SECTION 8 APPENDIX 3

The British Psychological Society

Division of Clinical Psychology
PSIGE – Psychology Specialists Working with Older People

Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Older People

November 2006

Purpose and status of this document

This document has been prepared by the PSIGE Training Subgroup on behalf of PSIGE – The Faculty for Psychologists working with Older People. Its key purpose is to guide members of the profession and training providers in ensuring that trainee clinical psychologists, upon qualifying, are able to meet the needs of older people, in whatever setting or context they come into contact with them.
The guidance within is also intended to aid in planning and evaluating the consolidation of experience and competences of newly qualified clinical psychologists working within the older peoples' speciality before transition from Band 7 to Band 8 within Agenda for Change.

The Faculty believes that it is the responsibility of each training course in conjunction with local Special Interest Groups and supervisors to work jointly towards these aims. This is in line with the current Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology (CTCP, 2002) that set out clear requirements for consultation with DCP Faculties in relation to:

- 'The expected capabilities which a trainee should gain to fit them for work with specific populations and groups' (Section A6).
- Provision of 'the reference information for the minimum supervised practice commensurate with competence in an area of work' (Section 7.2).
- And 'development of the syllabus' (Section 9.1).

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PSIGE is the Faculty for Old Age Psychology – www.psige.org

1. Introduction

Nearly a fifth (19.5 per cent) of people in the UK are aged 65 or older. They are consumers of 50 per cent of health and social care spending. Older people have at least equivalent rates of psychological distress generally as compared to younger people and show significant levels of depression and suicide as well as dementia.

However, just over five per cent of the Clinical Psychology workforce specialises in work with older adults (DoH and BPS National Workforce Survey 2003) and fewer than 10 per cent of clinical psychology contacts are with older people (DOH), reflecting historical imbalances in resource allocation, under diagnosis and under treatment. The recent Workforce Survey of Applied Psychologists conducted jointly by the British Psychological Society and the Department of Health showed no proportionate growth in services to older people over the last decade.

The NSF for Older People (for England) emphasised the need to root out ageist practice across health and social care to ensure that older people get access to both general services as well as specialist services for older people. Therefore, psychologists in most specialisms can expect to have contact with older people as part of their normal clinical practise and need to have an adequate understanding of this population as well as the clinical skills to address their needs. Contact can occur in Primary Care as directly referred clients of the service; in Adult Mental Health as clients, parents, and/or carers; Child and Adolescent Mental Health as grandparents or carers; in Learning Disabilities as clients and parents/carers and in Physical Health as clients and/or carers. This will also be the case for all specialist areas of work (such as forensic and substance misuse) when age boundaries are eliminated.

PSIGE, therefore, believes that to provide effective services, generic Clinical Psychology training should equip all Clinical Psychologists with the basic capability to meet the fundamental psychological needs of older people, including knowing when to refer on to specialist older adult services. In addition, the training experience needs to encourage, both in the general ethos and through specific aspects of the course, sufficient trainees to specialise in Older People's services post qualification.

1.1 The National Service Framework for Older People and the Older People's Skills and Competencies Framework

The most relevant current national policy frameworks are the National Service Framework for Older People (England) (which laid down the main priorities for services for this client group) and the developing Older People's Skills and Competency Framework. The recently published report, 'Everybody's Business' (DoH, 2005), identifies key areas of policy development for Older People's Mental Health Services. A summary of the NSF for Older People is given in Appendix 1. It is recognised that the NSF applies only to England, but this is suggested as a widely accepted framework with equal relevance to the rest of the United Kingdom.

Broadly the competencies identified within these documents require that all health providers, including psychologists:

- Are able to recognise and address discriminatory attitudes and practices.
- Are able to assess the needs and preferences of individual older people.
- Are aware of and can integrate factors to do with physical ill health, sensory impairment, disability and experience of health services into their routine practice.
- Are able to assess and intervene at the appropriate level with the main mental health problems occurring in older people.
- Have the knowledge and ability to promote healthy lifestyles in later life.

2. BPS Accreditation Criteria for Training Programmes in Clinical Psychology

The current Criteria for the Accreditation of Postgraduate Training Programmes in Clinical Psychology specify that:

Programmes should refer to the minimum standards which are identified and revised from time to time by the Division of Clinical Psychology's Faculties and Special Interest Groups for guidance in relation to the expected capabilities which a trainee should gain to fit them for work with specific populations and groups (Section A6).

The national standards as set out by the Division of Clinical Psychology's Faculties and Special Interest Groups (see Section B.2.5) will provide the reference information for the minimum supervised practice commensurate with competence in an area of work (Section 7.2)

The development of the syllabus should be informed by consultation with DCP Faculties and Special Interest Groups (Section 9.1).

The following points are of particular relevance to work with Older People:

Programmes will be expected to structure the training patterns of their cohorts so that they reflect workforce-planning requirements within the NHS. These requirements will be shaped in part by National Service Frameworks and national policies (Section B.2.5)

A fundamental principle is that trainees must work with clients across the lifespan, such that they see a range of clients whose difficulties are representative of problems across all stages of development (Section B.2.6.1)

While it is appropriate that Programmes should differ in their emphases and orientations, they must all provide academic teaching relevant to the full range of client groups and a wide range of clinical methods and approaches. This will include teaching on children, people with learning disabilities and older people (Section 9.2)

3. Required competencies, experiences and service settings

In order to assist in the implementation of the revised criteria, PSIGE has developed minimum standards to enable training programmes to provide trainees with the expected capabilities to fit them for work with older people.

Although these are listed individually for the sake of clarity, effective work with older people depends upon their effective integration. This can be learned and demonstrated in a number of ways including supervised practice, exercises and simulations, and academic work. PSIGE recognises that different courses will approach this in different ways and wishes to support the development and evaluation of new ways of demonstrating and evaluating capabilities.

Recommendation 1: *All trainees should have demonstrated the capabilities in Table 1 by the end of training.*

Table 1: Expected areas of capability for newly-qualified Clinical Psychologists.

Capability		NSF Standard	Accreditation Standard
1	Personal and professional recognition and understanding of how to address age discrimination	1	B1.1.6 B1.2.4
2	Able to recognise and manage the effects of differences in age between Psychologist and older people particularly in the implementation of psychological therapies	1	B1.1.2 B1.2.2
3	Able to encourage and support older people, their carers, and staff to increase autonomy, choice, and psychological well-being. Able to effectively work to increase motivation when it is low.	1	B1.1
4	Able to recognise and minimise psychological barriers to older people' independence.	2	
5	Able to demonstrate cultural sensitivity, and address culture specific expectations of ageing.	2	B1.1.2
6	Able to effectively communicate with older people. Able to overcome cognitive and sensory impairments to enable effective work to take place. Able to provide written information in the right format for an individual older person.	2	B1.1.1
7	Able to determine psychological formulations for older people with complex, multiple problems. For example, clients with co-existing dementia, depression, social isolation, substance abuse, and poverty.	2–7	B1.1.1 B1.2.1 B1.2.3
8	Able to effectively intervene, both directly and indirectly, to improve the lives of older people, and their carers, using psychological understanding and techniques based on a scientist-practitioner and reflective-practitioner model.	2	B1.1.1 B1.1.4 B1.2.3
9	Able to recognise and manage risk in older people.	2-7	
10	Have a basic knowledge of the range of services and agencies available for older people and how to access them.	3	B1.1.3
11	Able to work effectively with other providers of services for older people to address psychological aspects of health and health care.	3	B1.1.3 B1.1.4
12	Able to recognise and manage boundary issues when working with older people in different settings, e.g. patients' homes, medical wards.	2–4	B1.2.4

4. Mechanisms for achieving these competencies

All clinical psychology training courses should aim to ensure that they provide trainees with the knowledge and skills needed to develop the competencies outlined in this document through a mixture of academic teaching and clinical placement experience.

4.1 Academic Teaching

Recommendation 2: *It is important for teaching and other academic components of the Programme to provide a coherent body of knowledge relating to the needs of older people together with the skills needed for finding, evaluating, and applying this knowledge.*

Not all of this teaching needs to be within a single older persons' module, but when teaching is dispersed, care must be taken to demonstrate that trainees have been able to integrate the different topics. Similarities with and differences from other areas of work should be clear. As with supervised experience, transfer of knowledge from other areas needs to be explicit within training documents and demonstrated by trainees

Recommendation 3: *Trainees will have exposure to positive theories of age and ageing and explore ageist stereotypes and assumptions.*

Trainees will receive teaching in the majority of the following areas:

3a. *Models of individuality and personhood that recognise the diversity of older people and the heterogeneity of their needs.*

3b. *A life-span developmental perspective that recognises the importance of cohort and longitudinal effects, and includes gerontological theories of adjustment in later life, and the developmental tasks and roles of later life.*

3c. *Present and likely future individual experiences of old age; physical, social, psychological, spiritual, cultural, and sexual.*

3d. *Effects of ageing on cognitive function including "normal" or successful ageing and dementia and related conditions. This should include an understanding of the psychometric properties of assessments when used with older people.*

3e. *Understanding of legal, moral, and ethical issues, e.g. capacity, powers of attorney, protection and over-protection, do not resuscitate orders, euthanasia, choice, and consent, and their relationships to duties of care (e.g. Bournewood guidance).*

3f. *Models of healthy living and healthy communities, and interventions to promote good physical and mental health in older people.*

3g. *Models and techniques for older people's involvement in service planning and delivery.*

3h. *National policy frameworks (NSF) and other significant policy documents, e.g. Forget Me Not and the development of services within these.*

3i. *The social context of older people and current social policy e.g. Better Government for Older People, and financial benefits and pensions.*

3j. *Care frameworks and pathways including statutory, voluntary, and independent providers.*

3k. *Roles of other professions who work with older people.*

3l. *Abuse of vulnerable older people.*

3m. *Common problems of old age related to bereavement, different types of dementia, late-life depression, stroke, and physical health problems This should include current NSF target areas: for example falls and fear of falling, continence, pain, disability and quality of life, and end of life issues and palliative care.*

3n. *Models of psychological interventions for the common problems of older people at the individual, family, and systems level with the evidence base for their effectiveness.*

3o. *Suitable outcome measures including quality of life, independence, and symptom report measures.*

3p. *Essential psychological components of the medical care of older people.*

3q. *Preventative interventions for the common problems of later life.*

3r. *Pharmacology and older people including use and abuse of prescription and illicit drugs.*

PSIGE has developed a recommended curriculum for OP teaching (Appendix 2)

4.2 Clinical Placements

Supervised practice in work with older people has three functions: firstly, to enable the development of fundamental clinical skills and knowledge with wide applicability across all client groups; secondly, the provision of specific experiences in older people's work, particularly those where a number of capabilities have to be integrated; and thirdly the direct assessment of clinical competencies in these areas.

Recommendation 4: *Specific clinical experiences should be gained, at least in part, in a specialised Older Persons' service under the supervision of a Clinical Psychologist who specialises in work with older people.*

Recommendation 5: *Sufficient time should be spent within a specialist service for older people to allow the inter-disciplinary and inter-agency aspects of work to be understood.*

If this is not achievable, particular care will be needed, on the part of the Training Programme, to ensure that the trainee is able to integrate his or her experiences with older people in to a coherent whole; for example through seminars, case discussions or clinical or academic teaching. Joint working between Older Adult supervisors and supervisors from other specialties may be beneficial. A number of unintegrated disparate experiences with older people in order to tick off a number of discrete competencies with older adults are unlikely to be adequate.

Supervised practice should be arranged to allow trainees to gain and demonstrate the capabilities identified above. Though some of these may be transferable from other settings or client groups, they cannot be assumed to have been transferred without evidence. PSIGE recognises that means of evaluating transferable skills need to be developed, and wishes to contribute to this process.

Not all placements can guarantee all experiences and for some trainees minimum supervised practice will be over a series of placements.

Recommendation 6: *Trainees should have, within their placement experience, opportunities to reflect on the personal effects of working with older adults, especially in relation to feelings about ageing; including successful, robust aging as well as dependency, chronic ill health, loss and mortality, in order to develop the personal awareness required to address the individual client's needs.*

Recommendation 7: *Trainees' supervised experience should include the majority of the following:*

7a. *Substantive experience with a number of older people (an indicative number would be around eight or more) to ensure that appropriate clinical expertise in assessment and interventions is developed for the main presenting problems. This would usually include contact with at least one person with stroke, dementia, depression, a late life event (e.g. bereavement, terminal illness, or retirement), poor physical health, substance abuse or drug dependency, and complex problems (the co-existence of at least 3 of the above). This experience might occur on adult mental health, primary care or elective placements, or in work with families/carers. Experiences should reflect the age span within this group, i.e. people in their 7th, 8th, and 9th decades of life.*

7b. *A number of these cases should include neuropsychological and other psychometric assessments of intellectual function.*

7c. *A number of these cases should include direct interventions using recognised psychological models; for example reminiscence therapy or cognitive, behavioural, or psychodynamic therapies.*

7d. *A number of these cases should involve indirect interventions. They should include at least one with joint working with a non-NHS agency.*

7e. *At least one case should involve contact with family members*

7f. *At least one older person should be seen at home.*

7g. *At least one older person should be seen in a long-term care setting: for example, a nursing or residential home.*

7h. *At least one person should be seen in a ward, day hospital, or other NHS setting.*

7i. *A number of interventions should be evaluated using formal measures such as questionnaires or observational scales.*

7j. *There should be participation in service or practice developments that reflect the integration of psychological models into service delivery.*

7k. *There should be sufficient involvement with users and carers to grasp their personal experiences within the service system.*

4.3. Research

PSIGE welcomes and supports research that relates to the needs of older people.

The timing of older adult teaching and placements can influence the choice of trainees' small and large scale research projects. If projects have to be chosen before trainees have contact with older people, this may bias trainees against this area.

PSIGE feels that it is the responsibility of courses to ensure that the range of research is adequately reflected in the research teaching, and would be willing to assist in any developments that support this.

Recommendation 8: *Courses should ensure that trainees are aware of the potential of research in areas that relate to older people and are supported at all stages of the course in carrying out research in the specialty.*

4.4. Supervision

Supervisors need to be sensitive to the particular issues that may distinguish work with older people. Supervisors will need to be aware of, anticipate and, if needed, address the above issues at the beginning of the placement.

These issues may include:

Emotional factors

Trainees may experience high levels of anxiety about working with older people, especially if they have little prior experience with older people either in work or within their families. They may come to the placement with negative assumptions, fears about death and mortality and assumptions about clients' capacity for change.

Trainees are going to be exposed to ill health and at times death; this may trigger their own fears about their own future, mortality, and that of their parents.

Trainees may experience therapeutic impotence when faced with the reality of some people's lives.

Complexity

There can be a complexity of the client presentation – encompassing physical, mental, and cognitive difficulties.

There is a complexity to the service context, with clients involved in primary and secondary care within both specialist mental health, general medicine, social services, voluntary agencies.

Supervisors may need to support assessment and formulation and intervention planning to take account of these factors.

Models and theories

Supervisors may need to draw on a wide range of models drawn from neuropsychological, psychological, social construction, and health psychology.

It is especially important that supervisors are aware of the role of physical health problems (such as cardiac problems) and the possibility of early cognitive difficulties in their approach to assessment and formulation.

Therapeutic interventions

The evidence base for psychological interventions with older people demonstrates both the effectiveness of interventions and also the need for adaptations of techniques. Trainees may feel deskilled when faced with the need to modify their approach and question their own competence or the possibility of change. Supervisors may need to sensitively address this concern in order to give confidence and help the trainee to develop a broader therapeutic style.

Systemic issues
Many older people are referred from within a specific service setting and very many have carers involved in their lives. Systemic issues are likely to be raised within the placement experience. This requires the supervisor to help the trainee incorporate the right balance of systemic aspects and the individual client's needs for therapy. The placement may raise issues of abuse of vulnerable adults; it may also require discussion about power issues within relationships and services, and the responsibility of psychologists to challenge some of these.

Advanced generic supervisor training will address many of the issues that relate to older people's placements. PSIGE feels that there are some features of the older person's placement experience that justify being addressed in their own right. PSIGE is also aware that supervisors who do not work primarily with older people may be interested in some support in extending their supervisory skills with this client group.

Recommendation 9: *PSIGE has piloted a national supervisor workshop in this field in the autumn of 2005 which could develop as a model training module for supervisors for older people's placements and would recommend that this might be taken up by individual courses, if successful.*

4.5. Continuing Professional Development

PSIGE recognises that basic Clinical Psychology training cannot fully equip Trainees with all of the skills and knowledge necessary for successful work with older people. A systematic programme of continuing professional development under the supervision of a Consultant Clinical Psychologist who specialises in work with older adults will be needed to fully equip qualified staff for independent practice.

Review Process

PSIGE recognises that full implementation of these standards will be a challenge for some Training Programmes.

PSIGE will work in partnership with other specialties and Training Programmes to develop ways of flexibly training Clinical Psychologists to have the minimum capabilities identified in this document. There are many examples of existing good practice which PSIGE plans to disseminate nationally, in conjunction with training courses.

Specific areas of work that PSIGE would like to develop further are tools for auditing trainee experiences, methods for supporting supervisors in other specialties who are providing experiences with older people and ways of assessing transferable competencies.

These guidelines will be reviewed in 2009. At that point, if not earlier, CPD requirements should also be considered, including the type of competencies and experiences that should be consolidated in the first 18 months post-qualification.

References

Key documents

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Department of Health (2003). Workforce activity figures for England. doh.gov.uk.

Department of Health (2005). Everybody's Business – Integrating Mental Health Services for Older Adults. London.

Appendix 1 –
The National Framework for Older People (England)

The NSF for Older People specifies eight aims for Older Peoples' services:

1. To ensure that older people are never unfairly discriminated against in accessing NHS or social care services as a result of their age

2. To ensure that older people are treated as individuals and they receive appropriate and timely packages of care which meet their needs as individuals, regardless of health and social services boundaries.

3. To provide integrated services to promote faster recovery from illness, prevent unnecessary acute hospital admissions, support timely discharge and maximise independent living.

4. To ensure that older people receive the specialist help they need in hospital and that they receive the maximum benefit from having been in hospital.

5. To reduce the incidence of stroke in the population and ensure that those who have had a stroke have prompt access to integrated stroke care services.

6. To reduce the number of falls which result in serious injury and ensure effective treatment and rehabilitation for those who have fallen.

7. To promote good mental health in older people and to treat and support those older people with dementia and depression.

8. To extend the healthy life expectancy of older people

Appendix 2 – Model curriculum

Working with Older People: Outline syllabus for the academic component of the Doctorate in Clinical Psychology

Prepared by Linda Clare & Jan Oyebode for the PSIGE national sub-committee on clinical training – 20 January 2004

Introduction

This document presents aims, objectives, and an outline syllabus for the teaching on work with older people offered as part of the academic component of the doctorate in clinical psychology. Members of the PSIGE national sub-committee for Clinical Psychology training have prepared this outline. It is intended as a resource for PSIGE members, for directors and staff of clinical psychology training courses, and for clinical psychology trainees. It does not set out to prescribe what must be taught, but offers an overview of what a good Course might aim to include, either as a designated module on working with older people or integrated into the later life aspects of a generically organised curriculum.

PSIGE recommends that 'teaching and other academic components of the Training programme must provide a coherent body of knowledge relating to the needs of older people together with the skills needed for finding, evaluating, and applying this knowledge. Not all of this should be within a single module, but when teaching is dispersed, care must be taken to demonstrate that trainees have been able to integrate the different topics. Similarities with and differences from other areas of work should be clear. As with supervised experience, transfer of knowledge from other areas needs to be explicit within training documents and demonstrated by trainees.'

Aims and objectives of academic teaching on work with older people

Aims

1. To ensure that trainees have an awareness of common attitudes to ageing and to older people.
2. To develop an understanding of the professional, clinical and organisational issues pertinent to the care of older people, including themes of continuity and difference from younger adults.
3. To educate trainees about physical and psychological conditions more commonly associated with later life.
4. To develop clinical assessment and treatment skills necessary for working with older people, incorporating an awareness of cultural, age and cohort issues.
5. To provide trainees with enough information about common problems and themes, and ways of responding to these, for trainees to feel prepared for their work on placement with older adults, and enough guidance for trainees to know where to look for more in-depth information.
6. To enable trainees to identify where skills and knowledge they have gained in other areas of work are relevant to working with older people, and where they need to acquire different skills or develop existing skills further in order to work effectively with older people.
7. To stimulate enthusiasm for working with older people and encourage trainees to continue their involvement in this area.

Learning Objectives

On completion of their academic teaching trainees should be able to:

1. Describe the characteristics of older cohorts in terms of their life experiences, and physical, social, cultural and historical contexts, and conceptualise the challenges and experiences of later life using a lifespan developmental framework.
2. Be aware of factors that contribute to 'successful ageing' and well-being in later life.
3. Recognise ageism and its influence on society and professionals, including themselves.
4. Demonstrate knowledge of the dementias, including presenting symptoms, patterns of change in neuropsychological profiles, key assessment tools and effects on the individual and their family
5. Describe the characteristics of issues that are of particular relevance to psychological well-being in later life, including adjustment to dementia, bereavement and loss, sensory impairment, physical illness including stroke, and facing death.
6. Demonstrate knowledge of how longstanding mental health problems may manifest in later life.
7. Demonstrate awareness of the impact of common clinical issues for the older person, their family and any service providers.
8. Demonstrate an up-to-date knowledge of psychological theory in relation to the assessment of older people, taking into account the multiplicity and complexity of problems and risk factors that may present.
9. Demonstrate an up-to-date knowledge of approaches to formulation and therapeutic intervention with older adults, including both specific approaches, and how to adapt more standard interventions for use with older people.
10. Demonstrate knowledge of specific interventions for people with dementia and their families.
11. Be aware of systemic issues in relation to working with older adults' families and care systems.

Suggested syllabus content

1 General issues in ageing

- Attitudes and expectations to working with older people
- Relevant social history and demographic information
- Ageist stereotypes; ageism and its consequences
- The social context of older people; retirement issues including loss of social role, diminishing social networks; isolation and geographically distributed families, current social policy, including financial benefits and pensions.
- Discrimination and health provision
- Elder abuse
- Understanding of legal, moral, and ethical issues in relation to vulnerable older people, e.g. capacity, powers of attorney, protection and over-protection, do not resuscitate orders, euthanasia, consent to treatment, advance directives, Mental Health Act, and the relationship of these to duty of care
- Caregiving
- Diversity and heterogeneity among older people, and the effects of culture, ethnicity, gender and sexual orientation in relation to ageing
- Present and likely future individual experiences of old age, including physical, social, psychological, spiritual, cultural, and sexual aspects

2 Normal ageing and the impact of life events

- A life-span developmental perspective
- Gerontological theories of adjustment in later life; adaptation; successful ageing; models of healthy living and healthy communities
- Developmental tasks and roles of later life; typical life experiences
- Social changes with ageing
- Effects of ageing on cognitive function
- Effects of ageing on physical and sensory functioning
- Bereavement, death and dying
- Understanding the limitations of knowledge about ageing: methodological (e.g. cohort versus longitudinal studies); conceptual (e.g. 'intelligence' as in WAIS being related to younger people's lives); and data related (e.g. lack of age-related norms).

3 Physical and psychological disorders in older people

- Models of psychological formulation (such as Knight's maturity-specific challenge model) for helping to understand the common problems of older people including the influence of individual, family, and systems factors
- Interventions for the common problems of older people at the individual, family, and systems level with the evidence base for their effectiveness
- Preventative interventions for the common problems of later life
- Use of suitable outcome measures including quality of life, independence, and symptom report measures

3.1 Understanding dementia and related disorders

- Theoretical frameworks for understanding dementia, including medical models, Kitwood's dialectical model, social constructionist models, and biopsychosocial models
- Implications of these models for assessment and intervention.
- The subjective experience of dementia; models of adjustment and coping; awareness and denial
- The experience and needs of family caregivers of people with dementia; challenges and positive aspects of caregiving.

3.2 Presentation of dementia and related disorders

- Different types of dementia
- Differential diagnosis
- Prevalence
- Psychological and behavioural changes in dementia
- Impact of life events in dementia
- Impact of malignant social psychology
- Quality of life

3.3 Assessment of people with dementia and related disorders

- Good practice in pre-assessment counselling
- Neuropsychological assessment
- Psychological and functional assessment
- Good practice in telling the client the outcome of assessment
- Knowledge of current pharmacological treatments

3.4 Psychological problems in later life

- Presentation of depression in older people; prevalence; risk factors; prognosis; treatments and their outcome, especially psychological treatments.
- Late-onset versus earlier-onset depression
- Anxiety
- Psychosis with onset in later life

- Impact of earlier traumatic events in later life
- Continuation or recurrence of long-standing mental health problems
- Substance abuse and alcohol
- Complex reactions to bereavement
- Suicide and attempted suicide

3.5 Physical health in old age
- Aspects of physical well-being (e.g. sleep, sex).
- Life expectancy and active life expectancy; concept of reserve capacity; relationship between impairment, disability and handicap; disability and quality of life; rehabilitation; obstacles to recovery from illness; consent to treatment.
- Essential psychological components of the medical care of older people
- Physical problems more commonly associated with later life, including stroke.
- Falls prevention and fear of falling
- Continence
- Pain
- End of life issues and palliative care
- Pharmacology and older people including use, addiction to and abuse of prescription and illicit drugs
- Co-morbidity and interaction of physical and psychological problems

4 Service provision
- How services for older people have developed; national policy frameworks and other significant policy documents; care frameworks and pathways including statutory, voluntary, and independent providers; day care and residential services
- Recent legislation and directives as they relate to work with older people
- Multi-disciplinary and inter-agency working
- Roles of other professionals who work with older people.
- Memory clinics and their implications for assessment and intervention in dementia
- Community psychology approaches and older people
- Models and techniques for older adult involvement in service planning and delivery

5 Intervention approaches and clinical skills development
The development of clinical skills in a number of areas, including as many as possible of the following:

5.1 Interventions in the early stages of dementia
- Support groups for people with dementia
- Cognitive rehabilitation
- Psychological therapies
- Reminiscence and life review
- Work with couples and families where one member has a diagnosis of dementia
- Training and support for carers
- Knowledge of current pharmacological treatments

5.2 Interventions in the later stages of dementia
- Person-centred care
- Working in continuing care environments
- Approaches aimed at improving quality of care; dementia care mapping
- Cognitive stimulation (reality orientation)
- Validation approaches

- Working with difficult or challenging behaviours
- Adapting the environment
- Supporting family caregivers
- Working with care staff

5.3 Rehabilitation

- Neuropsychological/cognitive rehabilitation
- Psychological contributions to physical rehabilitation for older people (e.g. post-stroke, or with conditions such as Parkinson's disease)

5.4 Cognitive-behavioural approaches

- Cognitive-behavioural approaches for depression and for anxiety
- Interventions for fear of falling and the psychological contribution to falls groups
- Interventions for older people with psychosis

5.5 Other psychological therapies and approaches

- Psychodynamic approaches; working with transference and counter transference; CAT
- Interpersonal therapy
- Narrative approaches
- Solution-focused approaches
- Working with traumatic experience
- Family therapy with older people
- Working systemically with care staff
- Interventions for elder abuse
- Community psychology (including working with voluntary agencies)
- Subtleties of multidisciplinary and team work

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Tina Lee, Clinical and Academic Tutor, CASPD, Salomons, Southborough Tunbridge Wells, Kent.

Jan Oyebode (convener until summer 2003), Senior Lecturer and Course Director, University of Birmingham.

Alistair Smith, Consultant Clinical Psychologist, Central Lancashire Psychological Services for Older People, Lancashire Care NHS Trust.

Bob Woods, Professor of Clinical Psychology of Older People, Dementia Services Development Centre, Wales.

Appendix 4 – Consultation on initial draft

The draft was circulated for comments in February 2003 to:
All PSIGE geographical groups;
Chairs of GTiCP, CTCP, MPTB, DCP;
Chairs of DCP Faculties and Special Interest Groups;
Directors of Clinical Psychology Training Programmes (via GTiCP).

By mid September 2003, replies had been received from:
All PSIGE geographical groups;
Faculty of Addictions;
Directors of seven Training Programmes.

The draft was then revised to take account of new DCP requirements on the content of guidance documents and was circulated for comments to:
All PSIGE geographical groups.

The British Psychological Society was founded in 1901 and incorporated by Royal Charter in 1965. Its principle object is to promote the advancement and diffusion of a knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of Members of the Society by setting up a high standard of professional education and knowledge.

The Society has more than 42,000 members and:

- has branches in England, Northern Ireland, Scotland and Wales;
- accredits nearly 800 undergraduate degrees;
- accredits nearly 150 postgraduate professional training courses;
- confers Fellowships for distinguished achievements;
- confers Chartered Status for professionally qualified psychologists;
- awards grants to support research and scholarship;
- publishes 10 scientific journals and also jointly publishes *Evidence Based Mental Health* with the British Medical Association and the Royal College of Psychiatrists;
- publishes books in partnership with Blackwells;
- publishes *The Psychologist* each month;
- supports the recruitment of psychologists through the *Appointments Memorandum* and *www.appmemo.co.uk*;
- provides a free 'Research Digest' by e-mail;
- publishes newsletters for its constituent groups;
- maintains a website *(www.bps.org.uk)*;
- has international links with psychological societies and associations throughout the world;
- provides a service for the news media and the public;
- has an Ethics Committee and provides service to the Professional Conduct Board;
- maintains a Register of more than 12,000 Chartered Psychologists;
- prepares policy statements and responses to government consultations;
- holds conferences, workshops, continuing professional development and training events;
- recognises distinguished contributions to psychological science and practice through individual awards and honours;
- maintains a Register of Psychologists Specialising in Psychotherapy.

The Society continues to work to enhance:

- recruitment – the target is 50,000 members by 2006;
- services – the Society has offices in England, Northern Ireland, Scotland and Wales;
- public understanding of psychology – addressed by regular media activity and outreach events;
- influence on public policy – through the work of its Boards and Parliamentary Officer;
- membership activities – to fully utilise the strengths and diversity of the Society membership.

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