iapt
Improving Access to Psychological Therapies

NHS

IMPROVING ACCESS TO PSYCHOLOGICAL THERAPIES FOR OLDER ADULTS

COMPETENCE FRAMEWORK and INDICATIVE CURRICULUM

COMPETENCE FRAMEWORK

This framework has been developed under the guidance of Tony Roth with input from a wide range of experts in the IAPT and OP clinical, academic and research fields. It has been consulted upon and it should now be used to ensure that IAPT qualified staff and those on IAPT training courses achieve these basic standards of competence.

INDICATIVE CURRICLUM

This has been drawn up to assist local services to deliver training locally, based on the competence framework. It has been piloted in Southampton and Oxfordshire, supported financially by S. E. Central, and been amended in the light of their findings.

It is recommended that a joint approach to delivery of the training between the IAPT lead *and* the local OP specialist service is adopted. In some cases, this may involve joint working with the relevant University. It is recognised that the ability and opportunity for collaborative working between IAPT and OP specialist services vary across the country; it is clear that good collaborative approaches improve services and outcomes for clients.

It is expected that the curriculum can be undertaken over two days of training. It is recommended that preparatory reading is undertaken in advance of Day One, this is likely to take approximately half a day.

It is recommended that the first day is delivered to a joint group of PWPs and High Intensity Therapists of all modalities . The second day is differentiated for low and high intensity approaches to assessment and treatment and should be delivered separately. The High Intensity element is focussed on CBT and is therefore aimed at CBT therapists. A further recommendation for the four modalities of Counselling, Interpersonal Therapy, Couple Therapy for Depression and Dynamic Interpersonal Therapy will be issued in March 2013.

The curriculum is deliberately indicative in order to enable local trainers to build on their own experience and context. Local trainers will also want to take account of the extent of previous experience people may have in working with older people.

Materials to assist in delivery have been developed and tested jointly by Oxfordshire and Southampton and will be available formally from the end of February 2013.

It is recommended that, following training, each worker works with at least one Older Person with appropriate supervision

FORMAT

The indicative curriculum will be structured into modules as follows:

- Aims of Training
- Competences
- Teaching and Learning Methods

DAY ONE

MORNING

ASSESSMENT

A pre and post course self-assessment using the Therapists Attitude Scale (TAS) is recommended and attached as *Annex Three*. This addresses trainees' attitudes to old age and working with older people testing knowledge, values and confidence.

Module 1: BASIC STANCE

Aim of Module

To reflect on values and attitudes to Older Adults and the implications this has for engaging with an older person entering IAPT services.

Competences covered in this module:

Ability to draw on knowledge of the barriers for older people in accessing services

An ability to reflect on the assumptions and expectations that referrers may make about referring older people for therapy and the impact that this may have on referral patterns
An ability to reflect upon the assumptions and expectations that older people may have about being referred for assessment and treatment or accessing services and how this may impact on engagement
An ability to draw on knowledge of practical barriers faced by older people to accessing mainstream services

Ability to consider the impact of assumptions about ageing and old age

An ability for the practitioner to reflect on their own attitudes, biases and experiences in relation to older people and any impact that this may have on their work with older people e.g.:
• assuming that older people will find it easier to make use of "concrete" components of an intervention, and harder to use more "abstract" elements
• assuming that older people will not change
• assuming that older people do not want therapy
• assuming that the person's difficulties are an inevitable consequence of aging (e.g. that a decline in mobility is the explanation for their depression and no psychological process is relevant)
• assuming that most older adults will experience distress or pathology, or become dependent on others
• assuming that older adults are a homogenous group
An ability to take a 'holistic' stance that conveys respect and promotes engagement by:
• identifying the older person's strengths and resources as well as their difficulties
• helping the older person to develop meaningful goals which connect to previously valued roles
• valuing the older person's expertise in relation to their life experiences

Indicative teaching and learning method

- Start with demographics – setting the factual, positive context (busting myths, highlighting "living longer, living healthier").
- Positive exemplars of ageing used to challenge expectations e.g.
    - Fauja Singh – 100 year old marathon runner (took up running at age 86 for something to do)
    - Include normative examples as well, to avoid too much emphasis on outliers

Explore experience of working with older people in pairs and feedback

Project self into older person and consider appearance, social networks, lifestyle etc.

Quiz about ageing, help people to reflect on their current situation.

- Describe 'fallacy of good reasons' or the 'understandability phenomenon' in late life depression and corrosive concept of therapeutic nihilism.
-

Use case studies and vignettes e.g. experience of loss

Look at Bob Knight (2004, 2009)

Community dwelling older people (lower rates)

- Discuss Blazer (2010) and his 3 reasons why rates of depression are lower in older people (Positive optimisation, wisdom & better emotion regulation strategies).
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Specific populations (e.g. post-stroke depression, LTC residents, dementia etc.)

Discuss how the context of depression in older people may present differently but the techniques are the same (see example of dementia caregiver).

Module 2: BASIC KNOWLEDGE

Aim of Module

To become familiar with the demographics and factual issues related to the ageing population. There is a significant amount of material in this module which would be best addressed by preparatory reading.

Competences covered in the module:

Capacity to draw on knowledge of adult development and developmental trajectories in and towards later stages of life

An ability to draw on knowledge of the general efficacy of psychological interventions for older

people
An ability to draw on knowledge of the demographics of older age (e.g. longevity, prevalence of disorders or variations in lifestyle)
An ability to draw on knowledge of the heterogeneity of the older adult population, and how this will relate to the individual experience of clients
An ability to draw on knowledge of normal and abnormal ageing, e.g.:
• dementia vs. age-related decrements in functioning
• chronic depression vs. age-related loss of vitality/ energy
• clients who ascribe all problems to ageing and become hopeless and despondent vs clients who manage the challenges of ageing (e.g. long-term physical conditions/losses)
An ability to draw on knowledge of 'lifespan development' and factors relevant to understanding development in older life – e.g.:
• risk factors (e.g. elevated risk of completed suicide in older males over 75)
• impact of socio-cultural factors (e.g. ageism)
• impact of social isolation, loneliness and loss
• impact of trauma and adversity
• cohort factors (e.g. cultural mores of the period in which they grew up)
• attitudes and expectations towards ageing within the person's culture and community
An ability to draw on knowledge of normal reactions to bereavement
An ability to draw on knowledge of how common organic disorders present in older people
An ability to draw on knowledge that a successful adaptation to ageing may require the person to modify their investment in activities, values and priorities (e.g. modifying the extent to which their self-esteem is based on physical capacity)
An ability to draw on knowledge of the psychological impact of common long-term physical health problems (such as pain, arthritis, diabetes, cardiovascular disorders)
An ability to draw on knowledge of how functional and organic disorders interact (e.g. depression vs. dementia, depression or anxiety in context of early dementia, or physical illness and depression/anxiety)
An ability to draw on knowledge of the impact of role challenges and transitions in older age, e.g.:
• becoming a grandparent
• challenges and benefits of retirement
• bereavement
An ability to draw on knowledge of the impact/importance of resources accessed by the older person (such support systems and social networks)
An ability to draw on knowledge of the impact on carers of maintaining a caring role
An ability to draw on knowledge of the ways in which the older person's assumptions about ageing will impact on the manner in which they present
An ability to draw on knowledge of the impact on carers of maintaining a caring role, both:
• when the older adult themselves is a carer
• when the carer is a younger adult

Indicative Teaching and Learning

- Look at data on prevalence and incidence of depression and anxiety in later life (Use ONS website to check for local demographics) and address myths of depression in late life – more common, more difficult to treat, etc.)

- Generate differences between normal challenges and adaptations in ageing vs. abnormal challenges

- Explore cohort effects e.g. wisdom

- Outline empirical evidence for depression and anxiety in later life.
  - Continue to evidence how standard models of CBT work well with older people so as to debunk the myth that CBT needs to be modified to work well.
  - Note also that there is no definitive evidence that CBT is more effective than other interventions with OP

Preparatory study

1. A series of online presentations concerning OP and mental health:

   http://www.scie.org.uk/publications/elearning/mentalhealth/index.asp

2. Further reading(detail to found in ANNEX ONE**):**

   Blazer, D.G. (2010)
   Cartensen, L. et al (2011)
   Knight, B. G. (2004)
   Knight, B. G. & Laidlaw, K. (2009)

AFTERNOON

Module 3: CAPACITY FOR INTER AND INTRA-AGENCY WORKING

Aims of Module

Gain an understanding of gerontology and of the importance of multi-agency working and collaboration. Preparation for this module is best carried by mapping local services and it is recommended that the Benchmarking Tool in Annex 4 is used to structure this process.

Competences covered in this module:

Capacity for inter and intra-agency working

An ability to draw on knowledge of local services and agencies that work with older people, the ways in which these are accessed, and any barriers to access from these services e.g.
• Primary Care & physical health – General Practitioners, Specialist Nurses (e.g. COPD, Diabetes, Palliative Care, Community Matrons), Community Pharmacists
• Hospital services – e.g. Falls Clinics, physiotherapy, Pain Clinic, Sleep Clinic
• Social Services (Benefits, Care Commissioning, Adaptations & Equipment, Assistive Technology
• Mental Health services – Memory Clinics, Community Mental Health Teams for Older People, Specialist Older Adult Psychology, Admiral Nurses, Occupational Therapists
• Voluntary sector – Alzheimers' Society, Age UK, Carers UK, Guideposts, Crossroads, Dementia UK, Stroke Association
An ability to liaise with, and be guided by, specialist OA workers (from within IAPT or from local specialist teams)
An ability to work with other services and agencies to enhance access to psychological services

Indicative Teaching and Learning Method

- Present information on under-identification
- Draw on experiences of joint working
- Discuss the exercise on local mapping of resources
- Make explicit links with local OP Specialist and Dementia services
- Discuss the use of the IAPT Benchmarking tool (see Annex Four).

Module 4: SCREENING AND ASSESSMENT

Aims of Module

To become familiar with the key issues likely to affect assessment at steps 2 and 3 including awareness of how early dementia or mild cognitive impairment may present.

Competences covered in the module:

Basic screening and assessment skills

An ability to draw on knowledge of issues of capacity, consent and confidentiality in relation to work with older adults, and to apply this knowledge when planning assessments and interventions
An ability to consider patient/client's attitude to help as part of the engagement process (e.g. motivation, self-stigmatisation)
Where others are directly involved with the client (e.g. partners, family members, carers), an ability to engage with them and to identify their perspectives as part of the assessment
An ability to draw on knowledge of the actual prevalence of cognitive impairment in older adults, and:
• to be alert to indicators of cognitive impairment, and draw on knowledge of local procedures for its formal assessment
• to be able to discuss client's or carer's concerns about cognitive impairment
• to be aware of different types of dementia

An ability to know when to use outcomes measures designed specifically for older adults, and how to administer and interpret these measures
An ability to help clients with sensory or physical difficulties complete IAPT screening and assessment measures
An ability to identify any (contemporaneous) health and social care input the client is receiving and its implications for psychological therapy e.g.
• potential psychological impact of medical conditions (e.g. long term conditions, Parkinson's Disease)
• the need information and signposting on receiving benefits and entitlements (e.g. attendance allowance)
• extent and impact of poly-pharmacy, or the impact of failing to take prescribed medication

Indicative Teaching and Learning Method

It is recommended that case studies are used to illustrate potential needs to demonstrate the points identified below**:**

- Basic skills of engagement with older people
  - Age gaps, e.g. ways to respond when an older person thinks therapist is too young to help or understand?
  - Orienting an older person to therapy, e.g. stoicism and how to respond to 'got to grin and bear it/put up with it etc.' or 'it's because I'm old'; the need to explain the collaborative nature of psychological therapy
  - Checking that person wants to attend and has not been persuaded by others

  - Practical considerations, e.g. use of telephone, larger font, speaking louder or sitting on their 'better side' if have hearing difficulties, adjusting time needed in sessions accordingly and as appropriate, compensating for cognitive impairment e.g. use of more written material,
  - Keeping therapeutic focus sensitively (e.g. Lonely elderly person with little contact with others in week, to engage may need to spend some time listening to their week as part of sessions; or acknowledgement of physical health problems/worries and space for this as appropriate in sessions if arises)

- Awareness of anxieties about memory loss in the OP that may arise. For guidance about how to discuss these anxieties see ANNEX FIVE. This may best be addressed through the use of role play

- Ensuring that people are referred on where appropriate (e.g. to memory services)

- Familiarity with any specific questions and outcome measures that are devised for OP in IAPT:

  The IAPT minimum data set is suitable for use with Older People and should be used routinely. If, however, the scores on PHQ and the GAD do not seem to reflect the client's clinical presentation and the clinician has concerns that the scores are underestimating the distress, they may wish to use the Hospital Anxiety and Depression Scale or the Geriatric Depression Scale as additional measures.

- Concisely taking and summarising life / mental health histories that can span many years, potentially lots of information! Suggest asking clients to construct time-lines of significant life events as a homework task and use the data to help person reframe a negative narrative to one that acknowledges their strengths and resilience.

- Noticing the context and spotting the wider needs of the older adult as part of assessment and addressing these, e.g. pick up health and social care needs and signpost to relevant services (e.g. elderly person falling needing stair rail fitted and bath seat, someone struggling to manage their housework or food shopping perhaps needing a weekly care package arranging)

- Speaking with and gathering information from more than one person in the room, who may have different perspectives on the problem, e.g. family members, carers
  - Basic strategies of managing possible conflicts arising between different individuals present at assessment
  - Basic strategies on talking about sensitive issues in front of the person referred and those with them, and knowing when to ask to speak to individuals privately
  - Issues of consent and confidentiality when working with more than one person, e.g. 'is it ok if I ask your (wife/son/warden…) what she thinks about this?'

Awareness of issues around capacity and consent e.g. knowing when someone may need a capacity assessment and who to signpost to for this.

DAY TWO (FOCUSSED ON PSYCHOLOGICAL WELLBEING PRACTITIONERS)

MORNING

RECAP FROM DAY ONE:

- Basic Stance
- Basic Knowledge
- Interagency Working
- Screening and Assessment Skills

MODULE 5: INFORMATION GATHERING, INFORMATION GIVING AND SHARED DECISION MAKING IN LOW INTENSITY INTERVENTIONS WITH OLDER ADULTS

Competences covered in this module:

Information gathering and shared decision making at Step 2

In line with assessment methods employed in low intensity IAPT assessment procedures, an ability to gather information with the person and (where appropriate) with other relevant parties (e.g. carers/family members. other professionals)
An ability to work collaboratively with the patient to derive a problem statement that represents a shared understanding of their difficulties and that identifies their needs, strengths and resources, and to use this to agree an intervention plan
An ability to balance complexity against parsimony, and to ensure that while problem statements may take into account the person's life history (life story) they also remain focused on change in the here and now
An ability to draw on knowledge that not all problem statements need to include a life-long perspective, and that whether this is included depends on whether this will enhance or distract from an understanding of the problem, e.g.:
• whether the person has had life-long mental health problems
• whether negative reactions to a current event appear to be triggered by pre-existing vulnerabilities
• whether the current presentation reflects an age-appropriate reaction to loss of positives in a previously resilient individual
An ability to ensure that information gathering and shared decision making explicitly consider the relevance of sociocultural factors, such as:
• cohort beliefs
• internalised negative stereotypical beliefs and attitudes to ageing
• recent role transitions
• health status
• social network of the older person
An ability to ensure that information gathering, giving and shared decision making recognise the reality of the difficulties faced by the person (e.g. negative thoughts may be appropriate in the context of the reality of a difficulty)
An ability to include consideration of the person's needs along with their strengths
An ability to agree a problem statement with the older person that demonstrates an understanding of the reality of any age-appropriate challenges while still identifying areas of potential change

Shared Decision Making

An ability to work with the patient to identify treatment options that are realistic and achievable, and that they see as relevant
An ability to help the patient draw up goals that optimise functioning, using the principles of:
• selection (e.g. restricting the range of activities and focusing on areas where success is most likely)
• optimisation (enhancing available resources in order to maximise functioning (such as improving mobility by rebuilding muscle strength))
• compensation (e.g. compensating for loss of function in one area by substituting new strategies (such as using post-it notes to aid memory)

Indicative learning and teaching method

Skills focused role-play practice using scenarios based on PWP clinical methods for practice of assessment and engagement leading to collaborative problem statement and shared decision making with the older adult.
Key questions that should form part of screening OP are:

- Do you take care of someone else?
- Are you having any treatment for health problems?
- Have you had a fall recently?
- Would you say you had more problems with your memory than most people?

See ANNEX FIVE

AFTERNOON

Module 6: BASIC INTERVENTIONS

Aims of Module

To become aware of the ways that interventions may need to be modified to take account of the needs and circumstances of the older person

Competences covered in this Module:

Basic intervention skills

An ability to draw on knowledge of ways of overcoming common barriers to full engagement in assessment and/or intervention e.g.
• flexibility in the location and duration of treatment
• strategies to help client manage sensory or physical difficulties (e.g. documentation with larger font)

An ability to offer signposting to psycho-education related to specific health conditions (e.g. mild cognitive impairment, fear of falling)
An ability to adapt interventions in a way that takes into account the older person's needs and values, capacities/ resources and their social context e.g. by:
• modifying the goals of a behavioural activation programme so that they are achievable within the context of the client's physical limitations

• explicitly taking into account the older person's views on ageing that may influence their stance in relation to treatment aims or any proposed interventions
• helping the older person to identify potential solutions to difficulties that they perceive as inevitable consequences of aging

An ability to facilitate peer support & community integration (for example, by signposting the client to community resources (e.g. classes or support groups))

Indicative Learning and Teaching Method

Skills based role-play using scenarios of low intensity clinical methods (behavioural activation, problem solving, graded exposure etc.) with consideration of the needs and context of working with the older adult.

Module 7: ENDINGS

Competences covered in this module:

Ending the intervention

An ability to help the older person manage the process of ending the intervention
An ability to hold in mind that the older person may find it especially challenging to end the intervention because they value the emotional support offered by the PWP (and that this does not necessarily indicate any "pathology" within the client)
An ability to help the older person identify any ways in which they will find the ending challenging (e.g. losing contact with a supportive person whom they have come to value)
An ability to work with the older person to develop a plan to manage these issues in a way that allows for a constructive disengagement

Indicative Learning and Teaching Method

Preparing older person for endings, awareness of the possible context of the older adult maybe having the experience of losing many friends / family, isolation issues, impact of losing practitioner and of issues around dying

- Being prepared and willing to talk about end of life if this subject arises
- Explicitly talking about treatment ending and feelings about this
- Counting down number of sessions in advance
- Addressing isolation issues through signposting to community resources available in advance of ending
- Tapering endings

- Interventions – use of case studies touching on real life clinical examples.
- Inter and intra-agency working – discussion around local services, how they are structured and what services are provided as applicable to OA, and when to step-up patients.
- Role-plays using vignettes.

CONCLUSIONS and REFLECTIONS

Reflective session on how OA attitudes and thinking has changed with repeat questionnaire– as an open discussion.

POST COURSE ASSESSMENT

Use of TAS 2

DAY TWO (FOCUSSED ON HIGH INTENSITY CBT THERAPISTS)

MORNING

RECAP FROM DAY ONE:

- Basic Stance
- Basic Knowledge
- Interagency Working
- Screening and Assessment Skills

Module 5: FORMULATION AND GOAL SETTING

Aims of Module

To draw together assessment information to inform understanding and goal setting

Competences covered in this module:

Formulation

An ability to formulate collaboratively with the person and, where appropriate, with other interested parties (e.g. carers/family members)
An ability to derive a formulation of the client's difficulties, and to draw on this to work with the client to identify an intervention plan that that includes consideration of their needs along with their strengths and resources (including the personal , interpersonal and 'systemic' resources to which they have access)
An ability to balance complexity against parsimony, and to ensure that while formulations take account of the person's life history (life story) they also remain focused on change in the here and now
An ability to draw on knowledge that not all formulations need to include a life-long perspective, and that whether this is included depends on whether this will enhance or distract from an understanding of the problem, e.g.:
• whether the person has had life-long mental health problems
• whether negative reactions to a current event appear to be triggered by pre-existing vulnerabilities
• whether the current presentation reflects an age-appropriate reaction to loss of positives in a previously resilient individual
An ability to ensure that formulations explicitly consider the relevance of sociocultural factors, such as:
• cohort beliefs
• internalised negative stereotypical beliefs and attitudes to ageing
• recent role transitions
• health status
• social network of the older person
An ability to ensure that formulations recognise the reality of the difficulties faced by the person (e.g. negative thoughts may be appropriate in the context of the reality of a difficulty)

An ability to include consideration of the person's needs along with their strengths and resources (including the personal, interpersonal and 'systemic' resources to which they have access)
An ability to agree a formulation with the older person that demonstrates an understanding of the reality of any age-appropriate challenges while still identifying areas of potential change

Goal setting

An ability to work with the client to identify goals that are realistic and achievable, and that they see as relevant.
An ability to help the client draw up goals that optimise functioning, using the principles of:
• selection (e.g. restricting the range of activities and focusing on areas where success is most likely)
• optimisation (enhancing available resources in order to maximize functioning (such as improving mobility by rebuilding muscle strength))
• compensation (e.g. compensating for loss of function in one area by substituting new strategies (such as using post-it notes to aid memory)
An ability to draw on knowledge that selection, optimisation and compensation are interlinked, and that all 3 elements will be present in an intervention plan

Indicative learning and teaching method

- Understanding a lifespan developmental context for depression in later life. Use Laidlaw et al (2004) age appropriate contextualising formulation (e.g. cohort beliefs, health and social care needs, socio-cultural context (internalised negative age stereotypes), intergenerational stressors, role transitions, cohort, etc.) whilst maintaining therapeutic focus - what to put in or leave out.
    - Use of Case example

- Discuss Cohort as an important variable in understanding how to work with older people and focus on potential stigmatising barriers in therapy
    - Help therapists identify how cohort beliefs of the current older people may stretch back to Victorian times.

Key questions that should form part of screening OP are:

- Do you take care of someone else?
- Are you having any treatment for health problems?
- Have you had a fall recently?
- Would you say you had more problems with your memory than most people?

  See ANNEX FIVE
- Using formulation to guide sensitive consideration of goals for intervention
    - Knowing when to 'make better' and when to listen and foster coping and acceptance (doing versus being)
    - What to focus on when faced with a number of difficulties
    - Being explicit and clear when setting goals – e.g. which aspects of a complex presentation are being addressed specifically in therapy and which may relate to more indirect work

- Understanding the impact of physical health problems (e.g. person with COPD and anxiety, Diabetes and mood)
- Understanding impact of disability on the person (e.g. issues around identity and loss)
- Adding selection, optimisation with compensation (SOC: Freund & Baltes, 1998) as it is consistent with the active problem-focussed nature of CBT. SOC can be effective in showing CBT therapists how to optimise functioning in older people facing realistic and challenging aspects of ageing.
- identifying processes which maintain the client's difficulties alongside considering the longevity of those difficulties

AFTERNOON

Module 6: BASIC INTERVENTIONS

Aims of Module

To become aware of the ways that interventions may need to be modified to take account of the needs and circumstances of the older person

Competences covered in this Module:

Basic intervention skills

An ability to draw on knowledge of ways of overcoming common barriers to full engagement in assessment and/or intervention e.g.
• flexibility in the location and duration of treatment
• strategies to help client manage sensory or physical difficulties (e.g. documentation with larger font)

An ability to offer signposting to psycho-education related to specific health conditions (e.g. mild cognitive impairment, fear of falling)
An ability to adapt interventions in a way that takes into account the older person's needs and values, capacities/ resources and their social context e.g. by:
• modifying the goals of a behavioural activation programme so that they are achievable within the context of the client's physical limitations
• explicitly taking into account beliefs that the older person holds and that influence their stance in relation to treatment aims or any proposed interventions
• helping the older person to identify potential solutions to difficulties that they perceive as inevitable consequences of aging
• helping the client identify and consider the implications of a conflict between lifelong and cherished values/ beliefs and their changed circumstances (e.g. when beliefs about the importance of self-sufficiency conflict with an objective need for support in order to maintain independent living)
An ability to judge when to question beliefs, attitudes or assumptions, and when to foster acceptance (e.g. judging when challenging a person's life-long assumptions and beliefs may lead to unproductive upset rather than beneficial change)

An ability to facilitate peer support & community integration (for example, by signposting the client to community resources (e.g. classes or support groups))

Indicative Learning and Teaching Method

Explore evidence base more fully:

- Use Systematic Reviews and Meta Analysis data (e.g. Pinquart et al, 2006; Scogin et al, 2005; Wilson et al 2008) e.g see table 1 in appendix
- Discuss Cuijper et al (2009) showing that CBT as efficacious with older people as with younger people
- Discuss 2 recent RCTs of CBT in the UK with clinical populations showing CBT works

- Introduce case examples of depressed older people based on Sadavoy (2009) the 5 C's: Chronicity, Complexity, Comorbidity, Continuity, & Context
  - Show how well standard models of CBT fit with older people
    - Need to emphasise use of Behavioural experiments
    - Always use homework
      - CBT needs to be active and challenging.
    - Importance of Socratic questioning and use of DTRs
    - Importance of formulations at different levels
- Discuss how CBT is different with older people (Laidlaw & McAlpine, 2008)

- Adapting psychological therapy to the person and context
  - For people with cognitive problems
  - Enlisting family members as co therapists
  - The value of problem solving
  - Integrating and using skills of seeing and fostering an individual's strengths, resilience, wisdom etc.

- Ability to manage own and patients emotions in situations where cure may not be possible – health problems, degenerative conditions (e.g. managing feelings of helplessness in patient and as therapist)

- Appropriate balance between therapeutic optimism and realism (e.g. activity scheduling with someone who has arthritis)

- Working with or alongside other colleagues or family members
  - Liaison skills
  - Confidentiality issues

- Skills around life review
  - Life story books
  - Family trees
  - Meaning making (Erikson)

Module 7: ENDINGS

Competences covered in this module:

Ending the intervention

An ability to help the older person manage the process of ending the intervention
An ability to hold in mind that the older person may find it especially challenging to end therapy because they value the intimacy and emotional support offered by a therapeutic relationship (and that this does not necessarily indicate any "pathology" within the client)
An ability to help the older person identify any ways in which they will find the ending challenging (e.g. losing contact with a supportive person who they have come to value)
An ability to work with the older person to develop a plan to manage these issues in a way that allows for a constructive disengagement

Indicative Learning and Teaching Method

- Preparing older person for endings, awareness of the possible context of the older adult maybe having the experience of losing many friends / family, isolation issues, impact of losing therapist and issues of dying.
    - Being prepared and willing to talk about end of life if this subject arises
    - Explicitly talking about therapy ending and feelings about this
    - Counting down number of sessions in advance
    - Addressing isolation issues through signposting to community resources available in advance of ending
    - Tapering endings

    - Inter and intra-agency working – discussion around local services, how they are structured and what services are provided as applicable to OA, and when to step-up patients.
    - Role-plays using vignettes.
    - Discussion around issues of consent and confidentiality around OA treatment.
    - Explore ways of sustaining change with other supports

CONCLUSIONS and REFLECTIONS

Reflective session on how OA attitudes and thinking has changed with repeat questionnaire– as an open discussion.

POST COURSE ASSESSMENT

Completion of TAS 2.

ANNEX ONE

SUGGESTED READING LIST

Amariglio, R. E. et al (2011) Specific Subjective Memory Complaints in Older Persons May Indicate Poor Cognitive Function *Journal of the American Geriatrics Society***,** Volume 59, Issue 9, pages 1612–1617

Blazer, D.G. (2010) Protection from depression. *International Psychogeriatrics,* 22, pp. 171-173.

Boddington, S. (2011) Where are all the older people? Equality of access to IAPT services, *PSIGE Newsletter, 113,* pp. 11-14.

British Psychological Society Division of Clinical Psychology and the Centre for Outcomes, Effectiveness and Research (CORE) (2004) *Measuring Outcomes in Routine Clinical Practice: Paper 3,* BPS publications

Broomfield, N.M., Laidlaw, K., Hickabottom, E., Murray, M. F. Pendrey, R., Whittick, J.E. and Gillespie, D.C. (2011) Post-Stroke Depression: The Case for Augmented, Individually Tailored Cognitive Behavioural Therapy*, Clinical Psychology and Psychotherapy*,**18**, 202–217 (2011)

Cartensen, L., Turan, B., Scheibe, S., Ram, N., Erser-Hershfeld, H., Samanez-Larkin, G., Brooks, K. P., Nesselroade, J.R., (*2011*) Emotional experience improves with age: Evidence based on over 10 years of experience sampling. *Psychology and Aging,*26, 21-33.

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ANNEX TWO: CBT evidence for late life depression

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Authors	**Level of analyses**	**Results**	**Conclusions**
Laidlaw, 2001.	Focused review of eight studies of CBT for late life depression (review of five meta-analyses in addition to outcome studies).	When using the BDI as the outcome measure, CBT showed the largest treatment gains in comparison to other psychological therapies. Many methodological flaws evident in earlier outcome studies.	CBT is an efficacious treatment for late life depression. Evidence supportive of this comes from outcome studies and from meta-analyses and systematic reviews.
Pinquart and Sorensen, 2002.	122 Psychosocial intervention studies.	CBT and psychodynamic psychotherapy effective on self-rated and clinician rated measures of depression. Individual therapy more effective than group.	The review considered a number of moderator variables that influence outcome, and note that for clinician rated depression (CRD), longer duration of psychotherapy was more effective. For CRD there were larger improvements overall. Therapists with specialist training in older adults produced more effective outcomes.
Scogin et al, 2005.	20 Studies selected comparing six evidence-based treatments identified as beneficial. Combination studies and maintenance treatments excluded from review.	The following treatments met criteria for evidence-based treatments: CBT, Behaviour therapy, Cognitive bibliotherapy, Problem-solving therapy, Brief psychodynamic therapy and Reminiscence therapy.	The most notable omission in this review is interpersonal psychotherapy (IPT). Many of the interventions need additional support as the numbers of studies are still relatively small, and most report data on 'young' older people (age 60-75 years). There is also limited evidence when looking at the combination of psychotherapy and pharmacotherapy.
Cuijpers, 2006.	25 Studies, with 17 comparing psychotherapy with control condition.	Psychological therapies effectiv with older people. Broad inclusi approach to psychosocial interventions with moderate to large effect size (0.72) generate overall. No clear differences between different types of psychological therapies emerge	The quality of studies included in the review was variable. Definitive conclusions for comparisons between medication and psychotherapy were not possible due to insufficient studies, but no overall differences in outcome were identified. There was some indication that combination of medication and

			psychological therapy was more effective than either alone, but the numbers of studies are small.
Pinquart et al, 2006.	89 Studies (62 pharmacological; 32 psychological; & 5 combination treatments). Major depressive disorder in 37 studies; 52 studies with mixed diagnoses.	For clinician-rated depression, 66 per cent of patients receiving pharmacotherapy and 72 per cent receiving psychotherapy showed above average improvement in outcome. For self-rated depression, 65 per cent of patients receiving pharmacotherapy and 69 per cent receiving psychotherapy showed above average improvement in outcome.	CBT more effective for depression in comparison to other medications and psychotherapies. Indications suggest that minor depression or dysthymia responds better to psychotherapy than pharmacotherapy. Few studies (five) compared treatments with a control condition. There is a paucity of studies conducted with the oldest-old (aged 75 years and above).
Wilson et al, 2008.	Cochrane Review with 82 Randomised controlled trials of psychotherapy for late-life depression reviewed; nine studies included in analyses. Overall, 12 studies included in the review (three additional papers examined bibliotherapy). CBT was main treatment reviewed.	Seven CBT studies and two psychodynamic psychotherapy studies were included in the review and analysis. Five studies compared CBT with a waiting control condition. CBT was significantly more effective than waiting list controls with superior outcome for drop out of CBT compared to waiting list controls. Compared to active treatment controls CBT was superior in outcome. There was mix of group and individualized interventions.	Overall, narrowness of review limits definitive conclusions as very few studies met criteria for inclusion. Although there is a paucity of good quality randomised controlled trials, CBT is an effective treatment with older people in comparison to active treatment controls and waiting list controls.
Cuijpers et al, 2009.	112 studies compared psychotherapy outcome between older adults and adults of working. 20 studies involving older adult participants included in analyses.	The effect sizes of both groups did not differ significantly from each other (older adults: d = 0.74; younger adults: d = 0.67). Older adult and adult outcome studies report comparable effect sizes of 0.62, thus about 73% of psychotherapy pts improved. The older adult studies were more heavily weighted towards completer analysis rather than ITT. In regression analyses there was no effect for age of participants thus outcome in psychotherapy studies between younger and older	There is no significant difference between psychotherapy outcome for adult versus older adult in the research literature. There are gaps in knowledge in terms of outcome of psychotherapy with older adults including severe depression and depression in the oldest-old. "Although more research is needed on representative clinical samples, in older old adults, and in more severe forms of depression, our study shows that currently there is no reason not to apply psychotherapy for

		people are comparable.	depression in old age." (Cuijpers et al, 2009, p23).
Krishna et al, 2011.	Examined Data for group based psychotherapy interventions for late life depression. Of 360 papers screened, 296 were rejected , 64 were examined in detail & six included in review. All six studies all CBT based	CBT effective with overall significant mean difference at p <.001 CBT was more efficacious than waiting list conditions but not in comparison to active treatment control conditions. Gains in CBT were maintained at Follow-up although length of this was difficult to determine across studies included in review. Attribution between intervention and controls groups appear equal.	As with the cochrane reviewed reported by Wilson et al, (2008) above, the narrowness of this review limits conclusions about group-based CBT efficacy as very few studies met criteria for inclusion. The quality of studies was not optimal as most of the effect size can be atrributed to 3 of the 6 studies included in review. A number of the studies included young older adults in their trials.

See also the Matrix
http://www.nes.scot.nhs.uk/media/425354/psychology_matrix_2011s.pdf

ANNEX THREE: ASSESSMENT

Therapist's attitudes to working with older people scale (1)

Please take this opportunity to reflect on how you feel about working as a psychological therapist with older people. As with any clinical population it is likely that some aspects of such work will challenge you both personally and professionally. Please read the following statements and tick the response that best reflects your reaction. There are no 'right' or 'wrong' answers so please be honest in your responses!	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
I feel confident that I can adapt my therapeutic approach to meet the needs of older people.	4	3	2	1	0
Working with older people is less rewarding because they don't respond so well to treatment	0	1	2	3	4
Older people are bound to feel depressed given the losses experienced towards the end of life	0	1	2	3	4
I enjoy helping older people use their strengths and past experience to cope more effectively	4	3	2	1	0
Working with older people upsets me more than working with younger people	0	1	2	3	4
If a person is cognitively impaired there is very little point in offering a talking therapy	0	1	2	3	4
I find it difficult to know how to relate to older clients	0	1	2	3	4
Older people are more respectful and valuing of my service than younger people	4	3	2	1	0
Working with older people makes me worry about my own future	0	1	2	3	4
Real adversity in later life makes psychological therapy less effective	0	1	2	3	4
I find it harder to form a therapeutic relationship with an older person	0	1	2	3	4
I feel comfortable talking about death and dying with an older person as part of their therapy	4	3	2	1	0
Where there are limited resources younger people should be given priority for psychological treatment	0	1	2	3	4
As a therapist I can feel more overwhelmed by the challenges of old age than those faced by younger people	0	1	2	3	4
Older people struggle to think psychologically	0	1	2	3	4
I wish I could see more older people in my service	4	3	2	1	0

S.Boddington (2012)

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Background information:

1. **What clinical groups/conditions do you feel most confident working with? (tick any that are appropriate)**
   - ☐ **Children**
   - ☐ **Adults (up to 65years)**
   - ☐ **Older Adults**
   - ☐ **Other (specific clinical population (please describe)**

2. **How much experience do you have working with older people?**

   ☐ **No experience**

   ☐ **Minimal experience** (just a few cases)

   ☐ **Some experience** (enough cases to feel reasonably familiar with issues relating to older people)

   ☐ **A fair amount of experience** (regularly take referrals of older people)

   ☐ **Considerable experience** (this is the main area of my work)

3. **For how many years have you worked as a qualified therapist?**

   I am a trainee ❑

Thank you for your time in completing this questionnaire

Therapist's attitudes to working with older people scale (2)

Please take this opportunity to reflect on how you feel about working as a psychological therapist with older people. As with any clinical population it is likely that some aspects of such work will challenge you both personally and professionally. Please read the following statements and tick the response that best reflects your reaction. There are no 'right' or 'wrong' answers so please be honest in your responses!	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
I feel confident that I can adapt my therapeutic approach to meet the needs of older people.	4	3	2	1	0
Working with older people is less rewarding because they don't respond so well to treatment	0	1	2	3	4
Older people are bound to feel depressed given the losses experienced towards the end of life	0	1	2	3	4
I enjoy helping older people use their strengths and past experience to cope more effectively	4	3	2	1	0
Working with older people upsets me more than working with younger people	0	1	2	3	4
If a person is cognitively impaired there is very little point in offering a talking therapy	0	1	2	3	4
I find it difficult to know how to relate to older clients	0	1	2	3	4
Older people are more respectful and valuing of my service than younger people	4	3	2	1	0
Working with older people makes me worry about my own future	0	1	2	3	4
Real adversity in later life makes psychological therapy less effective	0	1	2	3	4
I find it harder to form a therapeutic relationship with an older person	0	1	2	3	4
I feel comfortable talking about death and dying with an older person as part of their therapy	4	3	2	1	0
Where there are limited resources younger people should be given priority for psychological treatment	0	1	2	3	4
As a therapist I can feel more overwhelmed by the challenges of old age than those faced by younger people	0	1	2	3	4
Older people struggle to think psychologically	0	1	2	3	4
I wish I could see more older people in my service	4	3	2	1	0

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Subjective change in attitudes to working with older people

Please mark a point on the scale below to indicate the extent to which attending this/these workshops has affected your awareness of the issues facing older people's mental health.

Much less aware	Less aware	No change	More aware	Much more aware
I	I	I	I	I

Please mark a point on the scale below to indicate any change in your inclination to work as a therapist with referrals of older people to your service?

Much less inclined	Less inclined	No change	More inclined	Much more inclined
I	I	I	I	I

Please explain the reasons for your responses

Thank you for your time in completing this questionnaire

ANNEX FOUR: IAPT BENCHMARKING TOOL

Is your IAPT Services accessible to older people?

With permission from Steve Boddington

Service: **Rater/s:**

Date:

	Aspect of service design:	Existing actions that already facilitate older people's access:	Further actions that could be adopted to improve your service:
1	Equity of Access Targets: *- What proportion of your services referrals is currently over 65 years old?* *- does this reflect your local demographic – on average there should be 18% referrals over 65years but varies locally*		
2	Does your service undertake ongoing publicity to attract older adults referrals? *In general GPs are poor at recognising common mental disorders in later life and seldom refer older people for psychological therapy. The 3rd sector, acute services and OP themselves also need to be targeted. Repeated and persistent publicity helps to resolve this pattern.*		
3	Modified 'engagement/filtering' procedures for getting into your service.		

	Older people may be reluctant to opt into psychological services due to: *1. Being unfamiliar with 'psychological treatments'* *2. having internalised ageist ideas about their value/ability to change* *3. Mobility/health problems* *4. Higher levels of agoraphobia*		
4	Offer home visits if necessary: *- A small proportion of older people will not be able to attend clinics due to mobility problems, visual impairments, agoraphobia, etc.* *- Sometimes an initial home visit may be all that is needed to break down reticence and encourage attendance at clinic/telephone appointments after that.*		
5	Offer help to complete IAPT forms where necessary: *1.People may be out of practice at form filling.* *2Psychological language may be unfamiliar* 3*There is a higher level of literacy problems amongst older people as educational opportunities were less equally available 60+ years ago.* *4 Mild Cognitive Impairment may affect ability to concentrate/focus.*		
6	Capacity to adjust the pace, length, frequency of sessions where necessary *- Can your therapists offer longer or shorter appointments to accommodate the needs of the patient?* *- Can appointments be scheduled*		

	more/less frequently? *- Can additional sessions be offered for patients who's progress is slow?*		
7	Do you have a resource for signposting to age-appropriate services? e.g. Alzheimer's Soc, sitting services, Carer's Centre, Age –UK Is this up to date?		
8	Are your staff trained to work with older people? *- Have all therapists (HI & PWP) received the 2 day training in applying their therapeutic skills to older people?* *- Do some of your staff have a special interest in such work (with appropriate additional training?)*		
9	Do some IAPT staff with a special interest undertake supervision of OP cases seen by all IAPT staff? *- This ensures that older people do not get overlooked and may be seen by therapists with an interest/knowledge/ skill in working with the client group*		
10	Are there arrangements for specialist supervision/ consultation from specialists working with older people? *- Arrange this with secondary care therapists specialising in work with older people*		
11	Referral to vocational/educational/occupational services:		

	- These should be set up to meet the needs of older people: opportunities for voluntary work, engagement in local community resources/activities. *eg – computer classes for older people*		
12	Be aware of possible cognitive limitations in older adults, and how they impact on therapy: *- Develop effective links with local memory services*		
13	How effective are the referral pathways between your IAPT service and the Secondary Mental Health services for older people? *1. Do you know the Psychologists/ Psychological therapists who specialise in working with older people in your area?* *-2. How often do you escalate referrals to secondary care?* *3. How often does your service receive referrals of older people with common mental health problems from CMHTs?*		
14	Is there an older person on your service user group? *- Active involvement of older service users will help to ensure that the service attends to the needs of older people* *- Older service users may have knowledge and experience of local resources that can help IAPT to integrate with wider network of health and social care*		

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ANNEX FIVE: Script for asking about memory problems

Evaluation feedback suggetsed that talking about memory problems can be anxiety provoking, so here are some possible ways of approaching this with your client. You will, of course, want to adapt this to your local situation.

"Do you have difficulties with memory or thinking clearly?"

- If client answers No:

  Are you (IAPT worker) concerned about your client's memory? Have you observed your client being forgetful, repetitive or confused, or having difficulty in finding their words when talking?
  - *NO: no further questions required.*
  - *YES: continue as below.*

- If client answers Yes (or if you are concerned about your client's memory):

  "That's a very common experience, especially when we're depressed or anxious*. It's also very common for people to worry about their memory, particularly if they have noticed a change. Is that something you worry about?"

  * If you wish to explain this more:-
  '*When you are anxious or depressed you may have trouble concentrating and you might not take as much notice of things – this, and your sleep often being disturbed too, can lead to memory problems*'.

  Whichever way they answer, continue:
  "If you do get worried about your memory, either now or in the future, you can get it checked out." Explain the local referral procedure e.g. to consult GP, or give memory clinic details.

- If the client asks you if you think there's something wrong, be honest and reply either:

  "I'm not worried, I just want to make sure you know what you could do if you were worried at any point, or if your friends or family were worried about you."
  Or
  "I don't know, but I think it could be a good idea to have it checked."

If the client asks further questions, you can explain that there are all sorts of things that can affect our memory such as normal ageing, illness, vitamin levels, alcohol, and a doctor or memory clinic will be best able to answer their questions.

ANNEX SIX: TRAINING MATERIALS

To be added from February 2013