RESEARCH ARTICLE

International Journal of Geriatric Psychiatry

Comparison of access, outcomes and experiences of older adults and working age adults in psychological therapy

Robert Chaplin[1,2], Lorna Farquharson[1], Melissa Clapp[1] and Mike Crawford[1,3]

[1]Centre for Quality Improvement, Royal College of Psychiatrists, London, UK
[2]Oxford Health Foundation NHS Trust, Oxford, UK
[3]Imperial College London, London, UK
Correspondence to: R. Chaplin, E-mail: rchaplin@cru.rcpsych.ac.uk

Objective: This study aimed to evaluate the access, experiences and outcomes of older adults receiving psychological therapies in comparison with adults of working age

Methods: Primary and secondary care providers of psychological therapy services participated in the National Audit of Psychological Therapies. The main standards of access, experience and outcomes were measured by retrospective case records audits of people who completed therapy and a service user questionnaire. Outcomes were measured pre-treatment and post-treatment on the PHQ-9 and GAD-7.

Results: A total of 220 services across 97 organisations took part, 137 (62%) in primary care. Service user questionnaires were received from 14 425 (20%) respondents. A total of 122 740 records were audited, of whom 7794 (6.4%) were older adults. They were under represented as 13% of the sample would have been expected to be over 65 years according to age adjusted psychiatric morbidity figures. People over 75 years had the third expected referral rate. Significantly, more older adults than working age adults completed therapy (59.6% vs 48.6%) and were assessed as having 'recovered' post-treatment (58.5% vs 45.5%). Older adults were more satisfied with waiting times and numbers of sessions, but there were no differences in self-reported experience of therapy.

Conclusion: Although older adults are less likely to gain access to psychological therapies, they appear to have better outcomes than working age adults. Further work is needed to improve access for older people.

Key words: older adults; psychological therapy; audit; clinical outcomes
History: Received 16 December 2013; Accepted 11 March 2014; Published online 15 April 2014 in Wiley Online Library (wileyonlinelibrary.com)
DOI: 10.1002/gps.4122

Introduction

Psychological therapies are effective treatments for people with anxiety and depression. Cognitive behaviour therapy (CBT) has been shown to be a highly efficacious treatment for people with major depression with numbers needed to treat of 2.75 (Driessen and Hollon, 2010) and also effective for a range of adult anxiety disorders (Hofmann and Smits, 2008). It has also been shown in a large randomised trial to be an effective treatment for older adults (Serfaty *et al.*, 2009). Psychiatric morbidity in older adults varies, but a recent meta-analysis found that nearly 20% of older adults in community samples had current significant depressive symptomatology, referred to as 'dimensional depression' (Volkert *et al.*, 2013). Furthermore, psychological treatments are often preferred by patients to pharmacological treatments (Bedi *et al.*, 2000).

Few studies have explored the efficacy of psychological interventions for older adults compared with adults of working age. A retrospective study compared outcomes of those accessing an older adult service ($N = 23$) and those accessing a working age service ($n = 20$), for the treatment of anxiety and depression (Walker and Clarke, 2001). Findings showed no significant differences in clinical outcomes although older adults showed greater improvement in home

adjustment scores. Working age adults were significantly more likely to drop out of therapy.

Older adults have historically had reduced access to psychological services; for example, Anderson *et al.* (2012), in a survey of health commissioners in England, Scotland and Wales, found that psychotherapy was available to older adults in only 68% of services that they commissioned, compared with inpatient or community mental health care in 99% of services. In the first wave of the Improving Access to Psychological Therapy (IAPT) evaluation in England, older adults were under represented at 4% of those accessing therapy rather than at the expected rate of 12.5% allowing for the age profile of the population and the morbidity rate of this group (Department of Health, 2011). Furthermore, the National Audit of Psychological Therapies (NAPT, Royal College of Psychiatrists, 2011), which included National Health Service (NHS)-funded services providing psychological therapies for adults with anxiety and depression in England and Wales, found that older people were less likely to receive therapy than younger people and over one-third of participating services had a policy that excluded older adults. In the UK, the Equality Act was legislated in 2010 to prohibit age discrimination in public services leading to an implementation strategy on banning age discrimination in the NHS in 2012 (Department of Health, 2012). The effects of this change in the law are yet to be evaluated.

The NAPT (Royal College of Psychiatrists, 2011) was established to evaluate the performance of NHS-funded services providing psychological therapies for adults with anxiety and depression in England and Wales. NAPT is commissioned by the Healthcare Quality Improvement Partnership (HQIP) as part of the National Clinical Audit and Patient Outcomes Programme (HQIP, 2012) and is therefore one of the mandated national audits for all eligible NHS-funded services. It is managed by the College Centre for Quality Improvement.

This paper aimed to calculate the relative access of older adults in comparison to adults of working age to psychological services against population and morbidity estimates for this group and to assess their experiences and outcomes of treatment.

Method

Setting and participants

The NAPT is commissioned by the HQIP as part of the National Clinical Audit and Patient Outcomes Programme (HQIP, 2012) and is therefore one of the mandated national audits for all eligible NHS-funded services. This paper used data from the second round of NAPT to investigate compliance against the access, acceptability and outcomes standards specifically for older adults (aged 65 years or older) compared with adults of working age. All English and Welsh NHS-funded services that provide psychological therapies to adults in the community for anxiety and depression were eligible to take part. Recruitment took place between January and June 2012. Data collection was carried out between April 2012 and January 2013. Initially, a 'service context questionnaire' was completed online by a senior manager of each service, which indicated whether the service provided primary or secondary care (Royal College of Psychiatrists, 2011). We report data gathered from a retrospective case record audit of people who completed therapy between 1 July and 31 October 2012 and a service user questionnaire that examined people's experience of services and their preferences and priorities.

Outcomes and statistics

Outcomes were measured on a variety of rating scales depending on the service. The analysis showed 95% (76 331/80 302) of service users had a pre-treatment and post-treatment scores recorded for at least one measure. The two most commonly used were the Patient Health Questionnaire (PHQ-9, Kroenke *et al.*, 2001) and the Generalised Anxiety Disorder Assessment (GAD-7, Spitzer *et al.*, 2006), which are part of the IAPT minimum data set. The PHQ-9 rates nine items measuring depression on a scale of 0–3 and is a screening tool for and overall rating of the severity of depression. A score of 10 or above (moderate depression) at assessment was taken as the cut-off for the presence of depression. When the PHQ-9 score is ≥10, there is an 88% sensitivity and 88% specificity for major depression. The GAD-7 rates seven items measuring generalised anxiety disorder on a scale of 0–3 and is a screening tool for and overall rating of the severity of generalised anxiety disorder. When GAD-7 score is ≥10, there is an 89% sensitivity and 83% specificity for generalised anxiety disorder (slightly lower for other anxiety disorders). A score of 8 or more on the GAD-7 was used as a cut-off for clinical caseness. Recovery was defined as scores moving from above the clinical cut-offs at intake to below the cut-offs at the end of treatment. For service users that had both PHQ-9 and GAD-7, caseness at intake was defined as above the clinical cut-off on either or both measures (cut-offs of 10 or more for PHQ-9 and of 8 or more for GAD-7). Recovery was defined as

being in the non-clinical range on both measures at the end of treatment. 'Reliable improvement' was based on the reliable change index for each measure—PHQ-9 = 6, GAD-7 = 4. Chi squared tests and odds ratios (ORs) with 95% confidence limits and a Mann–Whitney test were used to compare data for older adults with adults of working age. Because of the large number of tests, a Bonferroni correction was employed with a cut-off for significance of $p < 0.01$.

Results

Participating services and service users

A total of 220 services across 97 organisations took part—207 services in England and 13 services in Wales. One hundred and thirty seven services that took part in the baseline did not register for the second round. The most common reasons provided were as follows: 39 services stated that the audit was not appropriate for them, 32 services either no longer existed (13) or were no longer eligible as a result of service changes (19), 26 services cited a lack of resources and other priorities such as contract reviews and renewals, and 40 services had a mixture of other reasons or their reasons were unknown. Primary care services accounted for 137 (62%), secondary care for 48 (22%) and services both in primary and secondary care 35 (16%). Adults of all ages were treated by 175 (79%) of services, adults of working age only by 37 (17%) and older adults only by 8 (4%) of services. IAPT services accounted for 131 (60%) of services. One hundred and eighty one (82%) services were wholly within the NHS, 29 (13%) in the voluntary sector and 5 (2%) in the private sector. The remainder were services covering a mix of sectors.

Service user questionnaires were received from 14 425 individuals who specified their age—13 101 from adults of working age and 1324 from older adults. This was a 20% response rate. A total of 9850 (69%) questionnaires were received from women and 4370 (31%) were from men, and 12 651 (87.8%) were of White British ethnicity. A total of 7415 (46%) reported that they had received CBT, 4120 (25%) counselling and the remainder received mindfulness, psychodynamic, person-centred, solution focussed, cognitive analytic therapy, low intensity, other treatments or were not sure. The vast majority received individual therapy (Table 1). Diagnostic information is available on 42 896/67 290 (63.7%) of the individuals who completed at least two sessions of therapy and is provided in Table 1. There were no differences in the proportions of older adults and working age adults with depressive disorders or mixed anxiety and depressive disorders, but older adults were more likely to be diagnosed with generalised anxiety disorder.

Access to psychological therapies for older adults

A total of 122 740 case records were retrospectively assessed on people who had completed therapy between 1 July and 31 October 2012. Older adults accounted for 7794 (6.4%) of these 122 740 individuals and adults of working age 114 946 (93.6%). These proportions were compared with the statistics for age distribution in the 2011 census by the Office for National Statistics (2011), which showed that 9 223 073 of the 44 105 545 (20.9%) people in the country are 65 years or over. The proportion of service users treated in this sample therefore has an under representation of older adults, OR for working age adults to be treated versus older adults, OR = 3.90 (CI: 3.81–3.99).

Experiences and outcomes

Experiences and outcomes are shown in Table 1. Older adults were significantly more likely to decline or be deemed not suitable for therapy but less likely to be referred on; however, the differences were very small. Working age adults were significantly more likely to receive individual therapy than older adults and older adults more likely to receive group therapy than working aged adults, although, again, the differences were small. Older adults were 50% more likely to complete therapy: 59.6% versus 48.6% (OR 1.56, 95% confidence interval (CI): 1.49–1.63), with working age adults having nearly a double drop-out rate: 24.6% versus 12.5%, (OR = 2.19, CI: 2.04–2.34). The group of working age adults contained a higher proportion of people meeting the preset cut-off criteria for clinical caseness. However, a separate analysis on those people who met the criteria for caseness at baseline was performed. This showed that the higher completion and lower drop-out rates for the older adult sample were maintained (ORs in Table 1). There were small but significant differences in waiting times for initial assessment within 13 weeks and commencement of treatment within 18 weeks: older adults were marginally more likely to receive earlier assessment (OR = 1.37, CI:1.24–1.50) and treatment (OR = 1.33, CI: 1.21–1.45). There were no significant differences in the number of sessions, but a significantly larger number of older adults reported receiving only group treatment than working age adults (OR = 1.45, CI: 0.965–1.80). A far higher proportion of older

Table 1 Experiences and outcomes of people or working age and older adults of psychological therapies

	Working age adults		Older adults		Significance	Odds ratio (95% CI)
Number referred for therapy	114 741	(93.6%)	7786	(6.4%)		
General Population	34 882 472	(79.9%)	9 223 073	(20.9%)		3.90 (3.81–3.99)
Numbers expected in morbidity adjusted sample	106 804	(87.0%)	15 936	(13.0%)		2.20 (2.14–2.26)
Diagnosis	40 446		2450			
Depressive disorders	13 160	(32.5%)	790	(32.2%)	Not significant	
Generalised anxiety disorder	4865	(12.0%)	389	(15.9%)	$X^2 = 31.8$, $p < 0.0001$	
Mixed anxiety and depressive disorders	11 737	(29.0%)	669	(27.3%)	Not signifcant	
Number (%) completing therapy, whole sample	55 796/114 741 (48.6%)		4642/7786 (59.6%)		$X^2 = 392$, $p < 0.0001$	1.56 (1.49–1.63)
Number (%) dropping out, whole sample	28 195/114 741 (24.6%)		970/7786 (12.5%)		$X^2 = 352$, $p < 0.0001$	2.19 (2.04–2.34)
Number (%) completing therapy, those reaching clinical caseness	42 476/69 393 (61.2%)		3064/4150 (73.8%)		$X^2 = 265$, $p < 0.0001$	1.79 (1.67–1.91)
Number (%) dropping out, those reaching clinical caseness	15 622/69 393 (22.5%)		394/4150 (9.5%)		$X^2 = 390$, $p < 0.0001$	2.77 (2.49–3.08)
Waiting for assessment < 13 weeks	104 540/113 822 (91.8%)		7243/7744 (93.5%)		$X^2 = 27.6$, $p < 0.0001$	1.37 (1.24–1.50)
Waiting for treatment < 18 weeks	90 726/100 206 (90.5%)		6353/6854 (92.7%)		$X^2 = 34.8$, $p < 0.0001$	1.33 (1.21–1.45)
Individual therapy only	11 579/12 977 (90.4%)		1146/1305 (87.8%)		$X^2 = 11.7$, $p = 0.0006$	1.15 (0.965–1.37)
Group therapy only	724/12 997 (5.6%)		103/1305 (7.9%)		$X^2 = 11.6$, $p = 0.0007$	1.45 (0.965–1.80)
Treatment sessions: mean (range)	4.8 (0–600)		4.6 (0–90)		Wilcoxon $p = 0.982$	
Baseline: met criteria for clinical caseness	69 553/78 206 (88.9%)		4157/5219 (79.7%)		$X^2 = 409.9$, $p < 0.0001$	2.05 (1.91–2.21)
Treatment outcome 'recovered' (on those only who met initial criteria for caseness)	28 914/63 499 (45.5%)		2248/3841 (58.5%)		$X^2 = 245$, $p < 0.0001$	1.69 (1.56–1.80)
Treatment outcome 'recovered' or 'reliably improved' (on those only who met initial criteria for caseness)	37 086/63 499 (58.4%)		2626/3841 (68.4%)		$X^2 = 148$, $p < 0.0001$	1.54 (1.44–1.65)
Satisfied with waiting time	8500/12 956 (65.6%)		1008/1294 (77.9%)		$X^2 = 79.5$, $p < 0.0001$	1.85 (1.61–2.12)
Therapy helped me understand my difficulties	11 522/12 993 (88.7%)		1156/1297 (89.1%)		$X^2 = 0.44$, $p = 0.50$	1.05 (0.871–1.26)
Therapy helped me cope with my difficulties	10 733/12 972 (82.7%)		1085/1293 (83.9%)		$X^2 = 1.06$, $p = 0.30$	1.09 (0.932–1.27)
I am receiving the right number of sessions	8630/12 831 (67.3%)		887/1265 (70.1%)		$X^2 = 28.4$, $p < 0.0001$	1.14 (1.01–1.30)
If I have similar difficulties in the future, I would have this therapy again	10 813/12 935 (83.3%)		1068/1298 (82.2%)		$X^2 = 1.38$, $p = 0.240$	1.10 (0.945–1.27)

adults were assessed as having made either a 'recovery': 58.5% versus 45.5% (OR = 1.69, CI: 1.56–1.80) or a 'recovery or reliable improvement': 68.4% versus 58.4% than working age adults (OR = 1.54, CI: 1.44–1.65). More older adults were satisfied with waiting times (OR = 1.85, CI:1.61–2.12) and numbers of sessions (OR = 1.14, CI:1.01–1.30), but there were no differences in self-reported experience of therapy (helpfulness, whether they would have it again).

Discussion

Main findings

There appears to be a significant under-representation of older adults receiving psychological therapies despite evidence that these treatments are effective and legislation to end age discrimination in the NHS. To establish the rates of uptake of psychological therapies in this group, it is necessary to estimate the rates of common mental disorders. The National Centre for Social Research and the University of Leicester collaborated on a household survey between October 2006 and December 2007 to collect data on mental health among adults aged 16 years and over in England and Wales (McManus *et al.*, 2009). The data showed prevalence rates of common mental health disorders (depression and anxiety disorders) within the population and that adults aged 16–54 years had the highest prevalence rates, whereas older adults had the lowest prevalence rates (10–11%). Taking into account the expected rates of mental disorders in the community, the expected proportions of adults of working age and older adults in this sample are 106 804/122 740 (87.0%) and 15 936/122 740 (13.0%). Therefore, even taking into account the lower morbidity of the older adult group, they had less than half the representation expected (6.4%) in the case notes sample: OR of working age adults versus older adults, OR = 2.20 (CI: 2.14–2.26). This difference in access was particularly marked in the over-75-years group where only 2177 (2%) were treated from an expected population 7364 (6%).

It is unclear from this study whether this represents a failure to diagnose or refer older adults to psychological therapy services. Particularly, there may be a priority in treating physical disorders rather than co-morbid psychological disorders; for example, Tylee *et al.* (1993) found that the failure to detect depression in primary care was associated with a fivefold increase of serious physical illness in depressed women. Older people may have barriers to access services, for example, social isolation, disability, or they may hold views, beliefs and attitudes that may prevent them from recognising mental health problems as conditions that require treatment. For example, Happell and Koehn (2011) found that participants' perceptions of their own good mental health increased with age whilst they rated poorer physical health. In this study, 37 services (13%) reported a policy that excluded older adults. However, the age discrimination ban was implemented in the middle of the data collection period, so the effects on service provision and practice may not have been fully realised. Further studies are needed to see whether this plan has a delayed effect on access of older adults.

Despite only minor differences in waiting times to assessment and to treatment (marginally favouring older adults), older adults were also more satisfied with their waiting times but to a greater degree (10% more were satisfied than adults of working age) than could be explained by the actual waiting times. Other measures of satisfaction did not discriminate between the experiences of the two groups. This finding needs to be interpreted alongside other more general findings that older age predicts a higher degree of health care satisfaction (Rahmqvist, 2001).

The improved outcome and attrition rates for older adults cannot be explained by the smaller proportion of the group reaching the cut-off level for caseness as measured at baseline. This is because the clinical outcome analysis only included individuals who met caseness criteria at the start of treatment. Similarly, attrition and completion rates were in favour of the older adult group whether including the whole sample or the sub-sample of those who met caseness.

Studies reporting outcomes for older adults with depression treated with CBT show response rates of 55% (Hautzinger and Welz, 2004) and for generalised anxiety disorder of 45% (Stanley *et al.*, 2003). In larger community-based naturalistic studies, Barkham *et al.* (2011) reported a 40.7% recovery rate in over 16 000 patients in a primary care-based counselling study. Similarly, the first year of the IAPT outcome study reported that 42% of people receiving psychological therapies recovered although recovery rates were not individually reported for older adults (IAPT, 2011). The recovery rates in this study for adults of working age (45.5%) are in line with IAPT figures although the recovery rate in older adults appears to be better. This finding is novel given that few studies have compared outcomes between older and working age adults. A small study by Walker and Clarke (2001) showed improved completion rates of therapy (70%) and lower attrition rates for older adults (13%), a finding similar to this study.

Strengths and limitations

This study has the clear strengths of an extremely large sample size and broad geographical spread covering services throughout England and Wales. It covers a wide variation of treatment modalities and spans public, voluntary and private sectors and bridges primary and secondary care. It has employed robust outcome measures and assessed other aspects of the experience of treatment as well as outcome. However, there are some limitations. These include a low response rate to the service user questionnaire and the possibility that the respondents may be biassed toward positive experiences. This however would not be expected to differentially affect the responses of the two groups studied here. Older adults were significantly more likely to be treated for generalised anxiety disorder; however, it is unclear if the improved outcomes for older adults is related to this. There is also no information about the severity of disorders at baseline. Although the analysis of outcome is based on those with sufficiently severe symptoms to reach the level of caseness, it is possible that one group may have been significantly more unwell initially. As this was effectively a naturalistic study, therapist characteristics and modalities of treatment may have varied between the groups, and some are likely to have had additional treatment, including medication or other psychosocial interventions.

Implications

Older adults appear to be satisfied with psychological care and report better outcomes than working age adults. Further work needs to be aimed at increasing access for older adults and ensuring that psychological therapy services are provided on the basis of need not age. Despite having lower rates of common mental disorders than working age adults, the significant under-representation of older adults in the sample referred for psychological therapy needs urgently addressing. Efforts must be made to educate general practitioners to routinely screen for mental disorders in older adults and to educate them about the effectiveness of psychological treatments. Public information campaigns need to target older adults to raise their awareness to request psychological help for their mental distress. These initiatives will require evaluation. Further audits are needed to assess whether services are operating age cut-offs to exclude older adults and to disseminate the results of the effectiveness of treating older age groups to target the use of resources.

Conflict of interest

None declared.

Key points

- Older adults have reduced access to psychological therapy.
- Older adults have better engagement in psychological therapy.
- Older adults report better outcomes in psychological therapy.
- Older adults report greater satisfaction with waiting times and number of sessions.

Acknowledgement

The authors acknowledge Healthcare Quality Improvement, Partnership Ltd., Holland House, 4 Bury Street, London EC3A 5AW (www.hqip.org.uk).

References

Anderson D, Connelly P, Meier R, McCracken C. 2012. Mental health service discrimination against older people. *Psychiatr* **37**: 98–103.

Barkham, M, Stiles, WB, Connell J, Mellor-Clark J. 2011. The meaning of treatment effectiveness in routine NHS primary care psychological therapy services. *Psychol Psychother Theory Res Pract*. First published online: DOI: 10.1111/j.2044-8341.2011.02019.x

Bedi N, Lee A, Harrison G, *et al*. 2000. Assessing effectiveness of treatment of depression in primary care: partially randomised preference trial. *Br J Psychiatry* **177**: 312–318.

Department of Health. 2011. Talking therapies: a four-year plan of action, a supporting document to 'No health without mental health: a cross-government mental health outcomes strategy for people of all ages'. Department of Health, London. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213765/dh_123985.pdf

Department of Health. 2012. Implementing a ban on age discrimination in the NHS—making effective, appropriate decisions. London: Department of Health. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/212944/ban-on-age-discrimination.pdf

Driessen E, Hollon FD. 2010. Cognitive behavioral therapy for mood disorders: efficacy, moderators and mediators. *Psychiatr Clin N Am* **33**: 537–555

Happell B, Koehn S. 2011. Effect of aging on the perceptions of physical and mental health in an Australian population. *Nurs Health Sci* **13**: 27–33.

Hautzinger M, Welz S. 2004. Cognitive behavioral therapy for depressed elderly outpatients—a controlled randomized trial. *Verhaltenstherapie Psychosoziale Prax* **36**: 789–798.

Hofmann SG, Smits JA. 2008. Cognitive-behavioral therapy for adult anxiety disorders: a meta-analysis of randomized placebo-controlled trials. *J Clin Psychiatry* **69**: 621–632.

HQIP. 2012. How to implement changes from national clinical audit: a guide for audit professionals in healthcare organisations. Available at http://www.hqip.org.uk/assets/Downloads/Implementing-Local-Change-from-National-Audit.pdf

IAPT. 2011. Enhancing recovery rates in IAPT services: lessons from year one. Department of Health: London. www.iapt.nhs.uk/data/measuring-outcomes/enhancing-recovery-rates--iapt-year-one-report/

Kroenke K, Spitzer RL, Williams JB. 2001. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med* **16**: 606–613.

McManus, S, Meltzer H, Brugha T, Bebbington P, Jenkins R. 2009. Adult Psychiatric Morbidity in England, 2007: results of a household survey, The NHS Centre for Health and Social Care.

Office for National Statistics. 2011. Census data: age by single year, local authorities in the United Kingdom. Available at: http://www.ons.gov.uk/ons/search/index.html?newquery=census+2011&newoffset=50&pageSize=50&sortBy=&sortDirection=DESCENDING&applyFilters=true

Rahmqvist M. 2001. Patient satisfaction in relation to age, health status and other background factors: a model for comparison of care units. *International J Qual Health Care* **13**: 385–390.

Royal College of Psychiatrists. 2011. National audit of psychological therapies for anxiety and depression, *National Report 2011*. http://www.rcpsych.ac.uk/pdf/NAPT%20Report%20amended%20March%202012%20FINAL.pdf

Serfaty MA, Haworth D, Blanchard M, *et al*. 2009. Clinical effectiveness of individual cognitive behavioral therapy for depressed older people in primary care: a randomized controlled trial. *Arch Gen Psychiatr* **66**: 1332–1340.

Spitzer RL, Kroenke K, Williams JB, Lowe B. 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Arch Intern Med* **166**: 1092–1097.

Stanley MA, Beck JG, Novy, DM, *et al*. 2003. Cognitive-behavioral treatment of late-life generalized anxiety disorder. *J Consult Clin Psychol* **71**: 309–319.

Tylee AT, Freeling P, Kerry S. 1993. Why do general practitioners recognize major depression in one woman patient yet miss it in another? *Br J Gen Pract* **43**: 327–330.

Volkert J, Schulz H, Härter M, Wlodarczyk O, Andreas S. 2013. The prevalence of mental disorders in older people in Western countries—a meta-analysis. *Ageing Res Rev* **12**: 339–353.

Walker DA, Clarke M. 2001. Cognitive behavioural psychotherapy: a comparison between younger and older adults in two inner city mental health teams. *Aging Ment Health* **5**: 197–199.