responses were participants reporting eating to cope with stress or emotions, poor mental health impacting their motivation to change, and that poor mental health reducing sleep quality.

Service users were also asked whether they felt that they received mental health support within their current or most recent T2 WMS, and the extent to which that support met their needs. Figure 2 demonstrates that of the 24 participants who answered the question, 54.2% did not feel that their mental health needs were met. Participants were further asked how they would like their mental health needs to be supported in the future. Of the 27 responses, 59.3% of participants stated that they would like additional psychological support within their current, or most recent service, while 37.0% wanted to be referred by the service or self-refer for psychological support.

### 3.5 | Qualitative results

Four major themes emerged from the service user data, two of which included subordinate themes:

### 3.5.1 | Mental health and weight have a bidirectional relationship

Service users understood the relationship between weight and mental health to be cyclical, with each impacting the other. Participants spoke of the impact of weight on their self-esteem, but also that difficulties with their mental health impact their ability to engage in weight management behaviours. Service users perceived that person-centred care would help improve engagement and address the relationship between mental health and weight.

### 3.5.2 | Service user understanding of, and need for, mental health support

While service users stated that they wanted mental health support, and mostly within their current T2 WMS service, participant understanding of mental health support differed. Some cited behaviour change techniques (i.e. around '*unhelpful behaviours*' and the '*mental aspects of weight loss*'), which they conceptualized as psychological support. Others reported that they had not received any psychological support and wanted support with managing anxiety and '*personal individual support, like counselling, psychology or something similar*'. Overall, there was no unified understanding of what mental health support is needed, but the participant responses suggested that some people find behaviour change techniques in relation to eating behaviour to be sufficient, while others wanted more enhanced psychological support, which may go beyond eating-specific support. Some service users cited the need for specific psychological support for addictive, disordered, and emotional eating (see theme 4b).

### 3.5.3 | Service user experience of weight management services

This overarching theme contained three subordinate themes which reflect the service user experience of weight management services and mental health support.

*a. The role of the practitioner*

The data suggested a wide variation in care and that the quality of the service user experience hinges on the practitioner. An empathetic practitioner can have a transformative impact on service user experience, but service users described experiences of a lack of compassion and empathy from providers. Participants spoke about difficulties in building a relationship with the practitioner, particularly practitioners who did not have lived experience of obesity.

*b. Challenges in navigating the system*

This theme reflected challenges related to referral, joined-up care, waiting lists, and communication. Service users spoke about waiting a long time to receive mental health services, and healthcare professionals enacting care plans without discussion or consultation with the service user. Data suggested that participants often found healthcare systems and services to be confusing and overwhelming.

*c. Delivery approach*

This theme reflected the need for a person-centred approach and the impact of the mode of delivery, volume of resources, and use of apps in T2 WMS. For example, one participant spoke of finding an app '*difficult to engage with*', suggesting that digital services may not be appropriate for all service users. Service users also emphasized the need for person-centred care, delivered by trained professionals who can give appropriate and tailored advice, and data highlighted the added value of one-to-one sessions. This theme is linked with the 'Role of the Practitioner' (theme 3a) in which one participant expressed difficulties in group sessions ('*I feel I cannot be truly honest in a group class about my anxiety, disappointment and shame as I'm so much bigger than everyone else. Also feel people will judge me if I open up about my personal life'*) but that one-to-one support provided by the practitioner was invaluable.

### 3.5.4 | Obesity as an identity

This theme captured service user description and understanding of themselves, their experiences, and the way in which obesity is central to their identity. It included three subordinate themes which all feature emotive language centring obesity in the lives of these people.

*a. Loss of hope and motivation*

This theme reflected the experience of long journeys in weight management and is closely linked with the theme 'challenges in navigating the system' (theme 3b). Responses suggested that continual lack of joined-up and person-centred care has a detrimental effect, ultimately reducing motivation to engage with any weight management service or activity.

*b. Addictive, disordered, and emotional eating*

Many participants made a clear link between food and emotion, including eating as a coping mechanism. Some also conceptualized their relationship with food as addictive and expressed concerns around disordered eating and binge eating. Eating was always discussed in an emotive way.

*c. Negative impact of stigma and shame*

Participants described the impact of obesity stigma from a societal perspective, as well as the internalization of such stigma. They spoke about shame, anxiety and disappointment, a sense of isolation, having to tackle issues alone, and negatively comparing self to others (Table 1).

## 4 | DISCUSSION

### 4.1 | Main findings

To further understand people's psychological needs and provision of psychological support in T2 WMS, our mixed-methods survey

**TABLE 1** Illustrative participant quotes from service users, organized by theme

| | | |
|---|---|---|
| 1. *Mental health and weight have a bidirectional relationship* | | 'Depression can affect how I perceive myself or think I look fatter than I really am' |
| | | 'It impairs self-esteem which is central to everything' |
| | | 'Perhaps most weight difficulties are driven by or have underlying mental health problems' |
| | | 'I think mental health is a big issue that hinders weight management and that people with obesity should be treated wholistically' |
| 2. *Service user understanding of, and need for, mental health support* | | '…we have had a session on stress management and sleep. I imagine there will be more similar sessions as we go forward' |
| | | 'The programme followed by [provider] focusses quite strongly on mental aspects of gaining/losing weight' |
| | | 'Teaching me how to not let stress affect my eating. Only attended 6 lessons so far so hopefully more of my needs will be met' |
| | | 'Helped to identify some unhelpful behaviours but did not delve far enough into their causes. So temporary change occurred but once effort to implement the change the unhelpful behaviour restarted almost immediately' |
| | | 'I've had tier 2121 and group support. Both have been useful and helped me focus and stay focused. But neither of them helped me to find out why I treat food the way I do and that has to be the only way to change the behaviour' |
| | | 'I would have liked to talk with a psychologist or therapist to better help me with the emotional eating' |
| 3. *Service user experience of weight management services* | *The role of the practitioner* | '[…] the lady who ran it had obviously never had a weight problem and I didn't feel she was at all helpful and nobody seemed to feel free for open discussion […] She was a perfectly pleasant woman but had no empathy or I felt real understanding of what it's like to be morbidly obese and the great physical and emotional strain it puts you under' |
| | | '[…] I do however receive individual support from my wonderful practitioner [name redacted], after class, phone calls and texts and emails. I just wish I could have more one to one sessions with her as I get so much from her and feel I can relate and trust her' |
| | | 'I don't feel the therapist I had was suitable, and my only take away from the 6 months worth of sessions was that she told me I had "the palate of a child" which was neither helpful or useful' |
| | *Challenges in navigating the system* | 'The service provides an avalanche of overwhelming resource links which are daunting to venture into alone, it's not a helpful way for me to try to support myself' |
| | | 'Referred for counselling, but the waiting list is 6 months, so not had any counselling yet' |
| | | 'When I first sought help via the GP, wanting counselling and physical workout support, I was sent straight to tier 4 and found this out when I arrived at an appointment… to my shock that it was straight to surgery without any discussion or warning to me!' |
| | | '…Into my 3rd session and still not received the information pack they said they have supplied. Each week I have advised none-receipt only in the last week did they think to check my address which turns out to be wrong information. Considering I registered and it's also connected to GP practice—how could they get address wrong?' |
| | *Delivery approach* | 'There should be a link between the weight management team and mental health, but you should be able to review the support given and change therapist if the relationship isn't working' |
| | | 'The service offered in [place redacted] is different and I found it worked better. You book a 15-minute slot with a health practitioner who weighs you and then discusses that week's topic with you from your workbook and goes over your food diary to help you one-on-one. It's a different approach from the [name redacted] service and I found it worked possibly better than the group sessions' |
| | | 'Need qualified practitioner not as at present a leisure centre employee, just weighed and handout of booklets' |
| | | 'I found it really difficult to engage with the app' |
| 4. *Obesity as an identity* | *Loss of hope and motivation* | 'Sheer amount of time. 3 years in and no end in sight. Feel like I'm dying a little every day' |
| | | 'I live on my own and I am finding it increasingly difficult to be motivated to lose weight' |

**TABLE 1** (Continued)

| | |
|---|---|
| | 'I feel hopeless sometimes, that I'm never going to get healthy again' |
| *Addictive, disordered and emotional eating* | 'I feel I have a sugar addiction and as soon as I try to really cut down on my sugar consumption, I get very irritable and quite low in mood' |
| | 'My anxiety leads me to eat which lifts my mood, only for it to crash again a little while later, and so the circle begins' |
| | 'I'm aware that I comfort eat and sometimes binge eating. I don't yet have a binge eating disorder, but I could end up that way if I keep on behaving the same as I do now' |
| | '…not being able to channel my anger and frustration caused by what I now realize was the withdrawal symptoms from sugar and generally tasty food… I felt so resentful and unable to have my usual fix of a bar of chocolate or whatever' |
| *Negative impact of stigma and shame* | 'I am ashamed of my weight; I feel a failure as I have been overweight all my life. I hide away because I get anxious when people see how big I am' |
| | 'I feel I cannot be truly honest in a group class about my anxiety, disappointment and shame as I'm so much bigger than everyone else. Also feel people will judge me if I open up about my personal life' |
| | 'I don't feel comfortable going into the gym full of other people' |
| | 'Hopefully [WM service] will teach me to love myself and not be so ashamed and disappointed in myself' |

captured the views of service users, commissioners, and providers. The themes arising from the data were: (1) Mental health and weight have a bidirectional relationship (2) Service user understanding of, and need for, mental health support (3) Service user experience of weight management services (4) Obesity as an identity. The responses to the survey produced several important findings which highlight that understanding of psychological support needs further examination.

Across service users, providers and commissioners, responses suggested a disconnect in understanding of whether psychological support is currently a feature of T2 WMS. Most commissioners stated this type of support was not included in their service specification, while the majority of providers asserted that they do provide psychological support. Currently, T2 WMS is not designed or commissioned to include psychological support. It is therefore unlikely that providers will give additional psychological support that they are not commissioned to deliver.

When asked to describe the psychological support they had received, some service users described behaviour change techniques, while others stated they had not received psychological support and discussed broader conceptualizations of this including therapy/counselling and mental health support for stress, anxiety, and depression, either independently or in addition to psychological support for eating behaviour. In summary, our data suggest that there is no shared understanding of what 'psychological support' is, whether this is currently provided, and highlights a conflation between psychological support and behaviour change techniques for weight management.

The service user responses suggested that individuals with self-identified mental health needs perceive there to be a link between their mental health and their ability to manage their weight. Specifically, service users cited eating to cope with stress and emotions, poor mental health impacting their motivation to change, and that poor mental health reducing sleep quality. The link between emotions and eating behaviour is well-established in the literature, and emotional eating is associated with poorer weight outcomes,[21] and may be associated with difficulties in identifying and regulating emotions.[22] Additionally, our findings highlight weight stigma as a stressor, leading to feelings of isolation and inhibition of healthy behaviours, such as being active. Weight stigma is defined as a combination of prejudice, discrimination, and negative attitudes aimed at those perceived as overweight.[23] There is evidence that exposure to such social identity threat can provoke high a psychological stress response, which in turn can lead to negative emotional, physiological, and behavioural responses influencing weight gain.[24–27]

Forty-five percent of service users that completed the survey did not feel that they had mental health needs and were therefore directed out of the survey flow. This is an important finding and aligns with previous studies which have found between 20% and 60% of people living with obesity also have a mental health condition,[28] meaning there will always be a proportion of people who go into the service who do not have (or feel that they do not have) mental health needs. This suggests that appropriate screening for additional mental health/disordered eating needs is necessary at the outset of T2 WMS in order to better identify and support those with mental health needs. Given the complex relationship between mental health and weight, better identification of those with mental health needs and/or disordered eating is likely to impact on the likelihood of success for these service users.

However, for T2 WMS to be effective, we need to determine the needs of individuals at the outset and put service user needs at the centre of programme design and delivery. A recent study by Liapi and colleagues[29] which examined an integrated care programme for obesity and mental health concluded that service user needs are paramount and must be prioritized over and above organizational integration.

### 4.2 | Implications for policy and practice

Our findings can inform the development of weight management services for a substantial proportion of people living with mental health issues and obesity.

It is crucial that emotional eating is identified and treated in people seeking treatment for obesity, as there is evidence that caloric restriction may exacerbate emotional eating.[30] The qualitative data suggested service users identify their eating behaviour as disordered and problematic, including addictive, emotional, and binge traits, but that there is a lack of support and understanding for these issues. Psychological support specifically related to obesity, such as emotional, addictive, and disordered eating, does have a place within weight management services, but this will require additional training and resource as existing staff are unlikely to be qualified healthcare professionals and this support must be tailored to the individual person living with obesity. In terms of more specific mental health support, there may be an opportunity to triage into existing services. Such triage would likely require input from qualified healthcare professionals to communicate with GPs to make onward referrals.

A study of the Glasgow and Clyde Weight Management Service showed that patients who were offered additional psychological input from qualified healthcare professionals, due to their psychological co-morbidity (severe anxiety or depression), achieved similar or better weight loss outcomes than patients without this additional input.[31]

Service users were unequivocal in their description of difficulties in accessing appropriate, person-centred care for their weight and mental health needs. The role of the practitioner is crucial, suggesting that appropriate recruitment, training, and supervision of coaches and other providers is paramount, particularly ensuring that empathy and ability to triage to other services are well-established. Service users appeared to find one-to-one sessions to be more beneficial, but this may be associated with the ability of a coach to manage group sessions appropriately; further research into appropriate delivery models is necessary.

In summary, screening is needed to identify people with mental health needs, and enhancement of the service pathway is required for people who need psychological support that is distinct from their eating behaviours. This research with service users suggests two strands of support; (1) low-level psychological support for general health and well-being, and some support for disordered eating within T2 WMS, to include enhanced training by providers to offer a 'toolkit' of support similar to the Canadian 5As toolkit[7] (2) triage for people living with obesity and enduring mental health problems including, trauma, anxiety, depression, and eating disorders.

### 4.3 | Limitations and next steps

Although this report provides some valuable insight into service users experiences within weight managements services and their views on the role of psychological support within T2 WMS, limitations must be acknowledged. Despite promoting the survey through various obesity-related networks and community links, the data were based on a small convenience sample which was mainly female and white, collected using a survey that was open for 6 weeks. Although the survey reached 162 people, 80 of these people did not give consent and so could not progress to survey questions; 24 out of the remaining 82 participants started but did not complete the survey. This places limitations on the generalisability of the findings and the representativeness of the sample. We acknowledge that the sample as a whole might be more engaged and motivated compared to a general population sample that was not tier 2 service users. Some people may have clicked on the survey link but opted not to continue when they realized that the survey was not directed at people in their tier. It is not possible to conclusively state why individuals accessed but did not complete the survey; however, one hypothesis based on anecdotal evidence from colleagues in Obesity UK, is that many people who are engaging with weight management services are not aware of which tier they are in.

It is important to emphasize that the findings of this research are preliminary and provide a foundation for future in-depth assessment of what service users, providers, and commissioners perceive to be 'psychological support', including what this would look like in a tier 2 level service. Future research must seek to gather data from a larger and more representative sample.

## 5 | CONCLUSION

As we move towards more person-centred care, targeting and tailoring of T2 WMS are required. It is clear from our findings that the current tier 2 weight management service is not equipped to meet the needs of people living with obesity and associated mental health issues. There is a need for an integrated care service for people living with mental health issues related to obesity. The need for improved and integrated service is recognized by service users, providers, and stakeholders of these behaviour-changing T2 WMS, both in the published literature, and our survey findings.

### AUTHOR CONTRIBUTIONS

All authors developed the protocol which was registered by Tamara Brown. All authors designed the survey questions, Jordan Marwood set up the survey via Qualtrics and collected the data. Jordan Marwood and Tamara Brown analysed the survey data. Authors from Leeds Beckett University interpreted the data. Jordan Marwood and Tamara Brown wrote the first draft of the paper, and all authors were involved in redrafting the paper and had final approval of the submitted and published versions. This work was funded by the Office for Health Improvement and Disparities.

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## CONFLICT OF INTEREST

Jordan Marwood, Tamara Brown, Mariana Kaiseler, Kenneth Clare, and Louisa Jane Ells were funded by the Office for Health Improvement and Disparities to undertake this project. Jamie Blackshaw declares no conflict of interest. Tamara Brown holds an Academic honorary contract with Office for Health Improvement and Disparities 2022–2027. Tamara Brown has received consultancy fees from the British Dietetic Association General Education and the European Association for the Study of Obesity. Mariana Kaiseler declares no conflict of interest. Kenneth Clare receives consulting fees from Apollo Endosurgery, Inc. and Lilly. Kenneth Clare receives payment or honoraria for presentations, speaking, and educational events as a Member of Global Patient & Patient Organization Advisory Board for Obesity, Boehringer Ingelheim, and a Member of Patient Advisory Board for Novo Nordisk. Kenneth Clare receives support for attending meetings and travel as a Member of Global Patient & Patient Organization Advisory Board for Obesity, Boehringer Ingelheim and a Member of Patient Advisory Board for Novo Nordisk. Kenneth Clare participates on an Advisory board as a Member of Global Patient & Patient Organization Advisory Board for Obesity, Boehringer Ingelheim and a Member of Patient Advisory Board for Novo Nordisk. Kenneth Clare is Trustee for the Association for the Study of Obesity UK; Trustee for WLSinfo; Chair of the European Association for the Study of Obesity; and Director of Bariatric and Metabolic Surgery Services at Obesity UK. Alison Feeley is affiliated to the Office for Health Improvement and Disparities. Jordan Marwood is affiliated to the Office for Health Improvement and Disparities. Louisa Jane Ells holds grants for the National Institute for Health Research, Office for Health Improvement and Disparities and Leeds City Council. Louisa Jane Ells has received financial support (travel and accommodation) from the European Association for the Study of Obesity to teach at the 'train the trainer' event. Louisa Jane Ells is a specialist academic advisor to the Office of Health Improvement and Disparities.

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## ENDNOTE

* Commissioning is the process of assessing needs, planning, and prioritizing, purchasing, and monitoring health services.

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## SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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