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Clinical Psychology Services for Older People in Gateshead

Guide for Referrers

This document introduces the clinical psychology services that form a part of Mental Health Services for Older People in Gateshead. It describes the service offered by clinical psychologists (CP) and the referral routes and criteria to access the service.

1. Background

Clinical psychology services for older people in Gateshead have developed since 1988. There are now 4 clinical psychologists and 1 counselling psychologist making a total of 3.6wte staff.

Some clinical psychologists take doctoral trainees from the regional courses in Newcastle and Teesside for six-month clinical experience placements.

Assistant psychologists (pre-training) might also be a part of the psychology team. Their roles may vary, from service development and evaluation project work to supervised clinical work.

2. Parameters of the Service

Clinical psychology services for older people comprise the following staff:

[Diagram showing the staff hierarchy with Daniel Collerton as Head of Older People Clinical Psychology, Dr Claire Martin as Consultant Clinical Psychologist, Dr Claire Appleton and Dr Fiona Grant as Senior Clinical Psychologists, and Dr Kate Andrews as Counselling Psychologist.]

Currently, at any one time there are up to four clinical psychology trainees working within the psychology department.
3. **Service Details**

Clinical psychologists’ basic training involves completing a first degree in psychology followed by three years postgraduate doctoral training. Clinical psychologists working into mental health services for older people specialise in aspects of psychological work with older people.

3.1 **Direct Clinical Services**

Clinical psychologists working with older people offer the following broad services:

- Assessment and formulation (a psychological explanation of the origin and maintenance of the problem) as an aid to other care staff
- Psychological therapy (either individual, couple, family or group)
- Assessment of neuropsychological functioning
- Neuropsychological rehabilitation

Commonly referred psychological difficulties include:

- Memory problems
- Depression
- Anxiety
- Personality and relationship problems
- Obsessive compulsive disorder
- Challenging behaviour in dementia
- Psychosis and delusional disorders
- Carer stress

**Interventions**

**Generic**

- Psychological rehabilitation,
- Patient and carer support,
- Education and advice throughout the diagnostic process and beyond;
- Indirect work supporting and advising staff on issues relating to psychological aspects of a patient’s care. Indirect work will only take place after the psychologist has directly assessed the identified patient. The service will not provide indirect work without seeing the patient concerned.
- Training and education regarding psychological processes.

**Specific** psychological therapies currently offered within older people’s clinical psychology services include:

- Cognitive behavioural therapy (CBT)
- Cognitive analytic therapy (CAT)
- Psychodynamically informed therapy
- Systemic/family therapy
- Integrative therapy

NB. Not all clinical psychologists offer all forms of therapy
3.2 Assessment

Clinical

- All referred patients will be directly assessed by the responsible psychologist. This includes patients referred for indirect work.
- Assessment will be completed using a range of methods, which may include:
  ⇒ patient interview
  ⇒ relative/carer interview where relevant
  ⇒ standardised screening tools (e.g. measures of mood)
  ⇒ behavioural observation (e.g. in care home settings)
  ⇒ self-monitoring tasks.
A psychological formulation (see 3.1) will then inform any intervention offered to the patient/staff.

Neuropsychological

All psychologists currently take referrals for neuropsychological testing as part of the process of dementia diagnosis and care. It is useful for identifying detailed cognitive strengths and weaknesses, for cognitive rehabilitation and carer advice as well as providing differential diagnostic indicators (e.g. between depression and dementia; different dementia presentations; identifying at risk groups, such as those with mild cognitive impairment).

General indicators

- Basic cognitive screening (e.g. MMSE) has not provided enough information to facilitate rehabilitation or carer support.
- Cognitive screening has not helped to identify cause of problems (differential diagnosis).
- The patient is in a high risk group (e.g. mild cognitive impairment) or is known to have a high premorbid IQ, and subtle cognitive change has been reported but not found by brief screening instruments (e.g. MMSE) at rescreening.

Specific indicators

- Patient is willing to participate in cognitive assessment (3-4 hours total, spaced over several sessions)
- Patient is able to undergo cognitive assessment (physically, emotionally, practically)

Contraindications for Neuropsychological Assessment

- If neuropsychological assessment would not add to the care, diagnostic understanding or advice to patient/carer regarding presenting problems.
- If patient does not consent to undergo neuropsychological assessment

Criteria for Neuropsychological Retesting

Retesting would be helpful when:

- A diagnosis of mild cognitive impairment was the outcome of initial neuropsychological testing, and retesting (at 6 – 9 months) might assist diagnostic clarification.
- A recent significant change has occurred in the patient's cognitive presentation and the nature of the difficulties remains unclear.
- Retesting is likely to add to the care of the patient (e.g. where an up-to-date cognitive profile will assist rehabilitation)
3.3 Therapy

Potential indicators for referral may include (but are not limited to):

- If the patient requests a referral to talk about their problems
- When there is evidence of some subjective patient distress regarding their situation or mental health
- Where the psychological nature of the patient’s presenting difficulties are evident to the referrer but not to the patient (e.g. interpersonal difficulties)
- When the patient wants to change their situation
- When staff in a care team (e.g. inpatient setting) are finding that the patient is difficult to care for or appears to be worsening in their mental health
- When a need for specialist psychology assessment has been identified within the team as a means of aiding problem formulation, staff care practice or to forecast likely benefit from psychological intervention.
- When there is a complexity or severity of the presenting problems and underlying factors that might be helped with a psychological understanding

4. Referring to Psychology Services  (see referral form in this pack, or on our website)

4.1 Referral Protocol

- Referred to central point (see address on front sheet)
- Logged.
- Allocated to individual staff member.
- Service is directed towards those in the greatest need balanced by the likelihood of intervention being successful.

Patients are directed elsewhere, if appropriate, following assessment.

Decisions about appropriateness are the responsibility of the psychology service. If in doubt, patients will be assessed. Patients will be directed elsewhere without being seen only in exceptional circumstances e.g. if they live in the catchment area of another service.

4.2 Procedures on receipt of referrals

- Each referral will be stamped upon receipt and registered as a psychology referral.
- At this stage, referrals may be followed up with referrers, for example if additional information is required.

4.3 Consultant Referrals

Some referrals are usually taken by a Consultant Clinical Psychologist, though they may be seen by another member of staff under supervision for training purposes. For example:

Management of severe immediate risk

Opinions for legal proceedings
Initial appointments

- The patient will be sent a letter offering either a clinic or a home appointment at the discretion of the psychologist and a copy of this letter will be sent to the referrer.

Non attendance

- If the patient does not attend for their initial appointment a further appointment will be sent.
- If the patient subsequently does not attend, further appointments will only be sent at the discretion of the psychologist, on a case-by-case basis.
- For patients on CPA the clinician will notify the keyworker to enable any necessary action to be taken

5. Communication with referrers

- Outpatients. Letter within 5 days, immediate telephone contact in emergency.
- Wards / Day Hospital. Entry into medical notes, discussion with staff immediately following meeting the patient. Attendance at ward rounds, case conferences as necessary.

6. Clinical Reports

- A full report of the information gathered during assessment will be forwarded to the referrer (and copied to relevant other professionals) following the completion of assessment. A copy or an abridged version of this report may be sent to the patient/carer depending upon the nature of the referral request.
- Interim progress reports will be forwarded to the referrer should the patient be offered psychological therapy.
- Following completion of therapy or psychological involvement a final letter will be forwarded to the referrer (and copied to relevant other professionals).

7. Waiting List Management

The aim of the service is to work at the timescale needed for the service to effectively deliver psychological assessment and interventions that will influence the future care and treatment of patients. In general, this means responding within days, or a couple of weeks, to requests for assessments. Some settings may require a speedier response, for example acute medical wards; others may not suffer from some delay, for instance routine reassessments. If appropriate, intervention will be offered immediately following assessment. The service will not have a separate treatment waiting list.

For our full service Operational Policy please see our website at www.gatesheadhealth.nhs.uk/clinicalpsychology
Or contact Lorraine Jordison, Psychology Secretary on 0191 445 6690 lorraine.jordison@ghnt.nhs.uk