NHS Education for Scotland

The Matrix Evidence Tables

OLDER ADULT MENTAL HEALTH

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The Scottish Government

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RECOMMENDATION

A	Highly recommended
B	Recommended
C	No evidence to date but opinion suggests that this therapy might be helpful

Matrix: Level of evidence	Recommendation	
A At least one meta-analysis, systematic review, or RCT of high quality and consistency aimed at target Population	A	Highly recommended
B Well-conducted clinical studies but no randomised clinical trials on the topic of recommendation directly applicable to the target population, and demonstrating overall consistency of results	B	Recommended
C Widely held expert opinion but no available or directly applicable studies of good quality.	C	No evidence to date but opinion suggests that this therapy might be helpful

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PSYCHOTHERAPY WITH OLDER PEOPLE

INCREASES IN HEALTHY LIFE EXPECTANCY ARE PROFOUNDLY IMPORTANT AFFECTING NOT JUST THE AGE DISTRIBUTION OF SOCIETIES IN THE DEVELOPED AND DEVELOPING WORLD BUT ALSO THE COMPOSITION OF SOCIETY ITSELF.

In Scotland, the population aged 90+ is set to triple by 2033 and currently people aged 60+ outnumber those aged 16 and under. As a result there is a need to focus on improving access to psychological therapies for the oldest and most vulnerable members of our society.

Older people often present with psychological difficulties and physical comorbidity (for example as a result of conditions such as stroke and post-stroke depression) but also in relation to increased disability and frailty. A feature of psychotherapy with older people is chronicity as evidenced by a lifetime's experience of living with recurrent mental health problem. Depression and anxiety in later life are not necessarily disorders of late onset but may more often reflect a continuing or recurrent pattern. Additionally age-related developmental factors can result in change, for example, a diminution of social networks through loss. However increasing age in itself may not be a factor in the development of depression as most older people report high levels of life satisfaction and are better at emotional regulation than younger adults. As people are increasingly living longer, so multiple losses become more common. For many older people these transitions can revolve around loss of physical or psychological independence. Thus psychotherapy can be different in regard to the types of challenges that people may face as they age. This means that psychotherapists may need to have a wider knowledge base of health and physical comorbidity.

Sadavoy (2009) characterises five main 'C's' of working with older people and these are chronicity, complexity, comorbidity, continuity and context. This acknowledges that working with older people can be challenging and is a highly specialist intervention that is very often undertaken at a high level of intensity. Paradoxically as older people are a heterogeneous population there is much variability in terms of whether modifications or adjustments are necessary (Zeiss & Steffen, 1996) so psychotherapy can also be offered as a low intensity intervention such as self-help. Psychotherapy outcome with older people may be enhanced if therapists take account of relevant theories from gerontology in light of age challenges and emotional and cognitive changes in later life. Cuijpers et al, (2009) in their recent meta-analysis concluded that psychological therapy treatment outcomes are comparable for younger and older adults.

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DEPRESSION IN LATER LIFE

UPDATED 2011

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	Primary Care	Low-Moderate	Bibliotherapy (using non-older adult specific texts)	A [10]
			Life review therapy	C [6]
			Counselling	C [10]
Moderate	Primary Care and Secondary Care	Low - High	Problem-Solving Therapy (PST)	A [1, 5]
			Individual CBT	A [2, 4, 5, 11]
			Psychodynamic Psychotherapy [NB]	A [2, 14]
			Group-based CBT	A [3, 13]
			IPT maintenance post-recovery	A [7, 8]
			Behaviour Therapy	A [9]
Severe	Primary Care and Secondary Care/CMHT	High	Individual CBT * *CBT with medication may be more effective than medication alone.	A [5, 12]
Chronic or Treatment Resistant	Secondary Care / Highly Specialised Specialist Service; In-Patient Care	High	Individual CBT	C [12]

N.B. Most of the evidence for psychodynamic psychotherapy with older people is indirect, with the strongest evidence for psychodynamic psychotherapy vs CBT trials. At up to two years follow up, psychodynamic therapy was also shown to have beneficial outcome for late life depression (Gallagher-Thompson et al, 1990).

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ANXIETY DISORDERS IN LATER LIFE

UPDATED 2011

Level of Severity/ Functional Impairment[A]	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild	Primary Care	Low	CBT	A [5, 6]
Moderate to Severe	Secondary or Tertiary Care	High	CBT	A [1, 2, 4]
Chronic/Complex with evidence of executive impairment	Psychological therapy services with highly specialist practitioners	High	CBT (adapted for older people with anxiety and executive dysfunction using specialist protocol).	B [3]

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PERSONALITY DISORDERS IN LATER LIFE

UPDATED 2011

Level of Severity/ Functional Impairment	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate	Secondary Care	High	DBT	B [1]

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SEVERE AND ENDURING CONDITIONS IN LATER LIFE

UPDATED 2011

Level of Severity/ Functional Impairment	Level of Service	Intensity of Intervention	What Intervention[E]?	Recommendation
Moderate	Secondary Care	High	Cognitive Behaviour Social Skills Training for Schizophrenia	B [1, 2, 3]
		High	Group based CBT for older adults with Bipolar Disorder	C [4]

[E] The social skills training studies are conducted on participants that are quite young by the standards of other studies reported here. The age range is from 42 to 74 years in studies 1, 2 and 40-78 for study 3.

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PSYCHOTHERAPY WITH OLDER PEOPLE OVERALL CONCLUSIONS

The overall conclusion about psychotherapy with older people is that there is good evidence that psychotherapy is effective for depression and anxiety. Although, the literature on psychotherapy outcome with oldest-old is insufficient, outcome is not adversely affected by age as people in the oldest age range (80+) report similar outcomes to young-old people. Likewise there is comparable outcome for CBT between adults of working age and older people (Cuijpers et al, 2009). More specific age related conditions such as dementia, stroke and Parkinson's disease are being recognised as having significant psychological consequences for the individual and their caregivers.

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DEMENTIA

DEFINITION

SIGN 8635 defines dementia as a "generic term indicating a loss of intellectual functions including memory, significant deterioration in the ability to carry out day-to-day activities, and often, changes in social behaviour."

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DEMENTIA

UPDATED 2011

DEPRESSION AND ANXIETY IMPACTS NEGATIVELY ON THE QUALITY OF LIFE FOR THE PERSON WITH DEMENTIA AND CAN BE ASSOCIATED WITH AN INCREASE IN REFERRAL TO RESIDENTIAL CARE.

However, there is a paucity of research exploring the efficacy of psychological interventions for this client group. The evidence base for CBT for anxiety and depression in general older adult populations is growing and there is some evidence to suggest that it may also be applicable to treating people with mild to moderate dementia, as outlined in the table below.

DEPRESSION AND ANXIETY IN THE PERSON WITH DEMENTIA

Level of Severity/ Functional Impairment	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate	Secondary Care/ Specialist protocol	High	Behaviour Therapy	B [2, 3]
		High	CBT	C [1, 4, 5]

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COGNITION (AND QUALITY OF LIFE)

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild/Moderate	Secondary Care / Specialist	High / Specialist	Cognitive Rehabilitation	A [1, 2]
Mild/Moderate	All tiers of care including voluntary settings	Low	Cognitive stimulation therapy (improves cognition and quality of life)	A [1, 2,]
		Low	Maintenance CST (maintains gains in quality of life and improves cognition for those taking AChEIs)	A [3]

CST remains a highly recommended treatment for people with dementia and can include care workers with appropriate supervision. Research into carer led, one-to-one, CST is currently underway.

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MOOD

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild/ Moderate	Secondary/ care home/ day hospital	Low	Reminiscence Therapy for mood, including personalised activity	A[1,2*]
Moderate/ Severe	Secondary care/ Specialised	High	Reminiscence therapy to improve mood and some cognitive abilities	A[3*]

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INSOMNIA

UPDATED 2014

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild - Severe Insomnia	Secondary Care / Specialist	High/specialist	Psychological therapy for insomnia in dementia (Multi-component caregiver intervention, including daytime activity, sleep hygiene and light exposure)	A [1-4]

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PSYCHOLOGICAL INTERVENTIONS IN RESPONSE TO STRESS AND DISTRESS IN DEMENTIA

THE TERM STRESS AND DISTRESS HAS COME TO BE USED IN PLACE OF CHALLENGING BEHAVIOUR OR BEHAVIOUR THAT CHALLENGES.

National clinical guidelines (SIGN 86 and NICE 42) recommend that non-pharmacological interventions for the behavioural and psychological symptoms of dementia (Stress and Distress) be considered prior to the administration of psychotropic medications. The guidelines recommend that in the first instance, a full and comprehensive assessment be conducted and that any intervention be individually tailored taking into consideration the person with dementia's preferences, skills and abilities.

Unfortunately, although there is a clear drive towards psychological approaches in response to stress and distress in dementia within clinical guidelines and national policy (including Scotland's Dementia Strategy, 2013), the evidence-base for non-pharmacological interventions is limited. There is a paucity of research with suitably robust methodology, which limits the interpretation of findings with regards to evidence-based recommendations (as reflected in clinical guidelines). That said, there is a general agreement that formulation-led interventions that focus on the specific needs of the individual provide the most quality approach (James, 2011; BPS 2013).

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SUPPORTING DEMENTIA CAREGIVERS EXPERIENCING 'STRESS AND DISTRESS'

UPDATED 2015

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate	Community/ Secondary Care	Low	Multi-component interventions	A[5,18]
		High	CBT for depression and distress in caregivers	A [10, 15,17]
		High	Behavioural Management Training	A[16]

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PSYCHOLOGICAL APPROACHES IN RESPONSE TO STRESS AND DISTRESS IN THE PERSON WITH DEMENTIA*

UPDATED 2015

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Mild-Severe	Nursing Home	Low	Enhanced Psychosocial Care (to reduce neuroleptic Medication)	A[4]
Mild-Severe	Secondary Care	Low	Psychoeducation for caregivers	B[3]
Mild-Severe	Community	Low	Multiple Component Interventions for Caregivers	A[5,19]
Moderate-Severe	Community	High	Behaviour Management to reduce depression	B[9]

*N.B. Low intensity interventions require training and supervision to be effective

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SPECIALIST LEVEL PSYCHOSOCIAL INTERVENTIONS

The following interventions should be considered in the context of a highly specialist and comprehensive assessment of difficulties which will inform formulation-led interventions specific to the needs of the individual person with dementia based on specific psychological models (including the Newcastle Model and Cohen-Mansfield unmet needs model).

It is recommended at this level that practitioners participate in specialist training in specific theoretical approaches, assessment techniques and tailored interventions. Low or high intensity interventions outlined above may also form part of an intervention plan, if appropriate to the formulation.

PSYCHOSOCIAL INTERVENTIONS IN RESPONSE TO STRESS AND DISTRESS

UPDATED 2015

Level of Severity	Level of Service	Intensity of Intervention	What Intervention?	Recommendation
Moderate/Severe	Secondary Care	Low	Environmental Adaptation:	B[1,2]
			Doll Therapy within Clear Ethical Guidelines	B [13,14]
			Increasing Occupation/Stimulation (E.g. Music Therapy and Activities)	A[19]
			Simulated Presence Therapy (SPT): Important to assess the person's suitability for such as approach and monitor the responses closely.	B [11,12]
			Social Contact – real or simulated Including animal assisted therapy.	B [7,8,11]
			Validation Therapy	C [6]

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