NHS Talking Therapies

NHS Talking Therapies: National Curriculum for Non-CBT Psychological Therapies for Depression in the Context of Long Term Persistent and Distressing Health Conditions

Version 2.1

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This curriculum focusses on of the five non-CBT individual therapeutic modalities that are recognised and recommended for depression within NHS Talking Therapies for Anxiety and Depression (formally IAPT): Couple Therapy for Depression (CTfD) Behavioural Couples Therapy (BCT), Interpersonal Therapy (IPT), Dynamic Interpersonal therapy (DIT) and Counselling for Depression (CfD).

Contents

1. Entry Requirements

This curriculum assumes that practitioners applying for training will have attended and passed one of the following non-CBT Talking Therapies training programmes: Couple Therapy for Depression (CTfD)Behavioural Couples Therapy (BCT), Interpersonal Therapy (IPT), Dynamic Interpersonaltherapy (DIT) or Counselling for Depression (CfD). Applicants should be professionally registered/accredited to deliver one of these therapies within Talking Therapies services as detailed in the Talking Therapies Manual and have access to training cases through an Talking Therapies clinical service or through an established referral pathway with an Talking Therapies service (for example seeing clients within a Relate service that has a local Talking Therapies contract in place).

2. Competences

The competences outlined in this document are in part based on Roth and Pilling (2015), a competence framework for people with persistent physical health problems. This can be accessed at www.ucl.ac.uk/core/competenceframeworks. This competence framework relates to units 1.1-1.5 of the curriculum. It is anticipated that as training providers gain experience in the delivery of training and as clinical outcome data is collected, there will be further developments of the competence framework that address the specific adaptations of CTfD, BCT, IPT, DIT and CfD for working with LTCs (covered in unit 1.7).

3. Aims and Objectives:

Aims:

- To increase students' theoretical and research knowledge in working with peoplewith depression in the context of Long Term Physical Health Conditions (LTHCs), including neurological conditions [1].
- To introduce some practical skills for working with people with depression in thecontext of LTHCs, including neurological conditions and long-covid.

[1] Including neurological conditions with sudden onset (e.g. stroke), intermittent conditions (e.g. epilepsy), progressive conditions (e.g. parkinsons), and stable conditions with changing needs (e.g. cerebral palsy).

Objectives:

At the end of the course students will be able to:

i. Identify and reflect on their own values and attitudes to people with Long Term Health Conditions and the implications this has for engagement
ii. Demonstrate a critical understanding of theoretical models and evidence base that underpin interventions depression with Long Term Health Conditions, and become knowledgeable regarding the range of presenting conditions
iii. Have knowledge of the application of modality specific and generic models of adjustment to physical health conditions
iv. Conduct effective clinical assessment of people presenting with Long Term Healthconditions (in the context of age, life events, personal and medical history, medication (benefits and side effects) and planned medical/healthcare interventions), using this to inform clinical decision making
v. Manage engagement and formulation collaboratively
vi. Develop specific treatment plans incorporating existing evidence base fordepression and promoting the client's capacity for adjustment and self- management
vii. Develop idiosyncratic treatment plans in relation to specific long term healthpresentations
viii. Manage complex issues arising in Long Term Health Conditions presentationsdemonstrate self-direction and originality in tackling and solving therapeutic problems
ix. Practice as 'scientist practitioners', advancing their knowledge andunderstanding and developing new skills to a high level
x. Demonstrate an ability to adapt therapy sensitively to ensure equitableaccess for people from diverse cultures and with different values
xi. Understand the importance of multi-agency and inter-professional workingand collaboration and work effectively with other professionals

4. Outline structure of the curriculum

There are two sections of the curriculum. The first consists of a one day workshop focussed upon underpinning competencies for working with people with long-term health conditions and guidelines for adapting the specific modality to work with clients with LTCs. The second consistsof a self-directed learning module supported primarily by web based resources. This section focusses on gaining knowledge of LTCs that are the focus of the expansion and integration of Talking Therapy services.

Section 1: Underpinning competences for work with people with long-term health conditions – one day workshop or equivalent

(See Appendix for more detail of unit aims and competences):

UNIT 1.1	Therapists' Beliefs, Values and Assumptions about people with Long Term Health Conditions
UNIT 1.2	Knowledge of physical health conditions and their presentation and impact on the person
UNIT 1.3	Psychological processes associated with distress and depression in the context of Long Term Health Conditions
UNIT 1.4	Conducting a comprehensive bio-psychosocial assessment
UNIT 1.5	Formulation and treatment planning
UNIT 1.6	Working within and across organisations
UNIT 1.7	Adapting modality specific strategies for LTCs

Section 2: Web-based self-directed learning for specific health conditions

UNIT 2.1	Irritable Bowel Syndrome
	Chronic Fatigue Syndrome (CFS) / Myalgic Encephalopathy (ME)
	Chronic Pain
	Psychological Interventions for type 1 and type 2 Diabetes
	Chronic Obstructive Pulmonary Disease (COPD)
	Coronary Heart Disease (CHD)
	Cancer
	Long-Covid
	Neurological Conditions

5. Learning and teaching strategy

The training should be delivered by a LTHC expert alongside an expert in the specific modality of therapy. The specific learning and teaching strategy will be decided by the training provider. Thefollowing should be incorporated:

Section 1: Underpinning competences workshop

i. Didactic, experiential and skills-based methods with a strong foundation in the clinical procedures of working with people presenting with depression in the context of Long Term Health Conditions, and addressing the most up-to-date clinical guidelines.
ii. Skills-based competencies developed through small group experiential work and roleplay
iii. Additional self-directed study to include general and specific reading

for eachmodule and preparatory reading plus reference to web-based resources.

iv. Use of clinical vignettes, service user involvement and problem-based learning

v. It is strongly recommended that, following training, each training attendee works with appropriate supervision with health professionals with diseasespecific expertise.

Section 2: Web-based self-directed learning

i. Web based resources are available via the following link:
https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_54306&programmeId=54306

ii. In order to support effective provision of services in their local area students are encouraged to create a portfolio of resources based upon their web based self-directedlearning as well as their locally led assessment of available community resources. Thisportfolio should contain:

- Summary statements of the main LTCs, their presenting features, impact uponlifestyle and psychological functioning and medical treatments commonly associated with each condition
- List of local resources including support groups, specialist medical facilitiesand other community resources useful for signposting
- A self-reflective summary concerning their learning regarding LTCs, the interaction with depression and the adaptation of their specific modality to treating clients with an LTC and depression. The self-reflective statement should be discussed during site based clinical supervision at the end of theprogramme.

Assessment of Learning

All courses should assess learning by requiring trainees to submit evidence (via a log book)that they have:

a. Completed at least two assessment and therapy cases (and a total of atleast 10 sessions of therapy), where therapy has been delivered in the context of a long term physical health condition.
b. Evidence of reflection and learning from the training being applied to thesecases
c. Evidence of live supervision of this practice by an appropriately qualifiedsupervisor, and sign off of competence by this supervisor.

An agreement should be in place with participants on the course that performance on any assessments will be fed back to the clinical lead in the employing/host service. This is so that any action to address concerns regarding competence gaps can be addressedin the service.

UNIT 1.1: Therapists' Beliefs, Values and Assumptions about people with Long Term Health Conditions

Aims:

To help practitioners reflect on their beliefs, values and attitudes towards peoplepresenting with Long Term Health Conditions

Competences:

Ability for practitioners to reflect on their own stance, beliefs, values and assumptions aboutpeople referred with Long Term Health Conditions and any impact that this may have on their work

- Ability to draw on knowledge that clients may have had previous negative experiences with health professionals/treatment and the implications this has forengagement in therapy
- Ability to reflect upon the assumptions and expectations that people with LTHC may have about being referred for assessment and treatment and how this mayimpact on engagement
- Ability to reflect on the assumptions and expectations that referrers may makeabout referring people with LTHC for psychological therapy
- Ability to draw on knowledge of social, cultural and practical barriers faced bypeople with LTHC attending therapy
- Ability to take a stance that conveys respect and promotes engagement by:
- identifying the person's strengths and resources as well as their difficulties
- developing meaningful goals which connect to previously valued roles
- valuing the person' s expertise in relation to their illness
- accepting that some patients will view anxiety and depression as illness-relateddistress not a mental health problem

UNIT 1.2: Knowledge of physical health conditions and their presentation and impact on the person

Aims:

- To ensure that practitioners have sufficient knowledge of the conditions with which patients present

Competences:

- Ability to draw on knowledge of the physical health conditions with which clientsare presenting, including:
- diagnostic criteria and epidemiology

- the key physical symptoms that clients usually experience and associated impairment
- the usual medical and pharmacological interventions employed to manage the condition
- Ability to draw on knowledge of the impact of physical health conditions in the contextof life-cycle
- Ability to draw on knowledge of the way in which physical and mental health problemscan interact and impact on functioning (including the role of social, psychological, neurological, family and biological factors
- Ability to draw on knowledge of the ways in which both psychological and physiological mechanisms contribute to client presentations, and how these caninteract, e.g.:
- low mood leading to reduced physical activity, resulting in deconditioning
- symptom exacerbation leading to increased pain or breathlessness and toincreased low mood or anxiety
- the impact of some medications on cognition

UNIT 1.3: Psychological processes associated with distress and depression in the context of Long Term Health Conditions

Aims:

To give practitioners an understanding of psychological processes that contribute to the development and maintenance of depression in people with LTHCs

Competences:

- Ability to draw on knowledge of the relationship between distress and depressionand the negative appraisal of symptoms and illness
- Ability to draw on knowledge that negative appraisals can be magnified by unhelpful beliefs
- Ability to draw on knowledge that interpretations and appraisals are central to thedevelopment and maintenance of distress and disproportionate disability
- Ability to draw on knowledge that maintaining processes can and do worsen negative interpretations (and physical as well as psychological functioning), socreating cycles of feedback (“vicious circles”)
- Ability to draw on knowledge of specific psychological process that contribute tothe development and maintenance of distress and depression such as:
- attentional processes that increase the perceived severity and pervasiveness ofsensations and symptoms
- safety seeking behaviours (for example, excessive checking, avoidance of physicalactivity or situations, excessive reassurance seeking) which are understandable in the short-term,
- Other processes identified by specific models such as couple interaction processes in BCT, defences in DIT, etc. but which (in the long-term) tend to strengthen unhelpful beliefs, increase preoccupation and exacerbate concern
- imagery and intrusive memories, increasing negative appraisals and impactingmood disturbance.
- unhelpfully restrictive behaviour, such as generalised withdrawal from physical

activity or from role-related activity (such as relationships, work, hobbies), leading toimpaired mood, confirmation of unhelpful beliefs, reduced self-efficacy and disengagement from rewarding activities.

- changes in mood contributing to mood-appraisal spirals
- emotional avoidance/suppression (for example linked to anticipated emotional responses and unhelpful beliefs about those emotions, or "blotting out" illness ideas,but with regular intrusions and unease as a consequence)
- all or nothing ("boom or bust") behaviours (undertaking activities beyond the levelof which the person is physically or psychologically capable, resulting in symptomsurges (e.g. fatigue, pain) and leading to more negative appraisal
- interpersonal changes (such as those linked to a sense of unfairness, bitterness,mental defeat) eliciting negative or overly solicitous responses from significant others
- disengagement from significant others because of the health condition
- disuse and deconditioning originating from fear/avoidance patterns
- Ability to draw on knowledge of factors and mechanisms that can potentiate(and mediate) vulnerability to distress and depression, such as:
- perfectionism (setting unrelentingly high personal standards and concern aboutmistakes (both social and non-social))
- psychological inflexibility (becoming "stuck" in a particular view of the illness andsituation, and so limiting access to alternative, less negative understandings

UNIT 1.4: Conducting a comprehensive bio-psychosocial assessment

Aims:

To be able to conduct a comprehensive bio-psychosocial assessment using a range of methods (including clinical interview, standardised instruments, review of clinical recordsand liaison and discussion with healthcare colleagues, along with self-monitoring of symptoms and activities by the client) to gain a clear picture of:

- the impact of physical health problems on the client's psychologicalfunctioning (particularly on their mood)
- the long-term history of the client's problems
- the client's strengths and resources and current ways of managing their condition

Competencies:

Engagement

- Ability to engage the client (or couple) in the assessment process, for example by:
- validating the client's experience and indicating a willingness to hear their account
- responding to and addressing any uncertainty about, or suspicion of, apsychological approach

General assessment principles

- Ability to undertake a comprehensive assessment that encompasses:
- the client's account/understanding of their illness, and its impact on functioning
- depression, and other co-occurring psychological disorders

- pharmacological and medical interventions and any adverse impacts of theseinterventions
- presence and extent of self-management
- risk (including self-harm related to specific health conditions and to misuse ofprescribed medications, non-adherence to treatment or neglect)
- contra-indications for treatment
- inclusion of family or carers (with patient consent) where relevant to add an additional perspective and provide additional information

Specific areas of assessment

- Ability to identify the idiosyncratic psychological processes that may be fostering or hindering the client's adjustment to their condition, and which would be relevant to any intervention strategies Ability to help the client self-monitor in order to determineantecedents and consequences of specific behaviours
- Ability to assess the reactions of significant others to the client's illness (and thedegree to which this is helpful or unhelpful)
- Ability assess the resources available to the client (including physical, social and familial)
- Ability to employ appropriate measures, including those applicable to specificLong Term Health Conditions

UNIT 1.5: Formulation and treatment planning

Aims:

To be able to develop collaboratively a coherent, agreed and shared evidence-based workingmodel

To be able to formulate the relationship between distress and depression and physical health problems, and create an idiosyncratic narrative that helps the client makes senseof their illness and on-going difficulties, fosters hope and helps contemplate change

Competencies:

- Ability co-construct with clients a formulation, based upon a specific model, to guide treatment
- Ability to formulate the bidirectional relationship between psychological issues andphysical health problems and the role of education and self-management in improved outcomes
- Ability to engage the client in a collaborative discussion of the treatment optionsopen to them, informed by the information gleaned through assessment, the formulation emerging from the assessment, and the client's aims and goals
- Appropriate adaptation and flexibility of treatment where reasonable adjustments are necessary (e.g. longer or shorter sessions with breaks for those with cognitive impairment)
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UNIT 1.6: Working within and across organisations

Aim:

To be able to draw on knowledge of the benefit of co-ordinating with services offering physical health care to the client and ensuring that (where appropriate) interventions areintegrated with those services

To be able to determine when work across agencies and organisations is important forthe well- being of the client

Competencies:

- Ability to draw on knowledge that the welfare of the client is the principle reason for working across organisations, with other professionals and with carers/families, and
  to be able to determine when this is an appropriate response for a particular client
- Ability to understand the roles of different members of the multi-disciplinary teamoffering care to the patients and where appropriate how psychological treatment can integrate with these treatments.
- Ability to communicate effectively with relevant professionals within and across other agencies in an effective manner, and to understand clinical governance processes andconfidentiality issues (e.g. in relation to sharing information across organisations, useof data systems)
- Ability to liaise with healthcare staff in order to integrate psychological treatmentwith physical management
- Ability to draw on knowledge of common challenges to interagency/ interprofessional working and an ability to manage these appropriately
- Ability to ensure that the client, their carers and families are appropriately involved inand informed about decisions and plans arising from interprofessional/interagency working

Unit 1.7: Adapting Modality Specific Strategies for working with LTCs

Aim:

To enable students to learn how to adapt the ‘standard’ intervention strategies employed in their specific modality for working with depression in the context of cases where the client alsopresents with one or more Long term health Conditions

Competencies:

- Ability to draw on theoretical knowledge in the specific modality to adapt treatmentappropriate for clients with LTCs and depression
- Ability to appropriately implement modality specific treatment strategies with flexibility appropriate for the context of working with LTCs (for example: in BCT- ability to use guided behaviour change in a couple context, ability to implement communication interventions to assist couples to disclose emotions and thoughts related to depressionand the LTC, ability to assist couples to make decisions

related to the LTC, ability to assist couple to communicate effectively with the medical team and other systems)

- Ability to sequence modality specific interventions appropriately
- Ability to monitor client progress appropriately and to implement changes in the specificmodality in response to client progress