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NHS Talking Therapies Positive Practice Guide: Older People (2024)

In January 2023, Improving Access to Psychological Therapies (IAPT) services were renamed NHS Talking Therapies for anxiety and depression.

Older people are just as likely to benefit from NHS Talking Therapies as other age groups. However, people over 65 have experienced lower than expected referral rates ever since the programme was introduced. This Positive Practice Guide aims to support an increase in the numbers of older people benefiting from NHS Talking Therapies services by:

- Better supporting older people, their families and friends to recognise mental health need and seek help and;
- Delivering NHS Talking Therapies services that are fully equipped to meet their needs;

The NHS Talking Therapies Positive Practice Guide should:

- Be practical and useful for practitioners in talking therapies;
- Be informative to commissioners of services and;
- Guide Primary Care Healthcare Practitioners (HCP) especially GPs, on how to support referrals of older people to NHS Talking Therapies

All positive practice guides (PPGs), excluding women during the perinatal period, are applicable to older people. As such, they should be considered alongside this guide and in particular the PPG for Long Term Conditions. For more information, see: **www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/**

This Positive Practice Guide was developed over 2020-2021 by a working group made up of experts and practitioners in older people's mental health and talking therapies. The organisations below were correct at the time of the development of the guide.

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What is NHS Talking Therapies?

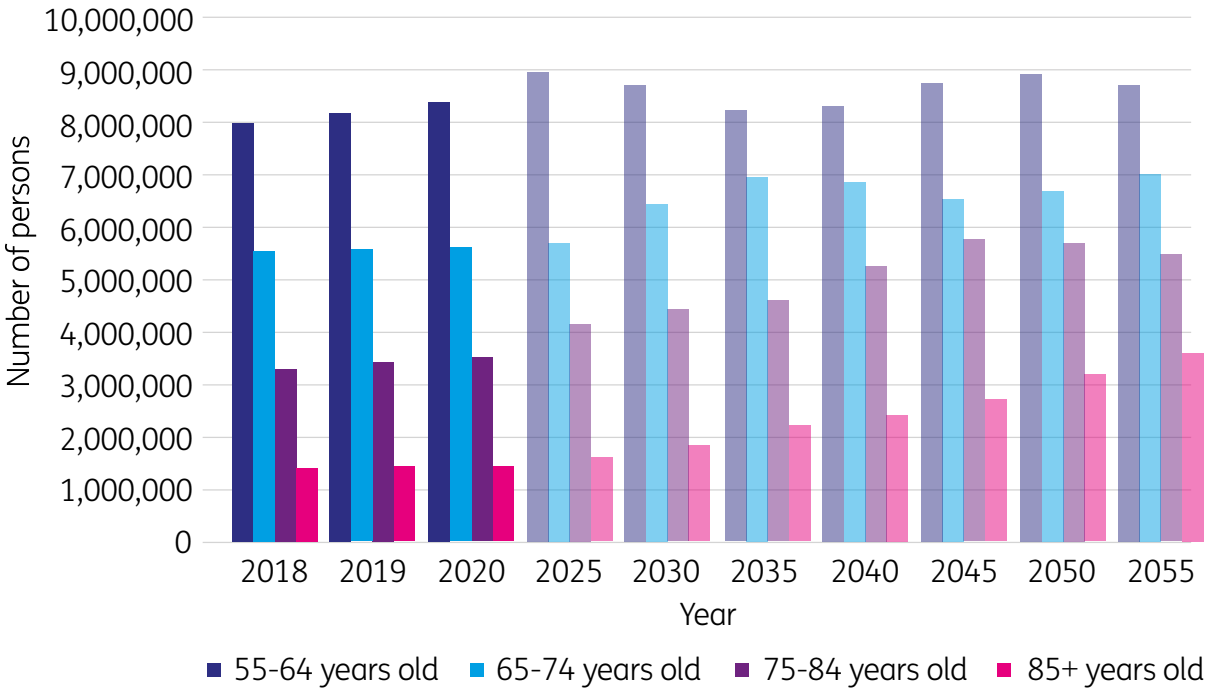
NHS Talking Therapies are free to access NHS services that provide evidence-based psychological treatments for people with common problems such as depression and anxiety disorders. NHS Talking Therapies also provides access to evidence-based psychological treatment for people with comorbid long-term physical health conditions (LTCs) or medically unexplained symptoms (MUS). People can access NHS Talking Therapies via their GP or they can refer themselves. There is no age-bar to NHS Talking Therapies. For more information about NHS Talking Therapies take a look at the NHS Talking Therapies manual, which can be found here: **www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/**

Background

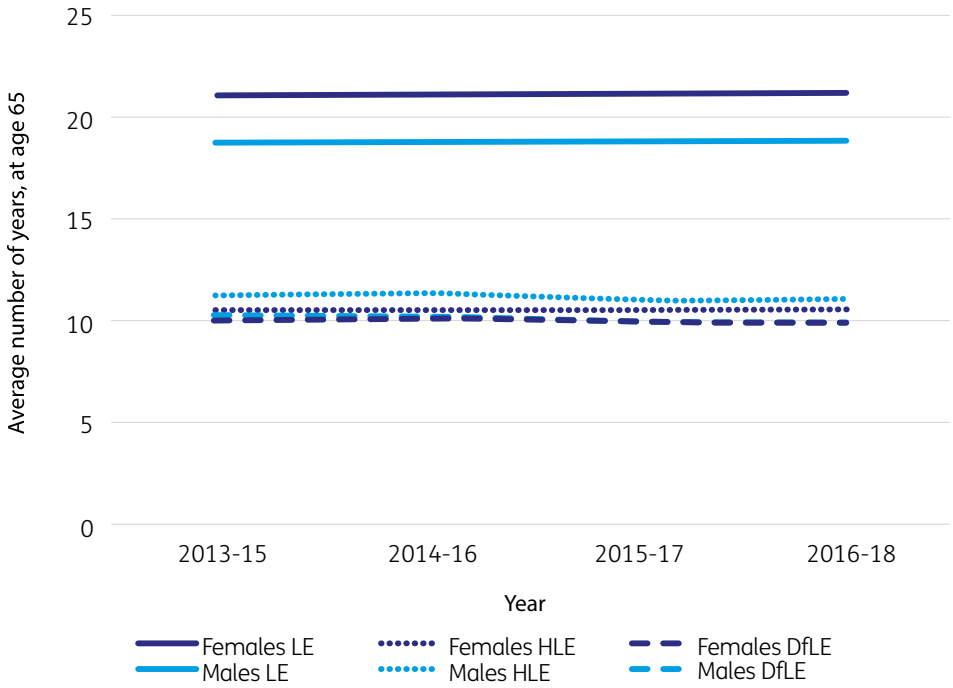
- Depression, anxiety disorders and the dementias are not an outcome of old age (Rodda et al. 2011). Recent estimates suggest that depression may affect 1 in 5 older people living in the community (NHS England and NHS Improvement 2017).
- Generalized anxiety disorder (worry) is the most common anxiety problem in later life and most anxiety problems are not a new presentation.
- Research evidence shows that psychological therapies are effective in treating late life depression and late life anxiety disorders (Laidlaw 2021); interventions including Cognitive Behavioural Therapy (CBT), Problem Solving Therapy (PST) and life review are recognised as especially effective with older people and remain effective in people living with long term conditions.
- Mental health problems may be poorly addressed in health settings as mental health is seen as secondary to physical health problems (Frost et al. 2019; Pettit et al. 2017); this is equally true among older people themselves and healthcare professionals (Age UK/Britain Thinks 2020).
- Older people often do not ask for support with mental health problems but when they do they are more likely to be prescribed medication rather than psychological therapies, even though studies have shown that older people prefer the latter and rate it as more acceptable than medication (Age UK/Britain Thinks 2020; Gum et al 2006; Landreville et al 2001).
- Depression very often co-exists with anxiety and may appear more complicated to treat as very often older people may present with a number of physical health conditions. Nevertheless, recovery rates for older people who access NHS Talking Therapies services are better than that reported for adults under 65 (Chaplin et al. 2015; Pettit et al. 2017).
- There is significant variation between local areas. People over 65 represent between 2.2% and 9.6% of referrals to NHS Talking Therapies depending on where you live (NHS Digital 2022).
- Referral rates decrease further as people become older and people over 75 represent just 2% of national referrals to NHS Talking Therapies (NHS Digital 2022).

Ageing in the UK

Actual and projected number of people aged 55 years and over, by age group, 2018 to 2055, England



Average Life Expectancy (LE), Healthy Life Expectancy (HLE) and Disability-free Life Expectancy (DfLE) amongst males and females at age 65, 2013-15 to 2016-18, England



“Older”

In this guide, we adopt the common shorthand term for identifying someone as an older person, i.e. someone aged 65 years and above, as this is still commonly associated with state pension age in the UK (currently 66 years and due to increase to 67 by 2028). All services should be mindful of the language they use and avoid terms such as “elderly”.

Most people do not consider themselves as ‘old’ even when well into their ninth decade (Chopik 2018). It is well known by those who work with older people that chronological age is the least useful piece of information about a person. In reality, there are many factors that determine how someone experiences some of the challenges more common in later life, and mental wellbeing is likely to be a powerful determinant.

Ageing and health

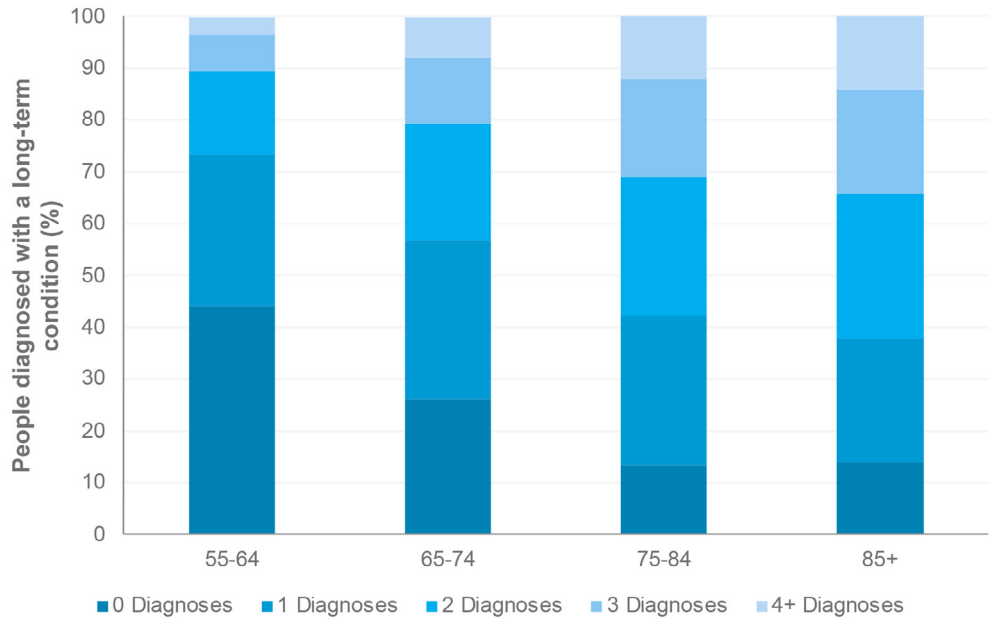
Contrary to common belief, older people report higher levels of wellbeing and more life satisfaction than adults under 65. Ageing researchers interviewed people from across the age span over a period of ten years and reported that emotional well-being and emotional stability increases as we age (Carstensen et al. 2011; Sim & Carstensen 2014).

This challenges the perception that low mood and depressive symptoms are a "natural part of ageing". However, we are just as likely to experience common mental health problems in later life and older people have every right to expect health and social care professionals and services to respond to symptoms and signs of depression, low mood, anxiety and worry.

Physical conditions (long term conditions or LTCs) are common in older people but the experience of ageing is as diverse as the people themselves. Not everyone who is older is frail, disabled or in need of care but conditions that are more common among older people include heart disease, diabetes, chronic obstructive pulmonary disease (COPD), stroke, dementia, and Parkinson's disease. Many of these conditions are also associated with a higher risk of depression.

For each of these long-term conditions, there is evidence for CBT in reducing co-morbid depression and anxiety (National Collaborating Centre for Mental Health 2018) and there is a great need for psychological therapists to become competent in supporting people with LTCs. It is equally important that LTC pathways and hospital liaison teams can accommodate and/or refer across to NHS Talking Therapies services.

Figure 1.7 Percentage of people with diagnosed long-term conditions, by age group, 2018/19, England.



Source: Age UK 2023: Analysis using waves 3 to 9. *English Longitudinal Study of Ageing (ELSA), 2018/19.*

Dementias

Cognitive impairment and dementia are not inevitable in later life and dementia is not an outcome of older age. As people age they may notice some changes in speed of processing ('fluid intelligence') while the accumulation of knowledge ('crystallized intelligence') often compensate for such changes. This is normal and is part of life for all. It is quite different from Dementia.

At age 65, 1 in 14 people (7%) have dementia and at age 80, it is still the minority of older people (1 in 6 people (17%)) who are diagnosed with dementia (Age UK 2019). A Lancet commission identified depression as one of nine modifiable risk factors for dementia, highlighting the importance of addressing this in older people (Livingstone et al 2017).

Being diagnosed with a dementia may be a very frightening experience for the person with dementia and for those who care for them. Depression and anxiety in people with dementia is common and can result in excess disability and poor quality of life and treatment, with antidepressants not yet established as effective (Dudas et al 2018). Support for people at the point of diagnosis may include, but is not limited to, psychological support.

Older people with a primary diagnosis of dementia may require multidisciplinary care for depression and anxiety in an appropriate setting and NHS Talking Therapies services may not routinely offer support for people with dementia. However, local services should be equipped to identify and refer people to the most appropriate and effective support.

More information is available from the Alzheimer's Society:

www.alzheimers.org.uk/about-dementia/symptoms-and-diagnosis/depression

Strategies for Relatives (START) resources which can be used to support caregivers are available here:

www.ucl.ac.uk/psychiatry/research/mental-health-older-people/projects/start/start-resources

Mental Health and Later Life

Mental health conditions such as anxiety disorders and depression are major contributors to poor quality of life in older people and are likely to significantly impact on the individual, increase healthcare costs and impact NHS services (Frost et al. 2019).

- Recent estimates suggest that rates of major depressive disorder (clinical depression) are reported at 8-9% and so-called sub-clinical depression (depressive symptoms) are 2-3 times more common than clinical depression (Pocklington, 2017).
- The Royal College of Psychiatrists estimates that depression affects 22% of men and 28% of women aged 65 years and above; anxiety disorders are estimated to affect 1 in 20 older people (RCPsych 2018).
- A Europe-wide survey of community dwelling older people (the mean age was 74) reported a prevalence of 26% for depression in Western Europe assessed using a single assessment measure. Three-quarters of respondents with symptoms of depression didn't seek help for their low mood (Horackova et al. 2019).
- The symptoms of depression in older people do not differ from that experienced in adults under 65 but common symptoms of depression such as hopelessness and apathy may manifest as outcomes of ageing, e.g. 'at my age it is all downhill from here', and, 'I am too old to change'. These commonly expressed thoughts may lead to people being denied access to treatments that are known to be beneficial (e.g. evidence-based psychological therapies).
- Older people with generalised anxiety disorder are more likely to present to primary care with somatic symptoms (e.g. gastrointestinal symptoms, aches and pains) rather than cognitive or emotional symptoms (e.g. worry or anxiety) (Flint 2005).
- Depression and anxiety disorders often co-exist. In a community study conducted over 10 years and across four counties of England, it was reported that three-quarters of people diagnosed with depression also experienced symptoms of anxiety (Wu et al. 2015).
- Older people who are depressed are at increased risk of frailty, functional decline, reduced quality of life and cognitive decline. Depression in later life is also associated with an increase in mortality not attributed to pre-existing physical health conditions (Rodda et al, 2011).
- Depression rates are higher in people who live in care homes and in people who are carers. It is estimated that 1 in 4 residents in care homes will have clinical depression (1 in 5 have an anxiety disorder) and up to 80 per cent of residents experience symptoms of depression (Chan et al 2019).

Delivering NHS Talking Therapies for Older People

- Older people make up only 5.6% (2021/22) of all referrals to NHS Talking Therapies although this varies across the country (NHS Digital 2022).
- Based on the age profile for England, the actual referral rate for NHS Talking Therapies for older people should be 12% but even this figure is low as older people constitute 1 in 5 of the population (20%).
- People aged 65-74 have an overall recovery rate of 61% following treatment, compared to 51% of adults aged 26-64 (NHS Digital 2022).

Making NHS Talking Therapies more accessible for older people

There are a number of potential barriers to older people accessing NHS Talking Therapies services. In this section, the guide takes an evidence-based approach to outlining three major barriers and suggest ways in which local services could help to address them.

Attitudes and beliefs of older people themselves

Research shows that older people think their problems with depression and anxiety are not severe enough to warrant help (Frost et al 2019) and in many cases believe their problems are a 'normal' part of ageing and are therefore untreatable (Wuthrich & Frei 2015). They may not recognise the symptoms of a mental health condition or realise what help is available. They may also feel uncomfortable talking about their mental health or not want to cause a fuss.

In some cases, older people may have experienced certain therapies before, such as counselling, and may not understand how other forms of psychotherapy may be different. This means older people need to be helped to ask for psychological support and services need to consider flexible assertive outreach to increase access.

Encouraging older people to refer themselves to NHS Talking Therapies services should be a priority for services. This is specially so as evidence suggests older people are very likely to refer themselves to NHS Talking Therapies (Prina et al, 2014) and many more would seek out therapy if they were enabled to do so.

Increasing access to NHS Talking Therapies services may be improved by publicising services in relevant places such as libraries, post offices and pharmacies. It is important to ensure advertisements are relevant to older people, using positive age-appropriate examples of care-seekers and non-clinical language which older people find easier to relate to.

- NHS Talking Therapies services should provide, and make accessible, self-referral routes for older people that are age-friendly and can be accessed by people without digital technologies. Technology can be a barrier and result in exclusion; however, assuming lack of IT skills or potential in older people can also be discriminatory (Health Education England, 2020).
- Services will better meet the needs of older people by recognising and challenging negative attitudes and stereotypes of ageing (e.g. 'I'm too set in my ways to change', 'it's better to offer help to younger people', 'I don't want to be a burden on others' and a 'stiff upper lip' attitude). This may include promoting the stories of people who have experienced and benefited from psychological support. Age UK has some resources here: **www.ageuk.org.uk/information-advice/health-wellbeing/mind-body/mental-wellbeing/talking-helps/**
- Health professionals should be encouraged to be age aware when it comes to mental health and help to start the conversation with their older patients. Older people may be more willing to engage in conversations about mental health when non-clinical language is used and tend to describe their own mental health using phrases such as 'feeling down', 'low', or 'out of sorts' (Age UK/Britain Thinks (2020).
- Develop age-appropriate multimedia (posters, flyers, videoclips, pdfs, etc) that can be used by NHS Talking Therapies services to enable access. This can be used on service websites, and in local GP surgeries.

Healthcare professionals

One of the most pervasive myths and misconceptions is that depression is a justifiable and natural outcome of the ageing process (Frost 2019) and older people will not want or benefit from psychological therapies. These perceptions can stand in the way of professionals asking older people about their mental health or referring them to NHS Talking Therapies. There is a need for all healthcare professionals and NHS Talking Therapies services to adopt positive practice towards older people and to challenge outdated negative stereotypes of older people.

As many older people place particular value on their family doctors, there is a specific role for GPs to proactively invite discussion about mood management and to endorse seeking psychological therapy (Nair et al 2020). When starting conversations, they should seek to use non-clinical terms, such as feeling low, out of sorts, or worried, which older people have been shown to find more relatable (Age UK/Britain Thinks (2020).

GPs and other primary care professionals can find that appointments may not accommodate the time necessary to engage with mental health challenges, particularly if that is not the reason a person has come in. Primary care services should consider using short screening tools as part of routine appointments or where they have concerns. All services should be provided with a person-centred focus and GPs should offer longer appointments to older people if they have concerns that the older person may need support with their mental health.

- Services should consider appointing older people champions who will run professional updates on age-friendly practices.
- Set up advisory groups for NHS Talking Therapies services that are representative of age and diversity of the population served by services. Advisory groups must have active involvement in staff recruitment and be party to service reviews to influence cultural change.
- The Older People's Mental Health Competency Framework (NHS, 2020) contains fundamental information about the essential skills, knowledge and abilities required to address the needs of older people with mental health problems. NHS Talking Therapies services should ensure staff have attended training on implementing this framework.
- Primary care services should consider using short screening tools to help identify depression and anxiety in older people. This could apply where someone is otherwise seeking help and support for a physical health problem. There is evidence that the following two questions are sensitive to whether someone may have depression:

1. Have you been troubled by feeling down, depressed or hopeless?
2. Have you experienced little interest or pleasure in doing things? (Tsoi et al 2017)

NHS Talking Therapies service flexibility

Services must be proactive in making themselves more accessible to older people, including by accommodating long term conditions and multimorbidity. They must also provide meaningful choices about a person's therapy. Services must recognise the diversity that exists in the community of older people in society and must make reasonable adjustments to accommodate this diversity.

Services should also recruit older people champions who represent BAME communities in particular to address and monitor barriers such as a lack of options for older people for whom English is not their first language.

- NHS Talking Therapies services should operate in line with the key principles for effective treatment in the NHS Talking Therapies manual, in particular that older "people should be offered a meaningful choice about their therapy". This should include choice over how and where therapy is delivered, the type of therapy from a range of appropriate NICE evidence based options and the clinician (for example, male or female).
- Services should implement measures to increase access, e.g. offering sessions in local and familiar locations such as within a GP surgery, or community facilities. NHS Talking Therapies services should be funded to accommodate home visits and outreach into care homes.
- NHS Talking Therapies services should develop clear pathways with other services, including local voluntary sector organisations, to share knowledge and best practice. This could include voluntary sector providers such as Age UK and the Alzheimer's Society, professional services such as old age psychiatry, and psychologists working with older people.
- Ensure NHS Talking Therapies services provide staff with appropriate training in working with older people and managing multimorbidity and frailty.
- It should be recognised that older people are a very heterogenous age group. Specific access targets for those aged 75 and above should be considered to address unmet need.
- Age-friendly NHS Talking Therapies will ensure strategies are in place to overcome sensory changes in older people (e.g. hearing impairment, visual impairment), that may act as barriers to care, and services must be proactive in supporting older people with mobility challenges and/or frailty to access treatment facilities. This includes ensuring larger numbers of the so-called oldest-old (those aged 85 years plus) are encouraged and supported to access NHS Talking Therapies treatment.
- Older people experiencing mild cognitive impairment (MCI) and those caring for them should not experience barriers to accessing NHS Talking Therapies services. Some staff may need specific training in how to tailor NHS Talking Therapies interventions for people with MCI.
- NHS Talking Therapies staff must have access to dementia awareness training and consider actions that allow for greater flexibility for appointments for people living with dementia and their caregivers, such as telephone, or video-conference calls, and home appointments if considered suitable. They may also consider having shorter but more frequent appointments.
- NHS Talking Therapies services must be fully accessible to all older people, including BAME and LGBT+ communities. This should include full regard to having an ethnically diverse and culturally representative workforce and availability of cultural and language translators and interpreters.

Home (Domiciliary) visiting and psychological therapy

If an older person cannot or does not want to attend psychological appointments as an outpatient, home (domicillary) visits may be arranged. Home visits have long been a mainstay of care for older people, especially in geriatric medical care and geriatric psychiatry services (Crome et al. 2000). A recent evidence-based review (Klug et al. 2019) suggests home-based interventions have a role in engaging difficult to reach populations and can positively impact on mental health outcomes. They can be particularly effective in supporting older people living with mobility difficulties or frailty who may find it challenging to travel. They can also be important for older people who feel more comfortable engaging with services in a place which is familiar and safe to them.

Psychiatrists tend to favour domiciliary visits because of the enhanced assessment opportunities they afford in terms of environment and family relationships (Crome et al, 2020). There is also evidence to suggest that home based interventions may be effective in preventing hospital admissions, reducing escalation distress and affording enhanced assessment opportunities when planning care and treatment (Klug et al, 2018 and Stobbe et al, 2014).

Where possible services should facilitate requests for home visits. There are important factors to consider.

Practical considerations:

- Talk to your service manager/supervisor when considering a client for a home visit and discuss making adjustment to your weekly clinical hours target accordingly.
- Make sure you take steps to keep yourself safe. Always adhere to your service guidelines on safe working/lone working and ensure that you consider risk/safety issues before your first visit.
- Always remain respectful to the fact you are being invited into the client's home. Keep to what has been pre-arranged for the visit and agreed with your client, including arriving on time and keeping to standard appointment length of time. It is also good to call your client on the day of the visit to ensure they are still happy for you to come to their home.
- Always arrange a pre-visit phone call with your client to discuss how the visit will work. If family members (e.g. spouse) will be present discuss what steps you will take to maintain confidentiality. Discuss with your client how to create a safe, therapeutic space in their home. For example, making sure you are able to use a private, quiet room free from interruptions from others, with no radio or TV playing in the background.
- Where possible, seek out supervision from someone who has experience of seeing clients outside of normal office settings.

Therapeutic considerations:

- Regardless of where you see your clients the goals (symptom reduction) remain the same and you should stick to the usual format. Agenda setting is even more important to maintain appropriate professional boundaries and a problem-oriented focus to discussions, which can be lost when a person is in the comfort of their own home. It is also important to continue to agree homework tasks to be completed in-between appointments.
- Home visits offer a unique opportunity for therapeutic approaches:
- Seeing a client in their own home can be useful in targeting behavioural experiments as you may detect 'safety behaviours' in the way your client moves around the home. The home environment may also lend itself more naturally to behaviour experiments such as when developing a graded hierarchy for leaving the house.
- Home visits also afford you the opportunity to observe how your client interacts with others and how they have adapted their home in light of their current difficulties.

- In-vivo behavioural experiments may be possible when doing home visits and when managing anxiety symptoms may augment and expedite treatment efficacy. It may be that when undertaking a home visit and as part of data-gathering you go for a short-walk outside the home, if the older person is able to, and ask them to monitor their distress levels. Afterwards you can use the event to capture, monitor and challenge negative cognitions.
- You will need to consider with your client in advance if and how you will include carers in your therapy sessions. Your client may feel more comfortable having a family member present or want someone to sit in to 'help with remembering what to do'. However, it is important to encourage them to consider what impact it may have on their willingness to talk freely. You should also take into consideration the nature of the relationship between your client and the person sitting in. If a family member or carer is present, agree some 'ground-rules' and a safe-word a client can use to ensure they can assert control in the situation if they become uncomfortable. Take steps to ensure that having another person present does not result in a loss of focus on your client's problems.
- Continue with outcome measurement as usual and consider how you can ensure your client is able to make their wishes known to you with regard to continuing with at home care. It can be helpful to have a more regular review of sessions to ensure the client is happy for you to continue to visit them at home.

COVID-19 and Mental Health Needs of Older People

This section has been compiled in response to the Covid-19 pandemic, which has had a significant impact on older people's mental health.

Older people have been disproportionately impacted by the pandemic and are reporting much higher than normal levels of mental distress. The proportion of older adults reporting symptoms of depression has doubled across the course of the pandemic (ONS, 2020), while Age UK research shows that a third of older adults are feeling more anxious than before (Age UK, 2022). On top of this older adults report feeling afraid to leave the house, becoming withdrawn, and losing confidence and motivation.

At the time of writing in Winter 2023, regretfully over 196,000 people in England have died as a result of the pandemic. At its peak, older adults who have lost loved ones were unable to say goodbye, attend funerals, or grieve with friends and family. In many cases the loss of their loved one was unexpected, sudden, or traumatic. Age UK research has highlighted the impact of bereavement during this time with older people reporting feeling depressed, anxious, isolated, and overwhelmed (Age UK, 2021).

For many older people, the pandemic has also brought back memories of previous losses and trauma. Older people who lost someone before the pandemic have found that the coping mechanisms they used to manage their grief, such as socialising with friends and taking up hobbies, were taken away from them and in some cases have never returned. For some older people there will be long-term psychological and emotional consequences which NHS Talking Therapies services will need to address.

The Covid-19 pandemic has also been especially hard for carers, who in many cases needed to increase their caring responsibilities, while at the same time losing access to support they depend on, such as respite services or family support. Carers have reported feeling depressed, isolated, and anxious.

Many older people still need help with a return to 'normalcy' following lockdown and NHS Talking Therapies services will need to respond to the growing need amongst older people. It will be more important than ever that NHS Talking Therapies services are accessible and appropriate for older adults.

There will be important issues to consider when providing this support. For example, there has been substantial physical deconditioning and reduced mobility amongst older people. Many older people have also lost confidence and are afraid to go outside, particularly during the colder months. It will be important that NHS Talking Therapies services can respond flexibly to these needs, including by offering home visits where appropriate.

Older people who have never experienced mental health problems before have also developed difficulties for the first time. These older people are less likely to be familiar with what support is available, making it essential that NHS Talking Therapies services proactively engage with older people and raise awareness of services.

During the pandemic, many services moved to being provided by telephone or video. This may work well for some older people but is likely to be a barrier for others who do not have access to the internet or feel comfortable having remote consultations.

NHS Talking Therapies services could provide older people with help using telephone and telecare services, including signposting to technical support. It should not be assumed that older people will not be able to adapt or be unwilling to accept care using multimedia and videoconference facilities. The same approaches adopted for adults aged under 65 should be offered to older people.

It should also not be assumed that older people will be inflexible in their decision with respect to telephone and telecare services. This decision should be revisited as some people may decline these services initially but may agree to try them at a later time.

NHS Talking Therapies services should be sensitive to the needs of older people with hearing impairment, cognitive difficulties, communication difficulties, or physical health conditions (e.g. arthritis) as they might find telephone and telecare services more challenging. Video calls are preferential to telephone calls for older people with hearing impairment, particularly if used concurrently with text or chat facilities in videoconferencing software. Older people should be provided with choice and supported to access services which work for them. In some cases older people will require face-to-face services and NHS Talking Therapies services should follow appropriate guidance on delivering this safely.

Older people with cognitive difficulties can be supported to use telephone and telecare services by talking them through what to expect and how to get the most out of their appointment. Those with physical health conditions that make it difficult for them to hold a phone for a full session should be encouraged to use a phone with a loud speaker, if possible.

NHS Talking Therapies services should consider in-reach to older people living in care homes. Researchers in Australia during the first wave of the COVID-19 pandemic launched a telehealth and counselling service for adults living in residential care settings. This innovative care approach demonstrated that older people valued the service and especially valued the use of technology that meant residents were able to see their counsellors (Bhar et al 2020).

A Practical Guide to Psychological Therapy with Older People

There is strong evidence from a wide range of sources that psychological therapy is efficacious with older people and as such there is no specific guidance from NICE that adaptations or modifications are required to depression and anxiety treatment protocols when working with older people. Therefore psychological therapists can be confident that older people who are offered standard non-modified CBT treatments within NHS Talking Therapies are likely to benefit from treatment as long as usual standards of competence of delivery are adhered to. Nevertheless, experienced practitioners who work with older people who experience common mental health problems often highlight that older people's presentation may appear qualitatively different due to high levels of comorbidity, some age-linked complexity and longevity of problems (Sadavoy, 2009). To augment treatment outcomes some therapists may find it helpful to draw upon additional resources when working with older people. This section of the guide aims to provide helpful pointers to therapists to enhance confidence in working with older people.

Contrary to popular stereotypes, ageing is not synonymous with depression and disability. When people age they are likely to report more complex emotional development, including a greater satisfaction with life regardless of the challenges faced.

Understanding that our lives are shaped by our experiences and accepting people are not necessarily consumed by negative past experiences means life experience can be a resource to draw upon in psychological therapy with older people. In CBT an emphasis on an ahistorical approach has tended to neglect the value life experience brings into therapy, meaning people are not encouraged to identify and utilise learning from the past in order to better manage in the here and now.

Wisdom Enhancement and life-skills

This section provides guidance on how to make the best use of life experience when working with older people. The use of timelines within CBT can be used as a step 2 or step 3 intervention. For example lifeskills can be incorporated into the COM-B model (Werson et al. 2020). Lifeskills can also be used as part of a formulation that is developed with the client being seen by a High Intensity (HIT) therapist. As such these additional resources are used within the existing skill set of the Psychological Wellbeing Practitioner (PWP) or HIT therapist.

As step 2 and step 3 interventions in NHS Talking Therapies are time-limited, and require strong adherence to treatment protocols, it is not expected there will be wholesale adjustments to accommodate lifeskills or timelines in treatments at step 2 or 3. Rather, the following is written as a helpful orientation to guide the thinking of the therapist when approaching work with older people. Nevertheless, a step 2 therapist may find this guidance helpful at the assessment stage, and a step 3 therapist can consider whether it is appropriate to incorporate some of these elements in accordance with protocols.

Lifeskills is an abundant resource when working with older people. The use of lifeskills is based upon contemporary theories of normal ageing and incorporates empirical evidence from wisdom (Baltes & Smith 2008) in later life (Bangen et al 2013). Contemporary research suggest that wisdom is more likely to develop in individuals following challenging life events when individuals reflect upon this experience and confront negative emotions (Weststrate & Gluck 2017). This rarely happens outside of psychological therapy, and with older people this type of approach promotes the development of personal wisdom. Lifeskills are also consistent with a strengths-based approach to CBT (Bilbrey et al 2020).

Therapists use a timeline to help clients reflect on a targeted and specific review of past experiences facilitating idiosyncratic exploration of coping with

setbacks thus promoting a greater sense of self-efficacy to enable change. The aim of a structured focus of past experiences is to empower the individual to 'own' their history so that they define it, rather than it defining them. It also facilitates a discussion of how the person has overcome adversity in the past and has gained skills to equip them to manage their current challenges in the here and now.

It is very common that when people review how they overcame adversity in the past, at the time of acute crises, the individual felt unable to cope when dealing with current problems. By revisiting events now with the benefit of 'wisdom after the event', it may become clear to individuals that feelings of helplessness, powerlessness or hopelessness are not facts and these feelings change as one starts to tackle the problem. In this way the past is a valuable resource to be used to empower clients in the here and now.

A structured review of how an individual has overcome adversity over their lifetime and has consequently gained lifeskills facilitates self-compassion (Laidlaw 2020) and reaffirms resilience. This approach is consistent with evidence that as people age they may be primed to develop better emotion regulation competence (Lantrip & Huang 2017), but that emotion regulation in older people is more likely to be optimised using targeted and specific tasks to develop this, and especially when that task is perceived as personally important or relevant (Isaacowitz et al 2017).

Timelines are a useful tool as they promote exploration of lifeskills and provide the older person with access to evidence they may have misperceived because of the negative cognitive biases evident in depression and anxiety disorders. Timelines can:

- Provide therapists with a tool to achieve a focused reappraisal of past experiences and to promote a greater sense of self-agency when dealing with current difficulties
- Encourage the client to focus on a factual review of events from their life history.
- Support people to become more self-compassionate and self-accepting.
- Encourage individuals to use concrete examples of lifeskills to enable re-appraisal, acceptance, problem-solving and attentional deployment to effect change.
- Help an individual recognise their resilience in the face of difficult circumstance by reflecting on life experiences in a structured way
- Provide a revised individual narrative where an individual is able to recognise and endorse lifeskills, thereby enabling a new approach to managing current difficulties.

Some principles to adhere to when using a timeline in therapy are as follows:

- Keep timelines short and focused (1 page only).
- Look for a chronology to the events listed in the timeline. Remember that big events from the past may be linked by a series of other events that may be less 'significant' but nonetheless are idiosyncratically meaningful to the client.
- Derive a clear and strong narrative, i.e. about being resilient, or a survivor.
- Examine chosen events from the timeline 'objectively' and use them to focus therapy on managing problems in the 'here and now'.
- Ensure that support is available to clients if in the course of the timeline they uncover difficult experiences.

Summary

Past life events are factually re-examined using timelines completed by clients to enable a review of idiosyncratic evidence by the client, demonstrating they are a competent and resilient individual. Evidence from timelines in CBT allow older people to learn from past experience and use this new knowledge to manage their current problems better. This is because they are able to see that they have overcome adversity in the past and can do so again.

Selection, Optimisation with Compensation (SOC)

Selection, Optimisation with Compensation (SOC) promotes the idea of resilience and the benefit of personal wisdom (Freund 2008; Freund & Hennecke 2015) by adopting an active coping strategy when faced with challenges of ageing, e.g, bereavement, disability, and frailty. SOC is consistent with a body of research demonstrating that older people can deflect aversive experiences if they adopt active self-regulatory strategies (Kunzmann et al 2014).

Selection of valued roles and goals is the first step in using SOC and often means the older person needs to focus their attention on specific tasks or activities (e.g. those that are most important to them and can be most realistically achieved), hence they 'select' what they want to continue to do in the face of challenges.

Optimisation basically means enhancing skill practice, it can of course be role play that optimises skills in therapy but it can also be targeted and focused practice of sufficient frequency to enable the skill to develop.

The final step in SOC is to adopt ***compensatory strategies***. In light of a current age-related challenge an individual will need to modify their approach in order to compensate for a change in circumstances/abilities. Adopting this approach with clients enables improvement in functioning in an important role/goal in life.

SOC fits well within the problem-focused orientation of CBT and is applicable for long-term conditions work. More information on SOC can be found in the NHS Talking Therapies clinician's guide to CBT with older people (Laidlaw et al 2016; Chellingsworth et al 2016).

Trauma-informed approach to care

A trauma-informed (TI) approach asks 'what happened to you' rather than 'what is wrong with you' (Harris & Fallot, 2001) and includes the principles of safety, trust, peer support, collaboration, empowerment and cultural, historical and gender issues (SAMHSA, 2014). Service delivery should follow a TI approach, particularly as older people may not describe their experiences as "a trauma". They may feel their experiences were just part of life for their generation, may never previously have been asked about it or may be more likely to report somatic symptoms, chronic pain or cognitive problems rather than psychological symptoms associated with trauma (Graziano, 2003). It may therefore be necessary to adapt language used during assessment, as well as to take more time to build trust and safety with an older person before they talk about traumatic experiences. As with working age adults, it is important to screen for trauma related symptoms of dissociation and PTSD (e.g. PCL-5) as these can interfere with recovery in psychological therapy if unaddressed. Formulations should be collaboratively developed to identify the links between past and current trauma (for example loss, ill health, isolation), including trauma triggers experienced during the Covid-19 pandemic, and presenting problems where relevant. Where PTSD is present, trauma-focussed CBT, and other evidence-based treatment protocols, should be offered as usual and can be enhanced by the use of timelines where there are multiple traumas over an extended period of time. However, any intervention offered should be based on a trauma-informed formulation, with a focus on establishing trust and safety for stabilisation.

Cognitive deficit and psychological therapy

Working with mild cognitive changes

Mild cognitive changes in working memory, attention and processing speed are common in older people. They can be caused by a range of factors including age, fatigue, low mood, stress or anxiety, pain, medical conditions, and medication side effects. It is important to compensate for them when delivering psychological therapy as cognitive impairments have been shown to be associated with a reduced response to CBT for generalised anxiety disorders in older people (Caudle et al 2007). A variety of standard therapeutic strategies can be used to compensate for mild cognitive changes (Boddington 2014), as outlined below:

- Schedule appointments for the time of day when the older person is most alert;
- Provide reminders of appointments;
- Provide capsule summaries throughout the session, as well as a summary of the session at the end. Encourage the older person to make written notes throughout the session or to record the session, if necessary;
- Repeat key concepts and skills within sessions and from session-to-session. Recap on what was discussed in the previous session at the beginning of the next session;
- Ensure there is flexibility to work at a slower pace. Check that you are going at an appropriate pace, slow down, and shorten the session length, if necessary. Offer shorter but more frequent appointments if helpful;
- Use worksheets that can be easily adapted for visual impairment;
- Use different coloured paper for home practice worksheets to help distinguish them from worksheets used within the session;
- Provide mid-week reminders to complete home practice.

Working with people with dementia and their caregivers

Older people with a primary diagnosis of dementia may require multidisciplinary care for depression and anxiety in an appropriate setting and NHS Talking Therapies services may not routinely offer support for people with dementia. However, local services should be equipped to identify and refer people to the most appropriate and effective support. This may include local NHS Talking Therapies services acting to improve general awareness of both dementia and the services available to support people living with dementia and their carers. **Note: There is no expectation that NHS Talking Therapies staff will administer any cognitive screens or even be expected to interpret cognitive screening scores. This section is simply to serve as contextual information.**

Understand level of severity. There is no single, or simple test for dementia but before starting to work psychologically with an individual who has anxiety or depression symptoms and dementia, it is sensible to try to gauge the level of dementia severity in order to tailor expectations for engagement. Assessment is complex and requires specialist training (see Dementia Revealed: What Primary Care Needs to know (2014): **www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf**. There is no expectation that NHS Talking Therapies staff will administer any cognitive screens themselves or even be expected to interpret cognitive screening scores but they should work with referrers to ensure that they are meeting the older person's needs.

Years since diagnosis is unlikely to be helpful and may be misleading. A more useful indicator is rate of decline over years and this can be checked with the referrer. Check with the referrer as to whether a diagnosis of a dementia has been made and whether a cognitive screening test has been performed to support the assessment and ask for details (See the Older People's Mental Health Competency Framework (Health Education England,

2020). The most common screening tests are the Addenbrooke's Cognitive Examination III (ACE-III) (Bruno & Vignaga 2014) and the Montreal Cognitive Assessment (MOCA). A score of 82 and less on the ACE-III and 26 and below on the MOCA are usual cut-off scores for a person likely having a dementia (Beishon et al. 2019).

Foster hope and restate competence. When working with people recently diagnosed with a dementia, emphasise preserved levels of function, and remind the older person they are still functioning as a valued and important individual in their relationships with friends and family. Provide space for exploring the personal experience of their diagnosis as some individuals diagnosed with a dementia experience a grieving process both for the loss they experience as a result of dementia (memory loss) and for the loss of a perceived future they had anticipated without dementia. If the person has not already done so you may consider discussing advance decisions the person may wish to make about their future care and help them consider whom in their family they will discuss this with.

Introduce more structure and more active guidance. Structured CBT sessions can be particularly helpful for people whose memory abilities are compromised and may be especially relevant in treating depression in dementia, with a focus on practical and pragmatic problem-solving.

The person with dementia can be encouraged to take a more active role in therapy, taking notes as the session goes on, recording sessions and listening afterwards, and making checklists to be completed at specific times in-between sessions.

Behaviour activation and scheduling with problem-solving are helpful elements of CBT treatment. This is because they target mood and motivational difficulties and problem-solving targets anxiety generated fear about how a person can cope with a dementia. Sessions can be shorter and occur at a different pace depending on the fluctuation in cognition of the individual. If useful, a confidant can attend the sessions with the person to aid recall for homework completion.

Supporting carers. There is very strong evidence that CBT is efficacious in reducing psychological distress in dementia caregivers (Kwon et al 2017). Partly this is due to the problem-solving orientation of CBT, which provides people with coping skills to manage the 'moving target' nature of problems arising due to dementia (Cheng et al 2019). Therapists working with dementia caregivers should spend time at the start of treatment understanding the reasons that the carer is providing care, and to explore the pre-morbid nature of the carer relationship.

STrAtegies for RelaTives (START) is an intervention that supports the development of coping strategies for carers of people with dementia and there is evidence it can reduce depression and anxiety (Livingston 2020). More information can be found here: **www.ucl.ac.uk/psychiatry/research/mental-health-older-people/projects/start**

Resources

Older people's experiences of mental health

Age UK (2016), 'Hidden in plain sight: the unmet mental health needs of older people'. Available at: **www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/rb_oct16_hidden_in_plain_sight_older_peoples_mental_health.pdf**

Age UK (2020), 'The impact of Covid-19 on older people's mental and physical health to date'. Available at: **www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf**

Age UK (2021), 'Impact of Covid-19 on older people's mental and physical health: one year on'. Available at: **www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/id204712_hi_covid-report-final.pdf**

Age UK (2020), 'Older people talk about why it's important to talk'. Available at: **www.ageuk.org.uk/information-advice/health-wellbeing/mind-body/mental-wellbeing/talking-helps/**

Independent Age (2020), 'Minds that matter: understanding mental health in later life'. Available at: **www.independentage.org/policy-and-research/mentalhealth/minds-matter-report**

Psychotherapy resources

British Association for Behavioural and Cognitive Psychotherapies (2019), 'IAPT Black, Asian, and Minority Ethnic Service User Positive Practice Guide'. Available at: **babcp.com/Therapists/BAME-Positive-Practice-Guide-PDF**

NHS Health Education England (2020), 'Older people's mental health competency framework'. Available at: **www.e-lfh.org.uk/programmes/mental-health-training-resources/**

University of East Anglia, 'CBT with older people, free online course;. Available at: **www.futurelearn.com/courses/cbt-older-people**

Age specific questionnaires: GAS, GAI, GDS, AAQ

CBT guidebooks

Laidlaw, K., Kishita, N., & Chellingsworth, M. (2016). Clinician's Guide to: CBT with older people, Department of Health.

Chellingsworth, M., Kishtia, N., & Laidlaw, K. (2016). Clinician's Guide to: Low Intensity CBT with older people, Department of Health.

NHS England has produced an eLearning resource for this positive practice guide, available through eLearning for Healthcare: www.e-lfh.org.uk/programmes/nhs-talking-therapies-for-anxiety-and-depression-positive-practice-guides/

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Age UK/Britain Thinks (2020), Older people, mental health and IAPT: an insights report (in press).

Age UK (2021), Impact of Covid-19 on older people's mental and physical health: one year on.

Age UK (2022), Press Release: New Research shows a "hidden" mental health crisis is debilitating older people: **www.ageuk.org.uk/latest-press/articles/2022/age-uk-press-release-new-research-shows-a-hidden-mental-health-crisis-is-debilitating-older-people/**

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