Barriers and facilitators to accessing psychological therapies for severe mental health difficulties in later life

Katherine Berry[1,2,*], Jennifer Sheardown[1,2], Uma Pabbineedi[1,2], Gillian Haddock[1,2], Catherine Cross[2] and Laura J.E. Brown[1,2]

[1]Division of Psychology and Mental Health, School of Health Sciences, Faculty of Biology, Medicine and Health, University of Manchester, Manchester Academic Health Science Centre, Manchester, UK and [2]Greater Manchester Mental Health NHS Foundation Trust, Manchester Academic Health Science Centre, Manchester, UK
*Corresponding author. Email: katherine.berry@manchester.ac.uk

Abstract

Background: The number of people growing older with severe mental illness (SMI) is rising, reflecting societal trends towards an ageing population. Evidence suggests that older people are less likely to seek help, be referred for and receive psychological therapy compared with younger people, but past research has focused on those with mild to moderate mental health needs.
Aims: This research aims to identify the specific barriers faced by older people with SMI.
Method: We interviewed 53 participants (22 service users with SMI aged over 50 years, 11 carers of people with SMI, and 20 health care professionals) about their views and experiences of accessing therapy for SMI in later life.
Results: Thematic analysis revealed five themes: organizational and resource issues; myths about therapy and attitudinal barriers; stigma; encouraging access to therapy; and meeting age-specific needs.
Conclusions: Barriers faced by older people with SMI are not only age-related, but also reflect specific issues associated with having a SMI over many years. Improving awareness of the benefits of psychological therapies is important not only for older people with SMI themselves, but also for their carers and staff who work with them.

Keywords: barriers; facilitators; later life; psychological therapy; qualitative research; severe mental illness

Introduction

More than 1.5 million people in England have a severe mental health illness, such as schizophrenia and bipolar disorder (Schizophrenia Commission, 2012) and it is estimated that over 20% of these people are over the age of 65 years (Public Health England, 2018). Globally, the ageing population is increasing rapidly. For example, in the UK in 1996, only a handful of areas had over 25% of their local population aged 65 and over but by 2036, over half of local authorities are projected to have 25% or more of their local population aged 65 and over (Office for National Statistics, 2017). Consequently the number of those with severe mental illnesses (SMIs) living into later life are also likely to rise (Cohen *et al.*, 2015). SMIs can also interplay with common age-related problems, such as physical disability, cognitive impairment and social isolation (Berry and Barrowclough, 2009). As a result, older people with SMI often have significant unmet needs, and are one of the most vulnerable groups within the health and social care system (Berry and Barrowclough, 2009).

Psychological therapy, such as cognitive behavioural therapy (CBT), is a well-established intervention for SMIs (NICE, 2014), and there is good evidence that older people respond as well to psychological therapy as younger people (Laidlaw *et al.*, 2003). However, research shows that older people are less likely to seek help, be referred for, and receive psychological treatments, compared with the general population (Prina *et al.*, 2014; Age UK, 2016). Possible barriers to access for older people include problems with transportation which impact on capacity to attend health care appointments, beliefs that it is normal to be anxious and depressed in old age, and beliefs by referrers that psychological therapy is less likely to be effective (Wuthrich and Frei, 2015).

These problems in access are likely be to particularly relevant amongst older people with SMIs, who are most commonly prescribed medication as the main form of treatment (Healthcare Commission, 2009). Medication has only limited effect on social and everyday living skills, which may be more problematic for older people with SMI than psychotic symptoms (Berry and Barrowclough, 2009), and can have harmful side-effects in old age due to changes in metabolism and increased physical disability (Huybrechts *et al.*, 2012). Although there are Improving Access to Psychological Therapies (IAPT) initiatives in the UK for both older people and SMI (http://www.iapt.nhs.uk), neither of these initiatives focus specifically on people with SMI in later life. This is important, as older people with SMI are likely to face different barriers to accessing therapy compared with older people with milder mental health difficulties, or younger adults with SMI (Berry and Barrowclough, 2009). For example, many people with severe mental health difficulties in later life may have been diagnosed several decades earlier and thus have been subjected to mental health services that had purely biological views of severe mental health and/or delivered coercive treatments. They may also have been deprived of opportunities to work or develop meaningful relationships with others as a result of prolonged or repeated hospitalizations.

There is a burgeoning literature on barriers to accessing therapy for working-aged adults with SMI given notorious problems with the implementation of evidence-based therapies in routine care. For example, both Berry and Haddock (2008) and Ince *et al.* (2015) reviewed studies examining barriers to implementing National Institute of Clinical Excellence (NICE) recommended therapies guidance for schizophrenia, including CBT. Berry and Haddock concluded that implementation barriers for psychological interventions, including CBT, were met at three levels: individual staff, service recipients and organizations which all interact. Ince *et al.* found that organizational constraints were the most commonly reported barrier to implementation, with all articles reviewed highlighting this factor as problematic. Lack of resources, lack of dedicated therapy time and specialist training, workload pressures, crisis management demands and staff shortages were specifically reported barriers. Even when healthcare professionals felt they had received adequate training and had adjusted their job roles accordingly, in some studies staff reported problems implementing newly acquired skills due to time and caseload demands. Local team factors including management that did not support the use of psychological therapies, negative team attitude towards psychological interventions and biomedical models of understanding psychosis, with a focus on symptom reduction as opposed to functional recovery, also influenced healthcare professionals' attitudes to incorporating psychological interventions in routine practice. However, the extent to which these barriers mirror barriers faced by older people with SMI needs to explored. This study therefore aims to gain an understanding of the barriers and facilitators to accessing psychological therapies for older adults with SMI from the perspectives of service users themselves, their carers, and healthcare professionals. We specifically decided to include carers in this study to the relative absence of their perspectives in previous literature but also because they are likely to play an increasingly important role in the lives of ageing people with severe mental health difficulties due to increasing levels of dependency. The ultimate objective of this research intends to guide the improved implementation of psychological interventions for this client group.

Method

Participants and procedure

The research was carried out according to the Ethical Principles of Psychologists and Code of Conduct as set out by the APA and the study was approved by an NHS ethics committee (reference number: 16/NW/0123). A total of 53 participants were included. These consisted of 22 people aged 50 years and over, who had been diagnosed with SMI, in addition to 11 carers of and 20 staff working with people meeting these criteria. We focused on adults aged 50 years and over as opposed to over 65 years, due to the 15–25 year reduced life expectancy in SMI (Schizophrenia Commission, 2012), and the rationale that people in middle age (50–65 years) were likely to be able to consider how experiences of growing older might impact on treatment needs and experiences.

Inclusion criteria for service users were: over 50 years of age; healthcare professional confirmed current diagnosis of a severe mental illness (such as schizophrenia, schizoaffective disorder or bipolar disorder); capacity to provide informed consent for interviews; consent to have interviews audio-recorded; and sufficient English language proficiency to take part in qualitative interviews. Carer inclusion criteria were: named carer for or living in the same household of a person with a healthcare professional confirmed current diagnosis of a severe mental illness over 50 years of age; over 18 years of age; capacity to provide informed consent for interviews; consent to have interviews audio-recorded; and sufficient English language proficiency to take part in qualitative interviews. Staff inclusion criteria were: direct experience of working with service users with severe mental health difficulties over 50 years; over 18 years; and consent to having interviews audio-recorded.

Participants were recruited from both NHS (primary, secondary and tertiary care settings, including both later life specialist services and working age services) and voluntary organizations across the North West of England using purposeful sampling to ensure people with a range of characteristics and levels of experiences of therapy were captured. See Table 1 for a summary of the sample characteristics.

After obtaining written informed consent, one-to-one semi-structured interviews were conducted by research assistants. The majority of service user and carer interviews took place in the person's own home, and the majority of staff interviews took place in the person's place of work. Interviews were based on topic guides that had been developed in consultation with service user and carer groups. The questions focused on participants' views and experiences of psychological therapies for older people with SMIs, as well as their perceived barriers and facilitators to this group accessing psychological therapies. All interviews were audio-recorded and later transcribed by the research team.

Data analysis

Interviews were analysed using thematic analysis which was supported with Nvivo. This approach was chosen due to its flexible nature, and lack of assumptions regarding epistemology. The six steps of analysis recommended by Braun and Clarke (2006) were followed. First, the researchers familiarized themselves with the data by repeated readings of the transcripts. Explicit events, thoughts and actions were then coded based on their relevance to the research question. Each code was then categorized into over-arching themes based on their commonalities. The analysis involved a recursive movement between the source, extract and theme to ensure that the themes were grounded in the data. The credibility and coherence of the potential themes was checked, and discussed at all stages by the members of the research team. Themes were initially defined and named separately within each participant group, then due to substantial overlap between groups, these were combined into one coherent thematic summary.

Table 1. Sample characteristics

	Service users (*n* = 22)	Carers (*n* = 11)	Staff (*n* = 20)
Gender % (*n*) female	41% (9)	64% (7)	70% (14)
Age mean (range)	61 years (range 50–78)	49 years (range 43–73)	44 years (range 23–59)
Ethnic group % (n)	77% (*n* = 17) White British	82% (*n* = 9) White British	80% (*n* = 16) White British
	5% (*n* = 1) White Irish	9% (*n* = 1) Asian	15% (*n* = 3) Asian
	9% (*n* = 2) Black British	9% (*n* = 1) African-Caribbean	5% (*n* = 1) African-Caribbean mixed race
	5% (*n* = 1) Black African		
	5% (*n* = 1) mixed race		
Diagnosis % (*n*)	68% (*n* = 15) schizophrenia		
	32% (*n* = 7) bipolar disorder		
Professional background % (*n*)			10% (n = 2) psychiatrist
			35% (*n* = 7) psychologist
			5% (*n* = 1) assistant psychologist
			35% (*n* = 7) nurse
			5% (*n* = 1) occupational therapist
			10% (*n* = 2) social worker
Nature of relationships to service user		73% (*n* = 8) spouse or partner	
		18% (*n* = 2) sibling	
		9% (*n* = 1) other relative	
Number of years contact with mental health services mean (range)	32 years (range 2–51 years)		
Number of years' experience as carermean (range)		17 years (range 2–30)	
Number of years' experience working in mental healthmean (range)			19 years (range 4–39)

Results

Five key over-arching themes were drawn from the analysis. These were labelled: organizational and resource issues; myths about therapy and attitudinal barriers; stigma; encouraging access to therapy; and meeting age-specific needs. Each theme is illustrated below with excerpts from transcripts to support key findings.

Theme 1: Organizational and resource issues

The first theme, reflected in transcripts from all three groups, related to the way in which UK health services are configured, and resource limitations within the National Health Service (NHS). These issues highlighted wider issues within mental health service provision, and were not necessarily specific to the delivery of psychological therapy, but resulted in medication being used to treat difficulties as it was perceived as providing a cheaper and quicker fix than psychological therapy.

Subtheme: Older people falling between the gaps

Local changes in how services were organized, coupled with resource limitations, meant services adopted strict entry criteria seemingly 'batting back' as many referrals as possible. This resulted in older people with SMI often falling through the gap between adult and later life services. Staff

highlighted confusion about whether older people should be seen by adult mental health services, who may lack experience in working with later life issues, or specialist later life services, who tend to focus on organic age-related problems such as dementia.

> *When we get referrals in for this team we're like ooh they're 70 they need to go to later life, and they might get bounced around a little bit.* [Staff member 03]

Similarly, staff also reflected that older people with SMI may fall between the gap between primary and secondary services. Due to their history of SMI people might not meet criteria for primary care, but as their mental health may be relatively more stable and they may present with less risk issues than younger people early in the course of psychosis, people with SMI in later life might not be prioritized within secondary care services.

Many service users and carers were also unclear about where to access psychology services, and expressed concerns that, within a resource-limited climate, the needs of younger people would be prioritized.

> *There's a lot of people out there who won't go for the help that they need, cos they don't know where to turn to.* [Service user 08]

> *As budgets are getting tighter, treatment has to be targeted more tightly where it might be felt to be more effective, and if you can help somebody with forty productive years ahead of them get well, is that not going to influence the decision compared to offering the same treatment to somebody in retirement?* [Carer 11]

Subtheme: Medication provides a quicker fix

Resource limitations meant that medical treatments were often seen to be prioritized over psychological therapies, which were perceived by some staff as being resource intensive with long waiting lists and consequent delays in access. As highlighted by this member of staff, providing treatments quickly was particularly important within the current organizational climate, where there were treatment targets to meet.

> *We work by, like, targets don't we. And we always have, like, big waiting lists, and I guess maybe prescribing somebody tablets might be seen as a quicker, a quicker way of improving a person's distress.* [Staff member 04]

The relative difficulty in accessing psychological therapy for SMI in later life resulted in older people and their carers being more accustomed to medical treatments for their difficulties, and more wary of therapies, which were less familiar to them as a means of treatment. Even if therapies were available and offered, this lack of familiarity with psychological approaches might mean people were reluctant to engage.

> *Maybe some older people might just sort of not know what to expect from psychological therapies even if they're offered it, they might refuse to have it.* [Service user 07]

Theme 2: Myths about therapy and attitudinal barriers

Although not universal across all participants, the second theme related to common myths and negative attitudes held by some service users, carers and even staff about therapy, and possibly also reflected the above themes of people's limited exposure to therapy and the predominance of medical treatments. Positive and negative attitudes towards therapy were not always mutually exclusive, with some participants expressing contrasting views.

Subtheme: Therapy will rock the boat

A common misperception of therapy held by service users was that it would focus on distressing past experiences and therefore do more harm than good. For example, service user 17 expressed the concern that '*psychological therapy may provoke certain things that were buried and make problems re-surface again.*'

Carers also expressed this concern, highlighting the stress that they had experienced over the course of their relatives' long history of mental health difficulties and the desire to avoid difficulties reoccurring.

> *I think if you probe too deeply, and you bring up too many bad memories, and you take people to places they don't want to go, I think that could be harmful.* [Carer 10]

Subtheme: No point in talking about problems

Relatedly, participants from all three groups reflected that people with SMI in later life may hold beliefs and attitudes typically associated with their cohort, such as the importance of stoical approach to dealing with problems and not talking about emotional issues, and that these attitudes might mean the concept of therapy feels unappealing to them.

> *Talking about emotional problems or anxiety and mental health problems, I think sometimes older people think it's a sign of weakness. Just to get on with life and pick yourself up and move along.* [Carer 02]

Subtheme: Too old to learn

A further attitudinal barrier is the belief that older people are too old to learn new things. For example, several service users referred to older people like themselves using terms such as '*quite set in their ways*' (Service user 07) and '*difficult to change*' (Service user 01). Similarly, one service user described his experience of attending a group therapy session and other people in the group being '*surprised*' that '*I haven't, sorted my problems out at that age*' (Service user 15).

Some staff also suggested that older people might not be suitable for therapy due to lack of potential for change compared with younger people.

> *Especially in later life because you're trying to teach people new things when they already have very set behaviours and, you know, it can be quite challenging I think to even get people to consider doing psychological therapies* [Staff member 15]

Subtheme: Later life is an ideal time for therapy

Despite some evidence of negative effects of therapy in later life, some participants from all three groups did express the view that older people could benefit as equally from therapy as younger people and, in some instances, felt that later life was a prime time for therapy.

> *As people get older ... I suppose they might be more kind of retrospective looking back over your life or, kind of, I suppose thinking about the future and thinking about legacy.* [Staff member 09]

> *I think at fifty, you can reason with yourself more, cos you're more philosophical, you've seen some places and of all sorts of thing fifty is a good time to go and see and just talk about it.* [Service user 09]

Therefore, although ageing was seen in a negative light by some participants, being more experienced and having greater insight into life's challenges was seen as potentially facilitating older people's engagement with psychological therapy.

Theme 3: Stigma related to diagnosis or help-seeking

The stigma associated with mental health difficulties was highlighted as a particularly important barrier in accessing therapy in later life, and this was seen as being especially relevant for the current generation of older people due to the ridicule and shame associated with mental illness when they were growing up.

> *There's a stigma involved, and you don't like talking about it with other people because they think you're crazy, they think you're a lunatic.* [Service user 02]

> *I think with older people it's a, it's a generational thing as well, you know. They don't want to admit that they're having to have help for a problem. I was the same: I didn't tell anybody I was having therapy.* [Carer 10]

Several service users also highlighted beliefs that may get in the way of them accessing therapy that resulted from having a long history of negative involvement with mental health services.

> *One of them sort of said 'NHS I blame you guys'. And, you know, they kinda see us as part of the NHS, and probably part of this horrible system that they've experienced.* [Staff member 04]

> *A lot of people, particularly who've had a lifetime of severe enduring mental illness, have had lots of very difficult experiences with professionals. Lots of difficulties in trusting people, lots of difficult sort of people leaving, some of the old wards, you've got people in their seventies eighties some of the old wards were awful.* [Carer 05]

Theme 4: Encouraging access to therapy

This theme highlighted ways in which barriers towards therapy might be overcome, and reflected either trusted staff or carers encouraging service users to attend. In order for this to happen it was important that psychologists worked more closely with staff teams and the wider family system.

Subtheme: Working with staff to encourage access

Both service users and carers highlighted that, if the topic of therapy was broached by a trusted member of staff who was already familiar to them, and who was informed enough about therapy to address any concerns they might have, then they would be more accepting of a referral for therapy and more likely to attend.

> *If put to them properly by a trusted person most people would respond favourably to the offer of psychological therapy.* [Service user 03]

> *If it was, um, suggested in the care programme as part of the ongoing care plan, I think she'd be more open to considering it than if it was suggested by an outside agency for no immediate apparent reason.* [Carer 11]

Staff members also reflected how one key method of helping staff to be sufficiently informed about therapy to enable them to encourage service users to engage, and also to help overcome staff negative attitudes towards therapy, was psychologists working as an integral part of the mental health team as opposed to a distant professional who saw the occasional 'cherry-picked' client. Working as part of the team was also seen as an effective means to manage resource

limitations. Psychologists who were interviewed reflected that they could spread their resources further by supporting staff in developing skills in therapy and psychologically informed thinking as opposed to simply providing one-to-one therapy for a limited number of service users.

> *Not just parachuting in and not just being there occasionally but being there and being part of the team and able to say 'ooh that person might be someone for psychology'.* [Staff member 17]

Subtheme: Importance of working with carers

Although carers expressed concerns about therapy, they also highlighted that they could play an integral role in supporting their relatives to attend therapy if those concerns could be addressed.

> *Well, I wouldn't want him to do anything he really didn't want to do, but I would encourage him. As I always do. I wouldn't hit him over the head with it, I'd do what I always do, and I'd go with him. Er, and if he wanted me to sit in I would . . . He would go for my sake. I think just, I think he might just go for my sake.* [Carer 01]

 Ways of addressing carers' concerns primarily related to conceptualizing them as an important part of the service user's social system by recognizing the challenges that they might face, their own support needs, and their need to be informed about what treatments were being offered to their relatives and why.

> *If you are in a family, it's like a tree. And there are different branches, but the tree is still a tree. It has its main and then everything is branched off but it's still connected. And even though they may have their mental issues, they're still part of the family. And if the whole family doesn't engage in the therapy [pauses] for me it has to be the whole to make that one person any better.* [Carer 08]

Theme 5: Meeting age-specific needs

Staff, service users and carers highlighted the importance of tailoring services and therapies to overcoming physical and cognitive barriers that are more likely to present in later life.

Subtheme: Physical limitations and mobility

Many service user participants expressed how their physical health problems made it difficult for them to move about and make their way to regular therapy appointments.

> *When you get older, there's a big issue especially bodywise because I can feel it now I'm starting to get aches and pains that makes me feel awkward because I can't move about.* [Service user 19]

> *The travelling you know is difficult, going on a bus, then another bus, or a bus a train and a bus, that would put depending on where you were going, for you therapy.* [Carer 01]

 As a result of such limitations, participants highlighted the importance of therapy for older people being provided in local settings or even in people's own homes.

> *So maybe if home visit haven't been offered that would be something that would be a good thing and if it could be offered widely to older people. I think it would be a way to get more benefit from the treatment itself.* [Carer 11]

Subtheme: Cognitive impairment

Service users also highlighted experiencing problems with concentration and memory deficits, and the consequent need to take these into account within therapy.

> *I think, their [other service users] concentration spans are not very long, and it would have to be quite repetitive and quite, I suppose, structured and bounded at some level.* [Service user 22]

Discussion

This study aimed to identify the barriers and facilitators to accessing psychological therapies for people with SMI in later life. The following five themes were identified: organizational and resource issues; myths about therapy and attitudinal barriers; stigma; encouraging access to therapy; and meeting age-specific needs.

The first theme reflected both resource limitations within the UK health service and boundaries between different types of services. In the context of limited resource, services responded by tightening referral criteria, meaning that older people with SMI were excluded from later life services on the grounds of not having organic problems and working-age services for being over 65 years. No doubt these problems were compounded by relatively recent moves in some Trusts but not others, towards age-less services rather than specialist later life services (Saad and Bangash, 2016). Similarly, older people with SMI seemed to get lost between primary and secondary care services, with difficulties being too complex for the former, but not as pressing for the latter. Although these issues reflected the provision of mental health services in general and were not specific to therapy, it is probable that the issues were more prevalent in terms of therapy referrals, as therapy provisions are even more scarce than other types of mental health treatments (Healthcare Commission, 2009; Schizophrenia Commission, 2012). Given that staff themselves were confused about where to make referrals to, it was not surprising that service users and carers were also unsure about how to access therapies even if they wanted to do so. Organizational and resource barriers were also highlighted as key by studies examining barriers to accessing therapy for working-aged adults (Ince *et al.*, 2015). However, our findings show that older people with SMI might be particularly vulnerable to getting lost within referral systems due to lack of clarity about whether or not they should be seen by later life services and similarly whether their difficulties meet criteria for primary or secondary care.

The view that medication is prescribed as opposed to referring people to therapy as the former provides a quicker fix is noteworthy of discussion. Although the likely speed of effect may play a role in treatment decisions, we know from the wider literature of prescribing practices that medication use is likely to be influenced by a complex array of factors including evidence-base, beliefs of staff about the causes of mental illness, patients' previous histories of medication use (with it being hard to cease prescriptions previously started), and polypharmacy (using medications to counteract the side-effects of another medication) (Svensson *et al.*, 2019). The limited access that older people with SMI have to psychological therapy could also partly account for the stereotypical views held by some service users, carers and some staff working with these groups of what therapy would entail, and its effect in later life. In turn, these negative attitudinal barriers may discourage referrals for therapy and help-seeking and thus mean that views remain unchallenged. The view that therapy is contraindicated because it might lead individuals to re-experience painful emotions and memories has been found to commonly inhibit help-seeking among younger adults (Vogel and Wester, 2003), including people with SMI (Ince *et al.*, 2015). It may, nonetheless, be a particularly important barrier within older adult groups due to the paternalistic misperception that older people may be more fragile. While it may be true that therapy can evoke strong emotions for some, this is an important part of emotional processing in relation to past traumas, and any skilled healthcare

professional would only enter into such work with clients when they are deemed to have the necessary coping skills and fully aware of any potential adverse effects (Grey, 2009).

The view that there is limited point in talking about difficulties was an additional barrier to accessing therapy that may be particular pertinent to the current generation of older people who grew up in an era where mental literacy was poor. Although there is now increased emphasis on talking openly about mental health within the media (e.g. www.time-to-change.org.uk), these campaigns are not specifically targeted at older generations whose previous learning in relation to dealing with emotions may be very much ingrained and reinforced by same age peers or carers (Laidlaw and Knight, 2008).

The opinion that older people are too old to change is a common ageist attitude that has been previously reported as a barrier for older people to accessing mental health services for milder to moderate mental health needs (Robb *et al.*, 2002). The finding that some staff participants also shared this view is concerning, as staff can act as significant gatekeepers to therapy services and may communicate these negative messages about change to service users themselves.

Despite the above examples of negative beliefs about therapy in later life, it is noteworthy that not all participants shared these views. On the contrary, some participants believed that older adults would benefit from therapy more compared with younger adults, due to having more wisdom and greater life experiences. In line with this finding, previous research with community-dwelling older people suggests that those with more positive representations of ageing are more likely to see the usefulness in seeking help from mental health professionals (Kessler *et al.*, 2014). However, much less research attention has been paid to positive images about ageing (Levy, 2009), suggesting that this is an area which requires further exploration in future research.

The stigma theme revealed that the majority of service-user participants were embarrassed to talk about their mental health difficulties, or seek help from a psychologist, due to the negative stereotypes associated with mental health difficulties. Stigma concerns have been conceptualized as a significant contributing factor for the under-utilization of mental health services for all age groups (Parcesepe and Cabassa, 2012), including people with SMI (Berry and Haddock, 2008; Ince *et al.*, 2015), but the negative impact of this stigma has been found to be stronger among the older age groups due to their exposure to particularly negative images of mental illness that were prevalent several decades ago (Laidlaw and Knight, 2008). Participants with SMI were also likely to have been recipients of aversive and disempowering mental health practices that may have further compounded negative self-stigma and resistance to help-seeking in response to mental distress.

In order to overcome the above barriers, participants highlighted the importance of clear and positive communication about therapy and its benefits from healthcare professionals. Clear and comprehensible communication to support informed decisions about treatment not only enhances service users' knowledge, but also promotes active participation in treatment (Kyle and Shaw, 2014). However, this first necessitates that psychologists need to work with potential referrers and gatekeepers to address any negative beliefs about therapy and inform them about what it involves. In this respect, staff highlighted the benefits of psychologists engaging in more face-to-face working within multidisciplinary teams so that staff could develop a greater awareness of the psychologists' role at the same time as them working to increase staff members' psychological mindedness. Similarly, carers were seen as key facilitators in terms of supporting service user access to therapy, but this would also necessitate healthcare professionals being aware of, and working with, the person's social support network, as opposed to adopting a more individualized approach to care that is typical within adult mental health services.

Participants also highlighted a number of adaptations to therapy that might facilitate engagement. These included offering appointments in local community centres or service users' own homes, and adapting the structure and format of delivery of sessions to compensate for problems with concentration or memory that might be more prevalent in later life. These adaptations are likely to be particularly significant for those with SMI due to the increased risk of physical and cognitive co-morbidities (Schizophrenia Commission 2012; NICE, 2014).

The importance of these adaptations have been recognized in previous intervention studies for people with SMI in later life (Berry *et al.*, 2013). However, the move of some Trusts towards age-less services, where one size fits all and staff do not have any specific training or experience in later life issues, would seem contrary to the importance of approaches which take into account age-related needs (Saad and Bangash, 2016).

Strengths and limitations

Our qualitative methodology, which sampled the views of different stakeholders, enabled an in-depth understanding of barriers and facilitators to accessing psychological therapies for SMI from multiple perspectives. Not only was the sample size relatively large for a qualitative study, it was also relatively diverse in terms of other factors, such as length of time since diagnosis, age range (middle versus old age) and professional group. Nonetheless, the sample as a whole was limited in terms of ethnic diversity, service user diagnosis, and diversity of relationship type for carers. Notably, our sample did not include people in contact with Early Intervention in Psychosis services and such individuals may have different experiences in terms of access to therapies given the new Early Intervention in Psychosis Access Standard in England which stipulates that all adults up to the age of 65 experiencing a first episode of psychosis should be offered CBT for Psychosis and Family Interventions.

Our decision to include people under 65 within samples could also be viewed as a limitation, as arguably those who are 50 may not represent the views of those over 65 years. As highlighted in the Method section, people with SMI have a reduced life expectancy of 15–20 years and consequently show signs of premature ageing, meaning that age-related changes will become relevant at a younger age. Previous research also suggests that even in 'healthy' people, age-related changes and issues become relevant and salient in midlife (Brown *et al.*, 2015). Furthermore, the definition of old age is somewhat arbitrary and the age of 65 which has traditionally been used within clinical services and research trials has been challenged in recent years with services and trials not using the age of 65 as a criterion. Relatedly, the distinction between working age versus retirement age (on which the 65 year cut-off is typically based) is less relevant to this group, given that all/the majority of them were not in employment. As a result of all of these factors we were less concerned about only interviewing those over the age of 65 years. Nonetheless, we did anticipate probable differences in barriers faced by the so-called 'young old' and the 'old old' and as highlighted above sought to sample people from each age range as part of our sampling strategy. Differences in barriers highlighted by people of different ages were not apparent in our analysis.

A significant number of participants within the current study expressed frustration regarding lack of access to therapy for older people. It is possible that some people were motivated to take part in order to publicize the issues this presented, meaning that the views of those who did not perceive access as problematic were not as well represented. Previous reviews of barriers to accessing psychological therapies in SMI have highlighted the predominance of organizational barriers (e.g. Ince *et al.*, 2015). Whilst this wider systems issue was certainly present in our data, there were more compelling themes raised at the individual level. Sampling a wider range of stakeholders, such as service managers and commissioners, may have raised the prevalence of organizational themes within our data and indeed, future endeavours to work with services to overcome barriers to accessing therapy for older people with SMI need to ensure that these individuals are fully engaged in the process.

Further research to consider perspectives across a wider geographical location would also be useful as the participants included in this study represent only a small proportion of the services operating nationally and internationally. Some caution is therefore required in generalizing these findings in a wider context. In particular services across the country differ in the extent to which the age of 65 years is used as a criterion to move from offering Adult Mental Health services to

Mental Health Services for Older People and it would be useful to explore the impact of this variation in practice on barriers and facilitators to access.

Conclusions and recommendations

This study suggests that older adults with SMI face considerable barriers to accessing and engaging in psychological therapies. Some of the barriers faced by this group are likely to be unique to this group, as they are not only age-related, but also specific to SMI, making access to psychological therapies doubly difficult. In particular, older individuals with SMIs are more stigmatized than other groups of service users, may have SMI-related physical and cognitive limitations to deal with, and show a greater lack of trust in mental healthcare professionals. The views and experiences of their carers were also shown to be important in facilitating access to, and engagement with, psychological therapy.

Efforts should be taken, at both local and national levels, to increase the perceived need and service availability of psychological therapy services for older adults with SMI. Educational campaigns specifically designed to focus on mental health in later life and available services and resources could be made accessible to this group of individuals, their carers, and staff who work with them. It is a welcome move that Early Intervention Services for psychosis in England now have an Access Standard which stipulates that all adults up to the age of 65 experiencing a first episode of psychosis should be offered CBT for Psychosis and Family Interventions. However, we now need similar standards for all age groups and those people with multiple episodes. Such standards should of course be accompanied by sufficient resources to meet the demand and a comprehensive strategy to audit implementation and evidence of age-discrimination in terms of access. Adequate staff training and supervision to increase front-line staff skill and confidence in delivery of psychological interventions and making referrals to more specialist services if necessary would also seem to be key on the basis of previous work exploring barriers to delivery of therapies for SMI (e.g. Ince *et al.*, 2015). Our findings suggest that having therapy specialists based within teams would be important in increasing staff psychological mindedness and willingness to embrace a more psychologically informed approach to care. At the individual level, therapy also needs to be adapted to meet the changing cognitive and physical health care needs of older people and recognize the importance of tackling issues that may be particularly pertinent for older people, such as lack of trust, stigma, hopelessness regarding the potential for change and talking about difficulties as opposed to taking tablets. Initiatives to improve access to psychological therapy for older adults with more common mental health problems may also help to inform work with older people with SMI. However, it is also important to recognize the unique challenges that those with SMI may face as result of long histories of medicalized treatment, iatrogenic effects of previous hospitalizations, lost opportunities to engage in work or relationships and more pervasive stigma related to diagnosis and help-seeking.

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