The Challenge of Delivering Psychological Therapies for Older People in Scotland

Report of Older People’s Psychological Therapies Working Group

December, 2011

Executive Summary and Full Report
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Executive Summary

1. Background

As part of its response to the HEAT target for delivering psychological therapies, in 2010 the Scottish Government established a Working Group of people with expertise in mental health improvement, education, service development and service provision relevant to the psychology of older people. They were selected from both statutory and voluntary sectors and included clinicians from several disciplines, and older people themselves.

The group was charged with the tasks of:

a. Reviewing the evidence on effective psychological therapies. This evidence base is now included in “Mental Health in Scotland: A Guide to delivering evidence-based Psychological Therapies in Scotland - The Matrix”\(^1\)

b. Providing recommendations about the most appropriate way to deliver these services. The report addresses this second task.

A raft of policy documents in recent years has addressed the wide ranging issues relating to achieving better health and care for older people, particularly the impact of long term conditions affecting health and well being in later life, and the impact of mental health problems on quality of life. The demographic shift, a better understanding of the inter-relationship of physical and psychological comorbidities, and the impact of the Equality Act in 2010, have highlighted the urgency of this challenge. Addressing the psychological therapies issue is an essential element of any effective response to this challenge.

2. Psychological problems for older people

People are living longer and the proportion of older people in the population is increasing markedly - the ‘demographic shift’. Many older people remain active, with a good quality of life and they make significant contributions to society, but many may develop physical and psychological problems. Long term physical conditions such as COPD, chronic pain, stroke, Parkinson’s disease are common in older people. Psychological factors have an important role in helping or hindering people’s response to treatments for such physical conditions. The co-morbidity of physical

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\(^1\) The Matrix is available at [www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix](http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/matrix).
illness and psychological factors in older people has a negative impact on outcome: long-term conditions increase depression and anxiety which in turn slows recovery. Psychosocial factors, such as loneliness and poverty also play a major part in exacerbating illness. Failure to address psychological elements hinders rehabilitation, leads to unnecessarily poorer outcomes, and overloads hospitals and healthcare systems.

3. Access to services

There is a strong evidence-base that psychological interventions with older people are effective. This is summarised in the MATRIX which accompanies this report. Despite robust evidence for this, older people do not have access to appropriate psychological approaches and treatments. Services must consider how to address this assertively if equality of access is to be achieved.

Fewer than 10% of older people with depression are referred to specialist mental health services, compared to 50% of younger adults. Eighty percent of older people with depression do not get any treatment at all, either medication or psychological therapy.

4. Vision for a service model for psychological therapies for older people

Improving the mental health of older people in Scotland requires a multi-faceted approach in which prevention is the key, building on the evidence for resilience in older people. This approach includes health promotion, community development and greater support for voluntary services. Unless prevention is addressed, therapy services will be overwhelmed. For older people psychological therapies are needed in three areas:

• mental health problems (especially anxiety and depression)
• dementia
• long term physical conditions

Development of appropriate psychological therapy services will require:

• service Redesign
• training
• resource allocation

This report provides a service redesign template (copy appended to this summary) describing the tiers of psychological interventions needed and the expected outcomes. The template is informed by seven underlying principles (see box below). The report makes a number of recommendations for delivering such a model. Details will be dependent on local circumstances.
5. Current capacity to deliver psychological therapies

- Current capacity for psychological therapy provision for older people is seriously compromised.
- For **low intensity therapy** there is potential for increased delivery within the AHP and nursing professions through training, support and well managed service redesign.
- There is no capacity to increase **high intensity and specialist** provision. Additional investment is needed here.
- There are insufficient psychology staff in older people's services. The level of psychology provision for older people is **less than one third** of the provision either for children or for adults of working age.
- Given the key role of psychology both in delivering psychological therapies and supporting the delivery of these therapies by other professions, the lack of these posts presents a major barrier to change.

6. Recommendations:

**The three most urgent service priorities are:**

- **To increase capacity for highly specialist, specialist and high intensity therapies for older people (Tier 4,5)** Investment in a skill mix of Clinical Psychologists, CBT Therapists and Clinical Associates in Applied Psychology, and encompassing both training routes and post-qualification posts is needed.
- **To increase the availability of evidence based low intensity therapies for older people (Tier 2, 3).** With additional specialist high intensity therapists in place, the capacity to train and supervise other staff in the delivery of low intensity interventions will significantly increase and should be made a priority for services where investment is made.
- **To extend the role of psychological therapists into services for older people with long-term conditions. (Tier 5).** Services for people with long term conditions, including where appropriate those provided by the Third Sector, must have access to both low and high intensity psychological therapy. Linking a proportion of any new investment in psychological therapies for older people directly to long-term conditions services would be one way to achieve this aim.
Delivering on the Seven Principles.

The report makes a number of recommendations in relation to different tiers. Broad timescales for delivering these are provided, although it is clear that there will be local variation depending on current resources and service redesign opportunities.

Developing a psychologically aware and age aware workforce (Tiers 0,1,2)
- A programme of age and psychological awareness should be developed in conjunction with NHS Education for Scotland. It should identify the levels of knowledge required for different staff groups including existing clinical and non-clinical staff, and pre-registration training.

Ensuring that older people have access to specialist services and to general services based on need not age (Tiers 3,4,5)
- Psychological therapy services for older people should focus their resources on people to whom the ‘5Cs’ apply (chronicity, complexity, comorbidity, continuity and context).
- If older people have needs which do not require specialist services, they should be seen by general adult psychological therapy services.

Goals for delivering a matched care approach adapted to suit the needs of older people:

Providing age appropriate self help materials, guided self help and CCBT for older people (Tiers 1,2)
- A specific short term project should be funded centrally to adapt available materials to be more age appropriate, including computerised CBT (cCBT).
- Local services should ensure that any guided self-help or similar services are aware of the specific needs of older people, and that older people are signposted to all appropriate services e.g. NHS-24 Guided Self-Help

Development of low intensity therapy provision by existing staff (Tiers 2,3)
- Boards should identify the numbers of nurses and AHP staff currently trained to a level where they could provide low intensity psychological therapies specifically for older people, as well as staff who could be readily trained to this level (with the support of NES as described in Principle 1).
- Service managers should work to redesign existing services and associated nursing posts in the most efficient and cost effective way possible, so that the delivery of low intensity therapies is integral to the work of these staff, including protected time for clinical supervision.
- In addition to people in the community, older people in mental health day hospitals and wards should have routine access to low intensity psychological therapies delivered by these staff.
Increasing capacity for High Intensity Psychological Therapies staff for older people in mental health services (Tier 4,5)

- The time of any existing old age service nurses and AHPs who are qualified CBT therapists should be protected to allow them to deliver high intensity therapies within their services. This should be linked to psychological therapies services for older people, with appropriate clinical support and supervision.
- Training of high intensity psychological practitioners should be reviewed in order to increase the workforce qualifying with specialist skills relating to older people. Experience of old age aspects of psychological therapy should be a training requirement of Scottish CBT and IPT courses.

Increasing capacity for specialist & highly specialist therapy & interventions for older people in services for mental health, dementia and long-term conditions. (Tier 5)

- Reshaping Care Steering Groups should take account of the role of psychological therapies in their development plans for older people’s services in acute, primary care and mental health services.
- A significant impact could be made if each Health Board funded one additional hospital based and one additional community based clinical psychologist to work in services for older people with long-term conditions, to support other staff in the delivery of low intensity interventions as well as to provide direct therapeutic input.
- Further posts should be considered to begin to address the paucity of psychological therapists working with older people with mental health problems and dementia. Per Health Board, one Clinical Psychologist and one CBT Therapist or Clinical Associate in Applied Psychology would make a significant difference to the service which could be delivered.

Assuring quality and efficient delivery of psychological therapies for older people.

- Outcome evidence needs to be collected, especially as assessed by the older service users themselves.
- A system of quality assurance is required (through ongoing continuing professional development and clinical supervision) to avoid risk of delivery of a lower level of intervention than is necessary (for example using expert consultancy clinics).
- Arrangements must be in place for clinical support as this is key to patient safety, adherence to evidence based practice, and safe practice where the evidence base is lacking.
- A standardised method of data collection to support service management, planning and clinical governance must be agreed and developed to ensure Boards can evidence improvements from their investment.

Table of Matched care Model attached
Delivering Psychological Therapies for Older People in Scotland

Matched Care Model for older people

Figure 1. Model of matched care psychological therapy delivery for older people

Tier 5: Highly Specialist therapies provided by those with meta-competencies

Tier 4: Specialist services hospital, Intermediate, nursing home, hospital at home & specialist community based care provided by specialists in old age

Tier 3: Mixed economy of HI & LI

Tier 2: Primary Health Care

Tier 1: Care by communities and Information service

Tier 0: Raising Public Awareness

*Meta-competencies here refers to the ability to draw on expert knowledge from a range of therapeutic models and knowledge of psychology and of ageing as well as expertise in understanding of the impact of neuropsychological impairments and the ability to adapt therapy approaches to account for such variables.
Table 1. Details of matched care delivery model for psychological therapies for older people
(Shading indicates Specialist Old Age Services (Tiers 4,5), General (Tiers 0-2), and mixed area (Tier3)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Locus</th>
<th>Provision</th>
<th>Outcome</th>
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| 5    | Mental Health (incl. dementia) | • Highly specialist psychological therapy and interventions for severe and complex or treatment resistant depression, anxiety etc.  
• Highly specialist psychological therapy and intervention support services for people with dementia and their carers for whom low or high intensity interventions are insufficient.  
• Highly specialist therapies provided by specialist old age psychological therapists with expertise in relation to the long-term conditions.  
• Training and support to specialist psychogeriatric and geriatric hospital and community staff in managing behavioural distress associated with dementia.  
• Provision and oversight of supervision, training and support for those providing specialist, High, or Low Intensity therapies for older people.  
• Training for care home staff in recognition of and prevention of depression and support for appropriate psychological interventions  
• Expert consultancy training and support on psychological interventions for acute hospital staff dealing with older people long term conditions….  
• …And with older people admitted with physical conditions comorbid with dementia. | • Delivery of evidence-based treatments adapted to work with the most challenging presentations of depression and anxiety (e.g. chronic physical treatment resistant depression, anxiety and depression in Parkinson’s disease, depression/anxiety in dementia etc.)  
• Better outcomes for people with complex psychological disorders, treatment resistant depression etc.  
• Marked improvement in quality of life and functioning for many people with dementia and mood disorders with reduction of distress in people with dementia with behavioural disturbance.  
• Increased expertise in nursing staff providing outreach support to care homes for people with dementia  
• Reduction of untreated depression in care homes.  
• Cost reduction to NHS from increased bed turnover resulting from better and quicker outcomes for rehabilitation in patients admitted for crisis points in long-term conditions.  
• Better management of dementia in acute hospitals, with reduction in excess disabilities arising from these admissions for acute illness, fractures etc.  
• Better range of support for stressed carers, with potentially improved capacity for them to continue home based care (see matrix). |
|      | Physical Health & LTCs (incl. dementia) | Acute hospitals, Hospital at home and intermediate care services. Multi-disciplinary teams for specific disabilities and long term conditions for older people (Stroke, Parkinson’s disease etc)  
Older people’s Mental Health Liaison Services into Acute hospitals | |
| 4    | Community and out-patient old age specialist psychological therapy services for severe or complex psychological problems (where old age issues are a significant factor) | • High Intensity(HI), Specialist, or Highly specialist therapy provided by old age specialist psychological therapists or clinical psychologists plus CBT therapists with additional OA training or specialist supervision  
• HI psychological therapy for anxiety and/or depression in early stage dementia, provided by old age specialist psychological therapists  
• Consultancy and support on psychological interventions for staff dealing with behavioural distress in dementia. | • Increased access for older people to specialist psychological therapy services when these are required.  
• Improved quality of life and reduced anxiety, depression and associated excess disability for the older people who have access to these approaches.  
• Reduction in avoidable admissions of older people with long term conditions to acute hospitals where psychological factors are exacerbating the condition or the person’s adjustment to it. |
|      | Mixed delivery model: Primary and Secondary care | Mixed economy of Low and High Intensity therapies  
• High Intensity psychological therapy provided by therapist primarily employed in Adults (of working age) services (see note 2)  
• Low intensity psychological therapy for anxiety and/or depression associated with stroke, COPD, falls, etc., provided by age specialist AHPs and nurses in the long-term conditions specialties, trained in these therapies.  
• Low intensity (or where necessary high intensity) psychological therapy for carers who are struggling to cope with the stresses of caring. | • Increased access for older people to age specialist psychological therapy services when these are required.  
• Improved quality of life and reduced anxiety, depression and associated excess disability for older people using service  
• Reduction in avoidable admissions of older people with long term conditions to acute hospitals where psychological factors are exacerbating the condition or the person’s adjustment to it.  
• Reduced pressure on high intensity and highly specialist therapy resource  
• Improved well-being and enhanced coping.  
• Reduction of crisis admissions and crisis interventions |
## Delivering Psychological Therapies for Older People in Scotland

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<th>Primary Care</th>
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<td>NHS24</td>
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<td></td>
<td>General services – (Age aware but not age specialist, except for Alzheimer’s)</td>
<td>Provision of LI therapies such as guided self help</td>
<td>Reduction of unnecessary referral for specialist services for anyone who could benefit from low intensity therapies.</td>
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<td>Provision of CCBT by NHS 24</td>
<td>Enhances independence as people see the possibility of learning for themselves how to deal with a problem.</td>
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<td>Age aware and psychologically aware advice and counselling on mental health problems in old age and on managing long term conditions by all members of primary care team.</td>
<td>Supports expert patient model applied in other parts of health service.</td>
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<td>Post diagnostic adjustment support to prevent depression in early stage dementia – provided by community staff, voluntary sector (Alzheimer’s etc. as per Dementia Strategy)</td>
<td>Reduction of likelihood of depression and anxiety in early stage dementia, &amp; concomitant reduction in excess disability.</td>
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<td>Reduction of unnecessary referral for specialist services for anyone who could benefit from self-help approaches. Enhances independence as people see the possibility of learning for themselves how to deal with a problem.</td>
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<td>Supports expert patient model applied in other parts of health service.</td>
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<td>Reduction of risk factors for depression and anxiety</td>
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<td>Enhanced independence as people see the possibility of learning for themselves how to deal with a problem.</td>
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<td>Reduction of risk factors for depression and anxiety</td>
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<td>Libraries, Health centres, carer organisations, advocacy services, websites.</td>
<td>Adaptation and development of current general adult self-help material to more age appropriate versions for older people and using age appropriate examples.</td>
<td>Reduction of unnecessary referral for specialist services for anyone who could benefit from self-help approaches. Enhances independence as people see the possibility of learning for themselves how to deal with a problem.</td>
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<td>Development of long-term condition specific information that is both age-appropriate and psychologically helpful.</td>
<td>Supports expert patient model applied in other parts of health service.</td>
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<td>In addition the model requires the development of the most effective means of making these materials and help accessible to older people.</td>
<td>Reduction of risk factors for depression and anxiety</td>
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<td></td>
<td>Communities.</td>
<td>Support for active engagement, reduction of loneliness and isolation.</td>
<td>Improved general well-being in older population</td>
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<td>Timely and appropriate age aware support for people with long term conditions,</td>
<td>Reduction of incidence of avoidable psychological distress</td>
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<td>Awareness of prevention of anxiety and depression especially in relation to LT conditions.</td>
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Notes:

a. However, this normally should not include the severe and endure mental health rehabilitation work normally undertaken by highly specialist SEMI teams. People who have such psychosis related problems and become elderly usually will be better served by continuing to be seen by the SEMI experts, and should continue to have access to those services. This fits with the principle of “needs not age based services”: The highest level of expertise for older people with these difficulties lies with the SEMI service staff.

b. Low intensity and High intensity refer to the definitions of interventions as described in the Matrix - See appendix 1.

c. Tier 4 may also be provided by non-age specialist psychological therapists – if age specialist issues do not pertain. Our position echoes that of Knight et al (2009) in discussing a competence model for older adults psychology in that older people presenting with affective distress that is not associated with age challenges can be seen successfully by specialists in psychological therapies, but that where issues become more complex and age specialist in nature these therapist must be aware of the limits of their competence and signpost these clients to tier 5 specialists in old age.