



CLAIRE HILTON

## Psychological therapies, older people and human rights<sup>†</sup>

### SUMMARY

Additional funding has recently been made available by the government for the treatment of anxiety and depression. However, this is targeted towards people of working age, to reduce expenditure on incapacity

benefit. That older people with the same mental illnesses do not receive equitable access to psychological therapies contradicts other recent government recommendations. Economic data appears to hugely influence provision of services for

this group of users, but is this appropriate and humane? The Human Rights Act 1998 (Chapter 42) has been largely ignored in the provision of mental health services for older people, and the centrality of this legislation needs further consideration.

### Government policies

Immense media enthusiasm greeted the news in October 2007 that the National Health Service (NHS) will spend £170 million per year on psychological therapies by 2010/2011. The announcement emphasised the provision of psychological interventions for people with anxiety and depression, to reduce expenditure on incapacity benefit and to restore people to employment. Pilot schemes were reported to have been successful.<sup>1</sup> It is estimated that such schemes should pay for themselves by reducing expenditure on benefits.<sup>2</sup> However, the psychological therapies are only part of a new broader employment scheme and their specific contribution to enabling re-employment has not yet been fully evaluated. Despite this, the scheme is being rolled out.

A major implication of this economically based therapy plan is that funding for psychological therapies will not be targeted towards older people with anxiety and depression, despite recent statements advocating equitable access to healthcare for older people. The *National Service Framework for Older People* states that 'NHS services will be provided, regardless of age, on the basis of clinical need alone'.<sup>3</sup> The National Institute of Health and Clinical Excellence (NICE) guideline on the management of depression proposes that 'The full range of psychological interventions should be made available to older adults with depression, because they may have the same response to psychological interventions as younger people'.<sup>4</sup> That older people can benefit from treatment for depression as much as younger people has long been established.<sup>5</sup> One could argue that older people should be prioritised for evidence-based psychological approaches on the basis that these produce no drug interactions or pharmacological effects on comorbidities frequently part of an older person's complex health state.

### Older people with anxiety and depression

As the population of older people grows, from 9.6 million in 2005 to (predicted) 12.7 million in 2021, the number of people with mental illness will also grow. One in four older people living in the community have symptoms of depression severe enough to warrant intervention. According to Age Concern, only a third of them ever

discuss it with their general practitioner, and only half of that number are diagnosed and treated, primarily with antidepressants.<sup>6</sup> Mental illness in older people affects families, carers, neighbours, and social and health resources, as well as the patient. Age Concern's report highlighted 'tremendous unmet need'.

For the entire adult population the lack of implementation of psychotherapeutic approaches has been described as 'the clearest breach of any NICE Guidelines for any illness affecting large numbers of people . . . That it continues is wrong in medical terms. But it is also a major economic issue.'<sup>7</sup> Unfortunately, the widely quoted *Depression Report*<sup>2</sup> did not report economic outcomes of treating older people. It is not stated whether they were excluded from the calculations or whether economic benefits were just not detected. However, because of the economic data, attempts are being made to mend the breach in the NICE guidelines for adults of working age. No such in-roads are being made for older people.

### Current funding trends

A review of the National Service Framework for Mental Health<sup>8</sup> stated that an additional £1.5 billion had been spent annually since 1999 on service development targeted at adults of working age. In contrast, the *National Service Framework for Older People* had no additional mental health finance attached. When progress on the Framework was reviewed in 2005, it was evident that older people had not benefited from some of the developments seen for younger adults, that age discrimination needed attention, and that further investment in specialist old age mental health services was required.<sup>9</sup> Sadly, this report also re-emphasised 'paper care' rather than funding: designing protocols and care pathways, giving care plans to patients, coordinating care and using the single assessment process. This amounts to hardly more than lip service. 'Good mental healthcare for older people is not optional,' the authors say and also, contradictorily, '[primary care trusts] should support access to assessment, treatment and care for all those at risk'.<sup>9</sup> Without substituting the magic word 'must' for 'should', options rather than obligations exist and experience suggests that what appears superficially to be the cheapest economic alternative will be chosen.

<sup>†</sup>See special article, pp. 186–188, this issue.



## Quality adjusted life year

The usual criterion for assessing benefit in health economics is the quality adjusted life year (QALY). It measures quality of life on a standardised scale comprising distress and function, and number of years of improvement achieved for a particular intervention.<sup>10</sup> The scale was derived mainly from acute medical and surgical interventions, unrelated to chronic illness.<sup>11</sup> Using QALYs for people with chronic illness and in old age has been criticised,<sup>12,13</sup> as QALYs neither reflect stresses on carers and family, nor are they derived from the values of older people in terms of their expectations of quality of life. For many older people, the ideal state of distress-free perfect function will never be achievable. In this group, increments of improvement may be small but extremely significant. For example, requiring help with dressing may cover a range of degrees of independence from needing intensive help to just needing prompting or help with shoe laces. Quality adjusted life years are unlikely to detect such small differences, yet such a change may have implications for family and carers, in economic terms, and for the person's dignity and self-esteem. There is no adequate scale for quality of life relating to older people's mental illness.<sup>13</sup> If the QALY, although inadequate for older people, is the standard tool for economic planning for mental healthcare, then we need to either use other tools or other principles for our modelling for older people's well-being.

## Human rights

Human rights are hardly ever mentioned in policies related to provision of services for older people with mental illness, even though the NHS is bound by the Human Rights Act 1998. Concerns about compliance with the Act are highlighted by the House of Lords and House of Commons Joint Committee on Human Rights (JCHR).<sup>14</sup>

Four articles of the Human Rights Act are particularly important in the context of older people's mental health. These are the prohibition of discrimination, the right not to receive degrading or inhuman treatment, respect for privacy and family life, and deprivation of liberty (articles 14, 3, 8 and 5 respectively). Dignity is not a specific legal principle, but is considered a fundamental value. Although age is not listed specifically as a criterion for discrimination, the JCHR based its entire proceedings on the assumption that age is included under 'other status.' Although the issues are complex, refusing to give treatment for distressing conditions on the basis of age as distinct from clinical evidence may contravene article 14, and perpetuating suffering in the absence of providing efficacious treatment may be equivalent to inhuman treatment (article 3). In addition, if illness remains untreated and is associated with a patient requiring institutional care, articles 5 and 8 may also be contravened. Legal challenges have not yet been made on the basis of these criteria.<sup>15</sup>

Inevitably, there are finite limits to healthcare resources. However, whereas for younger people policies may include an 'invest to save' element, even when the

evidence for an intervention is not fully conclusive,<sup>1</sup> it is almost always absent from policies for older people. I am not arguing for endless resources. I am arguing merely for adequate means, under non-ageist human rights principles, to implement and evaluate evidence-based treatment, to relieve suffering and distress, to maximise function, prevent morbidity and promote independence for older people. The JCHR was not convinced that the Department of Health complies with the Human Rights Act for health policies, neither were they convinced that NICE takes the Act into account in their decision-making. The JCHR stated that the Human Rights Act 'has an important role to play in moving the culture to one where the needs of the individual older person are at the heart of healthcare services'. The government response to the JCHR document further supports the centrality of the Human Rights Act to the provision of healthcare, stating that it is 'unlawful for a healthcare organisation to act in a way which is incompatible with the Human Rights Act 1998'.<sup>16</sup> Precisely what this means, however, may have to be determined through the courts.

Since the *National Service Framework for Older People*, there has been little move from rhetoric to responsibility or from ideas to implementation in older people's mental health services. Perhaps the JCHR document will trigger a rethink of policy on treatment for older mentally ill people. At present, 21st-century British society and government appear excessively materialistic and ageist, favouring employment and earning power rather than respect for the individual.

## Acknowledgements

My thanks to Marie-Clare Mendham, Dr David Jolley and Dr Michael Hilton for their comments.

## Declaration of interest

Under the criterion of 'or any close relationship with an organisation whose interests, financial or otherwise, may be affected by the publication of your paper', I work in a trust where I perceive older adults services to be less well-funded relative to services for younger adults.

## References

- 1 Department of Health. *Johnson announces £170 million boost to mental health therapies*. Government News Network, 10 October 2007 (<http://www.gnn.gov.uk/content/detail.asp?ReleaseID=321341&NewsAreaID=2&NavigatedFromSearch=True>).
- 2 Centre for Economic Performance, Mental Health Policy Group. *The Depression Report: A New Deal for Depression and Anxiety Disorders*. London School of Economics, 2006 ([http://cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION\\_REPORT\\_LAYARD.pdf](http://cep.lse.ac.uk/textonly/research/mentalhealth/DEPRESSION_REPORT_LAYARD.pdf)).
- 3 Department of Health. *National Service Framework for Older People*. Department of Health, 2001.
- 4 National Institute for Health and Clinical Excellence. *Depression: Management of Depression in Primary and Secondary Care*. The British Psychological Society & The Royal College of Psychiatrists, 2004.
- 5 Mayer-Gross W. Electric convulsion treatment in patients over 60. *J Ment Sci* 1945; **91**: 101–3.
- 6 UK Inquiry into Mental Health and Well-Being in Later Life. *Improving*



special  
articles

- Services and Support for Older People with Mental Health Problems: Second Report.* Age Concern England, 2007.
- 7 Layard R, Clark D, Knapp M, Mayraz G. Cost benefit analysis of psychological therapy. *Natl Inst Econ Rev* 2007; **202**: 90–8.
  - 8 Appleby L. *Mental Health Ten Years On: Progress on Mental Health Care Reform.* Department of Health, 2007.
  - 9 Philp I, Appleby L. *Securing Better Mental Health for Older Adults.* Department of Health, 2005.
  - 10 Phillips C, Thompson G. *What is a QALY?* Hayward Medical Communications, 2001 (<http://www.jr2.ox.ac.uk/bandolier/painres/download/whatis/QALY.pdf>).
  - 11 Rosser RM, Watts VC. The measurement of hospital output. *Int J Epidemiol* 1972; **1**: 361–8.
  - 12 Bosanquet N, Rawlins M. Quality-adjusted life years are too rigid for the NHS. *Health Serv J* 2005; **115**: 20–1.
  - 13 Royal College of Psychiatrists. *Response from the Faculty of Old Age Psychiatry to the NICE Appraisal Consultation Document: Donepezil, Rivastigmine, Galantamine and Memantine for the Treatment of Alzheimer's Disease.* Royal College of Psychiatrists, 2005 ([http://www.rcpsych.ac.uk/pdf/responseNICE\\_March05.pdf](http://www.rcpsych.ac.uk/pdf/responseNICE_March05.pdf)).
  - 14 House of Lords and House of Commons Joint Committee on Human Rights. *The Human Rights of Older People in Healthcare* (vol. 1). TSO (The Stationery Office), 2007.
  - 15 British and Irish Legal Information Institute (BAILII). *England and Wales Database.* BAILII, 2008.
  - 16 House of Lords and House of Commons Joint Committee on Human Rights. *Government Response to the Committee's Eighteenth Report of Session 2006–07: The Human Rights of Older People in Healthcare.* TSO (The Stationery Office), 2007.

**Claire Hilton** Consultant Psychiatrist, Mental Health Services for Older Adults, CNWL NHS Foundation Trust, Bentley House, 15–21 Headstone Drive, Harrow HA3 5QX, email: [claire.hilton@nhs.net](mailto:claire.hilton@nhs.net)

*Psychiatric Bulletin* (2009), **33**, 186–188. doi: 10.1192/pb.bp.108.021972

**PRADIP GHOSH**

## Improving access to psychological therapies for all adults<sup>†</sup>

### SUMMARY

New psychological services are about to roll out across England. The National Institute for Health and Clinical Excellence clinical guidelines have led to government investment in the Improving Access to Psychological Therapies (IAPT) programme. New IAPT services

should cut waiting times for psychological treatment of depression and anxiety disorders from months to days. They are intended to be available for all adults on the basis of need rather than age. It is not currently illegal for patients to be discriminated against by the National Health Service (NHS)

because of their age. The government intends to introduce new legislation against age discrimination in the provision of goods, facilities and services by the NHS. Further investment and service development will be needed to counter existing age-related inequalities in mental health services

No legislation currently protects people from age discrimination in the provision of goods, facilities and services by the National Health Service (NHS).<sup>1</sup> Increasing evidence of inequality in English mental health service provision between 'younger adults' and people over 65 years old has been reported, with lower use of services by older people with depression and anxiety disorders.<sup>2</sup> Newly formed mental health teams have provided services for adults of working age, excluding older adults. For example, a survey of English crisis resolution teams found that less than a third of mental health trusts provided the same service to older and younger adults and only one in six areas frequently provided crisis services to older people.<sup>3</sup> Investment in psychological services for older people has been called a 'national disgrace'<sup>4</sup> and recommended psychological therapies are reported to be almost totally unavailable for older adults.<sup>5</sup> In contrast, the Improving Access to Psychological Therapies (IAPT) programme has recently been described as 'one of the most important advances for NHS services in a generation.'<sup>6</sup> What is IAPT and will older adults benefit?

resulting in massive undertreatment of depression and anxiety disorders.<sup>7</sup> The 2006 Depression Report argued that NHS evidence-based psychological therapies should be available for all who need them and the most important benefit of government investment in psychological services would be the reduction in distress and suffering. It stated that investment would more than pay for itself through savings on other NHS services, fewer state benefits, and with more people working.<sup>8</sup>

In 2006, two IAPT pilot projects began testing the effectiveness of developing evidence-based psychological interventions in primary and community settings ([www.mhchoice.csip.org.uk/psychological-therapies/psychological-therapies.html](http://www.mhchoice.csip.org.uk/psychological-therapies/psychological-therapies.html)). The core purpose of these demonstration sites was to collect evidence to develop a business case for national roll out of the IAPT service model.<sup>9</sup> Although the pilots were reported to have achieved impressive outcomes,<sup>10</sup> they were criticised for only providing their services to people of 'working age', despite older people's ability to benefit from psychological therapies. Age Concern cited institutionalised age discrimination in mental health services.<sup>11</sup>

These criticisms appear to have been addressed in 2007 with 11 new 'Pathfinder' sites extending the scope of IAPT to support the case for further service expansion. A mandatory feature for all Pathfinder sites was the availability of services to people of all ages on the basis of

<sup>†</sup>See special article, pp. 184–185, this issue.

### IAPT pilots and pathfinders

Around the country, NHS psychological therapies have been either unavailable or subject to significant delays