

A COLLECTIVE RESPONSIBILITY TO ACT NOW ON AGEING AND MENTAL HEALTH

A Consensus Statement

Issued by key organisations integral to the support, care, and treatment of mental health in later life



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Ageing and
Mental Health

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Foreword

“Older people are discriminated by meaningless categorisations based on who is and isn't ‘of working age’ and arcane assessments by which health and social care decides who takes or avoids responsibility. The often complex and co-morbid needs of older people are subsequently discounted. Frustration and confusion characterise the carers' experience as we try to find what once seemed so simple: someone to help us look after our loved ones.”

Rebecca Toney
Carer and Primary Care Mental Health Worker
South Staffordshire Primary Care Trust

Formal consultation on the National Dementia Strategy for England has begun - the organisations endorsing this statement firmly believe it should mark only the starting point of a comprehensive commitment to address the full range of mental health problems in later life. *Dementia cannot and should not be seen in isolation from the rest of mental illness in older people. For instance depression affects three times as many older people as dementia.* It is essential that the funding and resources necessary are made available to implement sustained improvements across the spectrum of later life mental disorder, which must also include a focus on mental health promotion.

This issue affects each and every one of us - there is a clear imperative to act and make all of older peoples' mental health a National priority. It is no longer acceptable or wise to allow our response to this pressing problem to occur by chance or to continue to allow the fragmentation of older people's mental health into diagnostic silos, erroneously ignoring the complex interdependencies and multiple pathologies which we know to exist and have an impact. **All** of mental health in later life must be accorded the highest priority in terms of sustained vision, leadership and policy ownership, not falling through gaps between mental health and older people's policies.

With these issues in mind and an intention to establish some positive actions a summit on elders' mental health was hosted by the Royal College of General Practitioners (Jan 21st 2008; see *appendix for participants*). Those attending agreed we should highlight the need for urgent action through the release of a consensus statement.

We call for concerted action from government, responsible health and social care agencies and professional and third sector organizations to address the issues contained in this evidence based statement before it is too late. In so doing, we fully acknowledge our own roles and responsibilities in finding and supporting positive steps to improving the mental health and well-being of older people and the requirement to work in a collegiate way with others to secure sustainable development and a consensus of approach.

June 20th 2008

Investing In Our Future

Why a consensus statement?

In the last twelve months major reports from the National Audit Office, The Joint Parliamentary Committee on Human Rights, The Parliamentary Accounts Committee, Age Concern and Alzheimer's Society, challenge all of us to reflect on the current lack of attention paid to mental health problems in later life.

These reports are critical of the lost opportunities to invest and develop older peoples' mental health services through the National Service Framework for Mental Health (Department of Health, 1999) which excluded older people and the National Service Framework for Older People (Department of Health, 2001) which had too narrow a focus. The publication of Everybody's Business - Integrated Mental Health Services for Older Adults (CSIP, 2005) helpfully set out the key components of a comprehensive service for older adults with mental health needs. Regrettably though, there was no additional targeted investment to support implementation and in the absence of clear 'must do's', performance indicators or targets, commissioners and providers find it all too easy to disregard or distort what this Department of Health guidance states.

In 2006, a joint report from the Healthcare Commission, Audit Commission and Commission for Social Care Inspection identified deep rooted cultural attitudes to ageing in local public services, especially mental health. It is clear that national policy is not reflected in the commissioning and providing of services where older people's mental health is concerned.

"My mother had Alzheimer's and I loved her dearly and I cared for her. When she had to be taken into care I was devastated. After she died four years ago I tried everything to get a job short of begging. No dice. They didn't want to know. There is still age intolerance. This has to change... Now the whole day is a struggle. I read. I walk. I take part in a church choir. But I am depressed. I am a 76-year-old lonely woman with nothing constructive to do!"

Quote from 2007 UK Inquiry into Mental Health and Well-Being in Later Life, coordinated by Age Concern (Age Concern 2006)

A major focus of these reports is the predicted demographic change and the consequent increase in the frequency and impact of poor mental health in older people within our ageing society, coinciding with a reduced capacity of communities to provide support and care. The economic effect is highlighted by the Kings Fund (2008).

The Prime Minister's 2008 New Year message to the NHS identifies improved access to care as a government priority and a shared ambition of an NHS which is more personal and responsive to individual needs. Older people, however, are experiencing real cuts to services and the transfer of care from professionals specifically trained to address need to generic mental health services with no expertise or training in the mental health of older people.

For older people the skill set of staff may be significantly different from those working with adults of working age and the needs of the two groups may be considerably different (Minshull, 2007).

The Faculty of Old Age Psychiatry believes this is a means of avoiding investment in older people to provide the range of services to meet their need whilst erroneously claiming to combat age discrimination. Having always had less, older people in 2008 find themselves losing access to specialist services and facing indirect age discrimination.

This has fundamental consequences for the efficiency and effectiveness of the health and social care economies. As the Kings Fund (2008) show, only ageing will significantly affect the future prevalence of mental disorder, where it will increase for older people. The National Service Framework for Mental Health reaches its tenth year in 2009. There has to be clarity and direction. Whatever replaces this policy must be age-inclusive and clearly state what should be both commissioned and provided to match the scale of need.

“Good mental health care for older people is not optional”
(Department of Health 2005)

A consensus on areas for action

“This issue will affect every one of us, our families, friends and communities”.

Chris Manning CEO PRIMHE

“Until the government declares older people’s mental health to be a national priority with a clear direction for commissioners to address it, then nothing will change. Without that change services will, very soon, drown in this deepening sea of sickness and neglect. This is about more than just dignity and respect”.

Dave Anderson, Chair, Faculty of Old Age Psychiatry,
Royal College of Psychiatrists.

“I believe that the mental health and well-being of older people should become a top national priority. We have an ageing population and appropriate resources should be allocated to ensure that the increasing medical and community care needs of our older people are addressed”.

Steve Field, Chair, Royal College of General Practitioners.

Older Peoples’ Mental Health should be a national priority

a. Improving the mental health of older people is accorded the highest priority in terms of sustained vision, leadership and policy ownership.

- Recognise that mental health in later life is not only about dementia.
- Raise the expectations of older people themselves and their families to good mental health and emotional wellbeing.
- Challenge societal views that intellectual deterioration and memory loss are ‘natural’ consequences of ageing and changing life circumstances make it ‘inevitable’ that older people should become depressed.
- Within the Darzi review of the NHS, recognise that mental health impacts on all workstreams under review.
- Ensure older people’s mental health receives the highest priority avoiding the trap of *falling between the two stools* of mental health and older peoples’ policy.

- b. The National Dementia Strategy for England** should be seen as the starting point of a comprehensive commitment to address the full range of mental health problems in later life. Dementia should not be seen in isolation from the rest of mental illness. It is essential that the funding and resources necessary are made available to implement sustained improvements across the spectrum of later life mental disorder and must also include a focus on mental health promotion.

- c. Greater prominence and accountability** should be given at senior advisory and ministerial level for the delivery, as a minimum, of equitable and non-discriminatory care for older people with mental health problems which must anticipate the impact of a rapidly ageing population.

- d. World class commissioning** for older people's mental health is a 'world class issue'. The challenges of complex co-morbidities, diminishing informal care, multiple agencies (health, social, third sector, independent sector) requires skilled and informed commissioning.

Investment: policy, practice & research

Established National policy is still not consistently reflected in commissioning, service provision or regulatory processes (CSIP, 2005). A real concern is the evidence of reduction in service and investment for older people's mental health (we believe there are systemic failures of service provision) and service redesign which amounts to both direct and indirect age discrimination. We call on the Department of Health to give a clear and unequivocal policy steer and to address the inconsistencies between stated DH policy and commissioner, regulatory and provider behaviours.

a. Set higher standards of care

- This is not just about services designated as being for 'older people' we should expect as a minimum standard that ALL healthcare and social care professionals will receive appropriate training and skills development in the problems of ageing and complex co-morbidity.
- Reducing suicide in older people should be a priority, contributing to the overall Public Services Agreement on suicide reduction.
- Health and Social Care Regulators should elevate older peoples' mental health to a priority.
- Older people have the right to equity of access to a range of treatments appropriate to their needs. This must include resisting transferring care from specialist to general adult mental health services in the absence of evidence of advantage to older people.
- Professionals and the public should speak out against all forms of discrimination.
- Health and social care commissioners and providers should be held to account if services are discriminatory.
- Service redesign must be subject to public consultation which includes older people.
- Governance of care settings such as residential and nursing homes should be strengthened.
- Health care professionals should be concerned about fulfilling clinical roles which are not within the competencies reflected in their training and work experience.

b. Address current low levels of investment

- Denying older people access to age-appropriate specialist services is unacceptable.
- Challenge disinvestment in older peoples mental health services.
- Develop the evidence base for service provision and advocate 'invest to save' principles in commissioning.

c. Plan for the future as older people deserve a *fit for purpose* workforce yet the baseline could not be lower. Developing the future workforce should become an imperative given demographic changes.

A comprehensive workforce strategy is needed whose scope includes:

- Generalist healthcare: the breadth of workforce be they primary care, acute hospital, residential or nursing home.
- Specialist older peoples mental health – comprehensive and fully integrated into existing community and other relevant specialties.
- Social care and local authority wellbeing and health promotion joined up welfare systems, actively inclusive for older people.
- Third sector and independent sector – with an increasingly critical role as informal care becomes less available.

Collaborative multi-disciplinary/agency working is essential and requires:

- Joined up records and information systems.
- Practitioners and staff who are enabled to work effectively in teams and who can transcend unhelpful service boundaries.
- Clinical leadership and direction at local and regional levels.

A strategic investment in research and implementation to:

- Develop the most effective forms of treatment and service delivery.
- Provide evidence-based models of care like early intervention, home treatment, collaborative care and case management.
- Build the necessary infrastructure for getting evidence into practice across all sectors of health, social care, and third sector.

The Evidence:

Mental Disorder in Older People - the current situation

Currently about 3 million older people in the UK suffer from a mental health problem and this is expected to rise by one third over the next 15 years. *Depression is the most common condition and affects 3 times as many older people as dementia.* Delirium, schizophrenia, bipolar affective disorder, alcohol misuse, anxiety, agoraphobia, adjustment disorders will make up most of the remainder.

- At least 20% of older people in the UK have at any point in time a diagnosable mental disorder.
- 10-15% of all older people meet the clinical criteria for a diagnosis of depression (Beekman *et al.*, 1999).
- Mental health problems increase with age, for example, dementia affects 5% of those aged over 65 years and 20% over 80 years (Alzheimers Society, 2007) & the highest prevalence of depression is found in those over 75 (Kings Fund, 2008).
- 40% of people in care homes are depressed (Age Concern, 2006).
- Delirium affects 1-2% of people aged 65 and over living in the community and up to 14 per cent of people aged 85 and over. In terms of general hospital populations, on average delirium doubles the length of stay and halves the chances of successfully returning home. It is estimated that up to 40% of delirium could be prevented, (Royal College of Psychiatrists, 2006).
- Older people have the highest suicide rate for women and 2nd highest for men (National Confidential Inquiry into Suicides and Homicides) & the one age group where rates have not declined. In contrast with young people self harm in older people usually signifies mental illness, mostly depression, with high risk of completed suicide (Alexopoulos, 2005).
- Though dementia is the most costly medical condition in the UK (greater than stroke, heart disease and cancer combined) it only accounts for 20% of the mental health problems suffered by people over age 64 (Knapp *et al.*, 2007).

Co-morbidities or multi-morbidities are the *norm* in later life. Thus emotional and physical health problems of older people are entwined and manifested in complex co-morbidity.

- Those with a physical handicap have 5 times higher rates of depression.
- Depression co-existing with a long term physical disorder is common: e.g. 50% of *people* with Parkinson's disease suffer depression (National Institute for Health and Clinical Excellence, 2006), 25% following stroke (Chemerinski and Robinson, 2000), 20% with coronary heart disease (ENRICH, 2003), 24% with neurological disease and 42% with chronic lung disease (Sirey *et al.*, 2007).
- Depression produces a greater decrement in health than other long term conditions *and* is the highest determinant of disability world wide (Moussawi *et al.*, 2007).

Being equipped to meet these complex needs is critical in settings like primary care, residential care and acute hospital care.

Impact of socio-demographic changes

A demographic challenge The UK Prime Minister has said that demography is one of the top challenges facing the NHS. World leaders recognize that improved life expectancy and the rapidly increasing number of older people throughout the world, is one of the greatest challenges facing their nations.

- The UK population aged over 60 will rise from 21.2% now to 29.4% by 2050. People of this age will make up about 35% of the electorate.

The absolute rise in numbers over age 60 conceals a far greater proportional increase in the oldest old who will be the population most in need of health & social care.

- The UK over-85 population will increase by 50% over the next 15 years, from 1.2 million in 2005 to 1.8 million in 2021, compared with a 30% increase in the over-65 population (Craig and Mindell, 2007).
-

- In just half that time, the older black and minority ethnic (BME) population will increase by up to 170%.
- Compared to the over 65 population, the over-85 population are twice as likely to experience symptoms of depression and four times more likely to have dementia (Knapp *et al.*, 2007).

This is not purely a change affecting the UK – ageing is a global issue. For example

- In China the population aged over 60 will rise from 10.9% to 31% between now and 2050 (Zhang and Chen, 2006).
- In the USA the number of centenarians will rise from 72,000 in 2000 to 834,000 by 2050. (<http://www.grg.org/calment.html>).

Furthermore, health inequality rises with age (Chandola *et al.*, 2007) and demand on hard-pressed health and social care economies will be exponentially greater than the rising number of older people itself. The Commission of the European Communities strategy *Together for Health: A strategic approach for the European Community* (2008-2013), identifies as a key priority the development of more age related medical specialities, requiring an average 25% increase in healthcare spending by 2050 to meet the need of an ageing population (Commission of the European Communities (2007)).

Informal care – its importance and the effects of demographic change

Informal carers are at the front-line of support. In England currently, for dementia alone, informal care costs have been estimated at £5.2 billion (Knapp *et al.*, 2007), usually borne by families. Most informal care is carried out by spouses. That element provided by sons and daughters (in particular) will diminish as people have fewer children, changing social roles and greater mobility.

- The scale of this demographic change is shown in a Swiss study examining the ratio of people aged 50-74 (the usual age of informal carers other than an equally aged spouse/partner) compared to those over age 85: the ratio has declined from 68.9 to 1 in 1950 to 8.7 to 1 now, and is projected to fall to 3.5 to 1 by 2050 (Robine *et al.*, 2007).

If communities are successfully to provide support and care, then they must actively develop systems of informal care-giving, taking into account these demographic changes. Failure to utilise and develop informal care will put pressure on communities to provide more care home settings, as well as having major cost implications of NHS Continuing care:

- MacDonald and Cooper (2007) have estimated somewhere between 20% to 50% more care home places may be needed by 2023 rising to between 50% to 100% by 2043.

Changing ethnicity within our community

The minority ethnic population will increase (Kings Fund, 2008). The community prevalence of depression in South Asian older people may approach 20% (Rait *et al.*, 1996) and some ethnic minority groups are at greater risk of developing some forms of dementia and late onset psychosis.

Social inclusion

Several reports show how social exclusion can seriously impair the well being of older people (Age Concern, 2006; Bowers *et al.*, 2005). Social inclusion is explicit in European & National legislation but not always evident in the ways services are provided. Evidence shows that active social inclusion benefits the health and well being of older people

What is happening currently in healthcare?

Older peoples' Mental Health problems in Primary Care

Primary care is on the front-line in dealing with older peoples' mental health, supporting families and dealing with complex co-morbidities.

- Older people consult almost twice as often as other age groups (Craig and Mindell, 2007).
- 22% of older people will have attended their general practitioner within the last 2 weeks and 40% will have a mental health problem.

- Primary Care is a key NHS service provider for care homes where at least 40% of older people have depression and 50-80% dementia (Age Concern, 2006).

Detection of depression and dementia can be poor and primary care clinicians may lack the necessary consultation skills or confidence to diagnose late life disorders correctly. Two thirds of older people with serious depression may have symptoms that fit poorly with current classifications of mood disorders, which have been generated to reflect symptoms in younger people, and presentation may differ from younger people because of aging, physical illness, or both. Once recognized, depression is under treated in older people with around 5 out of 6 older people with depression receiving no treatment at all.

- Only one third of older people with depression discuss their symptoms with their general practitioner and less than half of these will receive adequate treatment (Chew-Graham *et al.*, 2004).
- Only one third of people with dementia are diagnosed and only 30% of general practitioners feel they have sufficient training to diagnose and manage dementia (National Audit Office, 2007).
- Only 2% of primary care practice nurses have received appropriate mental health training.

Part of primary care's difficulty is having insufficient access to specialist expertise. For example

- The quality of care and training in care homes has been reviewed as unsatisfactory and undervalued (Alzheimer's Society, 2007).
- 70% of the social care workforce lack qualifications and many are not trained.
- Primary care mental health "graduate" workers have, with few exceptions, focused on those aged under 65.
- Only 6% of older people with depression receive specialist mental health care.

In addition, there are training issues for GPs which are acknowledged:

“The Royal College of General Practitioners has provided a focus on the care of older people in our training curriculum but health and social care professionals should receive appropriate training of ageing and co-morbidities in the areas of physical and mental health.”

Steve Field,
Chair, Royal College of General Practitioners.

Older peoples’ Mental Health in Acute Hospitals

A typical district general hospital with 500 beds admitting 5000 older people each year will expect 3000 of those to suffer a mental disorder in addition to the physical disorder for which they were admitted (Royal College of Psychiatrists, 2005).

“Older people are the biggest users of healthcare, occupying almost two-thirds of our hospital beds. Yet they continue to be a low priority in both the planning and development of our health service.”

Anna Walker,
Chief Executive of the Healthcare Commission, 2006

Fifty to sixty percent of people aged over 64 admitted to an acute general hospital, will have or acquire a mental disorder during that admission. Depression, dementia and delirium account for 80% of these. This co-morbidity causes poorer outcome by increasing rate of death, morbidity and length of admission. In turn, these result in loss of independent function, reduced chance of return to independent living and further impaired quality of life. These are poorly detected and managed in general hospitals and there is limited access to specialist liaison mental health services. Yet, attention to mental health has been shown to improve outcome, efficient use of hospital resources and save money (Royal College of Psychiatrists, 2005).

Older peoples' Specialist Mental Health Services

"Further investment in specialist mental health services is required to provide care for those with greatest need as well as providing advice and support to mainstream services."

Better Health in Old Age, 2004

Ian Philp National Clinical Director for Older People

"This review has followed the remit of the mental health NSF – adults of working age. Comprehensive mental health care needs to go beyond this, to provide similar benefits for older people."

NSF for Mental Health – 5 years on, 2004

Louis Appleby, National Clinical Director for Mental Health

The speciality of older people's mental health is organized and trained to work with people suffering the full range of mental disorders. It is the only mental health service specifically designed to meet the needs of older people. Yet, access to these services is being reduced.

- Older people are denied access to services equivalent to rehabilitation, psychotherapy, general hospital liaison, assertive outreach, crisis home treatment and early intervention services available to younger adults.
- Older people with mental health problems are excluded from intermediate care.
- Greater liaison with older people's mental health services improves care, saves cost and reduces prescribing of antipsychotic drugs but one-third of care home managers report difficulty with access to these services (Alzheimer's Society, 2007).
- A UK survey of old age psychiatrists found 31% of services had implemented or proposed integration with general adult mental health despite 73% believing this would not benefit older people and 58% had experienced cuts to services in 2007-8 up to £2 million in one instance with an average of £800,000 (Faculty of Old Age Psychiatry, 2008 unpublished).
- A survey of clinical psychologists specializing in the mental health of older people reported 50% experiencing plans to amalgamate with adult mental health and in 20% of those amalgamation had failed and was being reversed (PSIGE, 2007 unpublished).

- The Faculty of Old Age Psychiatry and PSIGE believe these amalgamations are driven by cost savings to avoid providing older people with the range of services that would meet their need.

Access and Equality: A problem for Specialist Mental Health Services?

The point of access is crucial for older people.

- Indirect age discrimination may be defined as *apparently neutral practice that disadvantages people of a certain age, for example, designing services around the needs of young adults without taking older peoples needs into account* (Age Concern, 2006).

Access to services that cannot address need is not access but indirect discrimination. Older people often need specialist services organized, trained and skilled to meet their needs in the same way that younger adults, children and adolescents can access specialist services designed for their needs. For older people, the skill set of staff may be significantly different from those working with younger adults and the needs of the two groups may be considerably different (Minshull, 2007).

“Simply to say that all older people should receive the same service, as an expression of equality, is a mistake.”

Rt Hon Ivan Lewis. Minister for Health,
House of Commons Hansard Debates for 15th January, 2008

It is not only a mistake but also discriminatory to say that all older people, as an expression of equality, should receive the same service as younger adults when those services are designed to meet the needs of younger adults. Services should be provided by professionals with the training, expertise and competencies working within an infrastructure capable of meeting the identified need.

“I agree entirely with those who said that we need specialist expertise, staff training and, when appropriate specialist services.”

Rt Hon Ivan Lewis. Minister for Health,
House of Commons Hansard Debates for 15th January, 2008

The Commission for Social Care Inspection this year reports post code provision of social care for older people and the Minister was critical that local councils are interpreting the rules in different ways.

“It is vital to understand and respond to the specific needs of older people”

David Behan, when Chief Inspector of the
Commission for Social Care Inspection, 2006

It is also clear that the same post code lottery is occurring in health care as health commissioners interpret the rules in different ways.

Tackling access and inequality: Redefining Specialist Mental Health Service Models

There is a strong argument for a new prioritisation and investment of resources to reflect the rising number of older people and to redress the injustice that can deny older people access to care and treatment that meets need.

“Psychological therapies are just as effective in older people as they are in working age adults, yet there is a profound under-investment in psychological services for older people. In the 21st century, this is a national disgrace. The government needs to build in access targets for older people as part of the national Improving Access to Psychological Therapies (IAPT) programme to ensure that commissioners and providers provide the basic services to which older people are entitled.”

Dr Sinclair Lough Chair of the Faculty of Old Age Psychology (PSIGE)

- Age appropriate services must be developed that meet the needs of older people comparable to those designed for younger adults.

- Models of care for younger adults may not meet the requirements of older people and while age should not define an individual's need it can provide a proxy for a set of physical and mental health needs and a psychosocial context that is appropriately distinctive.

Furthermore any new prioritisation and reinvestment must avoid perversely limiting access to older people with mental health problems.

- Some commissioners are already separating specialist care for dementia from the other mental health problems to be managed by general mental health services without that expertise under the banner of *age inclusivity*.
- Such a separation of dementia from the larger and related range of mental health problems in older age fails to understand the complexities of these disorders, the differences between mental disorder at different points in the life span, ignores the context in which they occur and the networks necessary to provide the whole system response.
- In effect such a silo-like approach will perversely result in many older people being denied access to specialist mental health services for anything other than organic mental disorder.
- In the longer term diluting and fragmenting older people's mental health into organic and functional disorders will erode the skill base, training and recruitment of professionals dedicated to the development of this specialty and the need to address complex mental and physical co-morbidities.

A COLLECTIVE RESPONSIBILITY TO ACT NOW

Appendix

Mental Health Matters for Primary Care

A Summit about the Mental Health of our Elders

**Monday 21st January 2008
Royal College of General Practitioners**

Attendees

David Anderson, Royal College of Psychiatrists, Faculty Lead on Older People's Mental Health

Derek Beeston, Staffordshire University, Centre for Ageing & Mental Health

Julia Brown, Royal College of General Practitioners

Mike Bush, Associate Lecturer in Mental Health, Leeds Metropolitan University

Peter Crome, British Geriatric Society Chair

Joe Fearn, Samaritans

Paul Kingston, Staffordshire University, Centre for Ageing & Mental Health

Huw Lloyd, Royal College of General Practitioners

Chris Manning, PRIMHE

Ian McPherson, CSIP / NIMHE National Director

Margit Physant, Age Concern

Nadine Schofield, CSIP National OPMH Programme Lead

David Shiers, CSIP, West Midlands

Elaine Stanway, Staffordshire University, Centre for Ageing & Mental Health

George Tadros, Staffordshire University, Centre for Ageing & Mental Health

Mo Vaillancourt, PRIMHE

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