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## **Briefing paper**

### **Older people's mental health and wellbeing**

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### Key messages:

- By 2015, 850,000 people were estimated to be living with dementia in the UK. The emphasis in dementia services recently has been to increase the early identification and diagnosis of dementia. Services have been criticised for failing to keep pace with referral numbers and a lack of post-diagnostic support.
- In supporting older people with mental health conditions there is a need to consider the importance of 'triple integration'; integration of health and social care, primary and specialist care, and physical and mental health care.
- A continued focus is required on ensuring parity of esteem between physical and mental health. This should be reflected in the quantity, quality, and depth of teaching delivered on geriatric medicine and older adult mental health at undergraduate and postgraduate level.
- Other important principles are to take services to the person and support them in their own context, and to embed health promotion initiatives within services.

## Introduction

The older adult population is increasing across the world, and is projected to increase from 530.5 million in 2010 to 1.5 billion in 2050, when roughly one person in six is expected to be over 65, double the current proportion of older people.<sup>1</sup> In 2014, in the UK (United Kingdom), there were over 11.4 million people aged 65 or over<sup>2</sup> with 1.5 million people aged over 85. The number of people aged 75 and over is projected to rise by almost 90% by mid-2039 with the number of people aged 85 and over set to more than double.<sup>3</sup> BME (black and minority ethnic) groups are estimated to contribute over 16% of the population of England, but currently constitute only 8% of those aged over 60:<sup>4</sup> an increasing population of older adults from BME groups is another important projected change. In Scotland the population of pensionable age and older is expected to decrease by 4% from 1.06 million in 2014 to 1.01 million in 2020, but then to increase to 1.36 million by 2039, an increase of 28% compared with 2014.<sup>5</sup> In Wales the projected increase in people aged 65 and over between 2014 and 2039 is 44%,<sup>6</sup> and in Northern Ireland 74.4%.<sup>7</sup> These demographic shifts bring new challenges to health and social care systems, globally and across the whole of the UK.

It is estimated that 40% of people over 65 years old and over two thirds (69%) of over 85 year olds have a long term illness.<sup>4</sup> Sixteen million adults were admitted to hospital in England in 2014-2015, and, of these, almost half (47%) were aged over 65.<sup>8</sup> Up to 60% of older people in hospital have existing mental health problems or develop them during their admission.<sup>9</sup> Of people aged over 70 admitted as emergencies to an acute hospital, 50% have cognitive impairment, 27% have delirium, and 8-32% have depression.<sup>10</sup>

Social isolation and loneliness are major factors affecting the quality of life and mental health of older adults. Age Concern England published two reports on mental health and well-being in 2006<sup>11</sup> and 2007<sup>12</sup> and made a number of recommendations based on the evidence considered at that time: areas highlighted included active ageing, health promotion for older adults, and measures to reduce social isolation. A more recent report using data from the English Longitudinal Study of Ageing found that loss of independence underpins social exclusion and that increasing social exclusion links with lower quality of life and deteriorating health status: deteriorating self-rated health was associated with becoming excluded from local amenities; taking less exercise was associated with becoming excluded from social relationships; and becoming depressed was associated with becoming more excluded overall and becoming excluded from cultural activities.<sup>13</sup> Other important factors include ageism,<sup>14</sup> and the complex inter-relationship between physical and mental health.<sup>15</sup>

Increasing awareness of the latter together with the prioritisation of physical healthcare above mental healthcare has led to the inclusion of parity of esteem in terms of physical and mental healthcare in policy documents.<sup>16</sup>

Currently both the King's Fund<sup>17</sup> and the Royal College of Physicians<sup>18</sup> acknowledge that the NHS (National Health Service) is not meeting the needs of older adults, who are likely to develop complex co-morbidities, disability and frailty as they age. Hospitals are "on the edge" and care is "fractured".<sup>18</sup> A radical rethink is needed for the health and social care system to rise to this challenge.

## The evidence

### Organisation of care

The interfaces between health and social care, and between primary and secondary have become more fluid, with initiatives that bring secondary care into the community and primary care into hospitals. Purdy's review of the evidence in terms of avoiding hospital admissions<sup>19</sup> supports possible roles for hospital at home schemes; integration between primary and social care; and closer integration between primary and secondary care such as schemes involving specialist outreach as part of multifaceted interventions. 62% of hospital bed days in 2014-2015 were occupied by people aged 65 and over.<sup>20</sup> Of people aged over 65 admitted to a general hospital, 60% have or will develop a mental disorder during the admission: approximately 40% have dementia, 53% depression and 60% delirium.<sup>21</sup> Since older people with mental health problems are major users of secondary care services these initiatives are likely to bring major benefits for them.

Specialist older people's mental health services have been criticized in the past as ageist but one of ten key messages for those commissioning services for older people with mental health problems<sup>22</sup> is that older people's mental health services should not be subsumed into a broader 'adult mental health' or 'ageless' services,<sup>23,24</sup> and that the needs of older people with both functional and organic mental illness may be distinct from the needs of younger adults. Needs based criteria for specialist services have been developed by the Royal College of Psychiatrists.<sup>22</sup> The criteria are threefold: people of any age with a primary dementia; people with mental disorder and significant physical illness or frailty which contributes to, or complicates their management; and people with psychological or social difficulties related to the ageing process or end of life. Traditionally older people's mental health services provided home assessments in community clinics,<sup>25</sup> and the principle of community assessment brought practical advantages.

### The challenge of dementia

By 2015, 850,000 people were estimated to be living with dementia in the UK, with the number expected to rise to over 1 million by 2025.<sup>26</sup> There is evidence of a decrease in the prevalence of dementia in England between 1991 and 2011 of around 20% for reasons which are as yet not understood:<sup>27,28</sup> this challenges population projections for numbers of people living with dementia. The emphasis in dementia services recently has been to increase the early identification and diagnosis of dementia. This has led to burgeoning memory assessment services,<sup>29</sup> although there are a range of models in operation, including primary care memory clinics.<sup>30,31</sup> For example, the Gnosall model<sup>a</sup> has been shown to provide a better quality service at lower cost and with less use of hospital beds but is only one type of localised specialist model and has not yet been exported to a larger population. Criticisms of some models include failing to keep pace with referral numbers, and lack of post-diagnostic support services. People with dementia have worse outcomes when they become acutely unwell and are admitted to hospital: they are more likely to die,<sup>32</sup> at risk of longer hospital stays,<sup>17</sup> and likely to decline functionally during their stay resulting in a greater risk of moving into a care setting.<sup>33</sup>

a The Gnosall model of primary care memory clinic involves an old age psychiatrist working in the clinic in the Health Centre in partnership with a member of practice staff (the Eldercare Facilitator) who carries out initial assessments, maintains ongoing contact with patients and families after diagnosis, and liaises with primary care staff.

Dementia may be recognised for the first time during an acute admission, since it is commonly a co-morbid condition when people are admitted for other reasons. Purdy's King's Fund report highlighted two important factors in avoiding hospital admissions: continuity of care from the GP and integration of care, both health and social care and primary and secondary care.<sup>19</sup>

Alongside this, the population of older adults living in care homes in England and Wales has remained almost stable since 2001: in 2011, 291,000 people aged over 65 lived in care homes, and this represents only a small proportion (3.2%) of the total population in that age range.<sup>34</sup> Based on a range of studies the estimated prevalence of people with dementia in care homes in 2014 was 69%.<sup>26</sup>

The National Dementia Strategy was called Living well with dementia<sup>35</sup> and started a drive towards early diagnosis and increased education/awareness about dementia. For most people living with dementia means living in their own home, not in a care home, but they should have access to good quality, timely and appropriate health and social care services wherever they live. NICE later published a Quality Standard which set out 10 quality statements.<sup>36</sup>

ARBD (Alcohol related brain damage) may account for 10% of the dementia population, and a greater proportion of those with dementia under age 65.<sup>37,38</sup> The prevalence of ARBD is increasing<sup>38</sup> and very few services are available to support this group of people.

### **Mental health problems in later life**

Depression is regarded as the most common mental health problem in later life and a systematic review found a prevalence rate for major depression ranging from around 4% to 9%, and for depressive disorders ranging from around 4% to just over 37%.<sup>39</sup> The prevalence of depression is reported to be even higher in nursing home residents: figures of between 29 and up to 40% have been reported across nine European countries.<sup>40</sup> Depression is also associated with worse general health. Only a small proportion of older people with depression seek treatment. A Centre for Policy on Ageing review found widespread evidence of under-recognition and late diagnosis of depression in older adults: although 20-40% of older people in the community show signs of depression meriting treatment, only 4-8% consult a GP.<sup>41</sup> It was suggested that depression is often seen simply as a part of ageing.

Data from the Office for National Statistics show that in 2013 the highest UK suicide rate by broad age group was amongst men aged 45 to 59, but it is of note that the rate for 60 to 74 year old men had risen significantly from its 2012 level, to 14.5 per 100,000 in 2013.<sup>42</sup> It is a matter of concern that older adults have a higher completion rate (ie fewer attempts in relation to completed suicides) than adults in younger age bands.<sup>43</sup>

Older people may grow old with an established psychotic illness or develop a psychotic illness anew in late life, and the classification of late onset psychosis lacks clarity.<sup>44</sup> The prevalence of psychosis in older adults is estimated to be less than 3%,<sup>45</sup> and has been reported to be linked with hearing impairment, social isolation, and soft neurological signs.<sup>46</sup> There is a lack of research on treatment and service options for this group. Psychotic symptoms are, however, much more common, and occur in the context of delirium, dementia, and depression.<sup>47</sup>

Substance misuse in older people is an overlooked area and there is a significant increase in rates of licit and illicit drug use and misuse, together with rises in alcohol-related hospital admissions and mortality, amongst older people.<sup>48</sup> Only 6–7% of high-risk people with substance misuse problems over 60 years of age receive the treatment that they require.<sup>49</sup> Older people are more likely to have mild dependence and be motivated to abstain, but are less likely to complain of a substance problem. Individuals from some BME backgrounds have higher levels of alcohol misuse and resulting health problems than the general population, in particular older Irish and south Asian (Sikh) male migrants to the UK.<sup>50</sup> Both alcohol misuse and ethnicity are linked with social disadvantage.

## Discussion

Improving older people's mental health and well-being will need fundamental changes to how the health and social care system operates.

1. **How might services achieve real practical parity of esteem?** Older people's mental and physical health should be core business for the NHS. How much teaching do medical students receive on the assessment and treatment of older adults and in assessing both mental and physical health routinely as a matter of good practice? Is the quantity and depth of teaching sufficient to meet current population needs, when the oldest old are the fastest growing sector of the population; when comorbidity is known to increase with age;<sup>51</sup> when policy is to facilitate early diagnosis of dementia; and when the aim is parity between mental and physical health, countering ageism in health care?<sup>14</sup> Undergraduate and postgraduate medical teaching should embody parity of esteem in the quantity, quality, and depth of teaching delivered on geriatric medicine and older adult mental health.
2. **How might the boundary between primary and secondary care become more flexible?** Integration of primary and secondary care is suggested<sup>19</sup> but there are also ways of bringing secondary care into the community.<sup>52,53</sup> The NHS Five Year Forward View<sup>16,54</sup> makes the case in England for what has been called triple integration; integration of health and social care, primary and specialist care, and physical and mental health care. Triple integration is equally applicable across the whole of the UK.
3. **How might services be taken to people who need them rather than people taken to the services?** In the community hospital-at-home initiatives offer ways of treating older people at home without hospital admission<sup>19</sup> and avoid some of the adverse consequences of hospital admission. This approach could be applied to people living in care homes and those needing end of life care (particularly those with dementia).<sup>55</sup> In hospital this would mean taking care to the person rather than moving them between wards.
4. **Health promotion initiatives also need to be integrated into the system:** for example there is evidence that preventative exercise programmes are a cost-effective way of reducing the risk of mental illness in older people and the Centre for Policy on Ageing argues that the absence of such programmes may be an example of indirect age discrimination.<sup>41</sup>
5. **How might services involve older people and their families fully in assessment and ongoing treatment?** Services aim to be person-centred but should be equally relationship centred, which means involving their families and ensuring continuity of care in professional relationships (a concept also explored in the briefing in this series on *Living with long term conditions*).

## The role of medical professionals

Doctors need to recognise their responsibility as leaders to improve care through innovation and change. The General Medical Council states that "in their day-to-day role doctors can provide leadership to their colleagues and vision for the organisations in which they work and for the profession as a whole".<sup>56</sup> In mental health "new ways of working"<sup>57</sup> has eroded the leadership role of the consultant psychiatrist to the detriment of holistic care of their patients<sup>58,59</sup> and, in dementia care, there is a financial imperative to shift care to the cheapest possible provider with consequential loss of continuity of care and also de-professionalisation of dementia care.<sup>60</sup> Doctors have unique expertise which enables them to assess, diagnose and manage complex co-morbidities, with support from their multi-disciplinary colleagues. They need to continue confidently to lead in all areas providing health care for older people with mental health problems and resist further erosion of their role.

Alongside this, doctors have a responsibility to "keep the sick from harm and injustice",<sup>61</sup> to safeguard adults from abuse and neglect,<sup>62</sup> and to implement legal frameworks including the Mental Capacity Act.

GPs have a unique role in coordinating the care of older adults with physical and mental health problems: continuity of care<sup>19</sup> and advance care planning<sup>63</sup> are two areas that are key to providing better care. Resources and investment will need to reflect the key roles of general practice, the need for rapid supported discharge from hospital, and for responsive integrated community services.

Hospital doctors need to recognise that mental healthcare is an important part of the physical healthcare of older people using their services and that, in the vast majority of cases, older people should not leave hospitals having lost the functional abilities they had when they were admitted.<sup>33</sup> Rapid supported discharge back to the place from which the person was admitted should be the aim: Purdy found evidence to support a role for structured discharge planning in avoiding hospital admissions.<sup>19</sup>

It is ageist not to make available the specialist services that benefit older people with complex comorbidities and support them in their own homes. Early referral to specialist old age psychiatrists who operate as community psychiatrists and work both with and within primary care will enable integrated care plans across primary and secondary care, aiming to treat people in their own homes as far as possible.

Recruitment to general practice, geriatric medicine and old age psychiatry needs to be prioritised if older adults are to receive appropriate services to maintain their health and independence.

### Conclusion

The principles of care of older people with mental health problems apply across health and social care: they are

1. parity of esteem between physical and mental health;
2. flexible triply integrated services to provide seamless care;
3. taking services to the person, to promote independence whilst safeguarding the vulnerable;
4. health promotion despite disability;
5. person and relationship centred care at the core of flexible and appropriate services.

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