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Psychology Specialists Working With Older People

AIMS

- ◆ to promote opportunities for the exchange of knowledge and expertise between members;
- ◆ to promote a greater appreciation of psychological factors in ageing;
- ◆ to advise and participate in matters of teaching and training;
- ◆ to stimulate research and disseminate research findings;
- ◆ to act in an advisory capacity on issues relating to the well-being and provision for care for older people;
- ◆ to foster an exchange of information and ideas with other professional and voluntary groups.

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Letter from the Editor

Louisa Shirley

I AM VERY PLEASED to write this short editorial for the *Older People and IAPT Special Edition Newsletter*. This publication was conceived by a group of older adults' psychologists with a special interest in promoting therapy provision for older people. The papers aim to highlight thought and work in this area to coincide with national discussions. At the national PSIGE committee meeting at Parcevall Hall this year, we agreed that this needed to be an area of work that takes precedence, with the overall aim being to influence the development of IAPT to make it fit for purpose for older people. Our goals are: (1) to collate and publish information about how IAPT works nationally (across the nation) to improve access to psychological therapy for older people; (2) to facilitate communication between clinical psychologists developing services to improve access of older adults to psychological services; (3) to provide CPD for the profession and other clinicians/professionals; (4) to build on evidence by identifying key areas for further audit and research; and (5) to be key contributors to policy decisions relating to IAPT and older people across the nation.

This edition of the *Newsletter* was intended to address the first of these goals but clearly achieves more than this through providing a forum within which clinicians can share their experiences of service-development, providing information that enables others to develop their own knowledge base, demonstrating data collection and highlighting areas in which more data is required. Finally, the edition as a whole forms a document which could influence policy decisions.

I would like to thank Julia Boot, Louise Bergin and their colleagues for this important addition to the year's production.

Louisa

Letter from the Guest Editor

Julia Boot

THIS special edition *Newsletter* about Older People and IAPT has evolved out of several training events organised by PSIGE in Newcastle (June 2009), the Equalities in Mental Health conference in London (February 2010), the BABCP conference in Manchester (July 2010), and the Maudsley Hospital, London and Scotland (both in September 2010). These events have been well-attended and generated considerable interest about what was happening in terms of IAPT providing psychological interventions for older adults. The events have included presentations by the Department of Health, commissioners, trainers of IAPT workers and clinical psychologists working with older people within IAPT services. This special edition aims to capture the broadest picture possible of how IAPT is working for older people, by incorporating accounts of what is happening in particular psychological services across the country and views from the Department of Health, commissioners, the Alzheimer's Society, an older adult client and a GP. We are pleased to have contributions from psychological services at different stages in response to IAPT, including a Pathfinder site, 'first wave' sites and a service in Scotland that has not been allocated any additional resources to implement IAPT for older people. The situation regarding IAPT in Wales is mixed, with no specific funding and different areas adopting independent strategies. We hope to include articles about IAPT in Wales in subsequent editions. The key issue continues to be about the limited access of older people to IAPT services. Whilst the under-representation of older people in referrals to primary care mental health services is not new, questions have been raised in several

articles about the limitations of IAPT service models for addressing these problems with access. Concerns about age-inequalities and how to accommodate older people with dementia have also been highlighted. Other articles have explored the issues around offering psychological interventions to older people within specialist and 'ageless' primary care services.

We hope that this special edition provokes ongoing discussion and sharing of the issues around older people and IAPT. The good news is that there is an ongoing drive from the Department of Health to continue to improve access for older people to psychological interventions. We have been really grateful for the enthusiasm and commitment of all the contributors to this edition to share their experiences of older people and IAPT in their services to produce excellent articles within a very tight timeframe. We hope that this special edition also encourages other psychological services to collate information about access and report their local issues for older people. To facilitate this work, we have included some ideas for questions to ask in your service, at the end of this special edition. Our next steps as a National Committee are to set up an e-mail network of people interested in older people and IAPT and to develop a specific page on the PSIGE website. Finally, we are planning a follow-up 'IAPT and Older People' training event next September. Please let us know if you would like to contribute.

With particular thanks to co-editor, Louise Bergin.

Julia Boot

IAPT Lead, National Committee.

Letter from the Chair

Don Brechin

APPLYING known prevalence figures for common mental health problems to population demographics, around 21 per cent of people accessing Improving Access to Psychological Therapy (IAPT) services should be over 65 years of age. However, the actual figure can be as low as two per cent. So why is IAPT not working for older people?

This special edition of the *Newsletter* seeks to shed some light on this and other issues. Whilst the formal IAPT programme is specific to England the improving access agenda is applicable to all the nations of the UK and the issues that have been found in England are likely to be replicated elsewhere. Just as with adults of working age, there are clear economic benefits (as well as a moral imperative!) to ensuring good mental health in later life. For example, many informal carers are over 65 years of age, providing physical support to a spouse or sibling, providing free childcare to grandchildren or caring for someone with dementia. Yet we know that carers are among the most at risk of common mental health problems as a result of their role, putting their ability to care at risk. Clearly, it makes sense to support and protect these people.

By highlighting the needs of older people and focusing on areas of good practice, we hope to show that IAPT can serve their needs. However, this will not happen without thought and effort. We hope that this special edition of the *Newsletter* provides some clear pointers as to how to achieve this.

Best wishes.

Don Brechin

Introduction:

Age equality in mental health and older people: An overview

Polly Kaiser

*The oldest hath borne most: we that are young
Shall never see so much, nor live so long. (King Lear, 5.3.325)*

ISSUES OF AGE EQUALITY are not new. Shakespeare in *King Lear* gives a vivid portrayal of intergenerational conflict and certainly an example of ‘unfair access to care’.

Three-quarters of NHS clients are aged 65 and over but they receive only two-fifths of total expenditure.

In recent decades the issue of care for older people in society has been increasingly highlighted in numerous reports. Each decade seems to produce a report decrying the unfair treatment of older people or the lack of access to appropriate care and calling for age discrimination to be rooted out. The last decade has seen even more : From 2001 in the Forget-Me-Not Report (Audit Commission, 2001), the NSF for Older People 2001 Standard 1, Everybody’s Business 2005 to The Age Concern/Mental Health Foundation Inquiry into Mental Health Well-being, All Things Being Equal (MHF 2009), the Health Care Commission report July 2009, the Royal College of Psychiatrists’ position statement on Age Equality 2009, to the Achieving Age Equality in Health and Social Care Review 2009.

All of these point out the discriminatory treatment older people receive, particularly in the area of mental health. For example, many older people do not have access to crisis home treatment services, alcohol services or talking therapies (HCC, 2009). The Royal College of Psychiatrists estimates that 85 per cent of older people with depression receive no help at all from the NHS.

For 10,000 people aged 65 or over there are:

- 2500 people with a diagnosable mental illness.
- 1350 people with depression (1135 receiving no treatment).
- 500 people with dementia (333 not diagnosed).
- 650 people with other mental illness.

Age Discrimination in mental health services: Making equality a reality. Royal College of Psychiatrists’ position statement and compendium of evidence, 2009.

Sixty-four per cent of older people themselves think health and care staff don’t always treat older people with respect for their dignity (ICM Research Pain and Dignity survey, 2008)

Some of these reports have been driven by clinical interest and recognition that older people are not getting a fair deal or access to appropriate care. More recently concerns are being fuelled by the requirements of the Equality Act 2010. This makes provision for a new, single equality duty to be imposed on public bodies and those exercising public functions. It is expected that the new Equality Duty will apply from April 2011. The Age duty will apply in health and social care from 2012. It will ban age discrimination. There is a real concern that services will then remove any specialist provision erring on the side of caution regarding the Act – ‘everyone gets the same – we do not discriminate’.

However the Equality Act also:

- Has a statutory provision exception, i.e. state benefits.
- Has a Positive action provision, i.e. services can take positive action to reduce age discrimination.
- Has an Association provision, for example, carers or the relative they care for can take action

It does not mean that all older people need the same as younger people. It outlaws: only unjustified/harmful discriminatory practices; legitimate age-based practices will be able to continue and differences in treatment which are justifiable, beneficial or neutral can continue if they are 'objectively justifiable'. Different treatment by age is not automatically discrimination.

Different treatment can be 'Good' when age appropriate services are provided. The authors in the rest of this publication give many examples of such services. There can be positive action to redress unfairness. Different treatment can be 'Neutral' where difference reflect natural variation rather than being as a result of specific decisions about services. However, they can also be 'Bad' when there is direct or indirect discrimination. These have been defined as :

'Direct age discrimination will occur if people with comparable needs are treated differently, purely on the basis of their age. Indirect age discrimination will occur if people from different age groups, with different needs, are treated in the same way, with the result that the needs of the older person are not fully met.' (CPA, 2009)

How services are commissioned and configured so as to reduce discrimination and promote equality is still a challenge. As part of the Department of Health's review on achieving age equality they commissioned a tool kit which can be seen at:

<http://age-equality.southwest.nhs.uk/nhs-practice-guide>

This provides an extremely useful compendium of evidence and tools for health and social care organisations to help prepare for the requirements of the Equality Act. The National Mental Health Development Unit (www.nmhdu.org.uk) and National Development Team for Inclusion (www.ndti.org.uk) are working in partnership to test the mental health aspect of the tool kit out.

The toolkit is constructed so that a small group – an Area Audit Group (AAG) – from within a PCT/Local Authority area can work together and with local stakeholders/communities to self-audit the organisational system readiness for implementing the Act, with specific regard to tackling age discrimination in public services and achieving age equality. The results of this should be available in March 2011.

What is clear is that a one size fits all approach will not necessarily provide age equality. Equality is not about treating people the same but recognising their differences (Anderson et al., 2009).

The wealth of examples in this publication describes a variety of approaches to meet this challenge within the context of IAPT and talking therapy services and is a very welcome evidence base to promote age equality and reduce age discrimination.

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Talking therapies for older people

Jacqui Ruddock & Kevin Jarman

ON 20 OCTOBER 2010 the Chancellor's Spending Review announced funds to 'expand access to psychological therapies for the young, elderly and those with mental illness'. This announcement makes it explicit that the strategy to improve access to talking therapies needs to prioritise older people.

For a number of services, providing psychological therapies for older adults is already the norm. Older people have been represented within Improving Access to Psychological Therapies (IAPT) services since the Pathfinder sites of 2008. Pathfinder sites evaluated the efficacy of the IAPT service model and its ability to serve the needs of the whole community. In accordance with Lord Layard's Depression Report of 2006¹, the IAPT programme was designed to implement NICE guidelines to offer psychological therapies for those that required it, address long waiting lists for treating depression and anxiety and help to reduce the number of working age people claiming Incapacity Benefit because of poor mental health. Key performance indicators in IAPT services included the number of people accessing psychological therapies, recovery rates and the amount of people helped back into work. Revised performance indicators are currently in development as part of a transition to a talking therapies programme in April 2011 and Payment by Results arrangements. Payment by Results will link financial compensation to the delivery of key outcomes in supporting or enabling client:

- Access;
- Choice and experience;
- Recovery/improvement rates;
- Involvement and participation.

(e.g. employment, vocational occupation). Local sites defined the methodology for realising IAPT benefits for older people. Some sites developed their existing workforce to work collaboratively and sensitively with older adults and based services on the IAPT practice guidance for older people². Others recognised that services needed to be designed in particular ways in order to be fully accessible to older people and to respond to individual needs among this group. Regardless of the model used, the essential ingredient to effective and equitable services for older adults was and remains a commitment to deliver age inclusive services and to ensure that older people are fairly represented within IAPT services.

However, this commitment brought with it some fundamental challenges for the IAPT programme and its future, in particular, how to increase the proportion of older people accessing psychological therapies. Analysis of first wave sites concluded that older adults represented on average four per cent of those accessing IAPT between October 2008 and September 2009. This figure was questioned by some local sites that reported that they had a higher proportion of older people using IAPT services.

Moreover, to ensure equitable access, IAPT objectives include enabling a 12 per cent representation of people aged 65 and over. This is based on both the age profile

¹ Layard, R. (2006). *The Depression Report: A new deal for depression and anxiety disorders*. London School of Economics, The Centre for Economic Performance's Mental Health Policy Group.

² Improving Access to Psychological Therapies: Older People Positive Practice Guide (2009).

and the prevalence of depression and anxiety in the population. This figure is in line with the overall IAPT aim to meet 15 per cent of prevalence of depression within the local community and helps to inform the business case for providing an age inclusive service. The 15 per cent is formed on the basis that for every 100 people with depression only 50 seek treatment and only 25 are diagnosed. Only 80 per cent of those with anxiety disorders and 68 per cent of those with depression opt for psychological therapy. It is common for people to experience both depression and anxiety disorder at the same time. Fifteen per cent of prevalence is slightly below this and was established as a guideline for IAPT service by practising GPs interpreting data from the British Psychological Survey published by the Office for National Statistics.

The Talking Therapies Programme

The national IAPT team in the Department of Health (DH) is working with the NHS Commissioning Board to secure the future roll out of IAPT services in the period after March 2011 when the centrally led team will change alongside the advent of a new NHS structure. Furthermore, the advent of age equality legislation in 2012, means that talking therapies will naturally shift focus to ensure that new initiatives such as Payment by Results arrangements are not only age inclusive but also that services are recognised and rewarded for innovative approaches which:

- Enable older adults to make full use of the range of psychological therapies services; and
- Take into account circumstances such as retirement, full-time caring responsibilities, long-term physical health problems, medically unexplained symptoms and those that for a variety of reasons are not seeking employment.

In addition, extending access to psychological therapies for older people requires certain characteristics, which help create a service standard and provide a framework for GP consortia commissioning of IAPT. These service characteristics are:

- Age equality and diversity;
- Service flexibility;
- Older adults' involvement in service design;
- A data-conscious workforce.

Age equality and diversity

Age is a protected characteristic under the Equality Act 2010 and public bodies have a duty to ban age discrimination in services and public functions as of April 2012. The legislation means that IAPT services have a legal responsibility to evidence that older people and other protected groups are made safe from discriminatory practices, which maintain health inequalities³. In the DH, the objective is to surpass the requirements of equality legislation. The Healthcare Commission report *Equality in Later Life*⁴ concluded that older people did not benefit from health service developments to the same degree that younger adults did, which suggests a need for a realistic evaluation of the strength and weaknesses of IAPT services that will go beyond mission statements. Rather, the DH recognises that local services are better placed to identify and evidence practice, which serves the needs of older people.

The role of the national IAPT team involves disseminating this information to other services in order to replicate effective practice with full knowledge of the resource implications of providing this level of service.

The task for local sites is to raise awareness of:

- the existence of this good practice;
- the impact they have made;

³ The Equality Act 2010 came into force on 1 October 2010.

⁴ Commission for Healthcare Audit and Inspection (March 2009). *Equality in Later Life: A National Study of Older People's Mental Health Services*.

- demonstrate how older adults have helped shape age inclusive services.

The IAPT website enquiry inbox can be used to invite members of the team to see first hand the holistic nature of an IAPT service that is specifically developed to meet the common mental health needs of older people.

The expansion of services to older people also refers to a consideration of the diversity of older people to further reduce inequalities in access and outcome. Diversity relates to, among other factors, differences in ethnicity, physicality, religion and sexuality among older adults.

Age inclusive services are aware that IAPT service provision is different for people in their 60s in comparison to those in their 70s, 80s or 90s. There will be a similar consideration for individuals of the same age to avoid assuming that the physical capability of one 70-year-old is the same as another. Similarly, ethnicity, language and culture are all issues that have an impact on patient satisfaction rates, with some ethnic communities misunderstanding differences between the terms 'mental illness' and 'mental health'⁵. This will also affect recovery rates, as some older adults report that their satisfaction with the practitioner relates to the therapist's ability to understand their culture and to communicate in their chosen language.

This is not to suggest that language and culture is specifically an issue for black and minority ethnic communities. Instead, it is a recognition that clearly communicating what talking therapies is, operates to challenge a perception that some individuals will not receive fair treatment because of impairment, their cultural or ethnic background.

Efforts to ensure that the multiple identities of older people are built into service developments will be central to age equality initiatives that underpin extended access to IAPT. Services which can indicate how they have met the diversity of older people's

needs may have met the gold standard of the IAPT Equality Impact Assessment (EqIA) tool (e-link) and the national IAPT team would be interested to hear about such initiatives.

Service flexibility

At the heart of personalised care and dignity for older people is service flexibility. A key aspect to an IAPT service model is routine monitoring to ensure that the clinical outcomes of recovery or improvement in mental health are better than they would have been without psychological intervention. The cost benefits of designing services for older people are that they are more likely to attend sessions and complete psychological therapy than their younger counterparts. These fundamental ingredients and benefits support the tailoring of services to include longer treatment sessions, home visits or offering treatment in alternative venues, which are accessible and suitable for older adults. This also includes services incorporating initiatives that promote patient choice, such as therapists of the same gender. Dependant upon the workforce profile, staff may not be representative of the local community and so reduce the ability to offer patients this choice. However, it's more important that a service is culturally aware and competent when deciding what interventions are most appropriate for older adults.

Older adults' involvement in service design

Equality impact assessments (EqIA) remain a duty of equality legislation and show that the local community has been involved with reviewing and influencing the accessibility and experience of IAPT services. Community involvement refers to interviews, patient feedback, focus groups and patient experience questionnaires collated in order to gauge patients' perceptions of the service

⁵ Fountain, J. & Hicks, J. (2010). *Delivering Race Equality in Mental Health Care: Report on the Findings and Outcomes of the Community Engagement Programme 2005–2008*.

and to progress any recommendations made. It runs in parallel with promotional initiatives and partnership work with community groups to showcase the service and its benefits for all.

Equally, awareness-raising of the inclusivity of mental health services among older members of the community, involves work with religious centres and care homes. This could result in local sites establishing more links and partnerships in the community by setting up services within these venues, to offer religious and faith-sensitive services and to meet some of the geographical needs of individuals.

A data conscious workforce

Improving data collection is an important activity for a developing workforce because data gathering and analysis is fundamental to the IAPT model and evidence of the improvement or recovery derived from talking therapies. Using therapeutic sessions to collect core demographic information from individuals and ensure that all data fields have been completed is a central responsibility of the workforce. Complementary to this is providing regular cultural competence training for new and current staff to make sure that staff are equipped to respond appropriately to older people as part of providing an effective, culturally-sensitive, and good quality service.

Helpful questions to ask in your services about the quality and impact of services delivered are suggested in the 'Top Tips' section at the end of this *Newsletter*.

Summary

IAPT services for older adults embody the principles of the programme as a whole, ensuring that everyone who needs psychological therapy has access to a service, which is sensitive to individual and group need. The evidence that clinical outcomes for older adults is often better than for younger adults, highlights the cost benefits of extending access of psychological therapies to older people. The DH is committed to going beyond age anti-discrimination legislation and invites local sites to inform the national IAPT team who will in turn let other services know of local initiatives that can evidence improved access, involvement and recovery rates among older adults and their achievement of IAPT standards of equitable and inclusive services.

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Where are all the older people? Equality of access to IAPT services

Steve Boddington

Equality of access

IN JULY 2010, Glover, Webb and Everson published a review of the progress made by IAPT sites during the first year in which services were operational (2008/9). Of the 32 (out of a possible 35) first wave implementation sites from which data was analysed, they reported that four per cent of the referrals were aged 65 or above (Glover et al., 2010).

Given that 21 per cent of the adult population (18+) are aged 65 or above (ONS, 2010a), we can calculate an 'equality of access score'* (EoA score) of 19 per cent for older people represented in this data set (where a score of 100 per cent would indicate that older people were obtaining equal access to services as the rest of the adult population). This figure is in keeping with recent data from non IAPT primary care psychological therapy services in Glasgow (Broomfield & Birch, 2009) from which an EoA score of 20 per cent was calculated. Whilst these EoA scores are probably an improvement on older people's access to primary care psychological therapy services historically (Cobb & Shepherd, 2010; EoA score=15.3 per cent), they remain disappointingly low. However, the literature would suggest that equality of access to psychological therapies varies widely across services (Table 1), with those IAPT services that have appointed staff with a special interest in applying psychological therapies to meet the needs of older people obtaining slightly

higher EoA scores (Wong, 2010; EoA=33 per cent).

Data reported by Robson and Higgon (2010) in a non-IAPT psychological therapy service in Dumfries & Galloway; and by Boot and Hulmes (2010) as part of an IAPT initiative in Cheshire, relates to what appear to be services with a mixture of primary and secondary type care which include specialist 'older adult' services. However, these data generate EoA scores for older people of 35 per cent and 48 per cent respectively, which appears to support the value of employing staff with a special interest in delivering therapies to older people. Robson and Higgon also compare staffing ratios for older and younger adult services and finds the former to be under-resourced. In theory, this may be mitigated for services in which therapists are equipped to see referrals from across the full adult age range. However, as yet there is no evidence to suggest that this can be achieved.

Acceptability of service provision

In my experience there is a widely held view amongst IAPT services that '*older people can be referred, but they should be treated in the same way as everyone else*'. However, the existing data does not support this position. The Age Concern depression campaign (2008) indicated that older people's access to diagnosis and treatment for depression is undermined at three levels. First, older people are more reluctant to seek advice and support for

*EoA score = $\frac{\text{Percentage of older people (65+) seen by service}}{\text{65+ population as a percentage of the adult (18+ population)}} \times 100$

Table 1: Equality of access (EoA) data derived from reports of older people's access to psychological therapy services.

Service	Time frame	% 65+ (referrals to service)	65+ population as a percentage of the adult (18+) population	EoA score	Comments
NHS Greater Glasgow Primary Care Mental Health Service (Broomfield & Birch, 2009)	Jan to Dec 2007	3.21%	16%**	20%	Scotland have not implemented IAPT
Southwark IAPT service (Wong, 2010)	Nov 2008 to June 2010	4.4%	13.3%*	33%	
Western Cheshire IAPT service (Boot & Hulmes, 2010)	Sept 2008 to Aug 2009	10%	21%*	48%	Referrals to steps 3 and 4
Dumfries & Galloway Psychological Therapies Service (Robson & Higgon, 2010)	April 2008 to June 2009	8.9%	25.3%**	35%	Scotland have not implemented IAPT
Lewisham Primary Care Psychology & Counselling Service (Cobb & Shepherd, 2010)	1998 to 2008	2.2%	14.4%*	15.3%	Pre IAPT data

* Based on data from the 2001 national census (ONS, 2010b).

** This data is as a percentage of the total population as reported in the original studies.

mental health needs than their younger counterparts. Second, GPs are more likely to misdiagnose depression in this population. Thirdly, treatments are not offered as readily. This indicates that older people are not being treated in the same way as everyone else and provides a strong argument for promoting mental health and well-being amongst older people as a targeted activity for primary care mental health services such as IAPT.

The Inquiry into Mental Health and Wellbeing in Later Life by Age Concern and Mental Health Foundation (Lee, 2006) stated that:

Indirect age discrimination may be defined as apparently neutral practice that disadvantages people of a certain age, for example, designing services around the needs of young adults without taking older peoples needs into account.'

I would also argue that the referral rate to IAPT services is only one means by which equality of access can be measured. If specific provision is not made to cater for their needs many older people are unlikely to be able to gain optimal benefit from these services. Minshull (2007) stated that:

'Access to services that cannot address need is not access but indirect discrimination. Older

people often need specialist services and staff that are organised, trained and skilled to meet their needs in the same way that younger adults, children and adolescents can access specialist services designed for their needs. For older people, the skill set of staff may be significantly different from those working with younger adults and the needs of the two groups may be considerably different.'

Therefore, it is incumbent upon IAPT services that wish to take the equalities agenda seriously, that increasing access to psychological therapies includes the provision for flexible delivery according to service users' wider needs. For older people that may include:

1. Active and persistent promotion of services within older communities, with GPs and other sectors who work with older people. Wong (2010) provides strong evidence for the positive impact of such initiatives.
2. Self-referral amongst older people. This has not yet been evaluated and questions remain about what would encourage them to seek help for psychological problems.
3. Services offering sufficient flexibility to be truly accessible and acceptable to older people by offering home visits where necessary, addressing issues pertinent to later life adjustment and development as part of therapy and adapting the pace, length and frequency of sessions to fit with the older persons capacity to engage and respond to treatment. For example, some older people may need additional time and support to complete outcome measures or to make use of computerised therapy programmes.

IAPT services are working to achieve ambitious activity and outcome targets and it is understandable that less 'efficient' service users place an increased pressure on these. However, these targets were set at a time when the objectives of the IAPT initiative were focused on working age adults. As the scope of the service has expanded to include wider commissioning for the whole community (Department of Health, 2008) some acknowledgement should be made for the impact of this on targets, allowing case-loads to reflect the needs of the client group. Where such issues are addressed, there is evidence that recovery outcome targets can be achieved (Wong, 2010). Ruddock (2010) also reports that older people may be more reliable in their attendance and completion of therapy when compared to adults of working age.

Recommendations

This paper argues for the employment of specialists in therapy for older people within IAPT services who should work to optimise the impact of this limited resource. As well as providing therapies to older people, such specialists can support all therapists to work with older people by providing supervision and training to High Intensity and Psychological Well-being Practitioners. They may also act as ambassadors for promoting the referral of older people amongst health and social care staff and by encouraging older people to see help for themselves.

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Age Equality overviews:

Age-equality of access: Why aren't IAPT services doing more about it?

Geraint Price

THIS ARTICLE notes some of the potential obstacles to older people accessing IAPT services, and asks whether IAPT services could do more to address these obstacles.

I will suggest that an under-representation of older people is an expected and desirable feature of an IAPT service.

This view is bound to have been influenced by my own experience of working in a locality where, firstly, older people's mental health provision is strong, and secondly, the IAPT service works discretely within core IAPT specifications. These conditions mean that, in many cases, older people will be best served by being directed to specialist or other services rather than treated within the IAPT service, thus reducing the rates of access to IAPT amongst older people.

This may not be representative of the national picture. Provision for older people varies greatly across localities; and even between IAPT services, despite their national specifications, there is substantial variation due to differences between the pre-existing services on to which IAPT provision was grafted. If the local IAPT provider offers a broader range of services over and above core IAPT specifications, and/or if there is limited alternative provision available for older people, then the argument in favour of under-representation will be less applicable. I hope, nevertheless, that it will serve to illustrate that meeting older people's psychological therapy needs is not synonymous with proportionate access to IAPT.

Older people are under-represented in IAPT services because...

...referral rates are low.

This basic fact is the primary reason for the low numbers of older people accessing IAPT. Whatever else an IAPT service might do to try to meet older people's needs, in terms of staff skills and training, the range of interventions offered, service procedures and the like, access will remain inequitable if the service does not also market and publicise itself in a manner that elicits referrals of older people. If services are not doing this, it may be because...

...there are too many other competing demands.

Becoming an IAPT service entails the very welcome but time-consuming task of recruiting and deploying significant numbers of new staff, as well as configuring service procedures to comply with IAPT requirements for data collection and reporting, stepped care, provision of NICE-compliant treatment and a host of other start-up tasks. New IAPT services are likely to be fully occupied establishing their core service provision, and may struggle in the early stages to devote as much time as they would like to the needs of specific groups.

And when services do turn their attention to specific groups, older people are of course one amongst many populations to consider. People of black or minority ethnicity, people who are homeless, those with learning disabilities, offenders, and many other groups are also under-repre-

sented in IAPT services and equally deserving of attention. The capacity to run a campaign or initiative focussed on any specific group may be limited.

IAPT services may be more able to accommodate suggestions as to how to make their generic provision accessible to as many people as possible, including older people, for example, large print size of advertising materials, age and ethnic diversity in case examples used in routine guided self-help materials, etc.

...access for older people is not targetted or incentivised.

IAPT services are required to report the numbers of patients over the age of 65 who enter therapy, but these figures are not subject to targets. The primary targets pertain to the total numbers of patients entering treatment, and recovery rates amongst those completing treatment, irrespective of age, ethnicity or any other characteristic. These targets do not provide incentives for services to reach out to potentially harder-to-access groups, if they can instead find quick wins elsewhere.

On the other hand, IAPT targets are ambitious and many services struggle to meet them. For those services (the majority) who are not seeing enough patients to meet their targets, it is in their interests to attract as many referrals as they can find from any quarter, with older people being an obvious source of potential referrals to help towards targets.

The brake in the system, to deter services from taking on anyone and everyone into treatment indiscriminately, is the recovery rate target. A service could inflate its' intake figures by taking on large numbers of inappropriate cases irrespective of whether they are suitable for IAPT treatment, but this would adversely affect the recovery rate. The incentive, therefore, is to seek referrals of people who are likely to benefit from treatment. In this regard, older people should be a valuable commodity, as those who do access services tend to have good clinical outcomes.

The other key target concerns the numbers of people coming off unemployment or sickness benefits. This target is, clearly, aimed at adults of working age: older people are of no use to a service chasing this target. But these targets, though challenging, represent small numbers of patients in comparison with the overall target for patients entering treatment. Whilst in principle this target could encourage services to prioritise unemployed people of working age over other groups (including not only older people, but also younger adults in secure employment), in reality any services who are not comfortably meeting their overall intake targets are unlikely to wish to do this at the expense of overall referral numbers.

At present it remains true that there are no incentives to focus specifically on access for older people. This may change. Payment-by-results systems for IAPT currently under discussion include the proposal to make a proportion of a service's funding dependent on access criteria including (amongst other things) proportionate access by older people.

...IAPT Key Performance Indicators (KPI) do not recognise 'signposting'.

The first KPI target noted above concerns numbers of patients entering treatment. In addition to providing treatment, IAPT services also do a great deal of 'signposting', i.e. assessing patients and then helping them to access other services which are suitable for their assessed needs. If some older people (or any other patients) are assessed within IAPT and immediately signposted to a suitable other service without receiving treatment within the IAPT service, those patients do not feature in the KPI statistics.

If the KPI data were specified differently, to include the numbers of patients assessed rather than only the numbers entering treatment, then this would give a more complete indication of older people's access to IAPT services.

...IAPT services do not accommodate the practical needs of older people.

Home visits are a regular feature of most specialist older people's services, whereas in IAPT services this is a relative rarity, leading to concern that housebound patients may be denied access to services.

However, this is not necessarily the case. Housebound patients may be offered treatment over the telephone – an effective means of treatment delivery, as shown by the Doncaster IAPT demonstration site. And with computer literacy increasing amongst older people, online computerised CBT treatments facilitated remotely by IAPT staff may be a viable option for many.

It is likely that patients and practitioners working together through the telephone or internet may form a more effective therapeutic relationship if they have met face-to-face at least once. An initial, one-off home visit by a staff member for assessment, prior to these forms of treatment, may be a reasonable and realistic arrangement for an IAPT service to be encouraged to provide.

Another practical issue for IAPT patients is the expectation that they will complete questionnaires at every session. For people with visual or motor difficulties this may present challenges. The completion of questionnaire measures has been raised as a potential issue not only for older people but for other groups, for example, non-English speakers and people with literacy problems. In many of these cases, IAPT services have required their staff to deliver the questionnaires verbally to the patients, if necessary allowing additional session time in order to do this. In any case, an inability to complete questionnaires, irrespective of its adverse affect the service's data completeness figures, should never be used as a reason to exclude a patient from treatment.

...the IAPT model does not accommodate the specific psychological needs of older people.

PSIGE members will need no reminding that older people's mental health needs are not

identical to those of younger adults. For example, older people are less likely to meet formal diagnostic criteria for depression than younger adults (Evans et al., 2003). This is not to say that older people are less deserving of psychological support than younger adults. Instead, amongst older people, depressive difficulties may in some cases present differently or atypically. In particular, sub-syndromal depressive symptoms have been found to have a significant impact on older people's functioning (Lyness et al., 2007). In such cases, rather than existing as a discrete depressive syndrome, the sub-clinical symptomatology may be seen as a contributory factor in a multifactorial presentation incorporating a range of issues such as physical health, social support, and role transitions, which conspire to impair quality of life. This may call, in turn, for a multifactorial intervention involving joint working between a variety of professionals, which in some cases may be best delivered indirectly via consultation rather than through direct face-to-face contact with mental health clinicians.

An IAPT service designed to provide NICE-compliant treatment for diagnosed conditions might stumble when faced with this presentation, either in recognising the significance of the apparently 'low' levels of depressive symptomatology, or in providing the necessary integrated multidisciplinary response. The PHQ and GAD questionnaires may underestimate the benefits of an intervention whereby an apparently small improvement in depressive symptomatology contributes to a much more significant improvement in general functioning. Collection of data from patients being treated indirectly via multidisciplinary liaison and consultation, though not impossible, could raise practical challenges.

On the other hand, good outcomes amongst that sub-group of older people who do receive IAPT treatment suggest that, for this group, the measures are suitable for measuring change. Those older people whose difficulties are recognisable by non-

specialists applying unmodified diagnostic criteria, without allowance for different age-related presentations, are likely to benefit from IAPT treatment. It is possible, however, that those presentations more particular to older people may benefit more from treatment in specialist older people's mental health services. If IAPT targets for older people's access were to be set at a reduced level, commensurate with the reduced prevalence of typical presentations of depression and anxiety, this could provide an incentive for patients to be directed to the services which are best equipped to meet their needs.

...the national IAPT service specifications discriminate against older people.

Many of the points already discussed above (the definitions of the KPIs, the choice of questionnaire measures and the requirements for their delivery, the emphasis on face-to-face clinical contact over indirect working) could be taken as indications that IAPT services are working within a framework which fundamentally limits their ability to adapt their services to the needs of older people. It might be said that the IAPT initiative should have given greater thought in the first place to the needs of diverse groups including older people, rather than setting up an intrinsically inequitable system and leaving well-intentioned local providers hamstrung in their attempts to provide equitable access to their services.

From an IAPT provider's perspective, I can only say that the roll-out of IAPT so rapidly, within the short window of opportunity opened by the Layard report, has been an extraordinary achievement, and its delivery within the politically-required timescale has pushed providers to the limits of their capacity. IAPT as it currently stands is far from perfect. But I have little doubt that even the under-represented groups will themselves benefit more from certain core services having been rapidly established, followed by subsequent catch-up work to

accommodate their specific needs, than they would have done if the roll-out had been delayed and complicated in an attempt to accommodate all parties from the outset.

IAPT is evolving, with plans to extend its scope in terms of both the skills and training of staff, and the groups and needs to which it caters. If, in future, services operating under the IAPT rubric come to accommodate older people's needs more fully, then proportionate representation of older people accessing IAPT may become a valid expectation. But until that time, insistence upon full representation could have adverse effects, such as incentivising the tokenistic shoe-horning of older people into services regardless of their suitability.

Of course, current IAPT services must make efforts to ensure that they are accessible to all, including older people, who can benefit from them. But if these efforts are only partially successful, is this a bad thing? Persistent under-representation of older people in IAPT could be seen as a ringing endorsement of the need for specialist psychological therapy provision for older people.

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Commissioners' perspective:

Older people's mental health in primary care: A Commissioners' perspective

John Ellis & Claire Warner

THE UNITED KINGDOM has an increasingly ageing population, and older people are the highest users of health and social care services. It is forecast that the numbers of people with both dementia and other mental health problems such as depression will continue to increase significantly during the next few years.

Sixty per cent of people aged 65 and over have at least one limiting long-term condition, such as diabetes, and these patients often also have a mental health conditions such as dementia or depression.

Furthermore, with older age comes an increasing likelihood of mental ill-health:

- People over 85 are far more likely (one-in-four) to suffer dementia than people over 65 (one-in-20).
- Older people are far more likely to suffer depression through social isolation and physical ill-health and in many cases this is not identified until it becomes a significant problem.

The Department of Health estimates that 40 per cent of older people seeing their GP, 50 per cent of older people in general hospitals, and 60 per cent of care home residents, have a mental health problem.

These statistics present a major challenge for NHS commissioners. In a challenging financial environment, we need to devise service models that enable more people to receive appropriate treatment and at an earlier stage of their illness. We must plan now how best to meet this increasing demand for specialist mental health services in the future.

The Cambridgeshire Experience

The way forward in Cambridgeshire has been based on our successful experience in adult services with the setting-up initially of a primary care mental health team as part of local implementation of the National Service Framework for Adult Mental Health, much strengthened in 2008 by our selection as a first-wave pilot for the Increased Access to Psychological Therapies (IAPT) programme.

These new services were very well-received by local GPs, who quickly identified the need for a similar service to meet the mental health needs of the rising numbers of older patients presenting to them with both functional and organic mental health problems.

After discussions with key local clinicians a small pilot was established in September 2008 in three surgeries serving the market town of St Ives. Its aim was to identify and evaluate the most effective model for a primary care mental health service which would increase the number of management options for older people with either functional or organic mental health problems – including mild cognitive impairment and early memory problems.

The high level of co-morbidity in older people has always been recognised and therefore the service aimed from the beginning to improve both the physical and mental health of patients. Savings in physical health costs are the key to unlocking resources for additional investment in mental health services.

The Primary Care Service Model

The key features of the pilot service model were:

- A single point of access via electronic referral and rapid response – i.e. the referred patient would be contacted by the service within five working days.
- A stepped model of care – similar to that for adult services with patients typically seen first at the lowest step and promptly escalated if their well-being does not improve.
- Care as close to home as possible as transport is an issue for older people.
- Early identification and diagnosis with the aim of effective intervention before problems worsened.
- Access to a range of interventions, including low- and high-intensity psychological therapy, self-help materials, groups and also a range of resources delivered by the Alzheimer's Society.
- Promotion of 'co-production' with existing community resources, including local voluntary agencies and social care.
- Provision of training/education about common mental health conditions for primary care staff.

It was anticipated that the presence in primary care of this additional capacity would increase referrals to secondary care in the short term at least as previously unmet need is identified and people receive treatment at an earlier stage of their illness.

Longer term, we would hope that patient outcomes will improve because of the earlier diagnosis and signposting to effective help that the model delivers, and this is a key outcome measure of the pilot. At the least, we would expect this additional capacity to help us meet the anticipated increase in numbers as the population ages within our existing resources.

Outcomes so far

The pilot has been rigorously evaluated from the start using a wide range of outcome measures every quarter. To date it has delivered fewer GP consultations for these patients, reductions in medication, better

medication concordance and – the vital component – an improved quality of care leading to better patient outcomes. Feedback from service users has been very positive, and a valuable additional benefit has been increased support for carers of older people with mental health problems.

Anecdotally, we believe the service is also beginning to impact upon admissions of older people to local hospitals, although this is more difficult to demonstrate. The impact upon demand for secondary specialist mental health services can also only be measured over a longer period.

Next steps

Local GPs have been especially enthusiastic about this service from the beginning and very eager for it to be more widely available as soon as possible. As a result we are now consulting on a proposal to roll-out the service across Cambridgeshire, funded by a combination of additional PCT investment and resources released from reducing the number of acute beds locally. The new emerging local GP clusters have been very supportive of this service re-design and are now actively engaged in designing the future primary care service model.

Conclusions

This pilot and the subsequent roll-out of a countywide service model based on our learning from it has enabled us to:

- Address the inequality in access to psychological therapies between adults of working age and older people.
- Put in place capacity to help us cope with the increasing population of older people locally.
- Provide a service to meet a gap in provision repeatedly identified by GPs.
- Promote community co-production and strengthen relationships between key stakeholders during a period of financial uncertainty.
- Demonstrate the wider health system benefits of investment in mental health services for older people.

Key learning points for Commissioners

As commissioners we have reflected on our experience with the pilot and what we have learned:

- IAPT is an inappropriate name for a service like this, something like Primary Care Mental Health Service (PCMHS) is a much more easily understood and acceptable term for both GPs and patients.
- It is inevitable that future GP clusters will seek to commission a 'whole lifespan' primary care service rather than only the services for working-age adults that have to date been national policy priorities, and this pilot has enabled us to design a service appropriate for the specific needs of older people.
- The pilot has demonstrated conclusively that the adult IAPT service model is inappropriate for most older people (and indeed younger people also) – one size does not suit all ages.
- The key features of a successful model are:
 - Its profile and presence in primary care (especially the key role of the gateway worker who acts as the main contact point and source of advice for referring GPs).
 - Early diagnosis and signposting to help.
 - Involvement of the voluntary sector both as a commissioned service provider and pathway to other community resources.
 - Close links with local community services and medicine management teams.
 - Encouragement of self-help groups.

The more detailed quarterly evaluation reports and other helpful information are available on request from the authors.

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Training perspectives:

IAPT and older people: A training perspective

Steve Davies

THE Improving Access to Psychological Therapies (IAPT) programme introduced by the Department of Health in recent years (DH, 2008) has been described as the biggest psychological therapy experiment in the world. When the programme was subjected to an equality audit, however, some evidence emerged that this experiment was not being applied evenly. Some vulnerable groups of people were under-represented. One of these groups was older people. It was felt that this omission was partially due to structural, practice-based reasons (e.g. an IAPT service that had no disabled access or which didn't offer home visits). However, as with access to a number of services for older people, the role of ageism has increasingly been brought into play to account for the lack of older people using these services. This has been across the board from older people using leisure centres and accessing health and social care (DH, 2001, 2010), to older people not taking up benefit and other entitlements. So access is a major problem for older people in many situations and is not only resolved through removing explicit barriers to such access. For example, a service may remove an age cut-off in order to remove an explicit age barrier but this may have no visible effect on the service for older people due to ageist assumptions held by staff and clients. In fact, ironically, removing these barriers, although instinctively seeming correct, can actually lead to more institutional discrimination. The energy and expertise of a specialised team can become dissipated into a generic service where the anti-ageist work has not

been done and inherently ageist thinking and actions remain the norm.

So how can the training of IAPT workers assist in or obstruct this process? The training of IAPT personnel has been closely tied to the function of these workers. This is to assist people with mild to moderate depression and anxiety disorders to recover sufficiently to take part in the workforce again. This is clearly an aim which is largely incompatible with the life circumstances of older people, although a considerable number do work and, more routinely, support the workforce through usually unrewarded childcare. Rather belatedly, the IAPT programme has come to terms with its deficiencies in this area and equality compliant concepts such as well-being and resilience have become more prominent in the literature (IAPT, 2009, 2010). This tardiness has presented problems for trainers and the curriculum deployed to train particularly High Intensity IAPT workers. The models used are designed primarily for symptom reduction rather than well-being or resilience building. Also, outcomes have been focused on symptom improvement and return to work criteria rather than really measuring changes in psychological well-being. For example, it is quite possible for an older person to be 'symptomatic' on a measure of depression designed for younger person without really being depressed. The psychological challenges and dilemmas of being older, that can bring with it mild depression may actually be helpful to the longer term psychological well-being of the older person (Butler 1963; Laidlaw &

Knight, 2008). It allows space for the older person to review their life experiences and deal with some of the difficulties that constitute such a review. The purpose of life review is not to avoid psychological pain but to set it in its place in a person's life and to allow it to speak to the current situation. Thus, older people often approach psychological problems in a story like fashion and may be less amenable initially to a problem-focused approach, although this does develop. The IAPT trainee may need more skill in guided discovery within this narrative than is called upon in work with younger adults.

Training in IAPT skills requires the rapid acquisition of model-based approaches to particular psychological disorders. However, with older people, as with some other 'special groups', the research studies underpinning these disorder-specific models often excluded older people from their samples or only recruited very small numbers of them. The CBT trial work that has been conducted with older people has shown good results (Laidlaw, Thompson & Gallagher-Thompson, 2004) although there is some debate about whether elaborations on the basic CBT model were important in order to maximise effectiveness. Certainly taking account of the context in which older people live is seen as important in intervening in CBT (Laidlaw et al, 2004). This obviously needs to be included in any teaching on the subject to augment the standard conceptualisations of psychological disorders presented to IAPT trainees. The key difficulty with presenting CBT work with older people as highly specialised to trainees is that they often feel very de-skilled when it comes to approaching treatment with this group. This can lead to institutional forms of discrimination against older people being assessed for psychological therapies and CBT in particular.

Institutional ageism is not deliberate discrimination against older people. It is the often unintended consequences of well-intentioned attempts to increase access to services for this group of people. First of all, older people stigmatise themselves (Davies, 2006)

and this self-stigmatisation is the most powerful obstacle in society and in the therapy room. Good quality, empirically grounded CBT, delivered in an age-aware and anti-discriminatory fashion should be as effective for older people as for any group. James (2010), however, does make the valid point that older people are different as well as the same as other groups using CBT. So, the IAPT trainee may need some introduction to the biology and psychology of ageing and clinical assessment of the client may need the skills of a specialist older adult professional. However, assessment and intervention in CBT can be conducted in the same way as for younger groups as long as the IAPT trainee (or the experienced practitioner) bears the Laidlaw model in mind and approaches the client in a non-discriminatory fashion. Normalising the expectations of the clients may be a larger part of the initial socialisation process for older people? as literature indicates that this is often when clients drop out of CBT (Bennett-Levy, 2006; James, 2010). Training IAPT trainees in both anti-discriminatory practice and in socialisation skills may be a general consideration in the training of all IAPT trainees for practice in specialist populations such as older people.

Wykes (2009) states that the purpose of IAPT training at a high intensity level is to improve treatment success, to reduce treatment failure, to know the differences between these outcomes and to work to improve outcome using therapist responsiveness. Prochaska and Norcross (2003) indicate that the therapist's ability to notice and to respond to nodal points in the therapeutic process is a good definition of responsiveness and it distinguishes the novice from the experienced practitioner. In CBT, fidelity to CBT treatment is seen as important in training and supervision of CBT therapists (Milne, 2008) but clients usually indicate that it is the responsiveness of the therapist ('being understood') that is usually the most important factor to them. This is how Socratic dialogue can really improve the therapeutic experience. This is a method

that makes no assumptions about the truth as it is rooted in the stoical tradition of accepting what the person experiences rather than what they expect (Robertson, 2010). This surprisingly constructivist approach to data actually allows the exploration of discriminatory thinking by others and the client. In this way training IAPT trainees takes on a progressive edge – one is not merely training individuals in technical skills designed to alleviate suffering. These skills are important in CBT with older people but not sufficient to provide the tools for effective CBT practice with this group. As with all discriminated against groups, it is the duty of the therapist to engage with the self-stigmatisation of the client and the existential position in which they find themselves. Mental health stigma and ageism can lead to restrictive thinking and attitudes in both therapist and client (Lam, 2008). This needs addressing in training through the introduction of anti-discriminatory training for IAPT trainees.

What is the way forward for training IAPT workers in CBT work with older people? Firstly, this work needs to be integrated into the rest of the programme and not merely become an add-on to current training. Clinical examples and theoretical models should not only include adult mental health content, for example. Secondly, training courses should be able to demonstrate that they have used the advice available from

specialists such as the IAPT practice guides being produced for different groups of clients. Thirdly, there should be specialist supervision available for older people cases or those involving ageing issues on the course that IAPT trainees can access as a matter of course. This is crucial as it allows the key elements of training, modelling and experiential learning to be present. It also requires trainees to take on older people cases which should also be a requirement for IAPT training programmes. The IAPT curriculum is too adult mental health focused and requires adjustment for older people. Finally, courses should also offer teaching in anti-discriminatory practice as standard. One can see from the above that a lot of these recommendations apply to all of the 'special groups' identified by the IAPT equality audit. This is hardly surprising as all these groups have been excluded from the mainstream research and trainings in CBT. Now is the time to rectify that situation.

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Training perspectives:

Using master clinicians in a local setting as a lever for change

Angela Harris, Ken Laidlaw, Claudia Coelho & Linda Irvine

ACCCESS to psychological therapy for depression and anxiety is an ordinary expectation for most in the modern NHS (Bird, 2006; Layard, 2006). It is an accepted part of a mainstream menu of treatment options for people in distress (NICE 2007a; NICE 2007b; SIGN, 2010). It is also part of Scottish Government policy that there is access to psychological therapy for all. In Delivering for Mental Health (DfMH) the commitment is to *'increase the availability of evidence-based psychological therapies for all age groups in a range of settings and through a range of providers'* (SEHD, 2006). This commitment in DfMH is an ambitious yet achievable aim. It is also right that all older people should have access to high quality evidence-based psychological therapies delivered by highly trained practitioners (Department of Health, 2009; Laidlaw & Pachana, 2009).

There is a substantial evidence base for the effectiveness of psychologically-based interventions in improving physical and mental health care outcomes for the elderly but many more studies need to be conducted. (Gatz et al., 1998; Gerson et al., 1999; Laidlaw, 2001; Pinguart et al., 2006; Scogin et al., 2005). Until recently there has been limited availability of training available to NHS staff in Lothian who may have been interested in learning how to provide structured psychological therapies to older people. One of the key roles that psychologists can play is the training of colleagues in the application of specific psychological techniques and to increase psychological awareness. However, our experience suggested that, even where there were opportunities for training, places were not always taken.

In our Care of the Elderly service within Edinburgh, nurses and occupational therapists were telling us that they wanted to improve their confidence in producing and consuming research. Much of the evidence base for psychological therapies with older adults has accumulated since the late 1980s and some NHS mental health workers in Edinburgh felt they were not accessing this rich source of data and when they did, they felt uncertain how to apply it to their practice. We hypothesised that one reason for this may be to do with the fact that our service employs specialist staff who are highly experienced and slightly older than other nursing colleagues. For example, the mean age of Community Psychiatric Nurses in one team was 46.6 with the range between 31- and 57-years-old. Career nurses and other Allied Health Professionals who may have started their training for the Health Service aged 18 or 19 will have completed their academic training in the 1980s and 1990s or earlier. Moule and Goodman (2009) reviewed the history of nursing research and argued that there was a gap between research findings and their implantation into nursing practice in the UK in those decades.

'Specifically the arguments were that nurses did not read or understand research, nurses did not know how to use research in practice, nurses did not believe research, nurses were not able to use research to change practice and nurse researchers did not communicate well' (p.3).

If the Scottish Government was going to be driving Health Boards to provide evidence-based psychological therapies, it was clear

that there needed to be a greater understanding of what is meant by evidence and research.

In response to this perceived need, in 2009 the Older Adults Clinical Psychology Service in Edinburgh set out to do something truly innovative. We adopted a three-prong approach of initiating a Masterclass series with international thought leaders; a brief in-house CBT with Older People course; and the establishment of an Older Adult Research Interest Group. The function of the Masterclasses was to energise and stimulate a desire to embrace evidence-based psychological therapies. The aim of the CBT course was to build on this energy and develop psychological awareness. The idea was not only to start the process of upskilling the workforce but also to channel enthusiastic mental health providers on to an accredited training course to become qualified practitioners. The third prong was to create a safe environment where nursing staff and allied health professionals could develop research skills. This article will focus on the first initiative – the Masterclass concept and continue to give an overview of the Introduction to CBT with Older People course.

**The Masterclass Experience:
A truly unique, innovative and valuing
approach to training in psychological
therapies.**

We reasoned that if we were truly committed to providing world-class psychological therapies for older people in NHS Lothian, we should bring the experts in this field to Edinburgh to provide training. With the help and assistance of the Strategic Development Manager for Mental Health and Well-being with NHS Lothian Health Board, and support from the older adult subgroup of the Lothian Psychological Interventions Network (LPIN) we set out to bring some of the major thought-leaders and clinical academics to Edinburgh. The evidence base for CBT is stronger than for other forms of therapy (Gatz et al., 1998; Laidlaw, 2001;

Pinquart et al., 2006; Scogin et al., 2005) and so it was high on our list of priorities, but we also wanted to bring health care staff in Lothian face-to-face with leaders in other types of therapies.

It was felt important that the design of the Masterclass should include a number of features. It should be valuing for attendees and presenters if we were going to attract international speakers to travel to Edinburgh. The speakers should be recognised for being at the leading edge of development in the field. The speakers would be contributors to the evidence base but they should also be established clinicians and practitioners. Finally, the speakers should be experts in working with the client group of older adults.

We ran a series of four Masterclasses. Professor Bob Knight, a world expert in psychotherapy with older people, led the first class in the art and science of therapy (Knight, 2004). In our second Masterclass, Professors Larry Thompson and Dolores Gallagher-Thompson, from Stanford University joined Ken Laidlaw, leading experts in CBT with older people, to provide a high quality training event (Gallagher-Thompson et al., 2008; Laidlaw et al., 2003). Dr Mark Miller from the University of Pittsburgh introduced his cutting-edge developments of Interpersonal Psychotherapy (IPT) for use with people with depression and dementia. As Dr Miller is still developing ideas and has just recently released a book detailing his work, our service in Lothian was among the first to hear about this development (Miller, 2009). Inviting Mark to share his research with us represented an aspiration that the psychological needs of people with dementia would not be forgotten and has resulted in three of our Masterclass attendees gaining a small amount of money from the Mental Health Collaborative in Lothian to pilot a trial of CBT for depression in dementia to commence later this year. The final Masterclass of the inaugural series was led by one of North America's most renowned Geriatric Psychiatrists, Professor Joel Sadavoy, on the

topic of the therapeutic relationship in psychotherapy with older people using psychodynamic and CBT principles (Sadavoy, 2009).

In total, the four Masterclasses attracted 185 attendees drawn from staff from many disciplines all over NHS Lothian, other parts of NHS Scotland as well as from England. The Masterclasses were perceived as a truly innovative and valuing approach to training where 97 per cent of the evaluations were very positive. Eighty-one per cent of Masterclass attendees expected to make use of information in their workplace. Seventy-nine per cent felt the Masterclasses had developed their work-related skills.

We attribute the success of the Masterclasses to a number of factors. In times of frugality it is crucial to have a sponsor and budget holder who is prepared to support the venture and provide project administration support. We are also fortunate in that the clinical lead for older adults psychology, is an established clinical academic and these types of events are born out of personal friendships that have developed over a decade. Our experience is that anyone working in the older adult discipline shares a passion in disseminating their research in very generous ways. We also have work colleagues who are interested in what we do, and hungry to learn more about psychological treatments. We felt it important to value these colleagues by providing a training delivery that was congruent with the Masterclass concept as far as the venue and catering were concerned and feedback from the Masterclasses reflected participants appreciation of this approach.

The introductory CBT with older adults course

A training model was designed to deliver CBT training consisting of three consecutive full-day sessions followed by a further session lasting five hours leading to a total of 24 hours teaching. Course teaching and supervision was delivered by Angela Harris and Dr Ken Laidlaw. One supervision session to

each participant was offered in between the first three days and the follow-up. A participant handbook was written by Dr Ken Laidlaw. The course delivery was planned around the nine sections of the handbook and were: (a) Doing the basics of CBT with Older Adults; (b) socialising people to the CBT model; (c) pleasant events scheduling; (d) cognitive restructuring treatment; (e) formulation; (f) CBT with anxiety disorders; (g) CBT with older people; (h) working with homework; and (i) therapist factors in CBT.

To support the training, six books on CBT were provided. Two to four copies of each book were provided and participants selected some for their 'team libraries' on the understanding that they could share the resource with each other. Finally, there was a resource folder for participants that comprised copies of handouts, key therapy forms and relevant articles and CBT manuals.

It was important to assess the training across three levels of training outcome:

- **Level 1:** Participant reaction to the learning experience.
- **Level 2:** The aspects of the training delivery that had the greatest utility in supporting generalisation to clinical practice and non-clinical situations.
- **Level 3:** The practical barriers in delivering CBT approaches post-training.

Three self-report questionnaires were used to evaluate each of the levels: the Training Acceptability Rating Scale (TARS; Davis et al., 1989) was completed at the end of the course and two further questionnaires were sent out three months after the course finished to assess application of learning: Measure of Generalisability (MoG; Myles & Milne, 1997), and Barriers to Change Questionnaire (BARCQ; Corrigan et al., 1992).

Seven mental health nurses attended the course and their feedback was very positive. One-hundred per cent would recommend the course to a colleague; 100 per cent rated the workshop leaders as competent, motivating and able to relate effectively; 100 per cent were satisfied with the workshop (14 per

cent quite a lot, 86 per cent a great deal); and 100 per cent learned work-related skills (43 per cent quite a lot, 57 per cent a great deal). One-hundred per cent want to learn more about CBT; and the mean number of clients treated with CBT after the course was 3.5 clients. Some barriers were identified: the length of involvement with clients was too short; there was varying cognitive capacity of clients; some clients did not engage and the way that client care was organised meant that there was little opportunity to practice and other duties interfered. As a result of this feedback we are planning a specialist CBT training programme to help practitioners deal with barriers.

Originally our strategy was for the Masterclasses and the Introduction to CBT with Older Adults course to complement each other and we received positive feedback that this had been achieved. For example, in the context of improving access to psychological therapies, seven semi-structured scoping interviews with managers and clinicians were analysed qualitatively using thematic analysis methodology. Some of the emerging themes concerned the acceptability of the Masterclass series and their role in change to attitudes around education. One manager commented:

Yes, and it's giving people the broadest brush strokes and also fleshing out some of the themes. It's absolutely struck a nerve. I've not seen something have such a good reaction in a long, long time. The staff have come away consistently from things saying, 'That really made me think. I really enjoyed listening to that speaker.' Which is really nice to hear because we get sent a lot of stuff and I send out

lots of information on classes and courses and you can hear people just sort of hitting the delete button. And I don't blame them. But word's got round and I would imagine they're over-subscribed every single time. I think, whether it's been by design or not that you've actually got quite a good formula now, in terms of you've whetted people's appetites with some Masterclasses – got people talking, got them interested. And then, there's a course that looks at Cognitive Behavioural Therapies across the board. Because you've then got the next stage, people say actually I want to follow this up a bit. And by enthusing people or informing people from that, you've then got people who've applied for a formal training in it and so you've gone through a filtering process, a sort of triage. The Masterclasses enthuse people. People come back and they talk about it – they buzz about it. And then they go and do the course and they come back 'That's really, really great. You know I thoroughly enjoyed that' and they're buzzing again.

NHS Manager.

This paper has described two training interventions that were introduced to enable a culture of evidence-based practice amongst mental health workers in Edinburgh and nationally in Scotland: a series of Masterclasses led by world-class clinicians and an introductory course on CBT with older adults. We 'walked the talk' by using evaluations at different levels and as a result received very positive feedback that our innovations were well received and impacted the organisation and clinical practice.

'Lots of practical was provided with clinically relevant examples that I can easily put to practice.'

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GP perspective:

A GP view on the requirements of a Primary Care Mental Health Service for Older People that includes IAPT

Emma Tiffin

TRADITIONALLY, there is no doubt that older people have had the raw deal in primary care mental health services. Even with the advent of IAPT providing a much needed boost to psychological therapy resources in primary care, the focus has very much been on the adults of working age population due to the wider economy savings from getting people back to work. It has been hard to know where older people fit in to many of the existing service models that have developed to provide primary care mental health services. Any service for older people must be designed to meet their particular needs and many older people seek different outcomes, typically around social inclusion rather than paid employment. We can, however, thank IAPT for putting primary care mental health problems into the limelight for the first time and recognising the need for and value of, providing primary care mental health services for older people.

In Huntingdonshire we were fortunate enough to receive funding from our predecessor practice-based commissioning organisation, Huntscomm and NHS Cambridgeshire to pilot a primary care mental health service specifically for older people, aged >65 years (which matches secondary care Older People Mental Health Services (OPMHS) age cut-off). At that time in 2008, my view was that the existing IAPT service could not deliver what was needed for older people with mental health problems and this has proven to be true for a number of reasons that I will outline below.

There are multiple practical reasons why the original, prescriptive IAPT model developed by the Department of Health is difficult to implement for many older people's services. For example, telephone assessment is recommended, which is not possible for significant numbers of older people who have hearing impairment. Older people often take longer to assess over the phone and prefer a face-to-face assessment which may be a more effective option. In addition, and not uncommonly, carers are involved in a patient's care and it is useful to have them present for the initial assessment, to provide a collaborative history and support the patient. Therefore, it can be difficult to signpost older people to the most appropriate mental health service or worker, without a face-to-face screening assessment, carried out by a skilled mental health professional. It is for these reasons that our successful pilot Older People Primary Care Mental Health Service (OPPCMHS) model has included a Gateway Worker (GW) role, whose primary function is to screen and signpost all older people's mental health referrals and carry out face-to-face assessments when necessary.

Other advantages of the GW role include a single point of access and the opportunity to provide OPMH education and training for primary care professionals at individual or small group practice level. Local research has also shown that the majority of GPs would choose to have a single named professional to whom all OPMH patients are referred and that this same individual is available for advice when needed. The GW

fulfils this support and advisory role and in some cases, referrals can be avoided. In terms of the referral system itself, we have developed an e-mail referral system, resulting in a fast and efficient service, with a maximum two-day wait for referral screening. The GW screens all referrals and has access to consultant OPMH psychiatrist advice at the referral stage, ensuring a stepped-care management approach for patients and a seamless OPMH pathway with no primary/secondary care divide.

It is also important to remember that older people may have a functional mental health problem, memory problem or both, whereas in adults, a memory problem would be unusual. Therefore, there are additional skills required by the OPPCMHS team in the field of memory problems and dementia, which a generic, all-age IAPT worker would be unlikely to have without significant extra training. Older people are also much more likely to have co-morbid physical and mental health problems. Therefore, it is important that the OPPCMHS team, and particularly the Gateway Worker are familiar with a wide range of physical health, mental health and social care services that the patient may need to access, so that patients are signposted appropriately. This ensures an integrated OPMH service model, with the aim of providing a seamless care pathway for older people. Many older people are on multiple medications and concordance with medications is often poor, partly because patients do not have a good understanding of what they are taking and why. Access to proactive medicines management advice is therefore also a key component of the integrated model.

So why do we need an OPPCMHS and what are the financial considerations? Most importantly we have a demographically ageing population, with consequent increasing prevalence of dementia in particular. There are also an increasing number of physically fit and active people over 65 years old, who have a relatively high prevalence of depression, are typically excluded from 'adult' services and for whom there are few

referral options for GPs. Therefore, an increase in the capacity of OPMH services is necessary and we have to look at the most cost-effective way of achieving this. Our pilot has shown that increasing early intervention and support for older people with functional or organic mental health problems benefits patients, carers and health professionals alike. It has led to improvements in mental health outcomes for patients, reduced GP consultation rates and high patient and GP satisfaction. We anticipate that longer term we will be able to prove that the early intervention, integrated OPMHS model also results in improvements in physical health outcomes, with resulting reduction in overall physical and mental health care costs at both primary and secondary care level (including GP and outpatient costs, emergency hospital admissions and prescribing costs). In other words, an OPPCMHS is likely to be the most cost-effective way of increasing OPMH capacity in the short and long term, in addition to offering high quality OPMH care for all older people with a memory or mental health problem at any stage of their illness. In this way, crises could be avoided, resulting in improved outcomes and reduced mental and physical health care costs.

In summary, there are some fundamental differences that need to be considered when developing pathways for Older People and Adult Primary Care Mental Health services, which need to be factored into the Older Peoples Primary Care Mental Health Service models of the future. There are ideas developing in some geographical areas for 'integrated older peoples' pathways' that aim to meet the mental and physical health needs of older people in a single service, reinforcing the importance of mental health input for older people into general service planning. It will also be important to ensure that provider contracts and outcomes are rigorously monitored to ensure a service that is value for money, particularly in the current, challenging, financial climate. Development of a robust reporting framework involving regular evaluation and

reporting of outcomes (such as activity data, changes clinical assessment scores, changes in consultation and referral rates and changes in prescribing patterns) will also give OPPCMH services the best chance of receiving funding from the newly-forming GP consortia.

In terms of the commissioning model needed to achieve successful Older People's Mental Health service redesign, in Cambridgeshire we have found that strong collaborative working between PCT management (Head of Mental Health Commissioning and team), GP leads across the county (we have set up a formal network of GP Mental Health Leads in each locality, i.e. Cambridge, Huntingdonshire and Fenland) and the Mental Health Trust (multidisciplinary team involvement with strong project leadership) has, and remains critically important for service planning and development. We have used this team to communicate with the new consortia and gain their views and support, as always good communication and teamwork is the key!

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Alzheimer's Society perspective:

Working together with the NHS: A third sector perspective

Gill Lintott & David Moore

FOR MANY YEARS, the Alzheimer's Society has worked closely with Cambridgeshire and Peterborough NHS Foundation Trust (CPFT) by accepting referrals of people with memory problems and/or dementia from secondary health care services, co-facilitating groups and fulfilling requests for speakers to attend events. With the development of the Older People's Primary Care Project, the Alzheimer's Society employed a support worker, David Moore, to work alongside people with memory problems and their carers. This new joint working initiative is yielding significant results, which adds to the effectiveness of the pilot service (for further information about the service see Jim Leadbetter and Susan Hill's article in this special edition). One of David Moore's key roles has been signposting people with memory problems. He has shared the vast range of information that is available through the Society and the links to local organisations and community groups and compiled a service directory enabling people to gain support from the appropriate local agencies, suitable to meet their needs. Other roles include co-facilitating healthy memories and building confidence groups and undertaking carer assessments. David also co-facilitates a men's group supporting individuals at the end of their therapeutic treatment with a view to providing them the opportunity to organise their own activities and participate in community groups

Partnership working with an organisation the size and complexity of the NHS can be daunting for the third sector. Decisions are

often made at a senior management level where the direct involvement of a voluntary organisation is not necessarily considered. However, throughout this project, quarterly meetings have fully involved the Alzheimer's Society managers with discussions taking place and plans being shared. David is effectively involved with CPFT team members on a day-to-day basis. Ongoing training and supervision is undertaken in post. Whilst management supervision is provided through the Society, having a supervisor from the project ensures David's practice is effective. David has the opportunity to reflect on what he considers has worked well and what is not particularly successful for the person with memory problems. This allows greater insight for the whole team into a person's needs.

Reaching out to people with early memory problems dovetails with the Alzheimer's Society's flagship awareness campaign, called 'Worried about your memory?'. It encourages people to recognise the signs of dementia and seek help early. Following previous successful campaigns, the Alzheimer's Society invested in re-launching the campaign for 2010–11, mailing leaflets to GP surgeries across the country. Questionnaires sent to GPs found 55 per cent would like more information about local support services available for people with dementia and their families. Through working together in this project, access for people with memory problems and/or dementia to GPs has significantly increased and actual or perceived barriers between the Alzheimer's Society and GP practices have reduced.

With increasing public awareness, this new service design and delivery is addressing recommendations in The National Dementia Strategy (Department of Health, 2009). For example, people with memory problems and/or dementia traditionally excluded from secondary health care services have experienced better access to assessment, good quality information, psychological therapies and early symptom management. The Older People's Primary Care Project has resulted in prompt access to specialist services, earlier diagnosis and more support from voluntary organisations for people with memory problems and their carers.

We have noticed a clear advantage for people receiving support at an early stage of their memory loss has been an opportunity to talk to other people with similar experiences. Offering structured support through facilitated groups empowers people to make choices about what they want and can help enormously in planning their lives. Carers and people with memory problems are referred to local Alzheimer's Society services to seek additional emotional support as well as picking up practical tips about understanding confusion and memory loss. These services are tailored to support people and their carers throughout the duration of their illness, enabling them to maintain independence for as long as possible in the community.

David says that 'Early intervention is very beneficial for individuals affected by memory problems that can have an impact on their lives in a subtle and stressful way. Enabling an individual to optimise their current memory skills through discussing strategies with others in a group has been very productive. This safe and informative setting has given people self-confidence and developed their emotional well-being. At the end of the sessions, in addition to the group members, carers have commented on the improvement in their partner's mood, which subsequently improved their own well-being.

Demand for services provided by the Alzheimer's Society over the last two years has increased noticeably, with an increase of 100 per cent in referrals and 50 per cent in contacts compared to the same period last year. Despite looking at innovative ways to manage service provision, local services have been unable to respond as quickly as previously and waiting lists have been unavoidable. Although the increase is not solely down to this project (for example, there has been increased awareness through public and media campaigns) it has certainly been a contributing factor. Despite this, a major achievement of this early intervention service has been the increased access to support and information for significantly more people with memory problems. This is vital in helping people manage their memory loss and empowering them to maintain independence in their lives.

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Service examples:

Where have all the older people gone... three years passing? When will we ever learn, when will we ever learn? Still learning lessons in the East Riding of Yorkshire

Clare Hilton, Sven Law & Natasha Edgar

IN THE NEXT 20 YEARS the number of people aged 65 and over is expected to double (WHO, 2003). Europe currently has the highest proportion of older adults in the world, with the figures in the UK alone currently standing at 9.8 million (16 per cent) of the total of the UK population (Office for National Statistics, 2001) and by 2031 it is estimated that over-65s will account for 23 per cent of the national population in the UK (Eurostat, 2006).

It is widely documented that the prevalence of mental health difficulties for older adults ranges between eight to 20 per cent (Blazer, 2003; Beekman, Copeland & Prince, 1999). The prevalence of depression in people over the age of 65 years, averaged across Europe, is 13.5 per cent (Beekman et al., 1999, Draper & Low, 2010), being three times more common than dementia and increasing with age after 65 especially in those living alone with poor material circumstances (Age Concern, 2007; Wilson, Mottram & Sixsmith, 2007). In the UK, mental health problems are present in 40 per cent of older adults attending their GP, 50 per cent in general hospital and 60 per cent in care homes (Healthcare Commission, 2009). In addition, impaired independent function, more than cognitive function, appears to better predict the need for long term care (Anderson et al., 2010).

There is extensive evidence that psychological interventions are beneficial for older adults suffering from mental health difficulties (Wood, 2003; Laidlaw et al., 2003). Despite this, the evidence continually suggests that older adults underuse mental health services to a great extent, (Crabb & Hunsley, 2006; McMillam, Carr & Murray, 2010), psychotherapy is infrequently prescribed for older adults (Robson & Higgon, 2010) and Rothera et al. (2002) found the GPs prefer to prescribe anti-depressant to depressed older adults as opposed to referring for psychotherapy, despite the continuing growing evidence that psychotherapy combined with medication, yields the best outcome (Thompson et al., 2001).

In 2007 the Secretary of State for Health announced a substantial additional investment in improving access to psychological therapies (IAPT) on a national scale. Bearing in mind the prevalence of mental health difficulties, and the population estimates, the potential for this kind of service could have been hugely beneficial across the lifespan. In the first year the programme was rolled out through 10 pathfinder sites, of which the East Riding of Yorkshire was one. The aim was to develop a defined care pathway and services for IAPT. At this time, older adults were considered to be one of

the Special Interest Groups (SIG). In the East Riding, people over the age of 65 years has an estimated population of just under 100,000 and it was felt that they would represent a significant proportion of clients accessing the service (25 per cent). However, a 12-month follow-up study (Hilton, 2009) found that less than three per cent of people being referred to IAPT were older adults. East Riding are not alone in the low number of referrals as Broomfield and Birch (2009), Harte (2004) and Robson and Higgon (2010) all found evidence of under-referral of older adults into primary care – with referral rates of 3.21 per cent (older adult population consisting of 16 per cent); 9.7 per cent (local population of 18.9 per cent) and 8.9 per cent respectively. So despite the substantial evidence of the prevalence of anxiety and depression in older adults, the effectiveness of psychological therapies and the provision of a service that specifically aims to improve access to psychological therapies, it was still evident that the referral rate for older adults continued to be significantly lower than would be expected. This has prompted others to ask ‘Where are all the old people?’ (Broomfield & Birch, 2009; Robson & Higgon, 2010). This is a question that is imperative if IAPT services are to provide what it states on the tin – an ‘accessible’ service for older adults.

When the potential reasons for the low referral rate were investigated in the East Riding, multiple barriers were apparent (see Hilton, 2009). It was evident that in some cases, working age adults (WAA) were being prioritised over older adults through justification of the limited service. This was consistent with Broomfield and Birch (2009) and Harte (2004) who suggested that ageism on the part of the referrer may offer an explanation to some degree for the low referral rates. It also echoed the findings of the joint Healthcare Commission, Audit Commission and Commission of Social Care Inspection (2006) which identified deep-rooted cultural attitudes to ageing in local and public services, especially in relation to mental

health. In addition, there were issues of competency felt by IAPT workers, as the training they received concentrated almost solely on WAA and they struggled to feel competent working with the co-morbidity of difficulty presented by older adults. Thirdly, there were issues of lack of appropriate material for older adults, particularly for those working at level one. Finally, it was evident that there were constraints on the flexibility around the number, length and location of sessions that IAPT workers could offer.

It was evident that further work would be needed to target the identified barriers, to try to increase the number of referrals for older adults into the IAPT system. This paper describes the next steps taken in the East Riding of Yorkshire following our findings around perceived barriers in 2008–2009.

Next steps (2009–2010)

The next project was structured to address the identified barriers by:

1. Providing training for key referrers in the recognition of mental health difficulties in older adults (mainly GPs).
2. Providing older adults specialist training and supervision.
3. Allowing flexibility within the service delivery.

The original plan was to provide different levels of the above to different areas and compare the results in terms of outcome measures such as referral rate, competency rating and pre-post mood measure and patient experience. However, there were a number of constraints on the project during the last year. Therefore, the training for key referrers was limited to two main areas and a select number of IAPT workers were provided with four training sessions and supervision over a six-month period. Flexibility was allowed in the service for those workers that had received training in terms of location and time.

Method:

Training and Supervision Programmes

Training for primary care workers – this involved a training presentation with the following key points: (1) recognition of mental health difficulties (including short screening tools); (2) co-morbidity and masking of mental health difficulties in older people; (3) effectiveness of psychological intervention for older people; and (4) practicalities of the services. An additional question and answer session and further contacts were also offered. The training was provided to two areas by the IAPT workers within those areas and feedback was gathered at this time. The majority of people attending the presentation were GPs and practice managers. The three sectors and the public were not included in the target audience at this time.

Training for IAPT workers: The training involved four half-day sessions with the following themes: (1) Recognition of mental health problems in older people – understanding the observable factors that may indicate a mental health problem; (2) Co-morbidity of difficulties including physical, cognitive, emotional, personal history, socio-economic and cohort factors and formulation; (3) specific mental health difficulties, i.e. depression, anxiety and so on in older people and formulation; and (4) adaptation of intervention. A self-efficacy measure was taken before and after the training session.

Supervision for IAPT workers: Following the training supervision from an older adult specialist was offered the IAPT workers once they had older clients on their case load.

Data collected: GPs, High Intensity Workers (HIWs) and Psychological Well-being Practitioners (PWPs) were interviewed, using a semi-structured interview after training and at the end of the six-month period. This included questions around service provision for older adults, the effectiveness of the training for key referrers and the effective-

ness of training and supervision for IAPT workings (included a self-efficacy rating).

Results

Recognition and referral for older adults into the IAPT service (see Table 1)

There were a number of themes that arose following the presentation. Firstly, the waiting times for the IAPT services appeared to be an obstacle and there tended to be a pattern of referring to older adults' CMHT's and bypassing IAPT because of this. Secondly, it was evident that there continued to be a lack of understanding about the role of IAPT services, both the provision of the service and the idea that psychological therapies are beneficial to older adults, and the training appeared to address some of those issues. Thirdly, there were comments about the usefulness of understanding the link between physical symptoms and mental health. Fourthly, it was felt the training could target a more diverse audience (for example district nurses, long term condition nurses as well as reception staff and the voluntary sector) rather than just GPs as the main referrers. Finally, there were comments around the language used by IAPT such as 'anxiety and depression' which was felt to be unhelpful and GPs felt they did not have enough guidance on how to 'sell the service' to older adults. Overall, the presentation did appear to be useful in disseminating information about the IAPT service, the co-morbid links between physical health and mental health and understanding the usefulness of psychological therapies. However, there were evident limitations in terms of the target audience, waitlists for intervention and language use.

Competence in Working with Older People – Training and Supervision

Following the training and provision of supervision there was an evident improvement in the recognition of contributing factors to an older person's presentation and the observable factors that may indicate a mental health problem. There also appeared to be better understanding of the co-

Table 1: Comments referring to recognition and referrals of older people.

Comments following the presentation
'We are aware of mental health difficulties in older adults, but there isn't much point in referring to IAPT because the waiting lists are so long.'
'You have to make a decision, if you have a limited service, about the best use of that service.'
'I didn't know that this kind of thing was recommended for older people.'
'I wasn't aware off all the things that people could come with that might indicate depression.'
'The physical stuff and depression was useful, I didn't know that.'
'This would be better giving to our nurses, as they see a lot of older people.'
'It's difficult with the language you use – the older people I've seen don't really get 'anxiety', and the information isn't that helpful. How do I 'sell the service' if you like, to older people?'

morbidity of presentation for older adults and the adaptation that may need to be considered to deliver psychological interventions, including goal setting, pacing, flexibility and overcoming possible barriers. From the interviews it was evident that IAPT workers did feel they had a better understanding of the needs of older adults, and

felt that the provision of supervision from older adult specialist was useful, although it was felt that ideally it would be useful for this to be someone who also had knowledge of PWP and HIW specific interventions, for example an older adult CBT specialist (see Tables 2 and 3).

Table 2: Self-efficacy rating pre- and post-training sessions for four IAPT workers.

	Before Training	Training session 1 (recognition)	Training session 2 (co-morbidity)	Training session 3 (specific MH problems)	Training session 4 (Intervention & adaptations)
	Confidence rating (0–100%)	Confidence rating (0–100%)	Confidence rating (0–100%)	Confidence rating (0–100%)	Confidence rating (0–100%)
Recognition of contributing factors	Average score 35%	Average score 70%	Average score 70%	Average score 75%	Average score 80%
Influence of co-morbidity	Average score 30%	Average score 35%	Average score 75%	Average score 80%	Average score 80%
Understanding the interaction of different factors	Average score 25%	Average score 35%	Average score 75%	Average score 80%	Average score 80%
What changes may be needed to intervention	Average score 30%	Average score 35%	Average score 40%	Average score 35%	Average score 80%

Table 3: Comments on competency in working with older people.

Examples comments around the theme of competency
'The training helped to think about formulating older adults on a more holistic scale.'
'I felt better prepared to work with older adults.'
'At first I felt a bit overwhelmed with all the things we needed to consider, but then it actually helped me to think more about targeting my intervention.'
'It helped to this about pacing and things like that. Sometimes you feel so pressed with time, that I think you can out-pace and then the intervention would not be as effective.'
'This is someone that I would have probably stepped up.'
'It would be better to get supervision from someone who knows about older people.'
'It good to think about biopsychosocial issues in supervision.'
'In the future I think it would be good to have specialist that have IAPT and older adult expertise.'

Flexibility within the IAPT service

The themes that arose around flexibility seemed to fall into three main categories; language, time and location. In terms of language, it was felt that the language used, for example, the idea of 'neutralisation' in OCD was not helpful for some older adults and that language would need to be adapted to make these concepts more meaningful, for example, the use of person-centred metaphor. This linked to the idea of increased number of sessions, to be able to revisit concepts and to develop different and person-centred ways of communicating certain concepts. The third theme was the idea of flexibility round location of the intervention and to be able to deliver the intervention in someone's home. Overall, it did appear that being able to be more flexible with interventions, for example, being able to go to adults' homes and extend the number of session available was seen as being beneficial to the service (see Table 4).

Outcome measures (referral rate and patient experience)

The referral rates from the GP surgeries that received presentations and had IAPT workers who received training and supervision demonstrated an increased referral rate for older adults over a six-month period (6.1 per cent), compared to those who received none of the above (2.7 per cent). However, the figures were still lower than the expected

referral rate of 20 to 25 per cent. There had been a limited number of older adults that had received IAPT intervention by the end of the project (due to waiting times). Of those that had received intervention, the patient experience was positive and there was a general decrease in anxiety/depression scores.

Discussion

Evidence has suggested that older adults underuse mental health services to a great extent, irrespective of evidence demonstrating the need for such services (Crabb & Hunsley, 2006; Robb et al., 2003) and this trend was also being seen within IAPT services. The aim of this project was to try and target interventions at the identified barriers to accessing IAPT services for older adults, namely recognition, competence and flexibility. It is difficult to pull any robust conclusion from this data due to the small numbers. However, there are evident trends that emerged that can be commented on.

In terms of recognition, the results indicated that the training for primary care staff (mainly GPs) had some limited benefits in terms of re-education around the remit of IAPT services, understanding co-morbid links and realising the usefulness of psychological intervention for older adults. However, there continued to be issues around targeting the right people, for example district nurses, other primary care

Table 4: Comments on flexibility within the IAPT service.

Examples comments around the theme of flexibility
'It's important to make the service accessible to people in language that can be understood'
'I have found that when I use 'IAPT' language, it is difficult for the older clients I have found to understand what I am talking about.'
'I think ideas need to be revisited and repeated more with older people.'
'I think I could have provided a beneficial intervention, but I wasn't able to see them at home, so the case had to be stepped up.'
'It was really beneficial for him that I could do the intervention at home.'
'I think if I could I have perhaps three more session, the intervention would have worked well.'
'We can't do home visits, so it's difficult sometimes to deliver.'

staff, the voluntary sector as well as the wider public. Carr and Murray (2010) found that the most common point of contact for help-seeking behaviours included the GP, but more commonly family, friends and voluntary sector. There was also a theme around communication with GPs feeling they lacked the tools to adapt language to 'sell' the IAPT service. Similarly the IAPT workers also highlighted the need for flexibility around language. Such findings are not unique. Carr and Murray (2010) also found language to be a barrier preventing older adults accessing primary care teams. They found older adults reported low levels of anxiety and depression associated with certain difficulties (for example, physical illness and being a carer) but when the words 'stress' or 'low mood' were used, there was a higher response rate. The training and supervision programme appeared to increase workers' perceived competency with older client. It is possible that previously, these clients would have been stepped up the service. There was a sense that IAPT workers involved with older adults would benefit from specialist older adult supervision, ideally someone with CBT expertise. In terms of flexibility, it was felt that being able to have some degree of flexibility around session time, length and location was beneficial for patient experience. Finally, those older adults who were seen by the IAPT did show beneficial results.

Despite this, there continued to be a lower referral rate that would be expected, even with targeted intervention around recognition, competency and flexibility. As we know, there exists a number of extrinsic barriers to accessing services (Peprin, Segal & Coolidge, 2009), for example, ageism, recognition of mental health difficulties, recognition of the usefulness of psychological therapies for older adults and a lack of qualified mental health practitioners with specialist older adults knowledge (Anderson et al., 2010) as well as practical issues around waiting times. Although this project aimed at targeting some of those barriers, evidence remained that the project had not targeted all of the 'right' people, finding acceptable terms and language for the older adult population continued to be a barrier, as well as the continued theme of 'justified ageism' in terms of prioritising WAA over older adults.

Further to this are intrinsic barriers that exist and have not been addressed by this current project, for example, stigma, fear of psychotherapy and the idea that depression as a part of aging (Robb et al., 2003). These intrinsic barriers need to be considered alongside the extrinsic barriers, if IAPT services are to become more accessible to older adults.

There are evidently a number of limitations to these findings and they are by no

means methodologically robust. However, it is a starting point to thinking about the extra resources that may be needed for IAPT services to be accessible to older adults and there needs to be some robust research into service structure and delivery for older adults. This is particularly pressing in light of the new mandated care clusters approach, as it is imperative to ensure that adequate packages of care are available to meeting the needs of older adults within primary care.

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Service examples:

IAPT and older adults: Issues and interventions in promoting equal access to primary care psychology services

Natasha Jakub & Lisa Hulmes

This article is a reflection on the implementation of a local pilot study designed to promote mental health in older adults and increase their access to primary care psychology services.

National picture

THE PROFILE of psychological therapies has risen in recent years, partly through the provision of Government funding for the Improving Access to Psychological Therapies (IAPT) programme, which began following the Layard Report in 2006. Initially the funding for IAPT was dedicated specifically to addressing the needs of the working age population, however, IAPT was soon expanded to include specific client groups, of which older adults was one. In 2007, 11 'pathfinder sites' were identified, four of which pioneered the provision of psychological therapy for their local older adult population.

Evidence suggests that around three million older adults in the UK have mental health symptoms that can affect the quality of their lives (DH, 2009). Although older adults respond better to psychological interventions than adults of working age, low numbers of referrals to the appropriate services have been documented. Nationally the referral rates for older adults have been reported to be as low as 1.45 per cent of the overall referrals; with an average of four per cent, despite older adult populations being around 16 per cent of the overall adult population (Broomfield & Birch, 2009). Older adults are clearly under-represented and underutilising psychological services, despite being in twice as much contact with their GPs as other age groups (Craig & Mindell,

2007). Indeed, 22 per cent of older people will have attended their GP surgery within the last two weeks, of which 40 per cent will have mental health difficulties (Hilton, 2009).

Several explanations have been proposed for this low rate of referrals. These include the problems with GPs under-identifying mental health difficulties in older adults (Hilton, 2009), GPs being less likely to refer an older adult than younger adults to mental health services (Mackenzie et al., 1999), generational attitudes and beliefs around stigma and embarrassment preventing older adults asking for help (McMillan, Carr & Murray, 2010), and them lacking knowledge about what services are available (Buffin et al., 2009).

Clinical psychologists have a key role and responsibility in advocating for older adults, and in reducing age-discrimination in mental health services. Indeed, the Department of Health (2008) has emphasised the need to 'take steps to eliminate discrimination and promote equality of opportunity to offer psychological intervention to everyone who will benefit'. Opening up services designed for working age adults to older people is shown to be insufficient (DH, 2009). IAPT pilot programmes focused on older adults have found that 'they did not succeed in improving the numbers of older people being treated in the community' (Kirkpatrick, 2010).

Local picture

IAPT was introduced to the psychology service in Chester in September 2008, becoming a 'first wave' site. It had a remit to improve access and provide psychological therapies for older people and those with long term conditions. From October 2008 older adults had access to nine Psychological Well-being Practitioners (PWPs), two support workers, seven High Intensity Therapists (HITs), seven Counsellors and three Older Adult Psychologists. The local referral rate for older adults is eight per cent of the overall referrals, which is higher than the national average, but still falls short of the 17 per cent representation of older adults in the local adult population (Seymour-Hyde, 2010).

Whilst the introduction of IAPT has facilitated increased access for older adults, there is still vast under-utilisation of services with only 44 older adults accessing the HITs, counsellors or psychologists, out of an older adult population of 40,000 (Seymour-Hyde, 2010).

Developing the pilot study

With this in mind, our service decided to pilot a mental health promotion programme targeted at older adults and their GPs, with the aim of developing learning points about what would work to increase the number of older adult referrals to mental health services.

A study carried out independently by Age Concern and the University of Lancaster (Buffin et al., 2009) suggested that this may be achieved through community-based education and awareness programmes around mental health; and training in detection and mental health referral for GPs. Glynn-Williams (2008) also suggested raising awareness among primary care colleagues (including training and consultation on problem detection and formulation), and talking to referrers and older adults about the barriers that limit referral. Screening the well-being of older adults, and directly presenting the local availability and effec-

tiveness of psychological therapies to older adults has also been suggested (Broomfield & Birch, 2009). Older adults have reported that receiving information and advice, and being able to talk about difficulties were their most helpful interventions (McMillan et al., 2010).

Our hypotheses were that: (1) older adults were reluctant to initiate discussion of mental health difficulties with their GPs, and remained largely unaware of the expanded Primary Care Mental Health Services available to them; and (2) their GPs may be reluctant or not think of referring them for psychological interventions.

The aims of the project were to provide multi-stranded mental health promotion within a GP surgery, and compare it with another GP surgery that covered a similar population without any interventions. More specifically, we were working towards increasing both GP and older adult awareness of the local Primary Care Mental Health Services by carrying out mental health promotion within the surgery, and facilitating conversations around referral options with GPs and their older adult patients. We monitored the referral rates for older adults to the Primary Care Mental Health Services during the eight-week intervention and compared it to previous referral rates (just before intervention, and also one year previously).

Intervention

Three main intervention strands were developed following consultation of the literature, and with the GPs. The following interventions were then put in place in the GP practice for eight weeks:

1. A two-hour training session was delivered to all the clinical staff at the practice to give information about assessing older adult mental health, the local mental health services available, and the referral pathways. There were discussions to problem-solve why some older adults could be reluctant to accept referrals to mental health services, and potential ways to approach this in clinic.

2. A screening tool was developed and handed to each surgery patient over the age of 65 years by the receptionist. This was filled in while the patient waited for their GP appointment. It acted as a 'well-being MOT' in the form of a checklist of recent difficult events and a Likert scale rating self-confidence, mood, ability to cope, relationships with other people, stress levels, and hopelessness. An information sheet was available with the pro-forma, which explained the reason for the screening and gave examples of psychological support available in the local service.

This proforma was handed to the GP at the beginning of the appointment. If difficulties with mental health and well-being were identified, the sheet could then prompt a conversation about referral to the psychological services. The second side of the proforma was a referral form to the single point of access Primary Care Mental Health Team, which provided a quick and convenient method of referral for the GP.

3. Mental health was promoted in the GP waiting room using a display which included a 'well-being thermometer' and free self-help literature on mental health difficulties often experienced by older adults. The well-being thermometer was a visual prompt to encourage older adults in the waiting room to reflect on their emotions and to direct them towards the advice and information that was available.
4. The GP practice was visited an additional four times over the course of the pilot study to refresh the displays and spend time in the waiting room, talking to older adults about the literature and services available, gaining the opinions of the client group, and answering any questions from the staff at the surgery.

Results

Twenty-two proformas were completed by older adults, resulting in two older adult referrals to the Primary Care Mental Health

Team. Retrospective audit found no increase in older adult referral rates as a result of these interventions, in comparison to the control GP practice or prior to the intervention.

Learning points

On reflection, several key points from the pilot intervention are apparent in establishing learning points for future work in this area. Firstly, it was interesting to reflect on the comments of the older adults during this project. Many reported that GP appointments were not long enough to cover discussion of their physical health problems, leaving no time for psychological issues. Others reported that they didn't know a mental health service was available to them, would not think to mention problems with their well-being to their GP, and felt that the frequent use of unfamiliar locum GPs limited them from raising embarrassing problems that they then tended keep to themselves. These comments are similar to those reported in the UCLAN study and Positive Practice Guide for Older People (DH, 2009).

Secondly, the eight-week timeframe of intervention appeared to be too brief to change established working practices and attitudes within the practice. The project began to gain momentum only in the later weeks when the GPs themselves agreed to distribute the proformas directly to their patients and to discuss them during their consultations. Distributing information through receptionists was not effective in maximising uptake and would not be suggested for future interventions. This timeframe also did not allow for follow-up data collection, which would be recommended for future projects.

Continued input and promotion of the psychological services available for older people is also likely to be important for keeping mental health at the forefront of busy referrers' minds during consultations. It seems GPs tend to prioritise physical problems before mental health, and, there-

fore, shifting their focus and working practices could take time.

Thirdly, the practice manager later highlighted pre-existing communication difficulties within the GP practice, and several staff vacancies and sick leave. This limited the consistency of establishing the new working practices and is a useful factor to consider when choosing sites for such an intervention.

Finally, it seemed that providing more psychological workers to work in prescriptive ways with older adults (i.e. the IAPT approach) may be a poor fit with what the GPs and the clients are requesting. The GPs reported that their preference would be to have a part-time, in-house mental health professional to whom they could introduce the client to personally, on an informal basis. They commented that they would be encouraged to refer if they felt their patient would be seen in a familiar environment, by a person with whom the GP had a good working relationship. As GPs start to commission mental health services in the near future, clinical psychologists could have a key role in working with GPs to ring-fence and develop age-appropriate services for older adults that facilitate their access to psychological interventions. While this pilot is only a small step towards exploring the practicalities of this, it is nonetheless an increasingly topical and important area for older adult clinical psychologists, and future research has the opportunity to provide a true interaction between clinical need and appropriate service delivery.

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Service examples:

Lessons learnt – implications for the future of Older Adults Primary Mental Health Care

Jim Leadbetter, Susan Hill & David Moore

TWO YEARS AGO the Commissioners in Cambridgeshire released £50,000 to Cambridgeshire and Peterborough Foundation Trust to develop a 12-month pilot project to demonstrate successful outcome measures for an older people's primary care mental health service. The funding enabled the secondment from secondary care services of a community psychiatric nurse and a clinical psychologist (both half-time) and the recruitment of a full-time graduate mental health worker. The small market town of St Ives was chosen as a pilot site because of its relatively contained area and the enthusiasm of its GPs who had experience of the adult primary care pilot which preceded IAPT. The model chosen built on the best national practice with older people's services to date including that of the Salford team and SLAM, both described elsewhere in this document. In addition to using the broad parameters and measures of the adult IAPT model, the project also included the following:

- a medication management screen at initial assessment followed by the offer of a medication management group with the Gateway Worker and a Clinical Pharmacist (as clinical expertise would suggest that some older people are prescribed medications which they do not take as they do not understand what they are taking or why);
- provision of services to carers with mental health problems;
- a series of open groups publicised with non-pejorative labels to help people

combat loneliness and learn from each other;

- the development of a detailed Service Directory about local resources which were shared with older people, their families and staff involved, where necessary for signposting to other facilities;
- joint work with SLAM on assessment measures, which included a comparison with IAPT measures and the Hospital Anxiety & Depression Scale (HADS);
- the flexibility to step up/step down from secondary care services where necessary;
- regular clinical supervision for all team members;
- the support of the CMHT psychiatrists for complex cases;
- funding for limited transport and venue costs for group work in the core budget.

After nine months the funding was increased to establish the two qualified posts at 0.6wte and provide much needed administrative support to release clinical time. Additional funding was obtained for input from an Alzheimer's Society worker as a core member of the team to support those people with Mild Cognitive Impairment.

The initial lessons learned were in relation to the time it took to establish and recruit the team (with the impact on secondary care services of then absent qualified staff). Invaluable weekly meetings were held to talk through the detail required to set up the service smoothly. Obtaining space in surgeries and community venues, establishing reliable points for data collection,

learning to use several different IT systems and cope with the restrictions of IAPT data collection regulations were initially challenging.

The Team's success has been due to its enthusiasm to provide a service to older people who would not have had any help without its presence. They have learnt that assessment in primary care is equally complex but different to assessment in secondary care. Building good relationships with referrers and the older people themselves through a person centred approach has led to excellent feedback in independent audits. The Team's creativity has led to the development of new ways of marketing including a monthly newsletter.

Constant awareness of the need to develop and deliver successful outcome measures to ensure the roll out of the project across the Trust has promoted evaluation at all levels throughout the project. Quarterly feedback meetings with the Commissioners and the project group were lively and enjoyable discussions about how to continue to provide ever better services for older people.

The following sections provide perspectives from four people who have been involved with this project. Jim Leadbetter, Primary Care Gateway Worker for older people, Susan Hill (Graduate Mental Health Worker), a service user, and David Moore, dementia support worker for the Alzheimer's Society.

Primary Care Mental Health Gateway Working – role clarification and reflections in practice

Jim Leadbetter RMN (BA Hons Primary and Community Care Specialist Practitioner)

The following provides readers with a brief description and offers insights gained through reflection upon practice after two years' experience as a primary care gateway worker for older people (PCGW).

The PCGW for the St Ives pilot fulfils the role of initial assessor of routine referrals at point of entry for mental health services in

the St Ives locality; there is separate provision for crisis referrals. The resultant assessment serves to funnel referrals to the most appropriate of eight care pathways ranging from the primary care project (PCP) to secondary care mental health provision via the local community mental health team (CMHT).

It was soon apparent that the method of referral collection was unnecessarily slow (weekly collection at surgeries). Consequently, a secure electronic referral system was introduced. This took time to bed in but has resulted in a more timely response for older people and their carers. Close liaison with key administrative staff in the surgeries has been essential for successful implementation.

Sands (2007) points to the lack of theoretical foundation and shortage of evidence base for mental health triage both in terms of clear definition and description. Sands goes on to highlight an important distinction between mental health triage and more traditional triage models which usually involve brief screening. I would argue that this is a crucial distinction when considering the needs of older people who often require longer appointments and may have more complex multi-faceted or holistic needs requiring consideration. Cambridgeshire and Peterborough Foundation Trust already employs 'gateway workers' in adult services and will soon employ an increasing number in older people's services with the project's roll out. The role and function of the gateway worker may represent a valid area for future enquiry both in terms of identifying core activities and those which are more specific to specialist areas such as older people's services.

Mental health triage can take place through various means; paper triage (review of the referral letter), telephone contact or face-to-face assessment. A significant proportion of the triage assessments completed during the past two years have been completed face-to-face. Sensory deficits and preference for direct contact have reduced

the viability of telephone assessments. Home visits have been undertaken as necessary. In part this helps reduce barriers to accessing services and it is also especially helpful when considering the needs of individuals presenting with mild cognitive impairment. The PCP is accessible to all individuals within the community but does not have the resources to provide input to residential care homes or nursing homes. These referrals would, therefore, offer a clear cut example of a paper triaged referral which is directed to the CMHT.

I would suggest that successfully implementing the gateway worker model with older people relies upon good links with both primary and secondary care colleagues. This project has enjoyed good support from local psychiatrists and GPs. This has enabled smooth 'step up' and 'step down' between services where necessary for the benefit of older people. The advanced practitioner role such as the one described here requires a detailed understanding of systems (Dewar, 2010). I would argue that this local knowledge has been of fundamental importance over the past two years. This can be developed but does take time and experience.

The ability to signpost individuals and carers to community-based services is a central part of the gateway role. This is in part dependent upon the existence of suitable resources but also requires creativity and networking. It is argued that some older people require additional support to access helpful resources, which may be due to a lack of confidence or more practical considerations. I would suggest that the term 'guided signposting' is perhaps more constructive. As a project we still have some way to go in terms of creating truly beneficial networks for older people. This aspect of gateway work supports individuals to enhance their social presence and aims to help them engage in meaningful activity. This area of work fits well with the notion of recovery. The present working age adult IAPT measures are not sufficiently sensitive to record positive meaningful activity as a

successful outcome of intervention with older people.

It was envisaged that networking with locality services, for example, social care managers and district nurses, might help to identify suitable candidates for primary care mental health input. Whilst this remains a valid aim, work to reinforce these relationships requires further attention.

It is my belief that successful gateway working requires flexibility and a willingness to adopt a mindset which enables the individual to be seen as a core member of both primary and secondary care teams. Close working with practice-based staff is vital to ensure a regular throughput of primary care mental health referrals for older people. This can be achieved through regular physical presence at the surgeries and attendance at practice meetings. This presence can also aid gateway workers in their quest to provide advice and education for primary care-based staff.

The pilot project set out to explore medication management issues for older people. Broadly, the aim of this was to improve the mental and physical health of individuals, through group interventions designed to improve older people's knowledge of their prescribed medications. It was hoped that this increased awareness would lead to improved concordance and in some cases empower older people to discuss the ongoing suitability of prescribed medications with their GPs. We held one joint session in 2009 with the help of a specialist clinical pharmacist which was well received. The session identified a few specific prescription issues which were signposted to relevant GPs. Sleep problems emerged as a common theme for participants. (This later became a topic for a handout and an information group topic). At the triage assessment, questions are asked about concordance and understanding of treatments and this information is then used to select potential candidates for the medication sessions or to provide advice during the assessment interview. Based on an internal audit in 2009,

we found that 87 per cent of older people referred to the pilot project (total number of cases reviewed 54) were being prescribed four or more tablets. This underlined the importance of helping older people to improve their knowledge of what can often be complex medication regimes. The medication sessions are set to resume in the near future with robust outcomes measures currently under consideration.

Therapeutic interventions

Susan M. Hill MBPsS BSc (Hons)

The St Ives project offers a range of therapeutic interventions such as individual work with either a low intensity or high intensity worker, as well as groups including the Building Confidence and Healthy Memories groups. The following describes a range of these therapeutic interventions.

Building Confidence group

This group used a solution-focused approach, which followed the same structure each week. This approach was chosen for a number of reasons. There is an increasing body of research demonstrating its effectiveness (Gingerich, 2004; Kim, 2008; Corcoran & Pillai, 2007), despite it being a relatively new form of therapy. It was also considered to be an approach that would be beneficial for older adults (Seidel & Hedley, 2008). It has been found to be a relatively good way of coping with high volumes of referrals, is cost effective, and meets the growing preference for shorter, strengths-based and collaborative forms of intervention (O'Connell, 1998).

The solution-focused approach aims to 'build upon clients' strengths and to assist them achieving their preferred outcome by co-constructing solutions to their problems' (O'Connell, 1998). One technique in this approach is the use of the miracle question, aimed at eliciting group members' preferred futures, which enables this to become achievable (De Jong & Berg, 2002). At times the group members found some of the solution-focused concepts difficult to grasp, such as

'the miracle question' because they felt that a miracle was never going to happen. However, we found with further explanation the group members valued the question. The group format was changed, therefore, to spend more time at the start of the group explaining the purpose of the 'miracle question'.

Additionally, it was found that older adults gained further benefits from eight instead of six sessions and from a smaller group size of four to five people to allow space for talking and extra thinking time.

At the end of each of the Building Confidence groups I feel that each of the clients have benefitted from attending the group. I have noticed that group members possess a greater insight, they are able to take part in more activities but also have the confidence to take part in activities that they want to do rather than those they feel they 'ought' to do. The following provides a vignette of one group member's journey:

At the start of the group, one group member had recently developed glaucoma, and as a result had become very anxious. Her claustrophobia no longer felt manageable, despite having previously been under control. She found it difficult to accept her poor eyesight and that it might not get better. At the end of the group she accepted that her eyesight was not going to improve and realised that she could still sew and read, despite this being harder for her now. She was more positive about the future and began to manage her claustrophobia much better. At the start of the group she found it difficult to stay in the group room for the full two hours and had to have all the windows open and at times would need to walk around the room during the session. At the end of the group she no longer needed the windows open and would stay seated during the whole session. Since the group has finished she has informed me that she is going away for one night and travelling in an unfamiliar car, which she was unable to do at the start of the group.

Healthy Memories group

This group is for people experiencing Mild Cognitive Impairment (MCI). MCI is a syndrome defined as 'cognitive decline greater than expected for an individual's age and education level but does not markedly interfere with activities of daily life' (Gauthier et al., 2006).

Randomised control trials have shown that clients with MCI who have undertaken cognitive training demonstrated improved memory, attention, mood and psychological well-being (Belleville et al., 2006). As well as this, Londos et al. (2008) found that an eight-week cognitive rehabilitation programme focusing on practical memory strategies had positive effects on cognitive speed, self-rated functional ability and some quality of life domains.

The literature indicates that the incidence of mood disorders such as anxiety, restlessness and irritability occur more frequently in clients with MCI. Inevitably, clients with MCI have to cope with a number of everyday changes as well as an uncertain prognosis, all of which may affect their well-being (Hwang et al., 2004).

The group was planned to provide psycho-education, memory strategies and the space to discuss anxieties, fears and common problems. Interaction with and support of others in similar circumstances, as well as exchanging experiences and coping strategies is known to be beneficial (Cheston, 1998). This group started with five members and lasted for eight sessions.

The initial plan to provide information on a range of topics and strategies meant that it was a very packed session. It emerged that this was too complex for all of the group members, who have a range of cognitive abilities. The group content was then adapted to be simple, straightforward and with less information given during the session, which resulted in greater talking and thinking time.

The main lessons learnt from this group were:

- Repetition – this was achieved through 'core' themes repeated throughout each session.
- Structure – a timetable provided structure each week.
- Simple – only the basics of 'how memory works' were explained.
- Multi-modal – used different learning methods through activities and pictures.

The group was designed for the final session to contain a recap of the group, to which the carers were invited to attend. This was to provide support and education to the carers about memory loss because carers have been shown to report more symptoms of depression and anxiety than control groups (Garand et al., 2005). However, it was felt that the carers' attendance during this session affected the group dynamics. It appeared that the group members felt that the carers were invading 'their group'.

Nevertheless, carer understanding of memory is important to aid both the carer and the client to come to terms with their memory loss and how to optimise the client's current memory. I feel it is an important component to have in future groups but possibly in a different format. Another option could be to invite both the carer and client to attend the group together. Brodathy et al. (2003) found that psychosocial interventions aimed at the carer of people with dementia concluded that success was more likely if both the client and the carer were actively involved in the programme. It has also been thought to strengthen marital relationships between the client and the carer. On the other hand, from the experience of the Healthy Memories group, I feel that older people with MCI benefit from a separate space where they do not feel challenged or judged, away from their partner, to be able to express their memory concerns and issues. Once these issues were addressed the group worked well and clients began using memory strategies. The group appeared to enhance their emotional well-being.

In my opinion, this group was of great benefit to all the group members. At the end of the group they showed more insight into their memory loss but also worried less about their decline. They had also begun to use some of the memory strategies and displayed greater emotional well-being.

An example of one group member's story is below:

One of the group members was referred to the group from Secondary Care (CMHT). He was being seen in CMHT for non-compliance with his medication and would not accept assistance from anyone, especially his wife. At the end of the eight weeks both his wife and the CMHT observed a difference in his presentation; he was more animated and talkative. CMHT was also aware that he showed greater insight into his memory difficulties; consequently he became much more compliant with his medication and accepted help from his wife and other services. The CMHT were able to discharge him and he felt comfortable to attend the Alzheimer's Society pub lunch with his wife to increase his social contacts and maintain his emotional well-being.

Lessons learnt

Upon reflection, I believe that the aspects crucial for effective therapeutic intervention for Older Adults in a Primary Mental Health Care setting are:

- Space – this allows the clients 'thinking' and 'talking' time regarding their worries and concerns, in relation to both their mood and memory.
- Structure – this provides the clients with some predictability about the group content and allows them to feel safer within the group setting.
- Time – to offer a greater number of sessions (eight rather than six) and longer length sessions (two hours for groups) to allow greater 'thinking' and 'talking' time.
- Transport – being able to provide transport for group members enabled those in surrounding villages with poor public transport links or physical health

problems to attend. This was crucial to promote additional independence and to reduce barriers to attendance.

Service User article

Mrs X is 75-years-old and was referred through the MIGHT (Mental Health Intermediate Care Team) team to the Primary Care Team to see if intervention would help to improve her mood and reduce her anxiety. She attended a Building Confidence group. On initial assessment she was more depressed than anxious.

	Pre	Post	3/12 FU
PHQ 9	0	0	0
GAD 7	3	0	0
HADS Anxiety	3	0	4
HADS Depression	9	1	0

At the three-month review her HADS anxiety score had gone up but at that point her son-in-law had recently had a stroke, which she managed to cope with very well. At the start of the group, this member's aim was to go on a cruise in September. She managed to go on the cruise. Although she fell over and broke her ankle whilst there she still enjoyed it and said they had a wonderful time.

When asked to write for the *Newsletter* she wrote the article below.

Dear...

I hope what I have written will be useful and helpful. I am very pleased you asked me to write it. Hoping you are well and we will speak again.

The thoughts on what I have achieved through the group meetings.

When I was invited to join the Building Confidence group I did not want to, but I knew I needed help to regain my confidence; it was the best thing that I did.

We were a group of four who got on well together and felt that we could talk out our anxiety and problems easily, so week by week we all slowly progressed.

I began to set little goals for myself like having my family for meals again, which up until then I could not do or had not tried to.

It was a slow process of what I could achieve but as the weeks went by I was making good progress, but it was with the help of the group who helped me to do so.

Getting up in the mornings was no longer a big problem, my days were good days and my final big goal was achieved.

I was happy again and looking forward to a cruise holiday which was wonderful and I enjoyed it so much.

I'm sure the group members must have got a bit fed up with me saying at every meeting 'Listen to the little voices in your head that says you can do it, not the big one that says you cannot.'

It certainly worked for me, also attending the group meetings.

The Mental Health Primary Care Pilot Project – a joint venture between the Alzheimer's Society and Cambridgeshire & Peterborough NHS Foundation Trust (CPFT).

David Moore, Dementia Support Worker for the Alzheimer's Society.

In my experience, early intervention with individuals with short-term memory loss seems to be invaluable. The ability to comprehend difficulties and express anxieties in the early stages of memory loss appears to lead to a greater understanding of specific needs. From comments expressed by members of the Healthy Memories group, the opportunity to talk freely with individuals experiencing similar difficulties and anxieties in a secure and stress free environment, is helpful. Discussing these difficulties can also help facilitators target a range of suitable strategies.

One of the benefits of this project would appear to be the opportunity to engage older people and their carers early and provide continuity. This is an important part of maintaining the support and well being for the family as a whole.

Finally, being integrated into a multi-agency team has been a positive experience. The opportunity for all sides to bring their knowledge, experiences and different perspectives to the project has been extremely beneficial. The training, support and supervision have provided motivation and energy to succeed.

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Service examples:

Graduating from a Primary Care Psychology Service to an IAPT Service – the Southwark experience

Grace Wong & Steve Boddington

This paper provides an account of the transition of Southwark's Primary Care Psychology Service for older people into an integral part of an Improving Access to Psychological Therapy (IAPT) service, known locally as Southwark Psychological Therapies Service (SPTS).

Older Adults Primary Care Psychology Service

A DEDICATED Primary Care Psychology Service tailored to the needs of older people was established with the help of funding from Guy's & St Thomas' Charitable Foundation between November 2004 and February 2008, and from South London and Maudsley NHS Foundation Trust for another eight months afterwards. This initiative provided a uni-disciplinary psychology service, accepting referrals directly from primary care, community mental health teams (CMHTs), social workers and a physical health therapy team for people over 65 years in Southwark. For the first six months, it was staffed by a clinical psychologist (0.8 whole time equivalent, WTE) and an assistant psychologist (1.0 WTE). Thereafter, a counselling psychologist (1.0 WTE reducing to 0.6 WTE) replaced the assistant. This project was overseen by a steering group which met four times a year to whom the clinical psychologist reported.

Key activities included continuous publicity for the psychology service to Southwark primary care teams between 2005 and mid-2007 to establish recognition amongst GPs and other potential referrers. This publicity included:

- Regular mail shots (letter, leaflet, flyer, e-mail).
- Visiting GP surgeries to talk to them about the service.
- Participating in Primary Care Trust (PCT) locality events.
- Promoting the service via GP forums and newsletters.

The psychologists made links with organisations working with ethnic minority groups in the borough, encouraging them to consider the mental health needs of their older members. They also undertook psychological screening in primary care for people over 65 with chronic physical problems, given the high rates of mental health needs in this population.

These promotional activities resulted in a steady increase in recognition of the service within the local health and social care economy and an increase in referrals (Figure 1), with the largest proportion of referrals coming from local GPs (Figure 2).

Figure 1: Older Adults Primary Care Psychology Service – quarterly referral rates.
May 2005 – October 2008

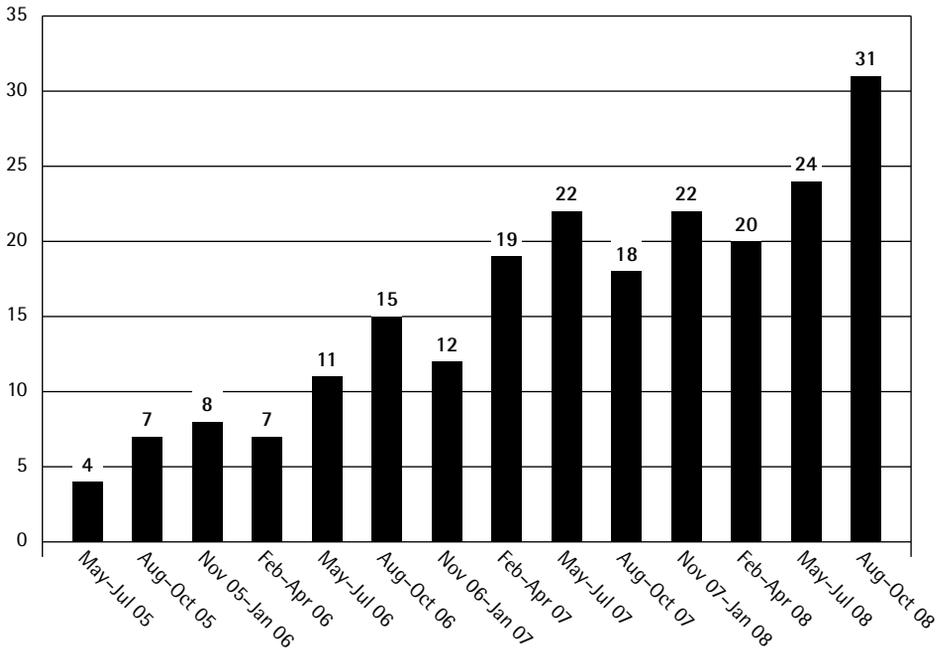
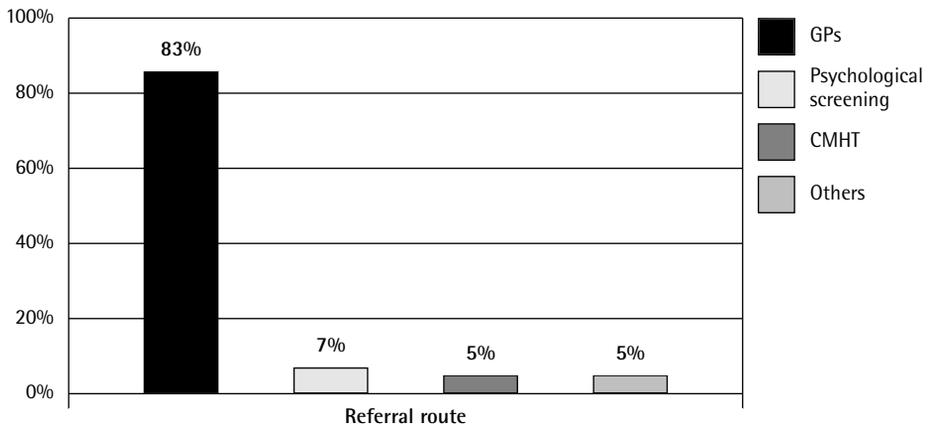


Figure 2: Older Adults Primary Care Psychology Service – referral route.

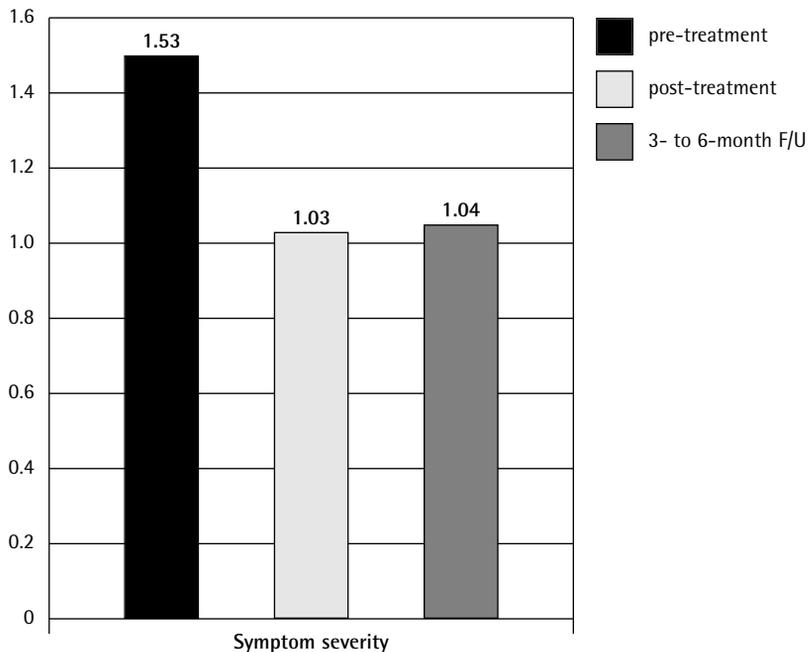


The service offered brief psychological interventions for older people with symptoms of depression or anxiety. It also provided brief screening assessments for older people with worries about cognitive decline. The Centre for Outcome, Research and Evaluation's outcome measure (CORE-OM) was adopted to monitor the impact of psychological therapy (Barkham et al., 2001). This was administered at the beginning and end of all interventions with a completion rate of paired CORE-OMs of 85 per cent. Outcome data showed a statistically significant reduction in symptom severity at end of treatment ($p < 0.001$, Figure 3), with an effect size of 0.83 and gains being maintained at a three- to six-month follow-up (that was conducted on a sample of referrals, $p < 0.001$).

Southwark Psychological Therapies Service (SPTS)

In November 2008, Southwark launched its IAPT service, named as the Southwark Psychological Therapies Service (SPTS). This service was established with an open referral policy for all Southwark residents aged 18 and over experiencing common mental disorders. However, specific local objectives were identified to promote access amongst black and minority ethnic (BME) groups, older adults and vulnerable young men. The new service incorporated the staff from several pre-existing services including the Primary Care Psychology Service for Working Age and Older Adults. Additionally, new funding was used to appoint Vocational Specialists (5 WTE), High Intensity (HI, 20 WTE) and Low Intensity (LI, 13 WTE) trainees over the first two years.

Figure 3: Older Adults Primary Care Psychology Service – clinical outcomes.



A number of specific adaptations were agreed to ensure that older people received an equitable and accessible service. These included:

- A separate waiting list and opt-in procedure.
- The offer of a home visit when appropriate.
- Ring-fenced clinical time from therapists with a special interest and skills in older people’s mental health.
- An adjustment of the pace, length, frequency and number of sessions where necessary.
- The right to opt-out of the telephone triage that was piloted by the service.
- Adaptations in the way in which every session measures are collected where necessary.

The psychologists with a special interest in older people’s mental health also negotiated to provide training to HI and LI trainees on the local courses, as well as an in-house training event for all qualified staff being transferred into the service from pre-existing services that have primarily assessed and treated working age adults previously.

SPTS data on older adult referrals

During the first 24 months, 270 referrals were received, constituting 4.4 per cent of the total referrals to the service. Of these, 236 were accepted (87 per cent) and 196 attended assessments (83 per cent opt-in rate). One-hundred-and-thirty-eight (70 per cent) of the initial assessments were undertaken by the therapists whose clinical time was ring-fenced for the work with older adults.

At assessment, 20 per cent of older adults were from ethnic minority groups, 35 per cent were male and the average age was 75 years. In total, 127 (65 per cent of those assessed) older people received treatment (28 per cent CBT at step 2, 72 per cent CBT at step 3).

Outcome data (on the 80 older adults who had completed treatment to date) showed a recovery rate of 54 per cent (27/50) for the older adults referrals which is above the target rate of 50 per cent recovery set for IAPT services nationally (see Table 1 for detailed breakdown of recovery data). Caseness is defined by having a PHQ9 score of 10 and over, and/or a GAD score of 8 and over.

Table 1: Recovery data for older adults in SPTS using the PHQ9 & GAD7 scores.

	End of treatment		
Assessment	Case	Non-case	Total
Case	23	27	50
Non-case	2	28	30
Total	25	55	80

Conclusions and future directions

The early promotion work demonstrates that it takes time, persistence and flexibility to get GPs to refer older people for psychological therapies, but they will. We believe that it is essential to consider alternative referral routes including promoting self referral and partnership working (with social workers, third sector services). Self-referral amongst older people has not yet been evaluated and given the current evidence relating to older people's reluctance to seek help (Age Concern, 2008) further investigation is required to determine how this might work.

This service was established on the premise that it must offer sufficient flexibility to be accessible and acceptable to older people's needs. The good recovery rates achieved for older people in Southwark has demonstrated the value of such a strategy.

Ongoing work is planned to renew publicity targeted towards the promotion of older adults referrals as the overall proportion of older people referred to the service is still well below a representative figure for the borough. Further work is also planned to develop appropriate step 2 (LI) interventions for this age group. This will involve the reworking of pre-existing age appropriate guided self-help materials, adapting behavioural activation initiatives to include local resources that are targeted to older people and the development of group CBT for people with chronic medical conditions (the majority of whom are older).

Finally, as the SPTS incorporates wider psychological therapy models in line with updated NICE guidelines, it will be important to ensure that treatments such as Interpersonal Therapy, Brief Psychodynamic Psychotherapy, Behavioural Couples Therapy and Counselling are developed in a way that meets the needs of older referrals to the service.

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Service examples:

IAPT and people with dementia in residential care – A training programme for Care Home staff

Ross Warwick, John Higgon & Fionnuala Edgar

Introduction – The Drivers of Change

SIGNIFICANT behavioural change is a common consequence of dementia, and this behaviour can often be challenging; challenging to the client, their friends and family and those employed to provide care. According to a recent survey of 197 residential care homes, the majority (73 per cent) recorded incidents of verbal or physical aggression from a person with dementia within the last three months. Over a third of respondents reported that a member of staff had been injured as a result of physical aggression (Berry, 2010).

Psychotropic medication has been the traditional first-line intervention for the management of challenging behaviour. However, reduction in levels of challenging behaviour is seen in only a minority of patients (around 20 per cent). Moreover, its use can be harmful: it has been associated with an increased risk of falls, death and cerebrovascular events (Bannerjee, 2009). Reports and guidelines about dementia including, amongst others, *Living Well with Dementia* (2009), *Remember I'm Still Me* (2009) and *Dementia* (2007) recommend that medication should be used as a last resort, and that an individualised assessment should be completed to look at the factors that could cause, aggravate and alleviate challenging behaviour. This latter point is enshrined in the Scottish Integrated Care Pathway ICP for dementia, which recommends that: 'Service users who develop behavioural or psychological dementia symptoms receive an intervention matched to their needs' (NHS Quality Improvement Scotland, 2007).

The IAPT for Older Adults programme does not specifically address the area of challenging behaviour, emphasising instead the importance of making 'traditional' psychological therapies more available to older adults. The Older Adults Positive Practice Guide (NHS, 2009) pays lip service to the idea that the needs of age groups will to some extent vary across the lifespan, but the guide nevertheless concentrates on depression and anxiety and the ways in which these might manifest differently across the lifespan. However, the current emphasis on the development of psychological approaches for management of challenging behaviour will require clinical psychologists to adopt IAPT-type models (tiered services, psychologists as trainers and consultants, etc.) in order to meet the substantial clinical need.

In summary, there is a clear need for anti-psychotic medication to be used more sparingly and to instead provide an individually tailored, person-centred approach to challenging behaviour management. This befits a psychological style of assessment and management. By extension, there is a need to improve the access people with dementia have to psychological treatment.

In Scotland, the aim of IAPT (to increase access to psychological therapy) has been endorsed by the Scottish Executive but no ring-fenced additional funding has been made available, so it has been necessary to address the problem of access to psychological therapies by means of re-design of existing services rather than the creation of a

new tier of service made possible by new money. In Dumfries & Galloway we were recently able to re-design our Older Adult service due to retirement of two senior clinicians. We re-allocated resources to create an additional clinical psychology post, which afforded us the opportunity to reduce and eventually eliminate the waiting list. We made the decision to maintain short waiting times by: (a) offering relatively brief one-to-one therapy; and (b) carefully considering the appropriateness of referrals. (Our department has a self-help service developed for individuals with mild psychological disorders. This service, which is independent of the Older Adult service, has no upper age limit so it is possible to refer a proportion of Older Adult patients to Self-Help.) The effect of this was to reduce the time spent delivering traditional one-to-one therapy, freeing us up to spend more time on training and supervision in line with recent professional guidance (BPS, 2007).

One example of this is our recently-delivered workshop on management of challenging behaviour. We made this training available to representatives of residential care homes to increase their knowledge of, and skills in using, psychological management techniques. The decision to provide training to residential care home staff was predicated on the understanding that they are very well placed to instigate and conduct a basic psychological assessment. They are more familiar with their residents than a visiting psychologist and have greater opportunity to gather information from case notes, relatives and friends. Furthermore, when it comes to the intervention, they are in a good position to make the necessary environmental changes, and share information with colleagues to ensure continuity and consistency. Those in senior roles should be able to shape facility guidelines and structures to accommodate new ways of working. Finally, if care home staff takes responsibility for the management of a challenging behaviour

case, it demonstrates their ability to effect change, meaning that the problem is under their control, potentially reducing staff stress and burnout as a result.

Training content

The primary objectives of the training programme were to: (1) introduce the basic principles of psychological management; (2) provide delegates with a 'Challenging Behaviour Toolkit' to be used to complete assessments from which hypothesis-driven interventions could be developed; and (3) publicise a new treatment pathway for residents presenting with challenging behaviour.

Objective (1) – Core Principles

Using presentations and the DVD *Darkness in the Afternoon* (The Dementia Services Development Centre, University of Stirling, 2006), delegates were introduced to the following fundamental principles of psychological management:

1. Placing the person at the centre of the assessment and intervention.
2. Understanding that all behaviour, challenging or otherwise, happens for a reason.
3. Characterising challenging behaviour as the communication of an unmet need (James et al., 2006).
4. The role of functional analysis in understanding the triggers and consequences of a particular behaviour.
5. Recognising the differences between individual members of staff in perceiving and responding to challenging behaviour;
6. The necessity of team working to ensure consistency and increase the likelihood of success.

Objective (2) – Challenging Behaviour Toolkit

The content of the Challenging Behaviour Toolkit is summarised in Table 1. Presentations and workshops were used to introduce and demonstrate the use of these tools.

Table 1: Content of the Challenging Behaviour Toolkit.

Name	Function
Challenging Behaviour Scale (CBS; Moniz-Cook et al., 2001)	Used to identify the behaviour that would be the target for change, thereby keeping the assessment focused and reducing workload (assess one behaviour, not several). Also used as an outcome measure to assess success of an intervention. Can be used to illustrate differences of opinion between care home staff.
The Newcastle Model (James et al., 2006)	A formulation model designed to populate a list of client needs through consideration of a range of variables.
Medical Checklist (Developed by Annandale & Eskdale OA CMHT)	An aide-mémoire to prompt staff to request completion of basic medical screens to check for any underlying physical causes of CB.
ABC Record Form/ Behaviour Frequency Record Form	Tools used to help identify behavioural patterns.

Objective (3) Treatment pathway

The treatment pathway summarised the order in which the components of the Challenging Behaviour Toolkit should be used. It made clear that the role of the Community Mental Health Team (CMHT) and Clinical Psychology service was to be largely consultative, supporting work completed by the care home staff. Direct referrals to the CMHT or Clinical Psychology would only be accepted once evidence was provided that the pathway had been followed and consultation deemed insufficient. A workshop was used to identify potential challenges to adopting this new way of working and ways in which these obstacles could be overcome.

The Process

Training was offered to representatives from each care home throughout Dumfries & Galloway. Invitation letters were sent to the managers of each facility asking them to nominate up to four members of staff for training. The letter stipulated that the training would be most suitable for senior staff members who worked with challenging behaviour on a regular basis and those involved in developing nursing care plans with other staff members. This was done on

the assumption that senior staff would be well placed to affect change within their facility and cascade information to others.

To date, three stages of the training process have been completed. Stage one was a pilot of the training, delivered over one half-day to representatives from the care homes of the Annandale and Eskdale Local Health Partnership (LHP). The training programme was subsequently expanded to include more detail on the reasons for changing management approaches to challenging behaviour and a second workshop looking at challenges to change.

During stage two, the expanded, day-long training was delivered to representatives from each of the four Older Adult CMHTs. Members of the CMHT regularly visited care homes throughout the region and as a result were in a position to reinforce the training and new treatment pathway. Their support was critical to the success of the training programme and it was crucial that they were in agreement with the new way of working.

In the final stage, day-long training was delivered to representatives from care homes within the three remaining Dumfries & Galloway LHPs. It was co-facilitated by the trained CMHT representatives. For stages

two and three, sponsorship was provided by Eisai Ltd., Pfizer and Abbott Nutrition. This ensured that the training could be offered without charge to the delegates and hosted in pleasant surrounds.

The Outcomes

Each delegate was provided with a questionnaire pack to be completed prior to arrival:

- The Challenging Behaviour Attributions Scale (Hastings, 1997).
- Emotional Reactions to Challenging Behaviour (Mitchell & Hastings, 1998).
- Difficult Behaviour Self-Efficacy Scale (Hastings & Brown, 2002).
- Optimism and Willingness to Help (Todd & Watts, 2005).

The same questionnaires were completed by delegates immediately and six months after training. Data is yet to be analysed; only those involved in the pilot stage completed training over six months ago.

Over a total of 3.5 days, 79 representatives from 32 of the 35 invited facilities have received training. Delegates comprised managers, deputies, nurses, senior carers, and carers. During stage two, 18 CMHT representatives from all four LHPs received training. The majority of CMHT representatives were CPNs ($N=15$) with the remainder comprising a support worker, social worker and occupational therapist.

The training was well received by all delegates. Comments included that it:

- 'Enabled me to feel confident to deliver appropriate training to staff.'
- 'Has left me with a different outlook on challenging behaviour.'
- 'Will certainly motivate me to improve my practice with challenging behaviour.'
- 'Was the best course I've been on in a while.'

The training has helped to standardise the level of psychological care provided to people with dementia who present with challenging behaviour. It has introduced a new way for all Older Adult CMHTs in Dumfries & Galloway to manage challenging behaviour referrals. Further, at least two

members of staff from each of the 32 care homes are now familiar with the concepts and language of psychological CB management. These representatives can act as a link between clinical psychology and their place of work, a name to ask for when a referral does come in.

To ensure that all relevant stakeholders are kept abreast of local developments, plans are in place to inform GPs and Social Work colleagues of the new treatment procedure. At present, GPs are able, at the request of care home staff, to prescribe anti-psychotic medication to care home residents, meaning that the treatment pathway can be side-stepped.

The Future

Anecdotal evidence suggests that the number of referrals to OA CMHTs has declined since the training was delivered. We are in the process of auditing this more formally and we plan to report the results in due course.

The next wave of training is scheduled for December 2010. Those invited to attend are representatives from each community hospital, the elderly medical wards and older adult psychiatric wards. A total of 72 people from 19 different facilities have been invited to attend. In 2011, the training will once again be offered to representatives from each care home.

We intend that the programme of rolling training will result in a better skilled care-home workforce that is able to identify and respond to possible psychosocial triggers for challenging behaviour in residents with dementia. In line with this, the role of the OA CMHT staff will become more supportive and consultative. This represents a better use of scarce health service resources. It also increases care-home residents' access to psychological approaches by making use of a tiered service delivery model.

The IAPT model was originally introduced as a means of facilitating return to the employment market of those working age

adults suffering from mild to moderate severity mental health problems. This created a form of embedded discrimination against the older adult population which the current expansion of IAPT services seeks to address. However, the older adult population tends to have differing needs to those of the working age population so the focus of psychological therapy is likely to differ, to some extent, between the two groups. Challenging behaviour associated with dementia is one area of psychological need which is to a large extent age-related. Its management depends upon specific psychological knowledge and skills that are rather different from the skill set that might be used with working-age primary care patients suffering from mild-to-moderate mood disorders. Even so, the principles of IAPT – stepped care, psychologists as teachers and consultants – can apply to challenging behaviour just as they can apply to other areas of psychological need.

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Service examples:

Later Life Primary Care Psychological Therapy Service – maintaining an identity within Salford Primary and Secondary Care Services

Olga Horgan, Sue Watts & Sharron Mitchell

History of the service

IN 1996, a strategic review within the Salford area found that older persons were experiencing high levels of psychological distress and that mild to moderate mental health problems in these individuals were not being identified by primary health care staff. Following this review, our service was developed to offer psychological and counselling therapies to this population and to undertake training to assist other health professionals in identifying mental health problems in older people. In 2001, our service was cited in the National Framework for Older People (DH, 2001) as an example of good practice in mental health provision for people aged over 65. From the beginning, the service aimed to provide input to people aged 65 years and above. However, we have always also offered support to carers under the age of 65 and to people experiencing 'later life' difficulties such as multiple losses, bereavements, health and physical disabilities, and mild cognitive problems.

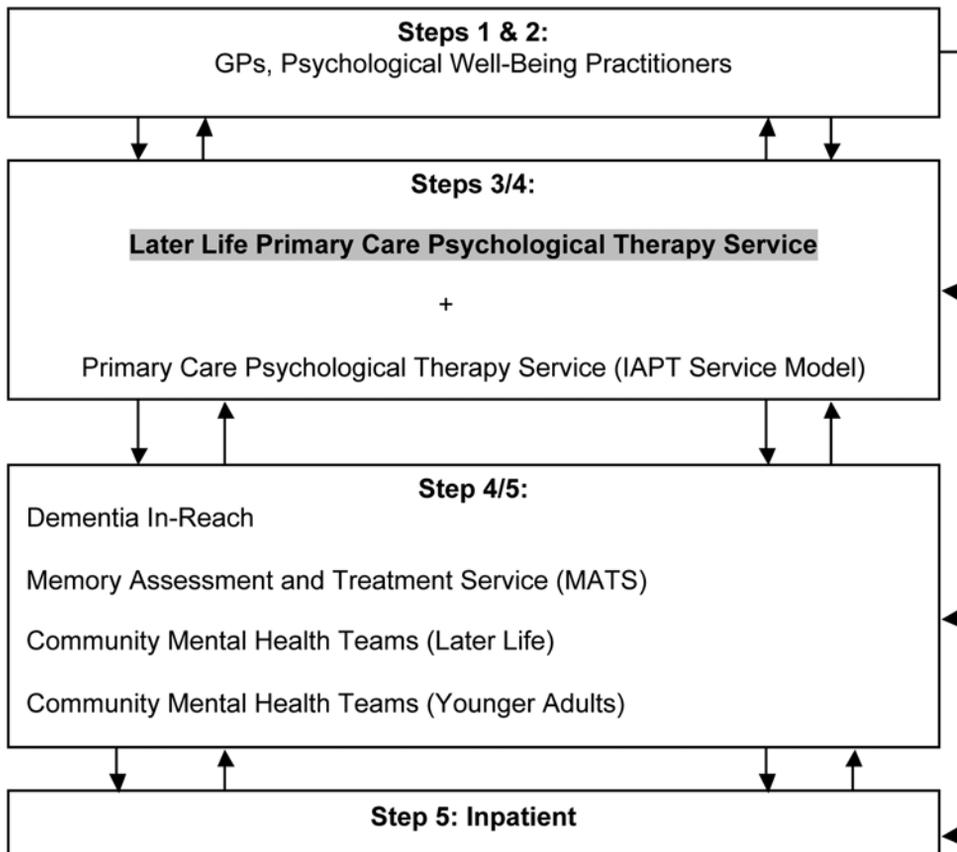
Staffing levels have reduced since the service was first set up. Current staffing includes three part-time counsellors, one part-time occupational therapist (OT), two full-time clinical psychologists, one full-time counselling psychologist, and one full-time assistant psychologist. Much of our work is carried out on an individual basis, engaging in one-to-one counselling, psychological, or occupational therapies with the client.

Our counsellors work within a range of approaches including person-centred, solution focused, humanistic and integrative counselling. Our psychologists use principles of cognitive behaviour therapy (CBT), cognitive analytic therapy, psychodynamic, schema therapy, acceptance and commitment therapy, and solution-focused therapy when working with clients. Our occupational therapist uses OT models incorporating physical, psychobiological, and sociocultural aspects of clients and their environments into interventions. Some aspects of CBT may also be incorporated into this work when appropriate. Given the range of clients that we see, and the range of abilities and difficulties experienced by these individuals, much of our work also includes providing indirect interventions and support to families, consultation and advice to other services, and teaching to non-mental health primary care colleagues.

Where does our service sit within wider mental health services?

Since our service was established, numerous changes to the provision of mental health services in Salford have and are continuing to occur. At the present time, we interface with both primary and secondary care mental health services, based within a mental health foundation trust. See Figure 1 for an illustration of where we sit within wider mental health services.

Figure 1



At primary care level, a majority of our referrals come from GPs and, since IAPT has been established, from Psychological Well-Being Practitioners based in GP practices. We also receive referrals from the Primary Care Psychological Therapy Service when clients' needs are considered more appropriate for our service (see explanation below). Other sources of referral come from the wider Primary Care, Social Care, and voluntary services, including physiotherapists, occupational therapists, Age Concern, and social workers.

At the secondary care level, we also receive referrals from the Later Life Community Mental Health Teams (CMHTs), Memory Assessment and Treatment Service (MATS), and from Dementia In-Reach. As

the diagram illustrates, individuals can be referred directly into our service, may be stepped up or stepped down from other teams, or be redirected from the single entry-point across the Later Life CMHTs/MATS/Dementia In-Reach services if considered appropriate. At present, we are working towards developing a primary care presence at the CMHT allocation meetings to support this interface and ensure that client's needs are met within the appropriate service.

Maintaining our identity within this mental health service

With the move towards developing services based on need rather than age (Everybody's Business, DH, 2005), it is imperative that our service no longer operates on an age-related

basis. When the service was started in 1996, our primary focus was on providing therapies to individuals aged over 65 years and to those aged under 65 years who were experiencing 'later life' difficulties. At this present time, with the national drive towards ageless community mental health teams, and with the development of ageless IAPT services, we must actively seek to maintain our focus on matching clients' needs to clinical skills within an efficient service configuration. Our identity as a specialism in issues associated with later life mental health and well-being, coupled with a commitment to pioneering treatment and care within this population, can help ensure that the current inequities in mental health services are not maintained in the new ageless services and that later life issues remain central. Thus, we are actively promoting our service as offering therapies to people both over and under 65 years with later life difficulties, and we must continue to underline the unique skills and provisions that our service can offer in relation to the other mental health services within the Salford community.

Where our service differs from IAPT, for example, is that it is comprised of staff who are specialists in working, specifically, with older clients and with clients experiencing issues and difficulties often associated with later life. Thus, we are skilled at taking into account particular cohort needs, whilst delivering therapies for later life issues such as adjusting to a diagnosis of dementia, caring for someone with dementia, adapting to physical illness and disability, and coping with multiple losses and bereavements. In addition to being skilled in providing therapies for later life issues, our staff are also adept at tailoring the delivery of therapies to suit the needs of clients with cognitive, sensory, and physical difficulties. Thus, whilst some of our clients could work within an IAPT model of service delivery, many would be unable to manage this model's pace of delivery, expectations for frequency of outcome measures, delivery of fixed numbers of sessions that do not account for

physical health problems prolonging or interrupting sessions, use of materials that are not inclusive or relevant to later life issues, and location of sessions within clinics rather than within the home. As our service offers neuropsychological assessments where appropriate, therapists can also assess and include this extra dimension of cognition within the client's formulation and adapt therapies accordingly. Moreover, staff in our service are also familiar with the influence of cognition on mental health presentations, and as such, are in a position to detect and monitor changing cognitive abilities and adapt therapies and treatments appropriately. These additional skills enable our service to be flexible and to adapt to the needs of older and younger clients with specific physical, sensory, and cognitive difficulties. In carrying out these adaptations, a significant part of our work also involves working indirectly with families and carers of our clients, which can include providing advice in and support on how to manage distress, tailored psychoeducational materials to assist clients in carrying out their interventions, and formulations to assist in a greater understanding of the client's needs within the context of the age-related life changes they are experiencing.

An additional aspect of our service delivery, and another area in which we differ, for example, from the Salford Primary Care Psychology Service (IAPT model), is in offering training, teaching, and consultation on later life mental health awareness to services within primary care and to users of these services. Thus, for example, we are involved in providing teaching to carers of people with dementia, and in offering advice and consultation to physical health specialists such as physiotherapists and occupational therapists based in physical health settings. We also provide promotional materials and training to increase the recognition and awareness of later life mental health problems in primary care staff, social services staff and other services that have a large amount of contact with older clients.

Have numbers of referrals changed since IAPT?

An April 2004 to March 2005 audit revealed that 312 referrals were received into the service during these months. Interestingly, whilst subsequent audits in 2006, 2007, and 2008 showed reduced referral numbers of $N=247$, $N=268$, $N=258$, respectively, our most recent 2009 audit has shown an increase in referral rates ($N=310$) to what they were in 2004. It is difficult to speculate as to what the reasons for these changes in referral rates might be. However, it could be that the initial drop was due to further developments of the Intermediate Care Psychology Service or to reduced staffing within the Later Life Primary Care Psychological Therapy Service and subsequent limitations in resources to actively promote the service.

These audits also indicate that there has been little change, overall, in the average age of people referred into the service. Thus, the mean age of people referred to the service in 2004 was 75.30 years, whilst the mean age of referrals in the 2009 audit was 73 years. What is interesting, however, is the fact that the number of accepted referrals for people under the age of 65 has increased from nine people in 2004 to 30 people in 2010 so far. The majority of these referrals in 2010 were from non-GP sources, including social workers, community matrons, and physical health physiotherapists and occupational therapists. Other sources of these referrals included GPs and Primary Care Psychological Well-Being Practitioners. The main reasons for these referrals were to offer therapies in relation to difficulties following physical illness, bereavements, and carer stress, and so this increased number of younger-age referrals could reflect the fact that our service is increasingly being recognised as specialist providers in these later life

issues. Another reason for the increase in number of younger-age referrals could be the improved recognition of the importance of psychological therapies, which has no doubt occurred following the development of the Salford IAPT service. However, it must also be said that this increase could be due to the recent closure this year of Salford's Intermediate Care Psychology Service, which was a service that provided therapies for individuals of all ages experiencing physical health difficulties in the community and following their discharge from hospital.

What does the future hold?

In maintaining an identity as primary care specialists in therapies for later life mental health and well-being, our service must continue to provide a flexible and needs-led service to our clients, whilst at the same time demonstrating efficiency and demonstrable outcomes. The nature of our needs-led approach means that we are in the process of developing a range of outcome measures which appropriately reflect and measure the range of clients' needs and the variety of therapeutic interventions that we offer. As a standard, the Hospital Anxiety and Depression Scale (HADS) is administered to all clients at the initial point of contact. However, when interventions are primarily indirect, involving family or psychoeducational approaches, outcome measures are being developed to account for these different aspects of our interventions since indirect and family work is particularly central to therapeutic interventions with this client group. The most important focus in the current climate is to continue to evolve and to actively strive to avoid losing specialist skills in the move towards the age equality agenda in mental health services.

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Top Tips:

A data conscious workforce: Top Tips for questions to ask in your IAPT service about older people

Jacqui Ruddock

Introduction:

Why is data important in IAPT?

DISTINCTIVE to IAPT services is the use of data to track service user access and progress within psychological therapies at every session. Overall, the NHS is data rich. However, the evidential culture within IAPT can only be sustained if workers continue to make improvements in accurate data recording, levels of patient disclosure and awareness raising of the value of data in planning and delivering quality services.

Questions for Practitioners to ask:

1. What proportion of older people are using your psychological services?
2. How does this compare with other services?
3. What barriers are preventing older people accessing or using your service?
4. How does the service involve older people and their families in their treatment and service development?

Questions for Service Managers to ask:

1. What is the upper age of older people using the service?
2. What is the most common age range of older people?
3. How does this compare with local demographics of older people?
4. What ethnicities of older people are represented?

Questions to ask the Primary Care Trust:

1. When was an Equality Impact Assessment (EqIA) of the service last completed and what were the findings for older people?
2. What preparations have psychological services made for age discrimination legislation?

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Notes for Contributors

The *PSIGE Newsletter* welcomes the following submissions for publication: articles, research updates, Letters to the Editor, book reviews. These can be on any aspect of psychological theory or practice with older people.

Articles

Articles form the bulk of contents submitted to the *Newsletter*. As the *Newsletter* aims to cover a broad, cross section of work with older people, we are happy to consider academic, descriptive, discursive, or review articles for publication. These can cover empirical investigations, pilot studies, descriptions of service developments, audits and evaluations. Articles should be submitted three months before publication (i.e. October for the January issue, January for the April issue, April for the July issue, and July for the October issue).

Articles of any length up to a maximum of 3000 words will be considered. Experimental reports should follow convention in terms of subheadings and sections: Abstract, Introduction, Method, Results, Discussion, References.

References should follow conventional format as in journals such as *Psychological Review*:

- (1) Book reference:
Mischel, W. (1986). *Introduction to personality*. New York: CBS.
- (2) Journal article:
Martin, A. & Fedio, P. (1983). Word production and comprehension in Alzheimer's disease: The breakdown of semantic knowledge. *Brain and Language*, 19, 124–141.
- (3) Paper in a book:
Garrett, M. (1980). Levels of processing in sentence production In B. Butterworth (Ed.), *Language Production (Volume 1) Speech and Talk*. London: Academic Press.

Research Updates

The *Newsletter* is particularly keen to publish contributions concerning ongoing research. These can reflect any stage in the research process, for example, ideas for discussion or early stage results, which are not ready for formal publication. Try to keep these submissions below 500 words.

Letters to the Editor

The Editor welcomes correspondence which combines brevity with rational argument. Letters may be edited if more than 250 words in length.

Book reviews

Submissions up to 250 words reviewing a text of relevance and interest to the PSIGE membership will be considered. These submissions must include full details of the book (including publisher).

The Editorial Board reserves the right to make minor changes to any submissions. Where major editing is necessary, the authors will be informed.

Images

The *Newsletter* is published in black-and-white. It is not advisable to send complicated, colour diagrams. If you are unsure, try printing the image or photograph out on a mono laser printer to check for clarity.

Please send original image files (.tif, .jpg, .eps or the like), not simply a Word document with the pictures imported into it, as these do not print properly.

Submission Procedure

All submissions must be written in language that is inherently respectful to older people and consistent with the British Psychological Society's guidelines.

All contributions must be word processed. Formatting should be consistent with the British Psychological Society's guidelines.

Please submit articles as a Word file via e-mail to the Editor.

When submitting articles please send the following information:

Full name;

Affiliation (title, place of work);

Contact details (should you be willing to be contacted by the membership);

Acknowledgements (as appropriate).

Finally, all reports of research should indicate whether or not Ethics Committee approval was awarded, and by which Ethics Committee, or whether the work was carried out as an audit/service evaluation project.

All contributions should be sent to: louisa_shirley@hotmail.com

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