Psychiatric Bulletin (2004), **28**, 411–414

original papers

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A survey of the provision of psychological treatments to older adults in the NHS

AIMS AND METHOD
A questionnaire was sent to old age psychiatrists to ascertain their experience, views and clinical practice regarding psychological therapies in their services.

RESULTS
The provision of psychological treatments of all modalities to older people is widely varied in Britain. The main difficulty seems to be a lack of resources, but it would appear that inexperience with psychological therapies applied to older adults is also a factor. Most mental health teams (95%) provide anxiety management therapy, and cognitive–behavioural therapy is widely available (76% of teams), but areas such as training and staff supervision appear to be poorly provided.

CLINICAL IMPLICATIONS
Suggestions are made to increase provision and quality of service within existing resources; improving services to the standards of the National Service Framework would be a bigger challenge.

Psychological therapies should be included in psychiatric services for older people with mental illness. Despite evidence of patients requesting psychotherapy (Evans, 2000), few services are able to provide much in the realm of psychological treatments (Garner, 1999). Quoting the National Health Service (NHS) Executive Review of Psychotherapy Services (NHS Executive, 1996), Garner highlighted the lack of evidence to suggest that older patients benefit less well than younger patients from a psychological or psychosocial approach.

Murphy (2000) surveyed consultant psychotherapists in England and Wales to ascertain how many of them were treating older patients; those aged 55 and over. Few old age psychiatrists appeared to be referring their patients to psychotherapy services. Murphy (2000) confirmed an anxiety about working with this age group on the part of some consultant psychotherapists, but could not explain the dearth of referrals from psychiatrists working with older patients. The majority of specialist psychotherapy departments (87%) declared no upper age limit to referrals, but admitted that they could accept older adults within their resources only because there were so few referrals of this nature.

Conditions such as depression, anxiety and dementia dominate the referrals to departments of old age psychiatry. Ageing and its challenges are about a series of adjustments, and these play a significant part in the aetiology of depression and anxiety (Murphy, 1982). A psychosocial treatment in these disorders is therefore an appropriate approach. The National Service Framework for Older People highlights the need for equality of service, and to phase out discrimination on the grounds of age (Department of Health, 2001).

Aim

This survey attempts to obtain a view from the old age psychiatric perspective, and in so doing make some contribution to the question which Murphy raises: why are patients not being referred to specialist psychotherapy services by old age psychiatrists? Moreover, if they are receiving psychological treatments elsewhere, are these being provided by members of the multidisciplinary team; nurses and occupational therapists in day hospitals for older people and in-patient facilities? The level of formal support and supervision for these staff is another element requiring elucidation.

Method

The Royal College of Psychiatrists Faculty of Old Age Psychiatry list (1998) was used to conduct a postal survey. The list contained names of 365 old age psychiatrists. There were also a number of psychiatrists from other specialties on the list whose responses were not used.

Two hundred and fifty-eight usable responses were returned, giving a response rate of 71%, which was considered acceptable for this kind of survey.

Demographics

The gender ratio of responses was: 58% male to 41% female (1% of respondents did not disclose their gender). The Faculty's gender ratio is similar, suggesting that there was no gender bias in the response rate.

Personal experience of psychotherapy is not a prerequisite of psychiatric training. However, 63 of the responding psychiatrists (24%) had experience of personal therapy. The range of psychiatric experience was extremely wide – there were responses from colleagues who achieved MRCPsych or equivalent from 1971 through to 1995.

Results

Models of service integration and delivery

Psychology
The responses presented two main models of partnership in psychiatric services to older people, one in which the

https://doi.org/10.1192/pb.28.11.411 Published online by Cambridge University Press

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psychology department is part of the directorate of old age psychiatry. Teams are integrated under an umbrella of 'elderly services'; psychiatry and psychology jointly dedicated to working with older adults. Another model was of psychology operating as a separate directorate providing psychology services to the old age teams, but not in an integrated way. Separate referrals would be made for psychology input.

Psychotherapy

Specialist psychotherapy services present another set of differences around the UK. Some old age services operate in NHS Trusts without a consultant psychiatrist-led psychotherapy service. Other trusts offer psychotherapy assessment and treatment to older psychiatric patients in a variety of different ways, depending on the resources available. Examples of creative practice include psychotherapists who provide formal support and supervision to old age psychiatry colleagues, in addition to accepting referrals for psychotherapy for older patients.

Access to specialist consultant-led psychotherapy service

One hundred and sixteen respondents (45%) stated that they have access to psychotherapy services without an upper age limit on referrals. Over half of these (73; 63%) had actually referred patients to the service in the previous 12 months. Of those who refer, most did so due to the complication of the case. Others admitted to lack of expertise within their own teams.

Thirty-eight old age psychiatrists (15%) expressed dissatisfaction with the local psychotherapy service; despite apparent open access. They reported finding that the specialist service dealt inadequately with the needs of older patients, particularly regarding physical needs and length of waiting lists.

Thirty-four respondents (13%) stated that their local psychotherapy services are known not to accept referrals of older patients over 65. Forty-seven (18%) reported that they are without a consultant-led psychotherapy service within the NHS trust. Forty-four of the old age psychiatrists (17%) admitted to not knowing whether their local service took referrals of older patients or not.

Who does what?

Common to old age psychiatry services was that a great deal of 'psychotherapy' of different modalities is being offered to older patients. The majority of providers are nurses and other members of the multidisciplinary team.

The psychological treatment offered in 246 of the responses (95%) was anxiety management. This is an evidence-based treatment for older users (Woods & Roth, 1996). The next most commonly provided treatment was cognitive–behavioural therapy (CBT), offered by 196 departments (76%). CBT was provided largely by psychologists, and by nurses supervised by the psychology team. Some departments employed art therapists and music therapists as part of occupational therapy. Treatments such as couple therapy (87; 34%) and family therapy (79%; 31%) were offered relatively commonly. They tended to be provided by the consultant and other staff members. Therapies such as grief work (9; 3%), carer's support andbereavement counselling were among the services least provided (Fig. 1).

Training and supervision

One hundred and forty-two of the psychiatrists (55%) appeared not to know of the level of psychotherapy training of the various multidisciplinary team members. Ninety-five (37%) declared that they were aware which staff were trained in the psychological therapies that they were delivering and 9 (3.5%) stated that they knew the therapists were untrained. Four and a half per cent did not respond to this question (Fig. 2).

With respect to supervision for the psychotherapy offered, as distinct from general clinical and management supervision, psychiatrists were asked about the provision of supervision for the therapists. Seventy-nine (30.6%) said they did not know whether supervised practice took place or not. However, prompted by the next question, 38% of these respondents wrote that they were 'probably supervised by a psychologist'.

Twenty-eight respondents (11%) declared that no one in their department was supervised for psychological work.

One hundred and seventy-four psychiatrists (67.5%) were aware of the levels and provenance of the supervision in their departments (five did not answer). The most common source of supervision was, in 84 cases (32.5%), from a qualified member of the existing team. Supervision from a specialist service, which could be either psychology or the local psychotherapy services was provided to 53 respondents (20.5%). Only 16 of the old age services (6%) 'bought in' supervision from outside the service. The three potential sources of supervision were not mutually exclusive and some departments had all three.

Anx Mx	CBT	Art Rx	Couple Rx	Family Rx	Dynamic Rx	CAT	Drama Rx	Group Rx	Grief Rx
246 (95%)	196 (75%)	90 (35%)	87 (34%)	79 (30%)	58 (22%)	31 (12%)	26 (10%)	8 (3%)	9 (3%)

Fig. 1. The psychological therapies offered in old age services in decreasing order of frequency offered; few services offered all while most offered only anxiety management (Anx Mx) and cognitive–behavioural therapy (CBT). Rx, therapy; CAT, cognitive–analytical therapy.

https://doi.org/10.1192/pb.28.11.411 Published online by Cambridge University Press

Aware of training	Don't know	Aware of no formal training	No response
95 (37%)	142 (55%)	9 (3.5%)	12 (4.5%)

Fig. 2. Psychiatrists' awareness of therapists' training.

Qualitative data: thematic analysis

Comments were invited from the respondents, of whom 75% wrote additional material in the space provided. Some comments were short, while others filled a side of A4. Comments were collated into the following themes, which appear in descending order of frequency.

1. Many of us are doing supportive work (not 'formal' psychotherapy).
2. The need for more work is recognised (would love to do more/too little time).
3. The expertise within the multidisciplinary team is utilised rather than other departments.
4. We need more training and supervision.
5. We use principles of psychological therapies and modify them (for use with older people).
6. The attitudes of psychotherapists is an issue (a few departments were thought to operate an implicitly ageist service that is difficult for frail elderly people to access).
7. The importance of an awareness of psychodynamics in all areas of this work.
8. Asking for evidence base to assist with resource allocation.

Consumer views

Although there was no direct access to patients' views about psychological therapies, psychiatrists were asked if they had experienced patients or their relatives asking for psychotherapy. Forty-eight per cent responded that patients had requested psychotherapy and 49% responded that relatives had asked for psychotherapy on the patient's behalf (Evans, 2000).

Discussion

This survey generates further questions about the nature of coalitions between psychiatry and psychology services, and which model works best for psychotherapy for older people. There seems little disagreement among old age psychiatrists that older patients should have access to some kind of psychological services. What is less clear, and accords with Murphy's work, is whether people are better off being treated by old age psychiatry practitioners experienced with older patients, or whether they are better referred to specialist psychotherapists and psychologists who may have little experience in working with older adults. It may be this tension that accounts for the lack of referrals to specialist agencies.

There may exist an element of behavioural effect. Psychiatrists having learnt that some psychotherapy departments are not easily accessible to older patients may simply give up referring. Others may only refer the really 'difficult' cases. It may be more acceptable to deal with patients' psychological issues locally, with members of staff that patients already know.

The range and number of psychological treatments on offer appears to be unacceptably limited, in view of evidence of potential improvements in relapse prevention, and treatment outcomes of depression and anxiety (Ong *et al*, 1987; Radley *et al*, 1997; Reynolds *et al*, 1999). Support for carers and people affected by dementia appeared to be particularly low.

This survey unearthed examples of excellent practice and cooperation between psychotherapy and psychological departments and old age psychiatry services. Other published examples exist (Terry, 1994; Martindale, 1995; Arden *et al*, 1998), but are taking time to filter into common practice.

With improved communication, psychotherapy, departments could provide a more accessible service to the elderly, as with younger adults (Haddock, 1999). Equally, psychotherapists can support and supervise members of the multidisciplinary team in their existing work (Fabricius, 1995; Stern & Lovestone, 2000). Members of the specialist elderly teams could also be encouraged and perhaps funded to attend appropriate training courses of various psychological therapies.

Psychologists, psychotherapists and occupational therapists working within teams and attending ward rounds raise the awareness of psychological work. This in turn enriches the experience of the rest of the multidisciplinary team, including psychiatrists (Waddell, 2000).

The issue of training parallels an ongoing debate about the training of specialist psychotherapists. While one does not wish to de-skill practitioners or undervalue the enthusiastic amateur, there is an issue of clinical governance. Practitioners should not be offering services beyond their level of competence and should achieve some level of minimum standard of practise. Rigorous views (Pedder, 1993) might exclude excellent nurses without formal psychotherapy qualifications, but the skills-based approach (Main, 1990) still requires the practitioner to be well supervised in order to understand and make use of countertransference and projective mechanisms. This is important in reducing risk of harm to vulnerable patients (Evans, 2001).

Conclusion

The provision of psychological therapies to older NHS patients with psychiatric disorder is extremely variable across the country, and the quality of the existing services is often unknown. It is unlikely that there will be new resources to fund improvements, however some changes could begin now with small investments only.

https://doi.org/10.1192/pb.28.11.411 Published online by Cambridge University Press

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A great deal of psychological work such as support groups, anxiety management and CBT happens within old age psychiatry departments, apparently provided by non-medical professionals. If these staff were offered adequate supervision and some additional training, quality of services could improve which may have an overall benefit on service and staff morale. Trainee psychiatrists should be included; higher trainees in psychotherapy might have experience of working with older patients (Bateman & Holmes, 2001). Expectations are likely to alter, as the cohort of older people changes with the next generation. This survey demonstrates that patients and their relatives are already asking for psychological treatments from a service that is traditionally more organic in its approach.

Acknowledgements

The author would like to thank the committee members of the Older Adults section of the APP (Association for Psychoanalytic Psychotherapy in the National Health Service) for their helpful comments in the preparation of the questionnaire: thanks to Siobhan Murphy for similar assistance. Thanks to Anthony Holgate and Gill Gibbins at the Royal College of Psychiatrists for their kind help and support, and all colleagues who responded to the questionnaire.

Declaration of interest

The author is a group analyst.

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https://doi.org/10.1192/pb.28.11.411 Published online by Cambridge University Press