

Older Adult Complex Emotional Needs: Recommendations for Services

FOREWORD

The NHS Long Term Plan made a commitment to provide people with severe mental illness with greater choice and control over their care and to support them to live well in their communities.

As part of the Mental Health Implementation Plan to deliver this, all Integrated Care Systems (ICSs) have received funding to develop and begin delivering new models of integrated primary and community care for people with severe mental illnesses. This includes care for people with complex emotional needs associated with a diagnosis of a 'personality disorder'.

The prevalence and importance of complex emotional needs in older adults is now being increasingly recognised. This document provides recommendations on what needs to be considered when thinking about how these services will meet the needs of older adults.

In doing this, services will be addressing health inequalities, by ensuring that age-appropriate access to care and support is available to all.

Professor Alistair Burns
National Clinical Director for
Dementia & Older People's Mental Health
NHS England and Improvement

Dr Amanda Thompsell
National Specialty Advisor for
Older People's Mental Health
NHS England and Improvement

AUTHORS

Dr Kathryn Dykes, Dr Natasha Lord, Polly Kaiser.

CONTRIBUTORS

Dr Suhana Ahmed, Dr Chess Denman.

CORRESPONDENCE

Please contact the authors via the Dementia and OPMH Policy Team at NHS England & Improvement via ENGLAND.DomainTeam@nhs.net.

AIMS OF THIS DOCUMENT

This document sets out the service need and clinical competencies required to ensure that the needs of older people with complex emotional needs (CEN) are recognised and met, and this group have equitable access to appropriate care and support. This document provides core recommendations that services should be following when developing, evaluating, and delivering services for older people with complex emotional needs. There will be additional areas that well-functioning services can further develop; however, the aim of this document is to focus on core functioning.

The cohort of older people considered here are located in all health and care services, and whilst these recommendations are largely aimed at mental health services (primary and secondary care, specialist older adult and all age or age inclusive services) they can be considered in relation to all providers, statutory and voluntary, where older people with CEN are receiving support.

The recommendations are grouped into the areas of data, workforce skills, service development, assessment, and intervention to provide clarity, although the need for service providers and commissioners to remove inequalities and barriers for older people run as a theme throughout.

This document can be used by services to consider current provision locally, guide the development of action plans and reinforce the strategic direction of workforce development, clinical pathways and the involvement of older service users and their families in care, research, and service development.

LANGUAGE

Although the language in this area can be contentious and tricky, in this document complex emotional needs is the preferred term used to refer to individuals who have had long term challenges in their emotional and relational functioning often, but not always, as a result of significant trauma in earlier life. This is a group of people who may attract a diagnosis of a type of “personality disorder”¹ or be thought about by others within this context.

Further discussion around the use of language in relation to diagnostic terms and the understanding of trauma in this area can be found in Appendix One.

COMPLEX EMOTIONAL NEEDS AND OLDER PEOPLE

Main points for consideration in this area are summarised below. Please see Appendix One for a more detailed discussion of the evidence base in this area.

- Psychiatric diagnostic manuals, much of the current evidence base, NICE guidance and so available support and clinical interventions tend to be based on a working age presentation of CEN, usually EUPD.
- The clinical presentation of older people with emotional regulation difficulties, difficulties around impulse control and significant and long-standing interpersonal challenges can vary markedly from that of younger adults.

¹ The term “personality disorder” is used in this document where it refers to research which uses this term. It is not the preferred term of the authors and so is used in inverted commas.

- Diagnostic tools are mostly designed for working age presentations of CEN, resulting in older people’s needs being misdiagnosed or overlooked.
- For some older people CENs become apparent or develop in later life. For this group their lives and the support structures within them scaffold the individual emotionally and relationally throughout life until such time as issues such as bereavement, loss or poor physical health unsettle the picture sufficiently for the difficulties and distress to require support.
- There is a higher chance of relapse, reduced functioning, and poorer outcomes for older people when “personality disorder” is present. This group of older people are more likely to have complex and chronic difficulties.
- Clinical risk presents differently in older people; those older people with a “personality disorder” make up 44% of completed suicides of older people.
- This differing presentation in older people makes identification of need challenging and this impacts on availability of appropriate interventions and support.
- Lack of recognition of need results in services and commissioners not recognising these needs and allocating resource appropriately.
- The bulk of NICE recommended interventions for “personality disorder” are psychological in nature. Psychological treatment is as effective for older patients as for younger adults.
- There is currently no evidence to suggest that NICE recommended psychological interventions are not suitable for older people with complex emotional needs as with other difficulties, but robust pathways to access them are lacking.
- Medication must be reviewed and deprescribed as appropriate to reduce unnecessary and potentially hazardous polypharmacy in older people. Medication reviews also allow consideration of the impact of physiological health on mental health (e.g., hypothyroidism) as well as reducing access to unnecessary medications from a risk perspective.
- Access to appropriate interventions and support should be based on clinical need, not age or psychiatric diagnosis.

SUMMARY

Currently there is a lack of recognition of the distress and support requirements resulting from complex emotional needs in older people. These difficulties can be disregarded, minimised, and framed through a different lens by older people themselves, health and social care practitioners with whom they are working and commissioners of services. This unfortunately results in persistent myths about clinical need, a relative dearth of research, assessment and outcome tools, clinical development, and strategic planning in this area. A presumption that clinical needs remain homogenous across the life course allows the neglect of older people’s complex emotional needs to persist. An example of this is access to a service being based on the receipt of a diagnosis of personality disorder, a diagnostic categorisation derived from an understanding of presentation of younger people which rarely represents the clinical picture of older people and so is rarely applied, leading to access to appropriate services being denied to this group. Access to services or clinical pathways being purely diagnostically based will therefore lead to inadvertent discrimination against older people and so services should be needs led.

The Royal College of Psychiatry recognise that older people suffer serious discrimination in mental health services. Adults over 65 do not have the same access to specialist mental health services as those under 65. Old age services have been excluded from investment and have seen reduced resources (Royal College of Psychiatrists, 2018). Additionally, the NHS Long Term Plan (NHS, 2019a) and the Community Mental Health Framework for Adults and Older Adults (NHS, 2019b) explicitly state the

expectation of the inclusion of older adults with serious mental illness in the new and integrated models of primary and community mental health care as well as the need to improve access to psychological therapies for this group.

This document makes recommendations to clinical services to ensure that access to appropriate care and support and associated resources and planning are enabled for older people with complex emotional needs such that these health inequalities can be addressed.

Older Adult Complex Emotional Needs: Summary of Recommendations for Services

This document provides core recommendations that services should be following when developing, evaluating, and delivering services for older people with complex emotional needs. There will be additional areas that well-functioning services can further develop; however, the aim of this document is to focus on core functioning.

Services may choose to benchmark themselves against these recommendations and use results to generate actions for service development.

Recommendation	Recommendation met? RAG rating
DATA AND RESEARCH– ensuring that older people have equitable access to quality interventions and to participate in research	
Data is collected by the service on the volume and type of clinical need within current older adult mental health services. This can usefully be done by completing scoping work within teams based on presenting needs, not diagnosis. (See work done in Greater Manchester and Worcestershire and Greater Manchester in Appendix Three)	
Data about clinical need in local older people’s services is considered with respect to local population and demographics	
Data is collected by the service about the number of older people (age 65+) who access a NICE recommended psychological intervention for personality disorder (based on clinical needs not diagnosis)	
Services providing support to older people with complex emotional needs routinely evaluate the effectiveness of the interventions they offer this group e.g., using regular outcome measurement.	
Service user feedback of interventions for complex emotional needs is routinely collected in an age appropriate and accessible way	
Older people using services should be offered the opportunity to be involved in research and service evaluation	
WORKFORCE SKILLS – ensuring the workforce has opportunity to build confidence and skills	
Staff, volunteers, and peer supporters working with older adults can access training relating to trauma/ trauma informed care specific to older people	
Staff working with older adults can access training on clinical skills which is adapted to the needs of older people and differences in clinical presentation e.g., managing distressing emotions	

Recommendation	Recommendation met? RAG rating
Staff offering specific clinical interventions to older people with complex emotional needs have received training in these interventions and delivery to older adults, e.g., structured clinical intervention, DBT, MBT	
Staff and volunteers supporting older people with complex emotional needs are in receipt of specialist supervision and/ or consultation from a suitably qualified older adult specialist. Included in this should be the opportunity for staff to consider the strong emotions which may be evoked by this work.	
SERVICE DEVELOPMENT – ensuring service development considers the needs of older people by design	
Peer mentoring and volunteering roles are configured and equitably offered to people across the adult age range, including older people. This may mean the reasonable adjustments are required.	
VCSE partners who work specifically with older people are involved in local discussions relating to service development where other VCSE partners are included.	
Opportunities for co-production are equitably offered to people across the adult age range, including older people. This may mean reasonable adjustments are required to ensure barriers to access are avoided and health inequalities reduced.	
Opportunities for workforce and service development, including distribution of resource/ finance, is equitable across services so supporting people with complex emotional needs of all ages	
The service resolves practical challenges which create barriers to service access for older people e.g., room access, access to toilets, access to hearing support (e.g., BSL translators, hearing loops etc), appropriate seating, appropriate lighting, transport services to ensure access to service provision.	
ASSESSMENT – ensuring older people with complex emotional needs are offered robust quality assessment	
Staff and volunteers supporting older people with complex emotional needs are aware of the differing language that older people may use to describe their life experiences, emotional state, trauma experiences and to discuss risk	
Staff and volunteers supporting older people consider complex emotional needs and long-term relational difficulties which may attract a diagnosis of personality disorder as a possibility when developing formulations of need	
Staff and volunteers supporting older people are trained and aware of the differing presentation of risk in older people	

Recommendation	Recommendation met? RAG rating
Ensure older people with complex emotional needs have a robust crisis/ safety which is co-produced where possible and easily accessible in a form that is appropriate for the person	
Ensure older people with complex emotional needs are active participants in assessment of their needs.	
<p>Ensure assessment of older people includes,</p> <ul style="list-style-type: none"> • A life span perspective • Relational history • Previous coping styles, including strengths • Opportunities to discuss experiences of trauma • Medication review, opportunity to reduce unnecessary polypharmacy 	
Staff and volunteers working with older people with complex emotional needs should involve the system around the older person in their work where possible. This may include family members, informal carers, paid care staff, GP's, ambulance, or other hospital services.	
INTERVENTION – ensuring interventions offered to older people with complex emotional needs are suitably adapted to meet specific needs of this population	
Access to interventions and pathways for complex emotional needs are not based on diagnosis but clinical need.	
Older people have access to a range of high quality NICE recommended interventions, delivered by trained practitioners, which have been adapted to meet the different needs of older people	
Care for older people with significant difficulties relating to complex emotional needs should be offered by an appropriate MDT.	
Older people should be included in decisions about their care which are as honest and collaborative as possible. Services should not over-offer care which is not practically available nor avoid offering a level of care available to others.	
The family and important others of older people with complex emotional needs are offered appropriate support, this may include psychoeducation, carer support or signposting to other agencies.	

APPENDIX ONE

COMPLEX EMOTIONAL NEEDS AND OLDER PEOPLE

This section provides an overview of the current evidence and thinking in relation to CEN and older people.

Complex Emotional Needs (CEN), more commonly referred to using the term “personality disorder” in the literature, are rarely attended to in relation to older people, although this is starting to shift. Psychiatric diagnostic manuals, the current evidence base in research, NICE guidance and so available support and interventions tend to be based on a working age presentation of CEN. More often than not this work and literature is also largely based on the group who may attract a diagnosis of Emotionally Unstable Personality Disorder (EUPD). This document is not limited to services supporting people who may attract a diagnosis of Emotionally Unstable Personality Disorder, although this diagnostic category in younger adult services tend to receive the most attention currently in relation to service provision, research, and resource allocation. In older adult mental health services, a greater proportion of people than in services for younger adults would not “fit” this EUPD category. Difficulties would be less consistent with antisocial difficulties but the traits of detachment and obsessionality are increased (Tyrer & Howard, 2020) with challenges around mistrust, “over-control”, anxiety, or avoidance.

Whilst no group is homogenous, there is growing evidence (Bangash, 2020) that the clinical presentation of older people with emotional regulation difficulties, difficulties around impulse control and significant and long-standing interpersonal challenges varies markedly from that of younger adults. This makes identification of these needs tricky for practitioners and individuals themselves, which has a resulting impact on the availability of appropriate interventions and support. Without this support not only do the under recognised needs of this group persist but the vicious cycle of lack of recognition results in services and commissioners not recognising these needs amongst the many competing demands for resource.

As people age the systems of support and care around them often become increasingly complex, often linked to frailty and physical health. This results in increased use of support services including physical health services, urgent and primary care. Furthermore, as people move into supported living, residential or other care environments the complexities of longstanding interpersonal difficulties can become significant, leading to frequent changes to accommodation, stigmatisation of the individual and heightened distress. Changes in cognitive functioning and dementia in addition to CEN brings further complexities in relation to the provision of appropriate care and support for some older people.

One of the main precursors of a diagnosis of EUPD is childhood trauma (Herman et al, 1989; Laporte & Guttman, 1996). However, as Kaiser and Blake (2022) and Marsh, Shirley and Robinson (2021) explain, the way that older people describe their difficulties and understand the language of trauma differs to that of younger people. Trauma in older people is often disenfranchised and overlooked by others as being either a distant past event (e.g. child abuse) or a normal part of aging (e.g. widowhood, chronic illness). The priority in clinical practice is in consideration of both what happened earlier in life but also what’s happening now (Kusmaul & Anderson, 2018). The clinical workforce must understand and adapt their language to best appreciate, communicate with and

support the needs of older people or the under recognition, under diagnosis and lack of access to support for this group will persist.

It is estimated that prevalence rates of “personality disorder” in older adults are between 10-20% of a community sample, (Abrams & Horowitz, 1999; Beatson et al., 2016; Gradman et al., 1999; Tyrer, 2014). Older people are less likely to attract a diagnosis of “personality disorder” than their younger counterparts (Thompson, Gallagher, & Czirr, 1988) and the clinical picture is further complicated by the co-morbidity between major depressive disorder and personality disorder (Kunik et al., 1994; Abrams, 1996; Wenger & Jerrome, 1999). These difficulties with diagnostic criteria of “personality disorder” in later life have led to services in Worcestershire and Greater Manchester conducting a scoping of people currently using their older adult community mental health teams considering features of clinical presentation aligned to CEN rather than diagnosis rates. Please see Appendix Three for further information on this scoping exercise.

Diagnostic classification of “personality disorder” also requires identification of difficulties beginning in early life but for some older people needs become apparent or develop in later life (Bangash, 2020). For this group their lives and the support structures within them scaffold the individual emotionally and relationally throughout life until such time as issues such as bereavement, loss or poor physical health unsettle the picture sufficiently for the difficulties and distress to come to the attention of others (van Alphen et al., 2015). There is a higher chance of relapse, reduced functioning and poorer outcomes for older people when “personality disorder” is present, and this group are more likely to have complex and chronic difficulties (van Alphen, 2012; Zweig, 2008). Older people with “personality disorder” are more likely to display somatic, depressive and anxious symptoms and higher functional impairment in comparison to younger groups (Frias et al., 2017). Additionally, increased somatization and seeking care from others can lead to difficulties in the provision of care and longer admissions (Beatson et al., 2016).

Additionally, clinical risk presents differently in older people. There is an increased risk of suicidal ideation for older people with complex emotional needs (Cruitt & Oltmanns, 2018 and evidence suggests that suicide ideation is the best predictor of completed suicide and older people with a “personality disorder” make up 44% of completed suicides of older people (Mattar & Khan, 2017). Older people who self-harm are at 67 times greater risk of suicide than the general older population and three times greater than the relative risk of suicide among younger people who self-harm (The University of Manchester, 2012). Services must be aware of and consider this context of elevated risk of suicide after self-harm in older groups during risk assessments.

SUPPORT AND TREATMENT

The bulk of NICE recommended interventions for “personality disorder” are psychological in nature. Unfortunately, there still persists a belief that older people cannot benefit from psychological therapies, evidenced by NHS Digital's finding that those aged over 85 are five times less likely than 55 to 59-year-olds to receive psychological help from primary care psychology services (NHS Digital, 2017). However, psychological treatment is as effective for older patients as for younger adults (Karlin et al. 2015; Rodda, Walker and Carter, 2011; Pinquart, Duberstein and Lyness, 2007) and evidence shows that a range of treatments, including but not limited to CBT, are effective treatments for older people with depression (Gould, Coulson and Howard, 2012; Laidlaw et al., 2008; Scogin et al., 2006). There is currently no evidence to suggest that NICE recommended

psychological interventions are not suitable for older people with complex emotional needs as with other difficulties, but robust pathways to access them are lacking.

SUMMARY

Currently there is a lack of recognition of the distress and support requirements resulting from complex emotional needs in older people. These difficulties can be disregarded, minimised and framed through a different lens by older people themselves, health and social care practitioners with whom they are working and commissioners of services. This unfortunately results in a relative dearth of research, assessment and outcome tools, clinical development and strategic planning in this area. A presumption that clinical needs remain homogenous across the life course allows the neglect of older people's complex emotional needs to persist. An example of this is access to a service being based on the receipt of a diagnosis of personality disorder, a diagnostic categorisation derived from an understanding of presentation of younger people which rarely represents the clinical picture of older people and so is rarely applied, leading to access to appropriate services being denied to this group. Access to services or clinical pathways being diagnostically based will therefore lead to inadvertent discrimination against older people and so services should be needs led.

The Royal College of Psychiatry recognise that older people suffer serious discrimination in mental health services. Adults over 65 do not have the same access to specialist mental health services as those under 65. Old age services have been excluded from investment and have seen reduced resources (Royal College of Psychiatrists, 2018). Additionally, the NHS Long Term Plan (NHS, 2019a) and the Community Mental Health Framework for Adults and Older Adults (NHS, 2019b) explicitly state the expectation of the inclusion of older adults with serious mental illness in the new and integrated models of primary and community mental health care as well as the need to improve access to psychological therapies for this group. Clinical services must support the importance of offering appropriate interventions based on need not age, but also the need to review medication and deprescribe to reduce unnecessary and potentially hazardous polypharmacy in older people with CEN. This document makes recommendations to clinical services to ensure that access to appropriate care and support and associated resources and planning are enabled for older people with complex emotional needs such that these health inequalities can be addressed.

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APPENDIX TWO

FURTHER INFORMATION AND CONNECTIONS

The Future NHS Platform has a variety of useful workspaces, including an online collaborative space around the NHS England and NHS Improvement National Adult and Older Adult Mental Health Programme (see <https://future.nhs.uk/AdultMH/grouphome>). This platform is free to register and has a range of resources including discussion forums. There are specific areas for “personality disorder” and psychological therapies for severe mental illness and a separate workspace for older people’s mental health (see <https://future.nhs.uk/AdultMH/view?objectID=14169136>). Webinars from RCPsych and FPOP and others are available to watch in this section.

The Faculty of Psychologists working with Older People (FPOP), one of the Faculties within the British Psychological Society is co-ordinating a Community of Practice around CEN, community transformation and older people. This FPOP workstream are organising a series of regular webinars in this email. Some of the previous webinars are available free of charge in the older people’s mental health space on the Future NHS Platform detailed above.

Dr Natasha Lord is coordinating an email discussion list. You can join this group by emailing Natasha.lord@nhs.net

OTHER USEFUL INFORMATION

- Community mental health transformation <https://www.england.nhs.uk/wp-content/uploads/2019/09/community-mental-health-framework-for-adults-and-older-adults.pdf>
- The Community Mental Health Framework for Adults and Older Adults | Royal College of Psychiatrists (rcpsych.ac.uk) National Collaborating Centre for Mental Health; 2021
- PHE Fingertips <https://fingertips.phe.org.uk/>
- Training material <https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/training-packs>

APPENDIX THREE

SUMMARY OF SCOPING EXERCISE INTO CEN IN OLDER ADULT CMHTS

Core methodology was agreed across services in Bolton, Salford and Worcestershire in order to better understand the presentation and clinical needs of people using the older adult community mental health teams. This work was undertaken as gathering data by diagnosis of any type of personality disorder did not illustrate or represent the clinical complexity, risk and chronicity of service user need supported by the teams. Current service users were therefore considered alongside a set of criteria which represented the clinical presentation of people whose difficulties may best map on to experiencing complex emotional needs.

A brief outline of this methodology is outlined below. Should your service wish to replicate this work please contact Dr Kathryn Dykes and Dr Natasha Lord who will be happy to provide further detail. Results from this work are currently in press for publication.

Overview of Methodology

1. Cross-sectional data was collected from all care coordinators in the team at one point in time. The exercise focused on all patients under full CPA. Gathering information about service users receiving “standard care” was not included.
2. Care coordinators were asked to consider their caseload in relation to the following criteria.
 - a. Length of stay in the service > 1 year/ 24 sessions?
 - b. Previous work with Crisis or Home Treatment Team?
 - c. Accessed Inpatient Services?
 - i. If yes for how long?
 - d. Do they have more than 1 referral into mental health services?
 - e. Have they been under mental health services for a significant amount of time?
 - i. How long?
 - f. Accessed mental health services repeatedly?
 - i. How often?
 - g. Does the person regularly call duty?
 - h. Does the person regularly call/ attend emergency services or GP?
 - i. Has the person found it difficult to engage with you in the beginning?
 - j. Does the person self-harm now or previously?
 - k. Does the person self-neglect?
 - l. Has the person ever attempted suicide?
 - m. Does this person find it difficult to maintain healthy relationships?
 - i. How? Qualitative information gathered
3. Additional information gathered included gender, age, mental health or dementia diagnosis, profession of the care coordinator.

APPENDIX FOUR

Service model options for supporting Older People with Complex Emotional Needs

The table below provides examples of the advantages and disadvantages one NHS Trust considered when considering different options of configuring mental health services for older people with CEN.

Potential Option	Advantages	Potential consequences of option
1. Do nothing	1. No funding application	<ol style="list-style-type: none"> 1. Does not meet with national direction – SMI agenda for Older People, CMHTS for Adult Mental Health and Older People and so forth 2. Does not meet Age Equality Act 3. Continued high use of services with high cost to the Trust and not addressing needs for the person
2. Increase adult mental health spend to include some OAMH needs	<ol style="list-style-type: none"> 1. No additional costs e.g. accommodation 2. Service offers provision to highest users of OAMH (8% of identified need) 	<ol style="list-style-type: none"> 1. Only accessible to older people with highest level of need 2. Delay in older people being able to access the service due to access criteria (note diagnosis for older people compared to need) 3. Incorrect identification of needs 4. Does not address remaining need within OAMH services (high use of inpatient services) 5. No transfer of skill for OAMH staff working with older people who have complex emotional needs (which present differently to AMH) 6. Doesn't allow for increase in need/ number of people accessing e.g. due to level of deterioration within people who have complex needs e.g. death of spouse, physical health decline, fears of mortality 7. Decreased patient safety for older people (age equality information for ageless services) 8. Decreased satisfaction with service (as above) 9. Interventions may not be adapted to meet the needs of older people accessing service 10. Clear criteria would be needed to ensure equity for older people

<p>3. Employ Older People Staff to sit with Adult Mental Health CEN service</p>	<ol style="list-style-type: none"> 1. Increasing AMH staff knowledge of older people with complex emotional needs 2. Increased skill sharing 3. Increased integration between OAMH and AMH for people with complex emotional needs 4. Enables Older People to be correctly identified and consideration of adaption of service 	<ol style="list-style-type: none"> 1. Poorer integration with Core OAMH function 2. Diffusion of the OAMH team 3. Loss of maintaining and developing OAMH service 4. Does not meet need of older people remaining within OAMH (high use of inpatient service) 5. Potential for Older People's staff to be subsumed with AMH as recognised current staff vacancies 6. Older Adult Staff attrition 7. Potential loss of skill mix / knowledge of older people 8. Staff wellbeing/ team identity (trauma informed care – caseload)
<p>4. Enhance OAMH service with specialist function for people with complex emotional needs</p>	<ol style="list-style-type: none"> 1. Correct identification and intervention for older people with complex emotional needs 2. Timely intervention 3. Up-skilling of OAMH staff, fits with transfer model and national directive 4. Core service with a Specialist function fits with national directive of sitting with community service 5. Assessment and Intervention adapted to needs of older people 6. Consultation, training and supervision to wider parts of the service including primary care, AMH 7. Training packages will be adapted to older people (cognitive and psychological aspects of aging) e.g., KUF under review to include older people 8. Old Age Specialism in understanding physical health and mental health interplay with medication 9. Specialist knowledge of physical health complications including personality changes related to dementia 10. Able to respond if older people's needs within their involvement with OAMH service such as death of a spouse (see lit review above) 11. No costs such as accommodation as staff members would sit within current provision 	<ol style="list-style-type: none"> 1. Higher initial cost to set up specialist function (aim; should reduce as meeting more older people with a complex emotional need) 2. As identifying need, clear parameters of offer will need to be more clearly defined if option 4 accepted so able to function effectively 3. Guidelines required for people who have been with AMH which service best meets needs – evidence for whether onset of difficulties/ continued difficulties are related to aging 4. For people who have accessed CEN services within AMH; further analysis of which service best meets their needs, to remain within an AMH offer or move to an OAMH offer

Glossary

SMI Serious Mental Illness

AMH Adult Mental Health

OAMH Older Adult Mental Health

CEN Complex Emotional Needs

APPENDIX FIVE

Example decision document from Worcestershire and Herefordshire NHS Trust regarding the provision of service for Older Adults with Complex Emotional Needs

Herefordshire and Worcestershire Older Adult Complex Emotional Needs Provision

Herefordshire Complex Emotional Needs Service, Worcestershire Complex Needs Service and OAMH Service Leads met to discuss access and suitability for older people to the current CNS provision based on several OAMH case studies and the previous business case options appraisal.

It was deemed by all leads of the service that the best option for older people was to fund an enhanced older people service based on the following rationale:

1. Access to service

- a. The current CNS service in Worcestershire requires a person to have a diagnosis of borderline personality disorder (BPD) (and to consider level of risk) and must be on HoNOS cluster 8
- b. The current CENS service in Herefordshire also requires a person to have a diagnosis of Emotionally Unstable Personality Disorder (EUPD) or BPD and the threshold is frequent parasuicidal behaviours and/or high use of service
- c. Older people are less likely to receive a diagnosis of BPD due to several reasons – do not meet the parameters, not recognised, may have traits and interpersonal difficulties crossing a number of different diagnoses and so forth
- d. Therefore, a number of older people with complex emotional needs would not be able to access the service

2. Appropriateness of service provision

Where a diagnosis of BPD has been made:

- a. The average cohort of people attending the CNS service are within their 20's, some people are aged in their 40's and the oldest person referred was 54 years of age
- b. Recognised not appropriate resource for older people to access for the following reasons:
 - i. People are in different Life transitions/ developmental stage
 - ii. Lack of peer support
 - iii. Therapy not adapted to meet the needs of older people, e.g., cognition, physical health co-morbidity; use of language and metaphor; theory to practice links for older people; adaptations to what is relevant for older people including access and skill with IT
 - iv. Other services have tried an age inclusive SCM group, and this was stopped as not appropriate to people's needs

3. Whole system and trauma informed care approach

- a. Older people accessing a CNS service (with additional funding attached here rather than enhanced OAMH offer) would mean that only those with the most intensive needs would receive a service

- i. The wider system would not have the same skills or understanding of the person's needs and presentation to work towards recovery and support work undertaken in CNS.
- b. All remaining older people with an identified need who would not need the enhanced offer, would also not have access to the right intervention. This has the potential to be costly as evidence suggests people remain in services longer as they are not having their needs met.
- c. Using a whole pathway approach to complex emotional needs/ trauma informed approach would ensure better understanding of people's needs and that skills are retained within the service
- d. Enhancing the OAMH offer meets the national directive of whole systems approach:
 - i. Vision
 - ii. Governance and supervision
 - iii. Integration
- e. The offer also meets with our Trust directive of developing trauma informed services and care

APPENDIX SIX

Summary of outcome measures used in Older Adult CEN staff training and service evaluation

Below is a summary of work completed by Dr Natasha Lord and colleagues in reviewing available outcome measures to evaluate staff training in SCM. This focuses on evaluation of staff perception and/ or knowledge of trauma and team morale and effectiveness.

For an evaluation of structured clinical management training with older adult staff please see Sandhu P & Lord N (2021). Please contact Dr Lord for further information at Natasha.lord@nhs.net.

Not an Option/ Limitations

Potential Option/ Few Queries

Great Option/ Accessible

Areas to assess	Name of Measure	What does it do?	Has it been validated?	To use?	Access?
Staffs Perceptions of Trauma	The Trauma-Informed Climate Scale-10 (TICS-10): A Reduced Measure of Staff Perceptions of the Service Environment	Trauma-informed climates prioritize staff and client experiences of safety, trust, choice, collaboration, and empowerment. The Trauma-Informed Climate Scale (TICS) was developed to measure staff perceptions of these values within the service environment. Respondents are asked to rate the extent to which they agree that their organization incorporates each of the measure's 35 items.	https://doi.org/10.1080/23303131.2019.1671928 The analytic approach yielded a 10-item scale reduction, with confirmatory factor analyses supporting the scale's construct validity and reliability ($\alpha = .91$).	Unsure if appropriate for the service evaluation. May be more useful as a follow up measure to assess how embedded the SCM strategies (trust, collaboration, empowerment) are within the team	Can't find a free online copy Unsure how to access/ to contact authors

Areas to assess	Name of Measure	What does it do?	Has it been validated?	To use?	Access?
	Attitudes Related to Trauma-Informed Care Scale (ARTIC)	<p>The ARTIC measures the favourable or unfavourable attitudes of service providers toward TIC. It is based on the premise that staff attitudes are an important driver of staff behaviour -- and the moment-to-moment behaviour of staff is a critical factor in successful implementation of TIC.</p> <p>Attitudes about:</p> <ul style="list-style-type: none"> • The underlying cause of problem behaviour/ symptoms (Subscale 1) • Staff responses to problem behaviour (Subscale 2) • Staff on-the-job behaviour (Subscale 3) • Staff feeling of self-efficacy at work (Subscale 4) • Staff reactions to the work (Subscale 5) <p><i>Example Question: "I am concerned that I do not/ will not have enough support to implement the care approach" vs. "I think I do/ will have enough support to implement the trauma-informed care approach."</i></p>	<p>Psychometrically valid, with overall and 7 subscale scores</p> <p>It has been administered globally to more than 20,000 professionals by school systems, human service agencies, state agencies, and researchers. There are three versions of the ARTIC for human services settings (45-item, 35-item, and 10-item short form)</p> <p>As the ARTIC Scale is a relatively new measure, no established norms based on a large national representative sample.</p> <p>https://traumaticstressinstitute.org/wp-content/uploads/2016/04/ARTIC-Webinars-2016_Final.pdf</p>	<p>Can help to answer the question</p> <p>'Did our interventions to implement TIC via SCM training lead to change?'</p> <p>'What domains with respect to attitudes (sub- scales) are strongest and weakest?'</p> <p>'Do staff need additional training or supervision related to SCM or TIC?'</p>	Free if have student license
	TICOMETER	<p>Measures the degree to which an organization is engaged in trauma-informed practices. It evaluates needs and progress in implementing trauma-informed care and ensuring its sustainability.</p> <p>Consisting of 35 items across five domains, the TICOMETER assessment takes</p>	<p>The TICOMETER has strong psychometric properties, creating new possibilities for assessing the level of TIC offered by an organization, monitoring progress in service delivery over time, determining</p>	Great potential	<p>Cost-\$275</p> <p>Online measure</p>

Areas to assess	Name of Measure	What does it do?	Has it been validated?	To use?	Access?
		<p>approximately 15 minutes for staff members to complete online and scores are available to the organization immediately. The five domains include:</p> <ul style="list-style-type: none"> • Building trauma-informed knowledge and skills • Establishing trusting relationships • Respecting service users • Fostering trauma-informed service delivery • Promoting trauma-informed policies and procedure 	training needs, and developing trauma-informed policies		
	Trauma-Informed Belief Measure	Assesses staff attitudes favourable to trauma-informed care.	Considerable empirical completed on this measure. A research project underway in collaboration with Tulane University Department of Clinical Psychology to revise this measure and strengthen its psychometric properties.		PDF Online https://traumaticstressinstitute.org/wp-content/uploads/2013/11/Trauma-Informed-Belief-Measure-Final-3.2-5-12.pdf
Team Effectiveness/ Morale	El Ansari et al, (2016) Community mental health teams (CMHTs) effectiveness survey	<p>Through 3-phrase qualitative study and evaluating survey scales' psychometric properties, 20 items demonstrated good measures of CMHTs, capturing 7 themes: 5-point Likert scale</p> <p>Questions detailed on page 316: http://dx.doi.org/10.1111/hsc.12203 </p>	<p>Through 3-phrase qualitative study and evaluating survey scales' psychometric properties, 20 items demonstrated good measures of CMHTs, capturing 7 themes: 5-point Likert scale</p> <p>Internal reliability of .91</p>	How to obtain measure?	Full access Permission given by developers to use for the service evaluation

Areas to assess	Name of Measure	What does it do?	Has it been validated?	To use?	Access?
	Cross-sectional Survey for multidisciplinary teams (Landry and Erwin, 2015)	Respondents were asked to answer the questions of team participation and team processes; team processes had a set of 6 categories; binary fashion (advantage/disadvantage)	No psychometric properties		
	Primary Care Team Dynamics Survey (Song et al, 2015)	31 items for measuring conditions for team effectiveness, shared understanding, 3 supportive processes perceived collective identity and perceived team effectiveness, 5-point Likert scale, full model	Internal reliability (.71-.91) Content validity-literature review to select 10 survey instruments based on conceptual model. A series of expert reviews and cognitive interview with attending physicians, nurses, and front desk staff were conducted to select 31 items	Unsure if it fits with service evaluation looking at pre and post, as questionnaire looks at communication, membership in team, vision which is unlikely to drastically change over a few weeks	No access
	Team Climate Inventory (TCI) Questionnaire (short version)	The TCI was developed to measure team climate among management teams in healthcare organizations. Based on a theoretical model, the tool measures four facets (vision, participative safety, task orientation, and support for innovation) in a 38-item self-report questionnaire.	Used in different countries	See above	No access