



October 2016

Hidden in plain sight

The unmet mental health needs of older people

We're Age UK

Age UK is a charity and a social enterprise driven by the needs and aspirations of people in later life. We are here to inspire, enable and support older people to help everyone make the most of later life.

Age UK provides information and advice to over 5 million people each year, runs public and parliamentary campaigns, and funds research exclusively focused on later life.

We support and assist a network of around 150 local Age UKs throughout England; the Age UK family also includes Age Scotland, Age Cymru and Age NI. We run just over 450 Age UK charity shops throughout the UK and also offer a range of commercial products tailored to older people.

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Contents

| | |
|----------------------|----|
| Foreword | 5 |
| | |
| Executive summary | 6 |
| | |
| 1 Introduction | 7 |
| | |
| 2 Policy context | 9 |
| | |
| 3 Access to services | 12 |
| | |
| 4 Complex care | 19 |
| | |
| 5 Where next? | 25 |
| | |
| Notes and citations | 27 |
| | |

The Knowledge Hub

Age UK aims to be a centre of expertise on ageing issues and a knowledge hub for all information relating to older people.

We make accessible the findings of research on the older population for free, and provide a comprehensive range of information on older people in the UK and internationally.

<http://www.ageuk.org.uk/professional-resources-home/knowledge-hub-evidence-statistics/>

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Foreword



The mental health needs of older people have long been recognised as under-treated. In major equality reviews for the Department of Health; research by the Royal

College of Psychiatrists; and most recently the independent Mental Health Taskforce, older people have been identified as having had substantial gaps in their access to services. This is despite the fact that up to a quarter of older people in the community are estimated to have symptoms of depression that may require intervention.¹

The numbers are broadly in line with other age groups, yet historically older people haven't been able to expect the same level of support. In earlier research, we revealed that older people with common mental health conditions were much less likely to be receiving talking therapies compared to younger age groups. At the same time, people over 75 were six times *more* likely to be on tranquilisers or similar drug therapies.

These issues have in the past been recognised by government, setting out to significantly improve older people's access to psychological therapies. However, as this report shows, we are still very far behind the modest improvement target set in 2011. Age UK

has been pleased to contribute to efforts to improve rates of referrals to talking therapies, but there is clearly much more to be done.

It is hugely worrying that older people continue to face attitudes that low mood and depression are just a part of ageing. This couldn't be further from the truth. If as a society we want to make the best of our longer years then we must urgently shift such perceptions around mental health and ageing. We are very pleased to publish this report and open out the debate on this crucial issue.

Caroline Abrahams
Charity Director, Age UK

Executive Summary

The Improving Access to Psychological Therapies (IAPT) programme, launched in 2008, aimed to increase the number of people accessing talking therapies such as Cognitive Behavioural Therapy (CBT) for common conditions like anxiety and depression. In 2011 the Department of Health set a target of 12% of referrals through the IAPT programme being people aged 65 and over. Five years later it is still not close to being met with national reporting showing it is currently at 6.1%.

At the current rate of growth in the proportion of older people being referred through IAPT, it will be fifteen years for the 12% referral target to be met.² This lack of urgency is reinforced by the findings of a survey of clinical commissioning groups (CCGs), which revealed that only three had set specific targets around increasing the proportion of older people accessing IAPT.

On average, older people are also waiting slightly longer for mental health

treatment, in particular old age psychiatry where waiting times have increased over the past five years from an average of 22 days in 2011/12 to 26 days in 2015/16.

Many older people live with both physical and mental health conditions, yet almost 40% of mental health trusts do not have a specific policy or strategy for supporting comorbidities (i.e. the presence of more than one long-term condition). Often, physical and mental health needs are inter-related and failing to address them together can severely undermine an older person's ability to recover from an illness or deterioration in their health. Furthermore, figures for older people detained in police stations and hospitals under the Mental Health Act suggest that mental health crisis care is not always adequately dealing with their needs.

In light of these findings, Age UK makes a number of recommendations to build on progress already made and ensure that older people's mental health gains not only parity of esteem with physical health concerns but parity with other age

Key recommendations

- Implementation of Mental Health Taskforce recommendations should include a work stream dedicated to meeting older people's mental health needs. This should include ensuring wide use of the new CQUIN for depression in older patients.
- Local health and care commissioners should fully understand the prevalence of common mental health conditions among the over 65s in their areas.
- Each clinical commissioning group and local authority should consider appointing "older people's mental health champions".
- All services should be appropriately funded and equipped to deliver fully integrated care that addresses mental and physical health and comorbidity.



1 Introduction

Why look at mental health and ageing?

One in four people experience a mental health problem at some point in their life,³ yet there are wide inequalities in access to mental health care. Under-treatment of mental health conditions remains common. The last available data from the Adult Psychiatric Morbidity Survey found that only 24% of people with depression and anxiety disorders were in any form of treatment.⁴ The Mental Health Taskforce report described how there was up to a two-fold difference in the amount spent on mental health services depending on where you live.⁵

The level of unmet need is perhaps even more pronounced among older people. It is estimated that depression affects 22% of men and 28% of women aged 65 or over,⁶ and 40% of older people in care homes,⁷ yet the Royal College of Psychiatrists has estimated that 85% of older people with depression receive no help at all from the NHS.⁸ Issues around loneliness, financial insecurity and dealing with major life changes may all represent risk factors for older people's mental health.⁹ This does not make depression a normal part of ageing, as many older people are led to believe.¹⁰ However, it can be a time in which getting the right

support becomes ever more important to overall wellbeing. With more of us living longer, it is more urgent than ever to consider older people and ageing in the context of mental health, and the implications this has for their care. This paper will review the current approach towards the treatment of older people with mental health conditions and highlight the gap between rhetoric and the reality of current service provision.

Hidden in plain sight

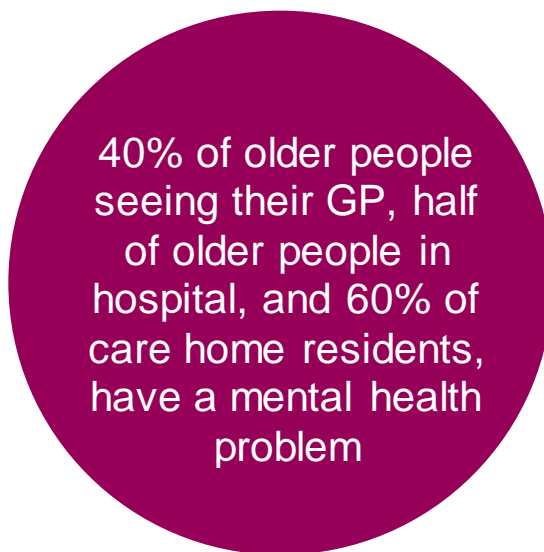
Britain's population is ageing rapidly. Over the next 5 years, the number of people in the UK aged over 65 is expected to rise by around 12% - representing over 1 million people.¹¹

A larger older population is likely to mean more people experiencing mental health conditions who could benefit from treatment. It has been estimated that 25% of older people in the community have symptoms of depression that may require intervention.¹² The Department of Health has estimated that 40% of older people seeing their GP, half of older people in general hospitals, and 60% of care home residents, have a mental health problem.¹³ In 2015, on an average day in a 500 bed hospital, 330 beds will be occupied by older people, of whom 220 will have a mental disorder, 100 each will have dementia and depression and 66 will have delirium.¹⁴

Mental health conditions in older people have been found to reduce quality of life and increase use of health and social care services.¹⁵ Yet supporting older people to stay mentally and physically well for longer is not only better for

individuals but makes good economic sense if it enables people to stay in work for longer, reduces demand on services or supports the ability to carry on caring for family and volunteering.

However, older people are often unlikely to seek help. Fewer than one in six older people with depression ever discuss this with their GP.¹⁶ This is in part because of the stigma surrounding mental health, but may also be because of a societal assumption that many of the symptoms are simply part of growing older. Yet we know that older people can often respond well to treatments such as medication and psychological therapies,¹⁷ and in some cases better than other age groups (see figure 1, page 14).



People over 65 are also significantly more likely to visit their GP than other age groups. A survey conducted by Populus in 2014 found that 85% of patients aged over 65 had visited their GP in the last 12 months. For those aged 25-34, the figure was 69%.¹⁸ Older people are more likely to be admitted to

hospital and will stay longer compared to other age groups.¹⁹ Such interaction with the NHS presents service providers with a greater opportunity to identify mental health conditions and therefore refer them to or provide treatment.

It is also crucial that older people reach the service that is going to best meet their needs. A study by the British Journal of Psychiatry compared the ability of general adult and old age mental health services to meet the needs of older people with enduring mental health problems. In the study, a group under general adult services had twice as many unmet needs after treatment compared to those using bespoke old age services.²⁰ In this context, it is concerning that there is evidence to suggest a trend in some parts of the country away from specialist mental health services for older people to all-age services.²¹

2 Policy context

Mental health

In recent years there has been a renewed focus on mental health. In 2011 the *No health without mental health* strategy was launched and in 2014 new waiting time standards were introduced in line with those in place for physical health. Under one of these standards, it is now expected that 75% of people referred to the Improving Access to Psychological Therapies (IAPT) programme should be treated within 6 weeks of referral, and 95% should be treated within 18 weeks of


referral. In January 2016, the Government pledged an extra £1 billion to improve mental health services across England²² and in February, the Mental Health Taskforce, set up by NHS England, published its report outlining priorities for mental health for the next five years. Accepting the report's recommendations, NHS England then published its implementation plan in July.

Mental health budgets have been cut by around 8% since 2010

However this renewed focus and additional investment exist within an overall context of funding pressures and a health service under considerable strain. While referrals to mental health treatment have increased, and the voluntary sector has taken on a greater role in service provision, reports suggest mental health budgets have been cut by around 8% since 2010.²³

In addition, there is already evidence that mental health services have historically been underfunded. The King's Fund has suggested that mental health problems account for 23% of the burden of disease in the UK, but spending on mental health services consumes only 11% of the NHS budget.²⁴ This creates a challenging environment in which to improve care as well as implementing the recommendations of the Mental Health Taskforce aimed at building more responsive services for people living with mental health conditions.

Recent initiatives, including the implementation plan for the Mental Health Taskforce, include a welcome emphasis on working towards better outcomes for people of all ages, including older people. However, while the plan spoke of achieving “an additional one million people receiving high-quality care by 2020/21”,²⁵ many of the specific investments are currently weighted towards areas including children, young people and maternal mental health.



“We know that older people are not always treated with the dignity they deserve because of ageist attitudes”.

Former Care Minister

Older people’s services

The Chief Medical Officer’s report on mental health in 2014 argued that: “[m]ental disorders in older age have been substantially underrepresented in policy discussions, falling between the focus of ‘mental health’ on working-age adults and that of ‘older people’ on dementia.”²⁶

The creation of a specific Dementia Strategy in 2009 was an important policy

focus, given that it is estimated that one in three people over 65 will die with a form of dementia, and up to 25% of all hospital beds are occupied by older patients with dementia.²⁷ This was followed by the launch of the Dementia Challenge by the then Prime Minister in 2012 to focus both on improved health and care and new research into treatments.

However, though it was critical and timely to see specific and targeted action on dementia, this focus may have been at the expense of other mental health conditions such as depression. This further sits in the historic context of under-treatment not only in mental health care^{28,29} but also broader inequalities in access for older people to key services such as cancer care³⁰ and surgery.³¹ The Equality Act 2010 finally outlawed age discrimination in health and social care,³² coming into force in October 2012. In 2011, the then Care Minister said “There can be no place for arbitrary age discrimination in the NHS. We know that older people are not always treated with the dignity they deserve because of ageist attitudes”.³³ Despite this, while 50% of younger people with depression are referred to mental health services, only 6% of older people are.³⁴

Despite the vital contribution of the Equality Act, one unintended consequence may have been disinvestment in specific initiatives aimed at older people. The Chief Medical Officer’s report on mental health³⁵ stated in relation to older adults that: “‘ageless’ services present potentially serious long-term threats to

mental health care for older adults, not only through immediate withdrawal of specialist service provision, but also through longer-term loss of specialist training. Such a radical change in provision should therefore be evaluated and demonstrated to represent an improvement before it is allowed to proceed further.”

The Mental Health Taskforce report acknowledged that “older people’s needs are also neglected, with many led to believe depression is a normal part of ageing.”³⁶ It stated that “wherever it is provided care should be appropriate to people of all ages”, however, it highlighted that “bespoke older adults services should be the preferred model until general adult mental health services can be shown to provide age appropriate care.”³⁷ It argued that NHS England should ensure that individuals being supported in specialist older age acute physical health services have access to liaison mental health teams (including expertise in the psychiatry of older adults) as part of their package of care. Furthermore that this should be incentivised through the introduction of a new national Commissioning for Quality and Innovation (CQUIN) framework along the lines of the dementia CQUIN focused specifically on the improvement in recognition and treatment of depression in older people.

Though the *No health without mental health* (2011) was a cross-government strategy to improve mental health outcomes across all ages, it did refer specifically to the need to reduce social isolation among older people and improve the mental health services

offered by primary care services. A prospective measure for loneliness was included for the Adult Social Care Outcomes Framework but abandoned in November 2014.

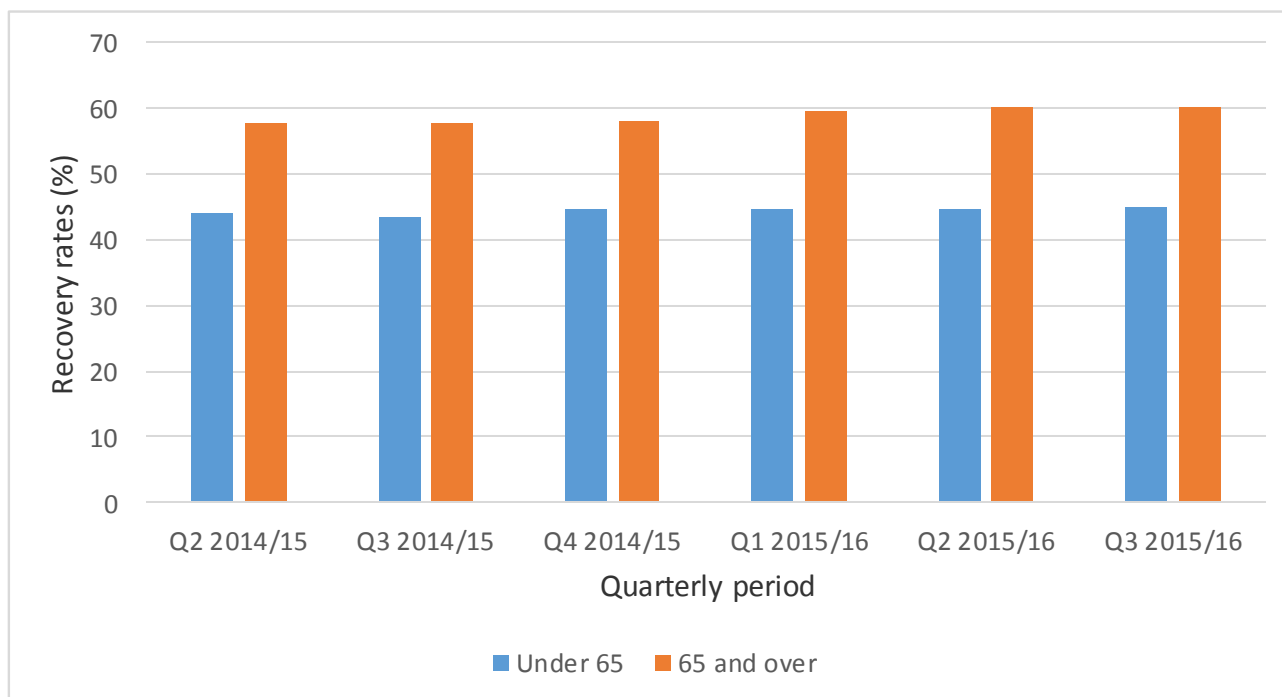
Improving Access to Psychological Therapies

The Improving Access to Psychological Therapies (IAPT) programme was established in 2008 to support implementation of national health guidelines for people living with depression and/or anxiety.

The programme recognised the large and growing prevalence of mental health conditions in the adult population and the significant impact they have on mental and physical wellbeing and a person’s ability to function day to day.

It set out to increase the number of therapists and the availability of services (sometimes referred to as “talking therapies”) that can deliver support and treatment for people with depression and/or anxiety. Initially focused on adults under the age 65, it was later expanded to include older people.

Figure 1: Percentage of patients who were classed as entering recovery following IAPT treatment, 2014-2016



3 Access to services

Improving Access to Psychological Therapies

Talking therapies can be highly effective in older people. NHS guidance states that “older people, especially those with depression, are as likely to benefit from talking therapies as everyone else.”³⁸ Indeed, recovery rates for those aged over 65 who have been through the IAPT programme are often better than for those aged below 65, as figure 1 shows.

Nevertheless, despite improvements in rates of access to psychological

therapies, older people continue to be significantly underrepresented in referrals compared to people under 65. Since 2008/9, the first year of operation of IAPT, to 2015/16, national reporting shows the total proportion of patients aged over 64 had only increased from 4% to 6.1%.³⁹ This is still well below the expected rate of 12% set out in the ‘Talking Therapies: four year plan of action’ in 2011.⁴⁰ Indeed, while the number of referrals has increased, the total proportion of older people has remained largely static (at around 5-6%). There also seems to be variation with age, as the vast majority of older people (roughly two-thirds) who access IAPT services are under the age of 75, with very few people over the age of 90 accessing these services.⁴¹ It is worth emphasising that the initial objectives of

the IAPT programme focused on adults below state pension age, and targets around improving access to employment further reinforce this emphasis.⁴²

As the figure 2 below shows, the rate of increase has been slow, and at the current rate of growth it would take until 2031 before the 12% target of referrals is met, another 15 years.⁴³

As well as looking at the national data, the Education Policy Institute, on behalf of Age UK, undertook a survey of all 56 Mental Health Trusts in England in April 2016. One trust had been subsumed into another, so of the 55 remaining trusts we received 52 responses, a response rate of 94.5%.⁴⁴

Figure 3 on page 16 shows the average percentage of referrals aged 65 and over across the trusts in the last five years.

At the current rate of growth it would take until 2031 before the 12% target of referrals [set in 2011] is met

We can see that while there has been improvement in the rate of referrals, this localised data confirms the national trends of slow increases, falling well short of the 12% target. Indeed, of the responses for 2015/16, only three Trusts had met the 12% target. While there will be variation in rates of over 65s per population across local areas, we would expect a greater number to be reaching the national target. The highest percentage of referrals in 2015/16 was 22.3% in one trust, while the lowest was just 2.8%. The average percentage across all Trusts for 2015/16 was 6.7%.⁴⁵

Figure 2: Proportion of total IAPT referrals aged 65 and over, 2013-2016¹

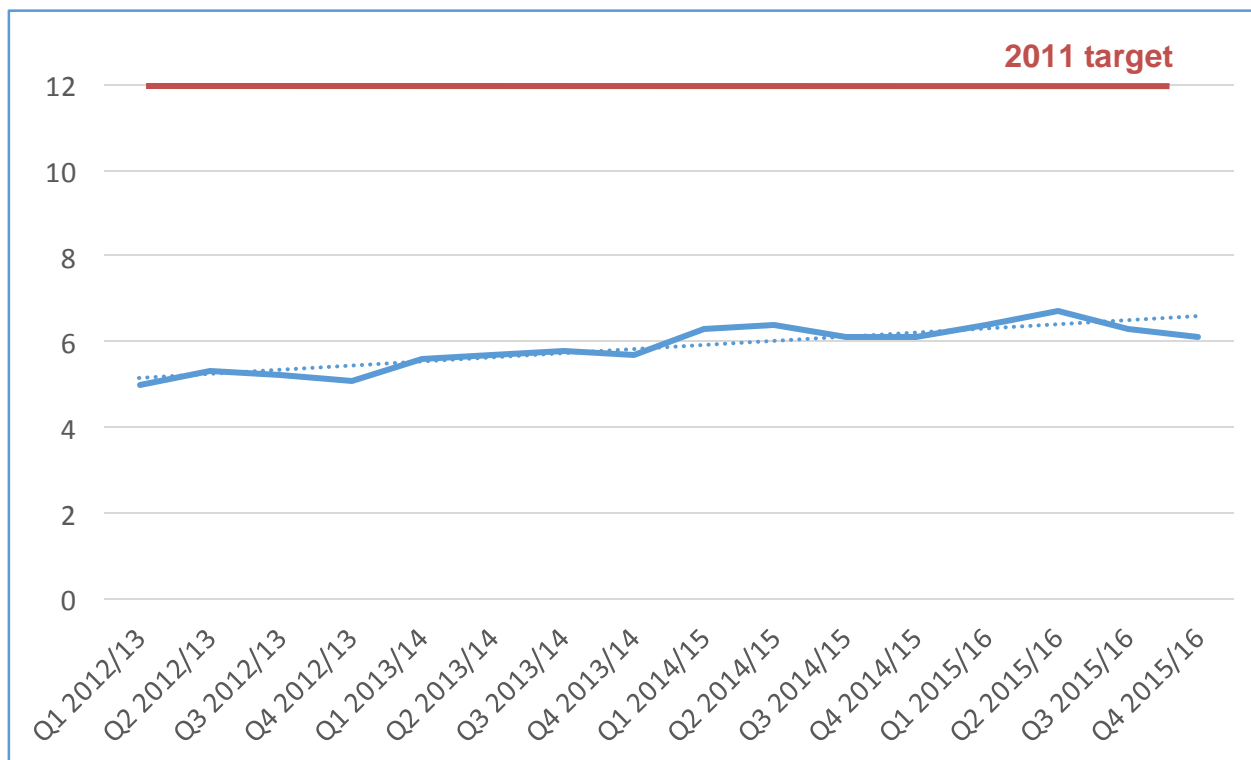
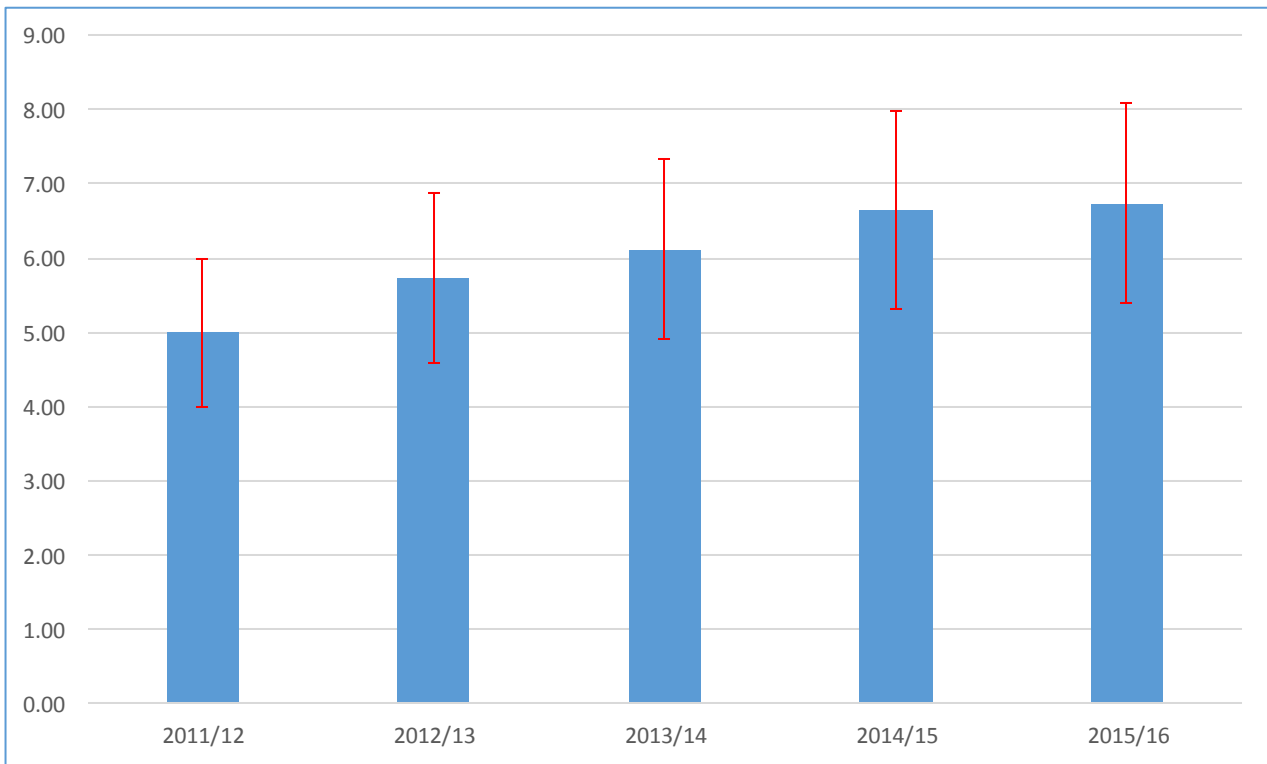


Figure 3: Average percentage of IAPT referrals to Mental Health Trusts aged 65 and over 2011/12 – 2015/16¹



NHS mental health trusts

Mental Health Trusts are local services providing health and care support for people living with mental health conditions. This can include hospitals with inpatient facilities as well as community services that provide support such as counselling and dementia care.

Many mental health trusts are also known as foundations trusts and can provide a wide range of physical health and social care services.

For example, Bradford District Care NHS Foundation Trust provides mental health support as well as services including palliative care and community matrons.

Waiting times

As part of a Freedom of Information (FOI) Act request, the Education Policy Institute asked all Mental Health Trusts about median waiting times for IAPT therapy for all adults and for those aged 65 and over.

As Figure 4⁴⁶ shows there has been a generally declining trend in waiting times for IAPT therapy over the last 5 years, from an average wait of 29 days in 2011/12 to 19 days in 2015/16.

However, it is important to note that this average was calculated excluding two outlying trusts, which had average waiting times in days of 203 and 173.5 in 2011/12 and 231 and 115 in 2015/16. This compared to the lowest waiting

times of 2 days in both 2011/12 and 2015/16, demonstrating the wide variation across trusts.

Waiting times for those aged over 65 have followed the broader trend of decline. Nevertheless, waiting times were slightly longer for those aged over 65 than across adults as a whole. The average median wait for those aged over 65 to access IAPT in 2011/12 was 30 days, and 20 days in 2015/16, compared to 29 and 19 days for all adults.⁴⁷

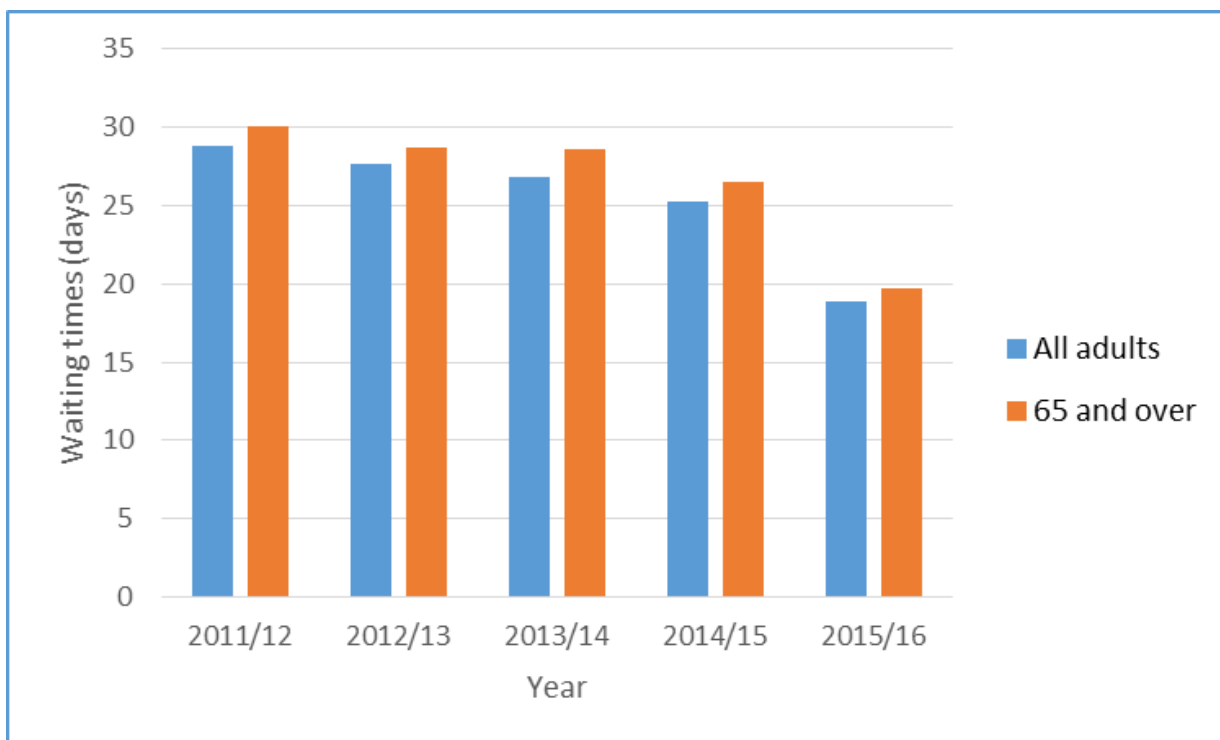
The future for IAPT and older people

In 2012, 43,000 over 65s were referred to psychological therapies via the IAPT programme (5% of total referrals). To

keep pace with the growing numbers of older people, IAPT providers will need to significantly increase capacity. For example, between 2012 and 2022 the number of people aged over 65 is expected to increase by over 20% in England.⁴⁸ This means the number of referrals would need to rise to 51,600 by 2022 just to stand still. To be meeting the 12% target in the same year, this would mean referring 123,840.

43,000 over 65s were referred to IAPT in 2012. To meet the **12%** target in 2022 would mean referring **123,840**.

Figure 4: Average median waiting time for IAPT treatment 2011/12 – 2015/16 across Mental Health Trusts¹



Age UK and IAPT

For the last three years, Age UK has worked with NHS England on a campaign to improve older people's access to talking treatments with the aim of fighting stigma and misconceptions that depression is an inevitable part of ageing. The campaigns aim to promote awareness of IAPT and usually run between September and March and have successfully contributed to the growth in referrals of older people during these periods.

The campaigns use Age UK communication outlets including the 'Wireless' radio station, 'Life Magazine' and the Age UK website to encourage older people, their relatives and carers to seek help through their GP if they, or someone they know, are experiencing feelings of unhappiness, anxiety or depression.

The work has included distributing bespoke materials to GP surgeries and working with Age UK Camden to produce films. These shared older people's experiences of talking therapies, in order to raise awareness of the effect life events and issues such as bereavement, living with a long-term medical condition and retirement, can have on an older person's thoughts and feelings and demonstrate how talking treatments can help.

In 2016, Age UK also published a guide for supporting mental wellbeing called *Your mind matters*. To download a copy, go to www.ageuk.org.uk/your-mind or call the national helpline on 0800 169 2081.



Unmet need

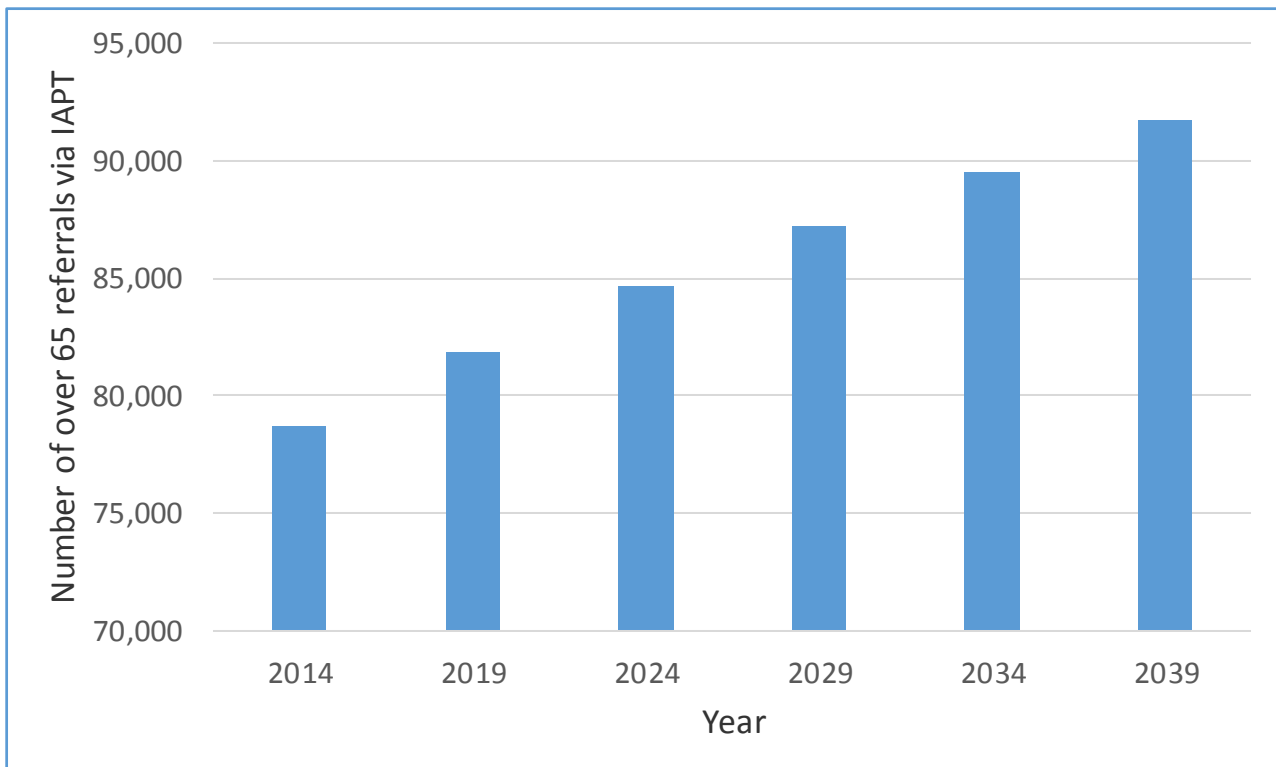
The original 12% target was based on the age profile of the population and the community prevalence of depression and anxiety disorders.⁴⁹ As the proportion of the population aged 65 and over increases, not only will reaching the 12% target of referrals become more challenging, but the target itself will also need to rise. EPI calculated that given the increase in the proportion of the population aged over 65, to match the projected prevalence of mental health need the target for referrals to IAPT would need to increase from 12% in 2014 to 16% by 2034.⁵⁰

Even in light of the existing target, improving access for older people does

not appear to be a priority. A survey of 211 clinical commissioning groups (CCGs) carried out by EPI in 2015 revealed that only three CCGs of the 130 that responded had set specific targets around increasing the number of older patients accessing treatment via the IAPT programme. Southampton City has a target of 7.5% being 65+ in 2015/16; the Isle of Wight had set the national target of 12%; and Leicester CCG had also set a target but did not specify the rate in their response.

Two other CCGs responded that they had aspirations to raise the proportion of older people referred to reflect the proportion of older people in the general population, but that these were not targets. Stockport CCG had an

Figure 5: Projected increase in number of 65 and over referrals to IAPT, if referral rate remains the same



aspiration of 19% of IAPT referrals being those aged 65 and over. City and Hackney CCG explained that they aimed to increase the proportion of older people referred to the service in line with the general population. Two further CCGs (Wirral and South Kent Coast) were in the process of establishing targets. 13 further CCGs responded with some information on steps they are taking to ensure more older people are able to access IAPT programmes, including: outreach and community engagement; working with GP surgeries and specific interventions for older people, including stepped care pathways and particular mental health interventions targeting older people (see box opposite).

Finally, national resources have also been developed to promote IAPT, including resources to help IAPT practitioners develop basic competences and skills to work with older people⁵¹ and the IAPT Older People's Promotion Campaign, based on a partnership between the IAPT National Team and Age UK (see page 18). Many of these resources are fairly recent, so the impact on increasing referral rates for older people or improving the level of mental health care offered to older people are not yet apparent. Nevertheless, it is clear that without comprehensive actions to encourage older people into treatment, the target of 12% of referrals being over 65 is not likely to be met.

Strategies taken by CCGs to improve access to IAPT programmes for those aged 65 and over

Outreach and community engagement

- Providing, or planning to provide integrated mental and physical health care for older people, e.g. improving the management of physical conditions such as diabetes (Cambridgeshire and Peterborough CCG, Surrey Health CCG).
- Older People's Champions looking at identifying barriers to referrals and any difficulties with engagement once referrals take place, linking with local community services, including carers' services and the trust memory assessment team (Trafford CCG).

Working with GP surgeries

- Promotion in GP surgeries through posters, promotional items and question and answer stands (West Leicestershire CCG).

Specific interventions

- Offer interventions designed to target the older age group such as anxiety management, behavioural activation and living well with aches and pains (Bedfordshire CCG, Southampton City CCG).

4 Complex care

Old age psychiatry

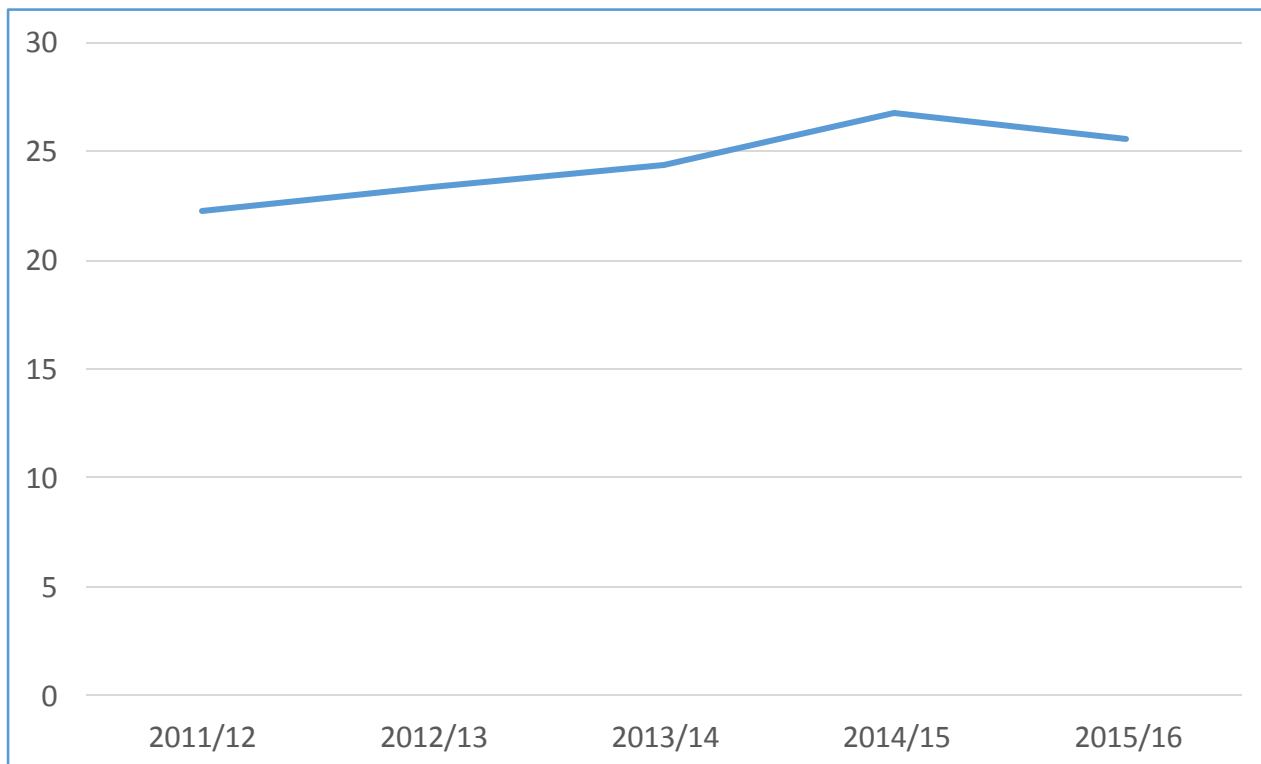
The Education Policy Institute's FOI request of Mental Health Trusts in England looked at waiting times for old age psychiatry, the clinical specialism for treating conditions such as severe mental illness in older people, for example schizophrenia. This showed that median waiting times have been increasing on average for these services, from an average median wait across trusts of 22 days in 2011/12, to 26 days in 2015/16, with a peak of 27 days wait in 2014/15 (see graph

below).⁵² This average of the medians provided by Mental Health Trusts also excluded three outlying waiting times, with one seeing the average median wait to access old age psychiatry in 2015/16 at 245 days, and another at 434 days, meaning that older patients in some parts of the country are having to wait more than a year to access critical services. Another saw an outlying waiting time of 326 days in 2010/11, though waiting times have since dropped to be more in line with the average.

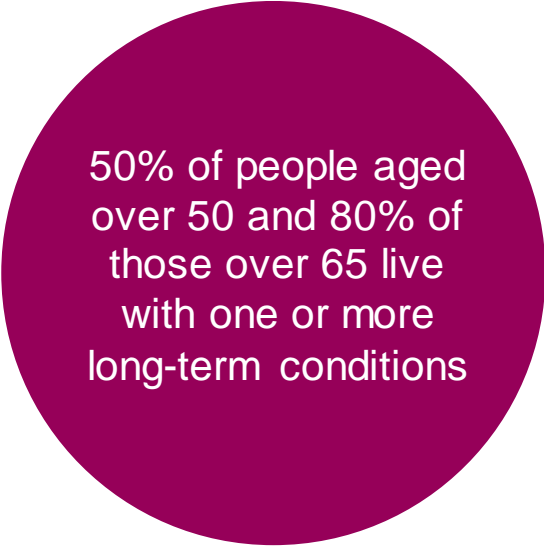
Comorbidity

An issue that can complicate older people's access to appropriate services is the increased likelihood for those

Figure 6: Average median waiting time for old age psychiatry across Mental Health Trusts, 2011/12 – 2015/16



aged 65 and over to present with a number of both physical and mental health conditions. The King's Fund estimates that around 50% of people aged over 50 and 80% of those over 65 live with one or more long-term conditions.⁵³ This makes the need to improve mental health treatment for older people even more pressing, given the well-established link between poor physical health and poor mental health.



50% of people aged over 50 and 80% of those over 65 live with one or more long-term conditions

A 2004 study found that an estimated 70% of new cases of depression in older people are related to poor physical health.⁵⁴ Older adults with physical health conditions, such as heart disease, have higher rates of depression than those who are medically well.⁵⁵ Conversely, untreated depression in an older person with heart disease can negatively affect the outcome of the physical disease.⁵⁶ Providing good mental health treatment therefore not only improves the wellbeing of the individual, it could also generate significant savings for UK health services through prevention of further physical health conditions.

The need for integrated care

Longer life expectancy should be celebrated. Nevertheless, the Department of Health estimates that by 2018 an estimated additional £5 billion may be required for the NHS and social care to manage the impact of comorbidities.⁵⁷ The Organisation for Economic Cooperation and Development (OECD) projects that long-term care spending in OECD-EU countries may double from around 1.2 to 2.4% of GDP by 2050.⁵⁸

Making sure the mental and physical health care of older people works in an integrated way will become more and more critical. There is increasing movement towards integrated care in the NHS, including greater integrated commissioning of acute, primary, community and social care and pooled budgets.⁵⁹ Since 2014, people over 75 have had an entitlement to a "named GP" (now extended to all people) as well as access to more proactive planning and interventions, including identifying mental health needs and referring to specialist support.

Nevertheless, much more needs to be done to ensure that integrated services address mental health needs as well as multiple physical health conditions. The Mental Health Taskforce recommended that older people being supported by specialist physical healthcare services should have access to liaison mental health support, incentivised by new payments for these services.⁶⁰

The King's Fund has recommended the routine provision of psychological education and support as part of cardiac and pulmonary rehabilitation and other self-management programmes including; greater use of peer support groups both locally and online, and the inclusion of clinical psychologists within multidisciplinary teams in the community, and liaison psychiatry/psychological medicine services in hospital wards, frailty units and emergency departments.⁶¹

The King's Fund also emphasised that staff in acute hospital wards and residential care homes should be given the appropriate training and skills to identify and respond to mental health issues in older individuals, including dementia, delirium, self-harm, depression and acute psychosis, rather than seeing some symptoms as merely part of the ageing process.⁶²

There has also been a focus on how to expand the IAPT programme to cater for the needs of those with long term conditions (LTC) and/or medically unexplained symptoms (MUS – see page 23). Fifteen therapy teams became IAPT LTC/MUS Pathfinder sites in February 2012, with roll-out begun in April 2012. However, the evaluation of these pathfinder projects (last updated in April 2014) referenced a lack of demographic information, so it is not possible to say with certainty how many older people were assisted as part of this initiative, and any difference made to older people's clinical outcomes.⁶³

Mental Health Trust strategies for managing comorbid mental and physical health issues

Given the importance of integrated approaches for older people's physical and mental health, we asked all 55 Mental Health Trusts what strategies or policies the trusts had in place for supporting people with mental and physical health comorbidities. 51 trusts provided a response to this question, of which almost 40% had no overarching policies on this issue. Only three had policies which specifically mentioned old age or older people.

40% of mental health trusts had no overarching strategies or policies for supporting people with mental and physical health comorbidities

The 20 trusts with no specific policies provided the following answers:

- two trusts had no policies at all;
- four currently had no particular overarching strategies on this issue but were in the process of formulating or updating them to be published shortly;
- two stated that while they had no specific strategies, National Institute for Health and Care Excellence (NICE) and IAPT best practice guidance relating to chronic and long-term conditions was followed;

Case Study: Elizabeth

Elizabeth is 88 years old and living in a residential care home in Essex. In recent years she has received some knocks – car crashes, falls, shingles, cancer, pneumonia – and these have left her physically frail and reliant on the help of carers.

In her early 70s, Elizabeth was involved in a series of car crashes, leaving her anxious and feeling unable to get into town. As a result, she was forced to relocate closer to town and her family. From these incidents, Elizabeth suffered an injury to her spine, resulting in movement becoming difficult. While the physical symptoms were treated, no mental health treatment was offered.

Following a fall, Elizabeth became more anxious and this resulted in her becoming housebound. From this point, her physical health started to deteriorate very quickly. While she could walk and move around the flat herself, the thought of doing so without a trolley became an unrealistic prospect for her. Her weekly shop was ordered by her grand-daughter and delivered to her home – the world outside of her flat seemed non-existent.

As she was no longer visiting friends and relatives there was little reason for her to stay in that flat, so she moved to sheltered housing where she had two carers a day come in to check up on her. Her family felt that some of these carers treated her with little respect and dehumanised her for being older – as they expected her to have little mental capability. Elizabeth, once a very social woman, lost her self-esteem and didn't mix with people around the accommodation. Again, her anxiety got the better of her, yet this was seen as a symptom of getting older rather than a mental health problem which could possibly have been treated.

Loneliness became a real issue and during this time Elizabeth would mention how sad she was and, occasionally, how she wanted to die. Despite concerns raised by her family, no psychological therapies were offered – even after her ex-husband passed away.

Following a period in hospital for surgery, Elizabeth became too anxious to return to her flat and live alone, so it was decided that she would move into a nursing home. Soon after, Elizabeth was diagnosed with breast cancer and underwent a mastectomy. Following this operation, no counselling was offered.

In 2014, Elizabeth's oldest son died and she was put on antidepressants. As a woman who had generally refused to take anything stronger than a paracetamol she was now medicated to the point where she was unresponsive, delirious and not herself.

In early 2015, the antidepressants were stopped and since then Elizabeth has appeared to be more like her "old self". Despite all she has been through, Elizabeth's family feel the healthcare system consistently overlooked her mental health. They believe that a younger person who had experienced physical health challenges, undergone major surgery as well as bereavement of a son, would be more readily offered mental health support.

- eight responded that while they did not have any specifically relating to these issues, they were covered indirectly by other strategies;
- one trust explained that it did not have any overarching policy on comorbidities, but that different areas of trust had their own policies relating to these issues.

The remaining responses included:

- one trust only had a policy on the physical assessment and examination of patients;
- one trust only had a nutritional strategy;
- one trust only had a policy on physical examinations in inpatient settings and a policy on nutrition and nutritional screening.

However, almost all of the overarching strategies made little to no specific mention of older people and policies aimed specifically at older people and their mental health. Given the majority of people in hospital will be older and more likely to be living with long-term conditions, this is a significant shortfall.

Medically Unexplained Symptoms (MUS)

Medically unexplained symptoms are “persistent bodily complaints for which adequate examination does not reveal sufficient explanatory structural or other specified pathology”.⁶⁴ They account for up to 20% of GP consultations and it is estimated that the annual healthcare costs of MUS in the UK exceed £3.1bn.⁶⁵ According to the NHS, many

people living with medically unexplained symptoms such as exhaustion (fatigue), pain and heart palpitations also have depression or anxiety disorders.

Mental Health Trusts and integrated care

Some of the examples from the Mental Health Trusts that have an overarching strategy or policy relating to the physical healthcare needs of their mental health service users included:

- Avon and Wiltshire had a physical healthcare policy;
- Barnet, Enfield and Haringey had an enablement programme strategy;
- Surrey and Borders had developed community pathway strategies to take into account comorbid physical conditions;
- Cambridgeshire and Peterborough had specific long-term conditions teams within trust services;
- Coventry and Warwickshire had a physical health and lifestyle screening policy for users of secondary care mental health services;
- Dorset and Poole are developing a “One Trust One Mind” programme that is designed to better integrate physical and mental healthcare services in the area (piloting in Poole);
- East London had a physical health policy.

Treating an associated psychological problem can often relieve the physical symptoms.⁶⁶ MUS appear to be more prevalent in people under 65. However, research suggests that diagnosing MUS in older people is more difficult. One reason could be that older people with depression are more likely to present with physical symptoms, and that 'somatic' or 'physical' symptoms such as fatigue, diminished appetite and weight loss which are considered typical depressive symptoms in younger, more physically healthy patients are often overlooked or simply seen as symptoms of physical disorders in older patients.⁶⁷

One study found high comorbidity with other psychiatric problems in older patients with MUS, and suggested that older patients should be routinely screened for mental health issues as part of a multidisciplinary assessment.⁶⁸ Another highlighted the issue of unexplained fatigue in older people and end-of-life scenarios can render some older adults at high risk of fatigue. It stated further that "[d]epression is likely to interact in the perception and impact of fatigue in later life".⁶⁹ There is, therefore, a likelihood that the underlying mental health problem is left untreated – particularly if the patient doesn't perceive the physical condition to be linked to their mental health.

Crisis care

We looked at the detention of older people under the Mental Health Act 1983 across police forces in the UK and found that 631 older people (aged 65 and over) had been detained by police forces from 2010-2015.⁷⁰ Over 90 of

these detentions related to older people being held in a police cell as a 'place of safety' when a hospital based place of safety was not available. One force indicated that the majority of those aged over 65 detained due to a mental health problem were living with dementia. Detentions of people in police cells while experiencing a mental health crisis is wholly inappropriate.



Data from 2012/13 indicated that the rate of detention under the Mental Health Act was highest for the 75 and over age group

In February 2016, 1,431 individuals aged 65 or over were detained in hospitals under the Mental Health Act.⁷¹ Data from 2012/13 indicated that the rate of detention was highest for the 75 and over age group at 99 people per 100,000 of the population. This was both the highest for any adult age group and much higher than the overall detention rate of 74.8 people per 100,000.⁷² Overall, people aged between 60 and 89 were most likely to be detained under the Mental Health Act in 2014/15.⁷³ In addition, figures indicate that detentions under the MHA are increasing, rising by nearly 10% between 2013/14 and 2014/15.⁷⁴ Older

people's crisis care will need to be looked at in more detail in future planning in order to avoid detentions in police stations and ensure that older people with more severe mental health problems are treated in appropriate settings.

5 Where next?

Our research demonstrates that while there has been some progress, older people's access to mental health services still lags behind that of people in other age groups. Societal perceptions and lack of awareness continue to hinder access by older people, especially those over 75, to appropriate talking therapies. Equally, services are not responding to their needs, whether by failing to join up physical health care with mental health care or by restricting access to specialist services such as old age psychiatry.

The target of 12% of referrals to psychological therapies being 65 and over has existed for five years, yet this is nowhere near to being met. It was reached by only three mental health trusts in 2015/16.

The increasing focus on mental health as well as integrated care has the potential to ensure that mental health needs are in future a core part of holistic health and social care plans for older people, helping them to live better for longer, and reducing any potential strain on the NHS. The implementation plan for the Mental Health Taskforce's recommendations is an encouraging step in the right direction. However, both the national and local NHS must ensure that older people are brought along on an equal footing to other age groups.

We identified the local authority areas in England expected to have the largest growth in their older population. When we looked at the overarching plans they are required to produce to demonstrate how they will improve health and



wellbeing in their areas, only one specifically referred to mental health care of older people. This suggests that there is a long way to go in having it recognised as a priority of all local health and care services.

There is also a need for consideration of the continuing place of old age psychiatry and how this and other specialisms and services catering particularly for the needs of older people can be safeguarded and developed. In addition, specific guidance relating to mental health crisis care for older people is notably lacking.

To build on progress made, and further drive equality for older people's mental health, Age UK makes the following recommendations, aimed at national government, local authorities, CCGs and frontline practitioners:

- Implementation of Mental Health Taskforce recommendations should include a work stream dedicated to meeting older people's mental health needs. This should include ensuring wide use of the CQUIN for depression in older patients.
- Local health and care commissioners should fully understand the prevalence of common mental health conditions among the over 65s in their areas.
- Each clinical commissioning group and local authority should consider appointing "older people's mental health champions".

- All services should be appropriately funded and equipped to deliver fully integrated care that addresses mental and physical health and comorbidity.
- NHS England must strengthen and expand its work with the voluntary sector in helping to drive up awareness of IAPT services.
- NHS Digital should consider further analysis of data about access to mental health services for older people to increase transparency. This will be particularly important in assessing the impact of NHS England's five year strategy for mental health and ensuring it truly is meeting the needs of people of all ages.

These are some of the steps we believe will help improve the mental health care of older people. For society in general, we must ensure the wider efforts to challenge some of the stigma and misconceptions about mental health do not leave older people behind. Though many of us will face physical, social and emotional challenges as we enter later life, we should not lose the expectation of the best possible mental wellbeing, whatever our age.

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provided in financial or calendar years, though for all questions the majority were in financial years.

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Older people’s mental health has historically been under-prioritised by health and care services. Access to key treatments such as talking therapies continues to lag behind other age groups. This report explores how well the NHS is doing in addressing these long-standing issues.

All older people should have their mental health needs fully acknowledged and where necessary, treated. All health and care services should join up the support offered to older people to ensure that their physical and mental health needs are addressed at the same time.

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