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Barriers and facilitators to providing CBT for people living with dementia: perceptions of psychological therapists

Therapists' views on CBT for PLWD

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Conflict of interest: The authors have no conflict of interest to declare.

Acknowledgements: The authors would like to thank all research participants for sharing their insights. We would like to thank Penny Rapaport and others involved in our expert consultation for their advice when developing the interview guide.

Data availability statement: The data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

Funding information: Joshua Stott was supported by a fellowship by the Alzheimer's Society at the time of this study. Grant number 236 (AS-CTF-14-005). The Alzheimer's

This article has been accepted for publication and undergone full peer review but has not been through the copyediting, typesetting, pagination and proofreading process which may lead to differences between this version and the Version of Record. Please cite this article as doi: [10.1002/cpp.2674](https://doi.org/10.1002/cpp.2674)

Society had no involvement in the study design, collection, analysis, and interpretation of data, writing the manuscript, and in the decision to submit the manuscript for publication.

This work was supported by the UCLH NIHR BRC.

Abstract

Many people living with dementia or mild cognitive impairment (MCI) experience anxiety and depression. Cognitive behavioral therapy (CBT) is a recommended treatment for adults, commonly provided through primary care psychological therapies services. This study explored the facilitators and barriers to providing CBT interventions for people living with dementia or MCI, as perceived by therapists working in such services.

Structured interviews were conducted with fourteen clinicians recruited through primary care psychological therapies services about their experiences of working with people living with dementia or MCI and their ideas about factors that enhance or hinder offering and delivering CBT to this population. Interview recordings were transcribed and analyzed using Thematic Analysis. Credibility checks were incorporated throughout.

Three themes were identified: 'attitudes towards dementia', 'competing demands', and 'pressure without support'. Perceived facilitators and barriers occurred across individual, service, and system levels. Facilitators were: positive engagement and outcomes for people living with dementia or MCI, positive attitudes of clinicians, and flexibility within some services. In contrast, perceived barriers were: stigma towards dementia and mental health in older adults, high pressure on staff to perform with a lack of support to do so, exclusion based on diagnosis, and inflexibility within some services.

Clinicians were confident that people living with dementia or MCI could benefit from CBT, with some adaptations to delivery. There are implications for staff support and training, and for commissioning practices relating to the tension between minimal resources, equitable access, and person-centered care.

Key practitioner messages:

- Therapists in primary care psychological therapy settings face particular challenges when delivering Cognitive Behavioral Therapy (CBT) to people living with dementia or mild cognitive impairment.
- Experience of successful engagement and outcomes for older adults support positive clinician attitudes towards working with people with cognitive impairments.
- Adapting therapy to meet the needs of individuals is an important facilitator for both older adults and people living with dementia or mild cognitive impairment.

Key words: Dementia; Mild Cognitive Impairment; Depression; Anxiety; Cognitive Behavioral Therapy; Service experience

Introduction

Dementia is an umbrella term for syndromes involving impairments in cognitive functions, such as memory and language, which disrupt a person's independence in daily life (American Psychiatric Association, 2013). Usually diagnosed after age 65, it is estimated to affect over 50 million people globally (Prince, 2016). Depression and anxiety are common in dementia (Ballard, Bannister, Solis, Oyebode, & Wilcock, 1996; Seignourel, Kunik, Snow, Wilson, & Stanley, 2008) and are associated with various adverse outcomes (Livingston et al., 2017).

Mild Cognitive Impairment (MCI), defined as subjective memory/cognitive complaint and objective cognitive impairment with no or minimal functional impairment in the absence of dementia (Winblad et al., 2004), affects approximately 4.5% of over 60 year-olds with prevalence rising with age (Sachdev et al., 2015). People with MCI are at increased risk of dementia, with conversion rates being estimated at 9.6% in clinical populations (Mitchell & Shiri-Feshki, 2009). Depression and anxiety are common (Chen, Hu, Jiang, & Zhou, 2018; Ismail et al., 2017) and are associated with poor outcomes, including increased conversion rate to dementia (Mourao, Mansur, Malloy-Diniz, Castro Costa, & Diniz, 2016). At the same time, anxiety and depression are associated with difficulties in memory and concentration, which may present as MCI (National Institute for Health and Care Excellence; NICE, 2019).

Evidence suggests that people living with dementia can benefit from psychological treatments for depression and anxiety (Orgeta, Qazi, Spector, & Orrell, 2015). This is of particular import given the inefficacy of antidepressants in this population (Banerjee et al., 2011). There is some emerging evidence that psychological treatments are also effective for people with MCI (Regan & Varanelli, 2013), although no randomized controlled trial yet has tested its effect on depression or anxiety in this population (Orgeta et al., 2015).

Psychological therapy is recommended for depression and anxiety in people living with dementia (NICE, 2018). A range of psychological therapies have been trialed (Cheston & Ivanecka, 2017), including individual cognitive behavioral therapy (CBT), which is also the most commonly offered approach in the general population. Yet, people living with dementia or MCI seem to have limited access to psychological therapy services. A UK survey identified psychological distress as the most frequent unmet need in community-dwelling people living with dementia, being reported by 21.6% (Miranda-Castillo, Woods, & Orrell, 2013). Older adults (even without cognitive impairment) are consistently under-represented in talking therapy services, despite good adherence and outcomes when they do access treatment (Chaplin, Farquharson, Clapp, & Crawford, 2015). Access issues may be compounded by the difficulty of diagnosing depression in people living with dementia due to substantial overlap of symptoms (Gutzmann & Qazi, 2015). In addition, beliefs about this population's ability to engage in CBT may act as barriers to accessing services. For example, Collins and Corna (2018) found that primary care physicians viewed CBT as less appropriate for people with additional cognitive needs, including dementia, and withheld referrals.

Such perceptions contradict the existing evidence suggesting that CBT can be successfully employed in people with mild to moderate dementia with appropriate modifications (Spector et al., 2018; Stanley et al., 2013), especially when undertaken by therapists who effectively utilize CBT components that support memory and new learning (Charlesworth, Sadek, Schepers, & Spector, 2014). Even if certain cognitive components of CBT may not be appropriate for an individual client's cognitive ability, behavioral components could still be clinically useful (Stott, Cadman, Scior, Brede, & Charlesworth, 2020; Teri, Logsdon, Uomoto, & McCurry, 1997).

Qualitative studies have the potential to provide valuable insights into the experience of service users and clinicians and can thus inform service development and adaptations to

better meet clients' needs. From existing qualitative studies, issues influencing access to psychological therapies include: stigma towards mental health among affected individuals; biases among professionals about the priority of mental health care for these groups; and rigidity within existing service systems limiting adaptability of service provision. Findings are similar for: older people (Chaplin et al., 2015; Collins & Corna, 2018; Frost, Beattie, Bhanu, Walters, & Ben-Shlomo, 2019), individuals with intellectual disability (Chinn & Abraham, 2016; Marwood, Chinn, Gannon, & Scior, 2018) and those with long-term health conditions (Hassan, Bennett, & Serfaty, 2018). Whilst similar factors might also apply to people living with dementia, there are currently no direct accounts to inform work with people living with dementia or MCI specifically. Therefore, the aim of the current study is to gain a better understanding of the potential facilitators and barriers to accessing and engaging with CBT for people living with dementia or MCI as perceived by clinicians working in primary care psychological therapies services.

Method

Ethics

The study received ethical approval from [*identifiable information removed*].

Recruitment and participants

Eligible participants were qualified psychological therapists working within Improving Access to Psychological Therapy (IAPT) services. IAPT services were an initiative to increase the national availability of primary care therapy services in England (Clark, 2011) and are the biggest provider of primary care CBT interventions for mild to moderate mental health difficulties within England, accessible via the National Health Service (NHS). Services use routine outcome measures to monitor patient recovery and

access and recovery targets are reported nationally. British Psychological Society accredited psychological wellbeing practitioners (PWPs) provide low intensity, protocolized interventions alongside qualified CBT therapists and psychologists, all considered to be eligible roles for participation.

As one of the goals of this study was to determine the barriers for people living with dementia or MCI to accessing services, which assumes that not all individuals who could benefit from talking therapies end up receiving such support, clinicians were not required to have had experience of working with this client group. A convenience sampling approach was used based on participants' availability and willingness to take part. Recruitment was selective to ensure a range of clinical training within the sample, and ultimately the first consenting respondents were suitable and recruited for participation. The study was advertised by emailing a recruitment poster addressed to the managers or admin team of 28 IAPT services within [Location removed], believed to be all IAPT services within this area at the time. Interested clinicians contacted the research team directly. Their services were not recorded to maintain anonymity. We wanted participants to feel reassured that they would not be identifiable from their views shared, and that these would not be fed back to their services. Four services responded to acknowledge the advertising email, three of which confirmed they had disseminated the advert within their staff. Thus, participants may have come from these four services, as well as others which did not directly acknowledge the advertising email. Recruited participants and clinicians known to the research team were asked if they knew other clinicians who might be interested in participating.

Potential participants were asked to confirm that they met the eligibility criteria. No response rate to the advertising email was noted, to maintain the anonymity of participants. Based on guidance for recruitment for qualitative studies using semi-structured interviews

and thematic analysis (Guest, Bunce, & Johnson, 2006) we aimed to recruit between 10 and 15 participants.

Procedure

Participants gave written informed consent and received £20 in recompense for their time. Interviews were conducted face-to-face, recorded for transcription and lasted between 30-50 minutes.

Interview guide

The interviews were structured around a topic guide (Appendix 1), which was developed for the purpose of this study, and informed by GroI and Wensing (2004)'s work on implementation of interventions. To ensure the topic guide had meaningful scope, IAPT experts and experts in psychological and psychosocial approaches for people living with dementia and MCI were consulted, and the guide was trialed with a trainee Clinical Psychologist with work experience in IAPT. As a result, definitions of dementia and MCI were added to the guide and small changes were made to phrasings for clarity.

Participants were asked to provide demographics, details on their current role and previous clinical experience. Then they were asked about their experience of working with older adults and people living with dementia or MCI, the positives and challenges of this work, how dementia or MCI affected their work, their confidence in working with this client group, and their awareness of the evidence base. Participants who had no experience of directly working with people living with dementia or MCI gave their perspectives based on their current knowledge and general experience in IAPT. Prompts were used to elicit information about the participant's personal views, service factors and societal or political factors.

Researcher perspective

The first author [*Researcher's initials removed*], a white British woman with a clinical background working in primary care psychological therapy services but without clinical or personal experience of dementia, conducted the interviews and led on the analysis. She held a strongly positive view of providing CBT to people with anxiety and depression who also have dementia or MCI, and a curious perspective of how this might work in a primary care context.

Analysis

Interviews were transcribed verbatim. Thematic Analysis (Braun & Clarke, 2006) was used to identify patterns of meaning across the data. Analysis was approached from a realist/essentialist position: participant's accounts were considered to be reflective of their true experience.

[*Researcher's initials removed*] kept a log of points of interest during data collection and analysis. The transcripts and logs were read thoroughly, and codes were generated using NVivo (NVivo, 2018) for administrative support. A second researcher [*Researcher's initials removed*] independently coded a subset of transcripts. These codes were then reviewed with the original coding by [*Researcher's initials removed*], and similarities and differences were discussed. [*Researcher's initials removed*] then returned to the entire transcript collection and recoded the data incorporating the new perspectives to ensure codes were comprehensively applied to all data, aiming to minimize personal biases during the process. The final set of codes was clustered into themes, which were refined in discussion with another research team member ([*Researcher's initials removed*]) and discussed with the research team. The data relating to each code was reviewed separately to ensure there was a consistent narrative within each theme and subtheme. The final themes were sent to two participants who

consented to take part in credibility checks from a participant perspective (Elliott, Fischer, & Rennie, 1999).

Results

Participants

Fourteen participants were recruited. Participants were seven PWPs, five CBT therapists and two clinical psychologists (Table 1). Ten were female, seven were of White British ethnicity, two of Black British, two Asian British, and three of other ethnic origin. The mean number of years qualified was 3.1 years (range 1-15 years). Seven had worked with people living with dementia or MCI in IAPT services, and the two clinical psychologists had received specific training on working with dementia or MCI during their clinical training.

Thematic analysis

Three themes and eight subthemes were generated (Table 2). Two participants gave feedback on the findings, and stated the findings represented their views as discussed in the interview, and broadly represented experiences of working in IAPT services.

Attitudes towards dementia. Both positive and negative attitudes towards dementia were evident within the data, which seem to facilitate but also hinder engaging people living with dementia in therapy.

Positive clinician attitudes. The attitudes of participating clinicians towards offering CBT to people living with dementia or MCI were overwhelmingly positive, regardless of whether a participant had experience of working with this client group. Nearly all participants felt that CBT had the potential to be useful, particularly with milder impairment. Some suggested that, ethically, CBT should be offered to people living with dementia or MCI, particularly considering the emerging evidence base.

“I’d say we’d definitely be wrong to not offer it because we think that someone – that it might not work for them.” P8 (PWP, no dementia/MCI experience)

A few participants expressed that working with people living with dementia or MCI is or would be rewarding, and working with new client groups adds interest to their role by learning new skills.

“Personally I do it [CBT with dementia] because I love it. So it can be challenging sometimes, but it’s also very rewarding.” P13 (Clinical Psychologist, dementia/MCI experience)

Cohort factors. Many participants felt that older clients showed strong commitment to therapy.

“They tend to come to their sessions, do the homework, they take the treatment quite seriously.” P9 (CBT therapist, dementia/MCI experience)

Yet, they sensed that self-stigma about mental health problems and services might be a significant barrier for older cohorts.

“There might not have been a culture in the past that you would access help or talk to somebody.” P2 (CBT therapist, dementia/MCI experience)

Negative referrer attitudes. Similarly, several clinicians felt that attitudes held by referrers might present a barrier. Some professionals were perceived to prioritize physical health over mental health treatment, or to withhold referrals to therapy services due to a lack of therapy awareness or assumptions about their ability to engage.

“The GP [primary care physician] might not pick up that actually they are depressed, because they kind of see it more as like a physical health problem.” P12 (PWP, no dementia/MCI experience)

“There was just like this underlying type of ‘well it’s not going to be successful anyway because people need these skills to be able to engage in therapy and they don’t have those skills.’” P5 (CBT therapist, dementia/MCI experience)

Societal attitudes and service provision. Almost all participants felt that prevailing perceptions of later life contribute to a lack of policy impetus and associated lack of service provision. Participants suggested that decisions about service provision might be negatively affected by discrimination against people with disabilities, stereotypical views of the needs of people living with dementia and a widely held fear of dementia.

“People are still very fearful of dementia and have a bad outlook or image of what having dementia might be like.” P13 (Clinical Psychologist, dementia/MCI experience)

In contrast, a few participants sensed that the increased awareness and focus on the importance of mental health in the media may have increased access to mental health services more generally.

“People are maybe a bit more aware of dementia and the effect it has and how it can have an effect on mental health problems, which means that people are more likely to actually think about psychology.” P11 (CBT therapist, no dementia/MCI experience)

Competing demands. Participants discussed how the structure of some IAPT services and the demands placed on therapists do not always fit with the flexibility required to meet the needs of people living with dementia or MCI. Many participants, both those with and without experience of working with this client group, felt that there were two opposing priorities, namely quality patient care, and offering a cost-effective service in the context of an under-resourced healthcare system.

Adapting therapy. Participants described perceptions and experiences of the challenges of working therapeutically with people living with dementia. Several clinicians

expressed concern about the effect of dementia-related impairments on the benefits of CBT, and how ability to engage might change over the course of treatment due to progression of their disease, and therefore queried whether CBT could help this client group.

“The person I was working with was coming back every week not remembering what we talked about the week before. So it’s quite hard to continue working with that.” P7 (PWP, dementia/MCI experience)

Other perceived barriers included: the high number of appointments this client group is likely to have with other health-related services, medication side-effects, and concern about implementing routine outcome measures.

However, some participants had positive experiences of engaging people living with dementia or MCI in CBT. Several commented that the cognitive impairment had little impact on the work, that the person had engaged well, and had a positive outcome.

“I can’t remember [the MCI] really affecting the work so much.” P2 (CBT therapist, dementia/MCI experience)

Most participants felt that individual differences can impact how well a client may engage with CBT, whether they have cognitive impairment or not. All participants felt that adapting therapy to meet the needs of individuals is an important facilitator to engagement, and several participants commented that adapting therapy for dementia would be no different to adapting therapy for other individuals who use the service.

“You get training for that about how to adapt things for those people who have learning disabilities, so I don’t see why it would be much different from doing that.” P7 (PWP, dementia/MCI experience)

On the other hand, some felt that it was important to know about specific memory problems, because it was necessary to tailor their approach accordingly.

“We need to know whether or not there are any more significant issues with this person’s memory, before we keep telling them not to worry about it, or you know ‘don’t worry about leaving the oven on’. You would approach these concerns differently, if this person does actually have more significant memory difficulties.” P10 (PWP, no dementia/MCI experience)

Participants discussed CBT-specific factors aiding such adaptations, including the collaborative, person-centered philosophy of CBT and the fundamental structure of protocol-based interventions, which participants felt could be containing for people with cognitive impairment.

“A lot of the resources that we use and the interventions, they are very, you know, clear, understandable, step-by-step interventions and I imagine that that could be pretty transferable and useful.” P10 (PWP, no dementia/MCI experience)

Involving others. Several participants discussed the potential for involving family members and carers by including them in sessions or asking them to support people living with dementia at home.

Participants acknowledged that many people living with dementia rely on help from others and therefore it would be useful for these people to gain insight into the therapy process. However, they emphasized the need to get the person living with dementia’s consent before including others. They identified several benefits of involving others, including practical support for remembering appointments, help with implementing homework, and as an additional source of information.

“It is useful to have [carers] in the assessment just to get a little bit more information and also find out how it is impacting the family system.” P8 (PWP, no dementia/MCI experience)

However, they were aware that carers might not be available or might not want to be involved, and of the extra work required to provide psychoeducation to carers. Further, participants were wary about the additional task of coordinating schedules, integrating the carer and managing dynamics in-session.

“I need to consider, erm, the carer as part of the intervention, so there will be kind of a system [...] I’m thinking of barriers and overcoming barriers at the same time.” P1 (CBT therapist, no dementia/MCI experience)

Service (in)flexibility. Almost all participants highlighted features of their service which support provision of CBT for people living with dementia, including accessible buildings, shared knowledge in teams through group supervision and older adult specialist leads. Yet, there seemed to be discrepancies across services in the flexibility and support available to clinicians to adapt their approach to meet an individual client’s needs. While some participants felt their services were flexible, most participants perceived the high volume caseloads dictated by the IAPT model to be limiting their ability to meet the individual needs of clients who may need adaptations in order to engage.

“I think [the service] does genuinely want to make the service accessible and be inclusive and flexible with how we deliver sort of the treatments that we have.” P2 (CBT therapist, dementia/MCI experience)

“There’s just so much constraints in terms of trying to be flexible and trying to adapt.” P5 (CBT therapist, dementia/MCI experience)

Several participants felt that people living with dementia would require longer or a greater number of sessions, but thought this would be problematic within their services. Many participants also commented on the lack of time available to make service delivery

adaptations, such as time to assess individual needs and abilities, to research recommended adaptations, and to attend necessary training.

A few participants expressed concern about the effect on the quality of their work with other clients as a consequence of coping with the extra demands of adapting therapy for people living with dementia.

“I think in an ideal world we’d just have a lot more time for anyone that we see, but in IAPT it doesn’t kind of work so well like that does it. It’s kind of back-to-back, and no time to think about anyone.” P12 (PWP, no dementia/MCI experience)

Commissioning and funding. All participants described the service commissioning context, and how this poses a challenge in offering flexible services. While participants commented on the resilience and dedication of NHS staff to keep providing good work in a changing and challenging context, they also described challenges of working within what they saw as an under-resourced NHS, and the effect of this on their work.

Participants were concerned that unreliable outcome measures for those living with dementia or MCI affected overall measurable recovery rates for the service, knowing that recovery rates can influence commissioning decisions. Almost all participants expressed concern about implementing outcome measures in this client group, due to memory problems potentially influencing the validity of measures.

“We’d be seeing patients that we can’t count towards recovery ...this would reduce our recovery rates, which would therefore forward impact how effective our service looks to commissioners, which would impact the funding we get.” P6 (PWP, no dementia/MCI experience)

There was also a perception of consistently increased targets without the necessary funding to meet the increased demand.

“It’s a lot to do with money. I guess the NHS mental health budget being cut but also the demand is to still see as many people as you can... they’re trying to do what they can do with limited time and limited resources.” P5 (CBT therapist, dementia/MCI experience)

Some participants perceived these pressures to have resulted in some services not accepting referrals of people living with dementia or MCI at all, something practitioners working in these services did not always agree with. For example, one participant pointed out that in her service, clients open to memory services were treated as not being eligible, even though they were unlikely to have mental health needs met at a memory service. Services not accepting referrals of people living with dementia or MCI was the main reason for some participants’ lack of experience working with this client group.

Several participants suggested that services’ hesitancy to support people living with dementia, and commissioners lacking emphasis on provision for this client group, might also be due to the still emerging and not well-known evidence-base for the beneficial effect of therapy in this client group.

Pressure without support. All participants described the pressure of a high-volume service model, and how lack of resources and training resulted in staff feeling unsupported. Adapting the service for clients with extra needs resulted in increased stress for clinicians. Participants felt that high expectations to see more people and meet higher targets resulted in therapists being stretched, exhausted and at risk of burnout.

“There’s high level of burnout because of kind of increased caseloads.” P1 (CBT therapist, no dementia/MCI experience)

One participant commented that staff felt undervalued, and that people who made decisions about caseload and targets had a lack of understanding of the challenges of the job.

Many participants expressed a lack of confidence working with people living with dementia or MCI, in particular due to a lack of knowledge and skills in the area. Only two had received specialist training. Some participants described difficulties distinguishing between disease presentation and mental health-related memory impairment affecting their ability to target treatment appropriately. Others expressed concerns about coping with clients' worry about the progression or impact of the disease, akin to the challenges of working with older adults who might worry about realistic problems (i.e. poor health, anxiety about dying).

Having personal or professional experience of dementia or MCI seemed to increase confidence or knowledge in providing this work.

"I have personal experience of dementia because my grandfather had dementia... I think I've got some of my own personal ideas of what might be helpful." P10 (PWP, no dementia/MCI experience)

Of those who had no specific dementia training, several participants said that learning how to adapt their work during training for people with diverse needs (learning disabilities, minority cultures) would be a useful transferable skill for this group. Yet, some emphasized considerations specific to the needs of people living with dementia, which should be covered explicitly.

Discussion

The current study interviewed therapists to gain a better understanding of the potential facilitators and barriers to accessing and engaging with psychological services for people living with dementia or MCI. The reported facilitators and barriers for providing CBT for people living with dementia or MCI in IAPT services can be viewed as occurring at individual clinician/client level, at a service level, and at a system level.

Individual clinician/client level. Facilitators include the clinician's past experience of successful engagement and outcomes for older adults, and positive attitudes towards working with people living with dementia or MCI. Perceived barriers were negative attitudes and stigma towards older adults and dementia.

Service level. Perceived facilitators included accessible features of services and therapy, adaptability of CBT, and involvement of carers to aid implementation. Perceived barriers were high pressure on staff with a lack of support, and exclusion from services based on a diagnosis of dementia or MCI.

System level. The facilitator was a growing evidence base influencing commissioning decisions. Barriers were perceived as the potentially restrictive nature of the IAPT model and limited resources, perceived to reduce clinical flexibility and increase clinician stress.

While there were points specific to people living with dementia or MCI, such as the potential impact of memory impairment on therapeutic work and exclusion by diagnosis, overall, the accounts of participants mirrored findings for other populations that services have struggled to provide for. Findings of positive clinician attitudes and beliefs that CBT could benefit people living with dementia or MCI are in line with findings regarding older adults, who tend to have good outcomes from CBT, but for whom referrals remain low (Chaplin et al., 2015). Clinicians' perceptions of systemic barriers preventing people living with dementia or MCI from accessing services resemble reports of referrers prioritizing physical over mental healthcare for older adults, in part due to assumptions that older adults are unable or unwilling to engage in mental health services, but also due to lack of time during consultations and perceived complexity of health needs in this population (Frost et al., 2019). Similarly, therapists providing CBT to people with learning disabilities have noted biased attitudes among referring professionals (Marwood et al., 2018). People living with dementia or MCI might be subject to an interacting stigma of both cognitive impairment and age.

Negative attitudes and stigma about dementia are likely to not only be held by referrers, but also by carers, people living with dementia themselves and wider society, which will also negatively affect help-seeking (Herrmann et al., 2018).

A few themes, such as working with people living with dementia being rewarding work, and involving carers in therapy, are based on the accounts of only a small proportion of participants, potentially due to the limited proportion of participants with direct experience with this client group. However, they seem to be in line with other studies, e.g., those exploring triadic relationships between people living with dementia, carers and health care professionals (Tuijt et al., 2020).

There are some conflicting ideas regarding therapy adaptations for clients with cognitive impairment. Most felt adaptations were essential; some commented that these adaptations would be no different to adaptations for other groups, whereas others felt adaptations for this client group need to go beyond this, and required specialised training to be implemented.

Many clinicians perceived their services to be inflexible due to a focus on targets and outcomes related to commissioning of services. Chinn and Abraham (2016) found similar results when they investigated barriers to provision of IAPT services for people with learning disabilities. They found discourse regarding ‘tightly defined eligibility criteria, measurable and uniformly operationalized process and outcome variables, efficiency and value for money’ (Chinn & Abraham, 2016, p. 576) to be associated with decreased level of inclusivity of services for people with cognitive impairments, with some clinicians feeling unable to adapt their practice within these constraints. While both studies were conducted in IAPT services in the UK, there are implications for services set up elsewhere in terms of balancing the need to commission effective services with the need for flexibility to promote inclusivity.

Participants' perceptions of working with older adults and people living with dementia were overlapping, despite asking questions about older adults and people living with dementia separately within the interviews. As age is an important risk factor for dementia, it follows that many clients presenting with a dementia diagnosis are of older age and therefore barriers or facilitators to engagement of services for older adults will also apply to these individuals, in addition to those related to cognitive impairment. Some individuals with a dementia diagnosis will have a high cognitive reserve and thus might be as cognitively able as other older people who do not have dementia (Stern, 2009). It is also important to consider that MCI is a 'diagnosis of uncertainty' with an unknown prognosis, which might 'resolve' when anxiety or depression are successfully treated (NICE, 2019). Under these circumstances, it might not be necessary to make a distinction as long as individuals are able to engage with the therapy and associated service requirements. In fact, having a diagnosis could be a disadvantage in services that exclude based on a diagnosis alone. Another explanation could be that some therapists may view dementia as 'an extreme form of ageing,' a common misunderstanding of dementia (Cahill, Pierce, Werner, Darley & Bobersky, 2015), and stereotypes about dementia are often portrayed as concurrent with dementia by the media (Low & Purwaningrum, 2020), potentially contributing to inaccurate therapist perceptions of dementia and ageing.

Increased clinician stress and workload was perceived by many participants to be a consequence of adapting clinical practice within tight service limitations. Indeed, organizational factors have been associated with high levels of burnout for PWP's and CBT therapists, and increased hours of overtime predict higher levels of burnout in PWP's (Westwood, Morison, Allt, & Holmes, 2017). This is of import, not only because of responsibility towards employees' wellbeing, but also because increased levels of burnout in IAPT have been associated with reduced treatment outcomes (Delgadillo, Saxon, &

Barkham, 2018). Further, it should be considered whether there are any potential negative consequences for people living with dementia or MCI working with clinicians who feel underskilled in this area. Negative experiences of therapy have been associated with loss of hope, loss of confidence and feelings of failure for patients (Hardy et al., 2019). Many participants reported low confidence in working with this population and that their training had not covered dementia or MCI. Given the qualitative methodology in this study we cannot be certain whether this is representative of the wider IAPT workforce. Some reported additional training was not commonly offered to clinicians due to a lack of financial resource and time. Clinical managers should source appropriate training and supervision to support staff in providing safe and effective interventions to this client group.

Limitations

While efforts were made to recruit systematically by sending the study information to all IAPT services within [*Location removed*], the study was also recruited for via word-of-mouth by clinicians with a connection to the research team. This limited the number and type of services involved and might have biased the sample recruited to this study. Further, this is a small-scale qualitative study which inherently limits the generalizability of the findings. Future research could investigate whether these findings are replicated in other IAPT localities and other therapy settings, using more representative survey designs.

Some participants had not worked clinically with dementia and participated based on their knowledge and assumptions about dementia and MCI, which could potentially limit the relevance of their answers. Yet, including their perspectives allowed us to identify systemic and attitude-related barriers which hindered these clinicians from gaining the experience, compared with only interviewing clinicians who had clinical contact with people living with dementia. Clinicians who had not worked with people living with dementia or MCI were more tentative about potential in-session barriers for engaging people living with dementia.

However, their views did not contradict those who had worked with people living with dementia or MCI. Due to the small sample size it was not possible to specifically focus on differences in attitudes of practitioners with and without experience of working with this client group. This could be explored by future research.

The diagnoses of dementia and MCI were discussed together due to overlap in presentation; it was beyond the scope of this study to separate out the experience of working with these groups. Further, the interview did not address how the diagnosis of dementia or MCI itself was discussed during therapy, if at all, which could have implications for patient care but future research could investigate this.

This study did not include the perspectives of other stakeholder groups, such as commissioners, service managers, referrers (primary care physician and memory service staff), carers, and most importantly people living with dementia or MCI themselves. These groups' perspectives are likely to provide further valuable insights.

Implications

The findings of this study highlight potential barriers to the accessibility of IAPT services for people living with dementia or MCI. If therapy services are not always available to them due to diagnostic overshadowing (i.e. excluded on the basis of dementia diagnosis) or other challenges for service provision with this client group, it is unclear how the psychological needs of this population are being met.

It appears more needs to be done to support and train IAPT clinicians to adapt their work, in particular as only two participants had received any specific training in dementia, and to support older adults with cognitive impairment to access the care they are entitled to. Addressing these issues should take into account the different levels at which barriers and opportunities for facilitation occur (i.e. individual client/clinician, service, and system level),

with potential for staff training, involving caregivers in treatment, commissioning discussions, and raising awareness among referrers, staff and wider society.

Within the services sampled, there was variability in perceived flexibility and equality of access. Only some participants were confident that their services are able to adapt to support people living with dementia or MCI; the experiences of staff within these services should be explored further to establish good practice and how this links with commissioning practices. A partnership model between health and psychology services may utilize the expertise within specialist memory services and provide more cohesive care (Carroll, Moss-Morris, Hulme & Hudson, 2020).

Increasing knowledge and skills within the workforce appears an important step, but this study also highlights the complexity of mental health commissioning. Despite the empathic and ethical views of individual clinicians in this study, services operate within a context of finite resources and economic priorities. It could be argued that changes need to be made at policy level for services to work together to provide effective interventions and equity of access while being adequately funded to do so. This is complicated by the fact that the evidence base for CBT for people living with dementia or MCI is still emerging, and in need of larger RCTs to demonstrate their effectiveness (Orgeta et al., 2015). Further work on this needs to be done, potentially by including a dementia classifier in IAPT services, comparing outcomes in the routinely collected national IAPT data set, and investigating routine outcome measures more suited to adults with cognitive impairment.

Conclusions

Clinician-perceived facilitators to providing CBT for people living with dementia or MCI in IAPT services were positive engagement and outcomes of people living with dementia, MCI and older adults in these services, positive attitudes of clinicians providing

therapy to these groups, and opportunities for treatment adaptation. Barriers include high pressures on staff with a variable level of support, negative societal attitudes towards older adults and dementia, and inflexibility of care alongside limited resources and training, perceived to restrict services for people with extra needs. This has potential implications for the commissioning of services in a challenging political context, and for training and support of clinicians working with limited resources. Future research should focus on increasing the evidence base for treating common mental health problems in people living with dementia or MCI.

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Table 1. Overview of participants' clinical experience presented in a randomized order

ID number	Professional role	No. years qualified	Worked with older adults?	Aware of dementia/ CBT research?	Worked with PLWD?	Had dementia training?
P1	CBT therapist	1	Yes	No	No	No
P2	CBT Therapist	3	Yes	No	Yes	No
P3	PWP	2	Yes	No	Yes	No
P4	Clinical Psychologist	4	Yes	Yes	Yes	Yes
P5	CBT therapist	1	Yes	No	Yes	No
P6	PWP	3	Yes	No	No	No
P7	PWP	3	Yes	No	Yes	No
P8	PWP	1	Yes	No	No	No
P9	CBT therapist	1	Yes	No	Yes	No
P10	PWP	3	Yes	No	No	No
P11	CBT Therapist	1	Yes	No	No	No
P12	PWP	2.5	Yes	No	No	No
P13	Clinical Psychologist	15	Yes	Yes	Yes	Yes
P14	PWP	3	Yes	Yes	No	No

Note: Psychological Wellbeing Practitioner (PWP), Cognitive Behavior Therapy (CBT), People living with dementia (PLWD)

Table 2. *Themes and sub-themes*

Theme	Sub-theme
Attitudes towards dementia	Positive clinician attitudes
	Cohort factors
	Negative referrer attitudes
	Societal attitudes and service provision
Competing demands	Adapting therapy
	Involving others
	Service (in)flexibility
	Commissioning and funding
Pressure without support	-

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