Interviewer: So can you start by telling me what your role is within IAPT and working with patients with long term health conditions.

14: So I'm a psychological well being practitioner and as part of my own special interests, I guess I do work, a bit more closely with patients that have long term health conditions, whether that's more on a clinical level, or whether it's to do more with outreach projects and liaising with other physical health care services.

Interviewer: OK, what do you mean by outreach projects? What would you usually do?

14: So perhaps if there's a bit of joint work that our service and another service are wanting to do, I might help set that up and whether that's a clinical kind of outreach there, whether we're arranging and emotional health check projects within that service, or if we're just educating their members of staff on what IAPT is just to encourage them to refer to us so it will either be to set up joint projects and you know, work a bit more collaboratively or it will be around educating their members of staff.

Interviewer: OK, and how do you find that outreach work then?

14: It's generally, I think, often quite well received by the other services. I think it does take a lot of time to fully explain the role that IAPT can play with their clients. I think it's quite a difficult thing I think for health care professionals to understand fully, and especially when they don't work within IAPT and often don't necessarily work within a mental health care setting for them to understand fully kind of what mental health need looks like and you know when and how IAPT might be suitable. I often find that that's a bit of a challenge for them but is often quite well received and they do often sort of mention that there needs to be something in place for their clients that do have mental health difficulties. So, I think they often recognized the need, but it's usually quite time-consuming to do that education.

Interviewer: And how do you manage that? If we do find it challenging or time-consuming, how do you manage that?

14: I think it's just about communication with the services. I think in the past we've kind of done one off sessions and that just hasn't been enough for their service, so I think establishing a bit more frequent communication and relationship with the services so that they can meet bit more frequently with us that we're always on their radar or umm give them an opportunity to sort of ask questions as a bit of a follow up usually works quite well and I guess it's just I mean maintaining that relationship a little bit rather than just saying ‘we've educated you now on IAPT so refer to us’. It works, but better when there's just a bit more of a yeah, a relationship there.

Interviewer: And is that manageable that relationship within your working in kind of environment?

14: I, I think it's definitely manageable to do, not, maybe not necessary with myself, but if you know with other people kind of being involved as well just because my time is a little bit more limited, but I think it's helpful for there to be any sort of one person that is that main point of contact for that service or for that team just so they know that you know there's one person to contact just makes it easier. I think for them, and I think it also makes it a little bit easier for us as a service to gain a bit of feedback. I think sometimes when there's a huge amount of people involved, it can be difficult to establish the progress that's being made and you know well how we need to kind of change things.

Interviewer: And how do you feel that supports patients then? That outreach work that you would do.

14: I think it's definitely it feeds back into their care in a real positive way because the staff hopefully after our work and contact with them a lot more skilled and knowledgeable about what to look up, lookout for umm and I think a lot of the time it's to do with their confidence in kind of highlighting that they've noticed a problem and you know, knowing how to handle that situation and what to do. Cause I think sometimes there's a bit of anxiety to bring something up and then not know how to contain it and not know where to send that person afterwards either. So, I think it definitely makes them feel a lot more confident in having those discussions with patients and also, I think it makes that pathway a bit clearer for the patient as well, especially if we're doing a project where they automatically get referred to the IAPT service. It stops them from having to dwell on it for too long and you know they may even feel that they need a bit more support making that contact. So yeah, I think it makes the professionals a little bit more confident having those conversations, but it also makes the pathways between the service is a lot stronger. So, patients end up in the right place.

Interviewer: OK, and how do you feel about working with patients of long-term health conditions?

14: I really like it to be honest. I will admit when I first started working within IAPT it wasn't an area that interested me a huge amount, but I think because I've had my own kind of experiences with my physical health and injuries and things like that, it's definitely made it a lot more relatable for me as I guess there's a as a topic and that sort of captured my interest a little bit to kind of start working with those clients, but more is like doing all these outreach projects. And then by doing that, I think I saw this or that there was like a huge need in that area. So, I think that just made me even more interested to target that, especially in the local area.

Interviewer: OK, and how confident do you feel in delivering treatment to those patients?

14: I feel a lot more confident now just purely because I've gone, I've just finished umm LTC training, top up training. So that finished about two months ago now, before that I was passionate about it and enthusiastic, but I probably wasn't as confident in managing some of the barriers that may come up and knowing kind of how to use the interventions a bit more

effectively. Whereas now I do feel like I have that skill set and knowledge. So yeah, I feel a lot more confident now.

Interviewer: OK, and he mentioned barriers there, So what would when your experience? What have been the barriers with those patients?

14: I think a lot of the time it's just been very understandable difficulties that have just meant that they've struggled to implement behaviour activation, how we would typically apply it to somebody that perhaps didn't have the long term health condition, so if they've perhaps, yeah, run out of energy or been physically incapacitated to be able to do something. I think previously in treatment that would sort of floor me, and I'd think, 'well, gosh, OK, how do we? How do we get back on track with that' Whereas now I kind of. I know, kind of how to work around that little bit more, and I think I feel a little bit more less anxious about the prospect of being floored by that because we know that it's completely understandable.

Interviewer: OK, and so when you come across those barriers before and there's been kind, those challenges has it had any impact on you as a practitioner?

14: Yeah, I, I think so. I think it's probably more anxious each time it so I yeah, I just bit more nervous maybe about how to deal with it. And then I think just for me, particularly just I get a bit like self-doubting and after I think before when I had those kind of barriers come up I would sort of doubt myself as a practitioner and I doubt myself in in terms of my competency as well.

Interviewer: And are there any ways that you would manage that?

14: Yeah, I'd always use supervision. I'm quite, I think I'm quite reassurance seeking and talents of using supervision for that. And then I think, for those kind of wider issues about any kind of maybe not feeling very competent. I'd just try and use my line management to reflect on it, and I feel like for me Line Management, the reflective element of it's important for me, so I'll often bring cases like that, where I've perhaps felt floored by patients. Or yeah, I just found it found that I couldn't really find path through what they were telling me. so yeh line management and supervision.

Interviewer: and are there any other ways that you feel those patients will have any more barriers that you think you've come across at all?

14: Yeah, I guess kind of certain kind of presentations from MUS has always been a tricky one. I've found just purely because they're in my experience, the patients that I've seen with MUS difficulties have been there, been have come because there hasn't been any other avenue that has been successful with their physical health so often find that we're kind of like the last service that they get referred to come, and there's often a bit of and what I've seen in those patients, a bit of anxiety around you know what role we play and how are we going to help them address their physical health concerns. So that's always been something too I've tried to

overcome by just kind of normalizing what it is that we do and just doing a little bit of education. And I wouldn't necessarily say it's a barrier or just say it's more of a small hurdle.

Interviewer: OK, and do you feel there are any presumptions or preconceptions about working with people with long term conditions?

14: I think I probably held them myself before I started working more closely with our LTC patients. I remember kind of in in in our kind of I guess our office area there was just this feeling of like low self confidence around working with LTC's and I think that probably is what underpinned my own apprehension about working with it because I just assumed that it was this really kind of tricky area to work with patients in. So yeah, I would have thought that, but I think for me that was something I challenged quite a bit on doing the LTC top up training and then also having had personal experiences of it as well. I think that really helped.

Interviewer: OK, and you mentioned the training there. What do you thinks it's helped with you delivering treatments those patients?

14: Well in terms of the biases side of things, I think they're quite open with that on the training and they do sort of actively ask people to describe their beliefs about that cohort and you know, think about why we might think like that. And I found that was a really helpful exercise just to challenge those beliefs a little bit more. I just think having additional content I'm a bit more. I'm quite like a nerdy learner. I guess you describe, always looking at learning a little bit more and I just found it really interesting to learn a bit more about the physical health conditions that they talk about on the course. Just 'cause that's never been something I felt particularly knowledgeable on, but also to kind of think about how we might adapt all the interventions that we're taught at Step two to, you know, be applicable for those conditions, so I just felt like I came away with it with a bit more knowledge about the health condition and then you know how to adapt those existing knowledge and skill sets that we already have to certain presentations.

Interviewer: OK, and if you've been working in the service for quite a while, do you think there's been changes overtime in how you deliver treatment to these patients?

14: Yeah, absolutely yeah. I think when I first started we were we were still we still have that separate LTC service which looking back probably did fuel some of the apprehension that people had around working with LTC because often the process would be once someone had kind of been acknowledged as an LTC client, and that's kind of what they needed, adaptations were in their treatment, they would be referred specifically to the individuals in our service that worked with LTC's. And I think there was that kind of idea of like lack of ownership in a way it's like here 'I don't need to work with you I can refer you onto that particular service'. And so I think that's been a major change in that now we incorporate, LTC's within our main service. So I think it's forced a lot of people too, you know, kind of just address that within themselves and kind of work with those clients, including myself. And so I think that's been a major change. I think looking at our assessment process, so I think that's probably also been another change,

we never used to ask patients around her physical health at the assessment, or ask if they had any conditions, whereas now we do and we don't just ask that particular question. We then have kind of other questions that feed off from that. If they do have a physical health condition so we ask them a bit more about what their knowledge of that condition is, how they manage it, what their feelings are about it. So we kind of get an overview of the relationship that they have with that side of things, umm which I think means that we're picking up more on that kind of LTC presentation a little bit early on.

Interviewer: OK and do you think there's been changes for patients, then, but do you think it's been beneficial for patients to those changes that you've noticed in the service?

14: Yeah, definitely . I think we, not only are we kind of highlighting a little bit sooner, I think we're also umm yeah, I think I just probably go on to lead to bath the patient care because we can ask them quite specifically then if that's something that they feel is relevant and they want to be taken into account with regards to their treatment. And I think also our courses have probably changed quite significantly as well since I first joined in that there are lot more and widely available now. And also the big change with our waiting lists in that patients were accessing their treatments sooner including LTC clients.

Interviewer: OK, and what differences do you feel there are working with patients with LTC compared to core IAPT patients?

14: I think there's usually some, there's usually some anxiety around their condition, more so than a patient that perhaps maybe does have some depression and maybe anxiety comorbidity it seems that anxiety, in my experience anyway, it's just been a little bit higher with those LTC clients just because they've got an understandable amount of worry that they perhaps have around their physical health condition, especially if it's something that's been newly diagnosed, and so if they are comorbid with anxiety, I do say that's usually a higher level of anxiety than are main patients, and I also think as well they've got very realistic and limitations perhaps so things that they would love to be doing, but aren't able to do as much or you know do in the way that they used to do. And that's something that I think they feel that they have to umm completely strike off from their life if they're no longer able to do it.
Whereas some of the work that we will do will often be just to kind of see if that's something that they can still incorporate in their life. But maybe in a way that they haven't thought of before or with some other adjustments that they haven't thought of. So I think they come into it believing that, 'OK, I can't do these things, so I'm going to strike them out', and whereas we would kind of teach the opposite and still think if we can incorporate that, I find that sometimes the interventions are a little bit more mixed than perhaps it would do if we were doing it in the main service. I think we do try and keep it as single strand as possible, but like I said, if there is that kind of higher level of anxiety, sometimes we might just take that into account in in incorporate something just to help them manage that anxiety. So the sessions in my experience tend to be a bit more meaty, a bit more packed and it may just not be one single thing that we're doing with somebody and maybe 90% single strand, but then with a little bit ad hoc bits thrown in to help them manage them or the other parts of the difficulties.

Interviewer: OK, and how do you feel about delivering that as a practitioner then, if it is a little bit different, a bit more meaty, does that have any impact on you at all?

14: Yeah, absolutely, I find that it's not a session that I can kind of go into with very little preparation. So do you try and make sure that if I do have an LTC client, I'm quite mindful about where I booked them in in my diary and not necessarily booked them in in you know, in a really busy period of time for me when I know that I'm going to be kind of just going from client to client and so I do try and make sure that I got a little bit time just before hand just to kind of make sure that I've got the materials up that we are using and what I usually tend to do I don't just do this specifically for LTC clients, but in my in my notes I always put in kind of what it is that we're going to focus on next session, so that if I am a little bit more pressed for time I can look at that and think, 'OK, Yeah, I'm I know I need these bits up'. So I feel like I've got a bit more preparation underneath, and I'm also a little bit more conscious of time or I try to be. Umm just in the sense I don't necessarily want to keep them on the phone for longer than the allotted time, because that's not always helpful. Umm but I'm just conscious and making the most of the time that we have. So umm I try and make sure that the sections of the treatment that we would normally have I just stick to those timings a little bit more quickly so that I can spend the vast majority of the time talking about this session and like the work that you're doing.

Interviewer: OK, and you don't have any difference in like building a rapport or therapeutic alliance with those patients at all.

14: It's good question. I don't think so, I think. I think 'cause I've had personal experiences of long term conditions and kind of feeling restricted and limited by things. I think that's kind of giving me a better insight into why someone might feel as exhausted with it as they are, or frustrated with it, so I think I've learned not to take those traits personally if the patient is presenting like that and in that I know it's not necessarily me that they're frustrated, I know it's because of the wider situation. So I think in a way I haven't had that difficulty myself. It is helpful. I often find that sometimes help a patient will have so many health care professionals working with them that they sometimes confuse me for someone else. And that's happened quite a few times, so I'm usually kind of still mindful to introduce myself and just make sure they know who I am and that they remember kind of, you know which professional I am because I've had sessions before where a patient is kind of thought that I've been someone from the ME service for a session, and that's been a bit tricky.

Interviewer: OK, and we talked about the barriers to kind of people engaging kind of in the service. Do you feel there are particularly facilitators or things that promote engagement In treatment for these patients.

14: what from the service to initiate?

Interviewer: or from you as a practitioner or the service.

14: I think to be honest we could probably be doing a lot more on outreach to certain population groups umm within LTC, I think there's still a lot of healthcare professionals that still don't know what IAPT is and the role it can have come. And I think in an ideal world we would like an outreach project with every area of physical health services. Especially with the local hospitals, so some of the bigger ones like Yeovil from Musgrove, I know that they often do, they have like kind of promotion days for different from different days, you know, kind of holidays and kind of things to do with physical health conditions. And I think that we could probably access that a little bit more. But I know COVID's kind of stopped a lot of those projects, so I don't know if that's realistic now. So yeah, I think there's a lot we could be doing more outreach. Umm I also feel like I website did some serious attention in that I don't think it looks like something someone with a physical health condition would ever go onto because they might just look at this in there 'I don't really know how this is pertinent to me' and so I think that there could be a lot more that we do on there. Whether that is just kind of like a specific LTC section with even like patient experience, videos and things like that would be really helpful. I think whenever I've looked at it from, with my physical health difficulties in mind after and think, 'this just doesn't, this doesn't feel relevant. I don't know how this kind of relates to me'. So yeah, I think there could be some work on there.

Interviewer: Are there particular components of treatment that you deliver that you feel are particularly helpful for patients.

14: yeah, pacing. I know probably everyone said that. But yeah, I feel like that's always a really helpful and intervention and a tool if we're not necessarily working on that completely, the concepts involved in pacing I think can be applied to every strand of intervention we deliver umm so, yeah, whether it's a single strand intervention, whether it is being applied as a sort of ad hoc tool, I think that always I'd say like 90% of the time played a part in my LTC treatments.

Interviewer: What is it about pacing then that you think is helpful?

14: I think it's just it's that more gentle approach and it gives that patient that permission that they don't need to act in the ways that they would have done previously, and they don't necessarily need to fall into that boom and bust cycle, so knowing that they can be gentle with their activity know that they can pace themselves in in the way that feels right for them. I think it just gives them that permission to do it rather than that, as I think they come into that mindset with the idea of OK 'well, that's laziness or that's you know, I'm not I'm not making the most of my time' and they have all these expectations and beliefs that they should be acting in certain ways and I think pacing is just a really nice way to just work around that and give them an alternative choice

Interviewer: OK and are there any components or treatment that you deliver that you feel are particularly challenging to deliver for those patients at all.

14: I found CR to be a tricky one, not necessarily intervention itself, but more so what the client will use or do with CR. I often find more, so without LTC patients that the cognitions that they bring aren't always NATs specific, and I think it's quite common to do that for any patient. They may bring a number of different cognitions that aren't always in line with what we would work at at Step two, but I just find that seems more prevalent without LTC clients, and that there's usually a session that's needed to kind of identify or support them in identifying the NATS's a bit more clearly, and so I just yeah, I just find that they often bring thoughts that are probably linked to deeper issues, or they're bringing cognitions that are perhaps true. Umm so cognition like ' I can't I can't work anymore' or 'my condition isn't going to get better' so I find that although that's still something we can work with and we can kind of have to take that down a different road of 'OK so even if that is true, what is it that we can do about that? How can we address it more from like a problem solving perspective'. There is an element there of OK, those thoughts do have a tendency to be true.

Interviewer: OK, and how are you supported and delivering treatment for these patients?

14: And so we will have weekly case management supervision, myself just 'cause my hours that tends to be fortnightly and which is still is still fine 'cause my sessions with my LTC clients do tend to be fortnightly anyway. Umm and then I we do have clinical skills as well, which is quite useful, especially if it's a condition that I've not heard of before. So I think it's quite an interesting place to just take that to the group and see if they've ever dealt with that before, and umm if they have any kind of tips to share.

Interviewer: And is case management supervision is that helpful specifically for those patients.

14: Yes, I would say so. I think I feel a lot more lost without it, even though I usually have a fair idea of what I'm doing. It's nice to just have that confirmed by someone else and say, 'yeah, that's you know the right thing to do'.

Interviewer: And he mentioned the training and we talked about how it was helpful. Is there anything from the training that perhaps wasn't your helpful, or you felt there could have been more or something different.

14: I am trying to think now, I was a while ago we had our teaching days, they were back at the beginning of the year. Yeah, I get, I get the rationale of why they did it this way, but I did wonder if it could maybe be different, just the structure of it in there is usually one day, a month or so and just for me and how I learn, I would have liked to be a bit more frequent I think. I understand why they did it that way because they wanted us to practice with their clients in between those sessions, but for me I just I really valued the teaching experience and would like that to be more frequent. I also think is why it was done remotely because of COVID and I would have preferred it to be in person, but I think that's just me and my learning style.

Interviewer: OK, is there any further support outside of those things that you mentioned that you think could be beneficial to help support you delivering treatment to those patients?

14: umm I don't think its necessarily helpful for the implementation of treatments 'cause I got case management supervision for that, but I think looking at like the impact of LTC clients on me and especially 'cause I have a tendency to like over relate to patients with LTC's, usually my line management really helpful for that. Especially if I feel like you know I'm getting quite attached to a patient or I feel really feel for them and their situation. I just find line management so good place to just diffuse that.

Interviewer: OK, and do you feel that COVID has impacted on treatment for these patients at all?

14: yeah, I think it's probably impacted how well they've been able to engage in the treatments that's been offered, but also in how well we've been able to access those patients. You know, with fewer people being able to have contacted their GP umm through COVID, and I think that's kind of had an impact on how many referrals we've had with our LTC clients, not just with their GP, but other physical health care settings. I think there are a lot of patients that haven't accessed their physical health department and therefore our referrals had probably subsided. And I think there's just always felt like there's been this underlying sense of anxiety in all of the patients I've treated in a sense that, they are obviously anxious about the COVID situation because her physical health, but it is, it is an anxiety that's really understandable, and it's not necessary disproportionate to the situation. It's just always there. So that's had an impact sometimes in how we've delivered a treatment, because it's just taking a while to work out ok is that anxiety actually disproportionate, or is it really understandable and actually safe to be a bit anxious as well.

Interviewer: And what about long COVID, is that something that you've come across at all?

14: I have literally come across one and that was today, in a patient I reviewed from our LTC group that had long COVID, but I haven't actually had any other patient contact with long COVID since then.

Interviewer: And how do you feel, how would you feel about working with patients long COVID.

14: originally, I felt fine with it and to be honest and I've had like a couple of the training sessions that were delivered by the IAPT national webinars. I think in this moment right now I probably felt that anxious about it, but I think that's probably just because of the patient I've just worked with umm today in in that, it was really difficult to identify what she wanted help with, whether it was anxiety, or whether it was pacing related stuff because she was quite anxious about catching COVID again and she's had long COVID for a year now and she was quite anxious about catching COVID now and it impacting another Christmas, and that seemed to be quite prevalent issue but I didn't necessarily, I found it quite difficult to identify whether that will actually the treatment focus, or it was the underlying issues of her energy and concentration.

Interviewer: OK, so that all of the questions that I have was there anything else that you wanted to discuss that you felt would be important to know about your experience working with patients with long term conditions.

14: No, I wish there were more adaptations that IAPT could make up for them, just in the sense of our sessions at Step 2 and the focus of them. I don't know whether it was just the patients I've worked with or me just getting used to using the interventions in the recommended way. But I've often found that it I feel like I could do with more sessions at Step 2, and I've often approached my supervisor a few times now and sort of asked and tried to present a rationale for further sessions, because I feel like it's either taken a while for them to implement it, or it's taking a while for them to understand it. So yeah, I just wish sometimes we could be more flexible with the sessions that we offered.

Interviewer: OK, that's great, thank you I will stop the recording.