Improving Access to Psychological Therapies

National Curriculum for CBT with Older People. 2nd Edition.

(Revised February 2016)

Introduction: The indicative curriculum for working with older people has been revised with the main focus of the revisions on making the curriculum more flexible to implement and deliver; giving guidance on how to increase detection and access rates for older people and also answering key questions as to how CBT may be different with older people. Primary support materials take the form of two new practical clinician's guidelines (High and Low Intensity) that provide clinicians with a set of guidance, tools and worksheets to use when working with older patients. These materials more fully address how clinicians can understand normal ageing (high subjective life satisfaction and low rates of depression and anxiety) and differentiate this from abnormal ageing (depression, anxiety, dementias etc.). This information is designed to be helpful to all clinicians in using the recommended augmentations and techniques. Existing IAPT staff trained prior to the revised curricula release should access the new clinical guidelines as essential continuing professional development (CPD) training and are expected to set aside dedicated CPD time to update themselves with the new materials. A commissioning brief is being sent to all BABCP and BPS accredited training providers, to the accrediting bodies and to service and education commissioners. The briefing is to ensure appropriate training is available in each area consistent with this curriculum and guidelines. In updating these materials, reference is paid to the previous IAPT Older Peoples Committee members, in particular Professor Tony Roth who guided the development of the older people competency framework.

The two-day indicative curriculum structure is recommended as follows:

Day 1: Fundamentals of working with Older People

Day 2a: Low Intensity Age Appropriate CBT with Older People,

Day 2b: High Intensity Age Appropriate CBT with Older People

The delivery should comprise of at least 50% practical skills training of the competencies and interventions within the curriculum. Day one, 'Fundamentals of working with older people' is suitable for both high and low intensity practitioners and both may be present at the same training day should providers wish to do. The content of day 1 is also suitable for practitioners from other modalities who may wish to attend to learn more about the context of working with older people in psychological therapies services. Separate day 2 content for both Low Intensity CBT 'Day 2a' and High Intensity CBT 'Day 2b' is then specified. The curriculum is designed to be flexible so that it can be delivered into high and low intensity university programmes as required core content; but also as CPD for practitioners who may have trained before the curriculum was published. Academic programmes are free to deliver the training consistent with their own delivery schedules as long as all of the outcomes are covered within the training and the equivalent of two full days of content is provided. The competencies should be followed to implement the learning outcomes at programme level.

Day 1: Fundamentals of working with older people

Competencies for day 1:

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 therapy 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 therapist 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 makes a person' s depression 'understandable')
• 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

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.:
• Maturational factors – positive (e.g. wisdom) and negative (e.g. physical wear and tear)
• 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

Capacity for inter and intra-agency working

An ability to draw on knowledge of local services and agencies that work with older people, and the ways in which these are accessed e.g.
voluntary sector – Alzheimer' Society, Age UK, Carers UK, Guideposts, Crossroads, Dementia UK, Stroke Association
• Primary care & physical health – General Practitioners, Specialist Nurses (e.g. COPD, Diabetes, Palliative Care, Community Matrons), Community Pharmacists
• Mental health services – Memory Clinics, Community Mental Health Teams for Older People, Specialist Older Adult Psychology, Admiral Nurses, Occupational Therapists
• Social services (Benefits, Care Commissioning, Adaptations & Equipment, Assistive Technology
• Hospital services – e.g. Falls Clinics, physiotherapy, Pain Clinic, Sleep Clinic
• Voluntary sector – Alzheimer 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

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 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 screening tools designed specifically for older adults, and how to administer and interpret these measures
An ability to help clients with sensory or physical difficulties complete screening and assessment measures
An ability to assess 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)
• Any gaps between benefits received and their entitlements (e.g. attendance allowance)
• Extent and impact of poly-pharmacy, or the impact of failing to take prescribed medication

Indicative teaching and learning content for day 1:

This day should begin with assessment of knowledge, attitudes and confidence in working with older people. This should then be repeated at the end of the two days of training. This day should cover contemporary accounts of ageing in the UK. Content should cover up to date demographic information (Lifespan, longevity and health), factual information about prevalence and incidence of depression and anxiety in later life and that older people constitute a very heterogeneous group (up to 4 generations aged between 60-100). There should be an active learning task about positive and negative aspects of ageing in order to address expectations for change in therapists working with older people. Presenters are encouraged to actively dispel any myths surrounding the ageing process, depression and anxiety. The prevalence and incidence of depression and anxiety in later life should be considered and any myths that depression is more common, more difficult to treat etc., should be addressed (We recommend that presenters consult the ONS website (http://www.ons.gov.uk/ons/taxonomy/index.html?nscl=Population) to check for up to date demographic data pertaining to the UK). The evidence base of CBT/LICBT for Older People should be discussed and awareness raised as to how services can consider their own access and engagement rates for older people and what the barriers exist. Those attending should gain an understanding of gerontology (the science of ageing as opposed to illness in later life) and the importance of multi-agency working and collaboration where required. A key learning task for attendees is to be exposed to evidence that the majority of older people do not become depressed or anxious. Clinicians are to be encouraged to consider how this data can be used when working with people who are depressed or anxious and who (erroneously) attribute their problems to age. Presenters may wish to consult ONS data from the UK that shows older people are amongst the happiest age groups in society (http://www.ons.gov.uk/ons/dcp171776_431796.pdf) Discussions can characterise how the 'understandability phenomena' (Unutzer et al. 1999) can impact upon health-seeking and

referrals which needs to be addressed. Differences between health, successful ageing and situations in which problems arise should be considered. Exercises should examine own beliefs regarding ageing and older peoples suitability for CBT based approaches.

As part of the training it should be discussed and clarified that whilst the context of depression or anxiety in older people may present differently (e.g. comorbidity, physical health problems, lifelong mental health history, losses or bereavements etc.) the symptoms of depression and anxiety disorders are the same and therefore behavioural and cognitive techniques that are used to treat these symptoms are the same evidence based techniques used for working age adults. These techniques may require age appropriate augmentation from gerontological perspectives and ways in which these can be used will be briefly introduced in day 1 and then relevant LIBCT and HICBT techniques with specific skills practice taught on days 2a/2b. Cohort effects, intergenerational linkages, health status and other areas from the contextual framework should be introduced. Managing time effectively and dealing with contextual challenges such as long-term conditions or memory problems should be part of the session as well as helping practitioners to address any potential engagement issues or concerns. Concisely taking and summarising life/mental health histories that can span many years with potentially lots of information should also be addressed. The use of patient constructed time-lines of significant life events as a homework task should be introduced as a way in which to manage time and the challenge of long histories in assessments and can be used in subsequent sessions for wisdom enhancement techniques. The importance of homework as the central component of sessions should be discussed and challenges of managing these considered.

Curriculum support materials for day 1:

- Clinician's Guide to Low Intensity CBT with Older People
- Clinician's Guide to CBT with Older People
- Although no specific slide sets have been put out with the guides to enable courses to develop their own teaching slides, the authors of the materials are happy to provide support with this if required and slide sets devised by the authors for each of the three days can also be provided upon request

Day 2a: Low Intensity CBT with Older People

Competencies for day 2a:

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 identified 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 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 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 goals 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 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)

Basic intervention skills

An ability to draw on knowledge of ways of overcoming common barriers to full engagement in assessment and/or interventions e.g.
• Flexibility in the location and duration of treatment
• Strategies to help the 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 existing evidence based LICBT 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 imitations e.g. through collecting the values of previous activities that can no longer be undertaken, or SOC for adaptation of activities where there have been losses in function.
• 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 ageing and using wisdom enhancement strategies where appropriate to help the older person to recognise their own solutions and strengths in dealing with previous adversity that may be helpful to their current situation
An ability to facilitate peer support & community integration (for example, by signposting the client to community resources (e.g. classes or support groups))

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 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 for day 2a:

Day 2a is specifically designed for Low Intensity CBT practitioners who assess and treat patients at step 2. Supervisors of step 2 practitioners may want to attend the day to ensure that supervision meets the needs of the workforce and the differences between step 2 and 3 treatment augmentation when working with older people is clarified. Day 2a should be a mix of theory and skills focused role-play practice of assessment and treatment techniques using scenarios based on the PWP clinical methods.

Discussion of how CBT approaches may be different with older people (Laidlaw & Kishita, 2015) should take place including how to manage the challenges that ageing may bring. A good primer text is the paper by Professor Joel Sadavoy (A noted North American Psychiatrist working with Older People), in which the experience of working with older people

is discussed in light of five key elements that is different when working with older people: chronicity, complexity, comorbidity, continuity and context (Sadavoy, 2009).

Suggestions for helping prepare older patients for using LICBT self help approach and managing endings should be enacted as practice scenarios. Addressing isolation issues through signposting to community resources available in advance of ending should be used. Skills practice in the use of time-lines to manage time effectively and the use of the problem statement and goals to keep focus on a plan it, do it, review it approach should be maintained and the essential nature of homework tasks made explicit. Augmenting standard LICBT techniques for patients with physical health comorbidities that may impact upon treatment should be outlined, with the use of appropriate theories from gerontology such as Selection, Optimisation and Compensation (SOC), values, wisdom and timelines should be taught and their application to step 2 interventions practiced using relevant scenarios. At the end of the training a reflection exercise on what has been learned and how this can be transferred into participants practice should be undertaken.

Curriculum support materials for day 2a:

- Clinician's Guide to Low Intensity CBT with Older People
- Although no specific slide sets have been put out with the guides, to enable courses to develop their own, the authors of the materials are happy to provide support with this if required and also slide sets devised by the authors for each of the three days can be provided upon request

Day 2b: High Intensity CBT with Older People

Competencies for day 2b:

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

Basic intervention skills

An ability to draw on knowledge of ways of overcoming common barriers to full engagement in assessment and/or interventions e.g.
• Flexibility in the location and duration of treatment
• Strategies to help the 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 imitations
• Explicitly taking into account 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 ageing
• 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))

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 for day 2b:

Day 2b is specifically designed for High Intensity CBT practitioners who deliver CBT at step 3. Supervisors of step 3 practitioners may want to attend the day to ensure that supervision meets the needs of the workforce and that the extended formulation and treatment augmentation techniques are clarified. Day 2b should comprise of opportunities to practice conceptualisation of more complex cases (with emphasis on physical comorbidity and/or frailty) using a range of conceptualisation frameworks. Discussion of how CBT is different with older people (Laidlaw & McAlpine, 2008) should take place including chronicity, complexity, comorbidity, continuity and context (Sadavoy, 2009). The use of the comprehensive conceptualisation framework (Laidlaw et al. 2004) can be introduced as one of a number of approaches to age contextualised approaches to CBT. In this teaching there should be an emphasis on how CBT is different with this client group and a focus on age appropriate CBT. The main elements of age-appropriate CBT is that there is use of an age-contextualised conceptualisation (at the very least taking account of generational and familial

cohort beliefs), optimal ageing (selection, optimisation with optimisation), attitudes to ageing and age-related negative cognitions and wisdom enhancement (timelines). The use of CBT for people with dementia and dementia caregivers may enhance the validity of this teaching for practitioners.

The age appropriate contextualising formulation framework (Laidlaw et al. 2004; Laidlaw & Thompson, 2014) (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 should be introduced and practiced. Discussion of the contextual areas as important variables in understanding how to work with older people and focus on potential stigmatising barriers in therapy should be part of the training to help therapists identify how these may impact on treatment. Using age-appropriate CBT formulation (Laidlaw, 2015) to guide sensitive consideration of goals for intervention e.g. 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. a person with COPD and anxiety, Diabetes and mood), understanding impact of disability on the person (e.g. issues around identity and loss). The importance of effective management of time and keeping a focus on homework and the goals set for treatment during sessions should be reinforced within the training as essential to outcomes.

Curriculum support materials for day 2b:

- Clinician's Guide to CBT with Older People
- Although no specific slide sets have been put out with the guides, to enable courses to develop their own, the authors of the materials are happy to provide support with this if required and also slide sets devised by the authors for each of the three days can be provided upon request