Haringey Council

Report for:	**EVIDENCE SESSION, Adults and Health Scrutiny Panel**	**Item Number:**	

Title:	**Physical and Mental health care for older and or frailer people with functional mental health problems.**

Report Authorised by:	**Beverley Tarka - Acting Deputy Director, Haringey Council** **Jill Shattock - Director Commissioning Haringey CCG**

Lead Officer:	**Liz Evans**

Ward(s) affected: **All**	**Report for Key/Non Key Decisions:** **NA**

1. Describe the issue under consideration

1.1. The purpose of this paper is to provide evidence to the Adult and Health Overview and Scrutiny Panel on the physical and mental health care needs of older and / or frail people with functional mental health problems. Many older frailer people will also have multiple long term conditions (LTC's). The term "functional mental health" encompasses depression, anxiety, schizophrenia, suicidal feelings, and personality disorder and substance misuse. It includes those with severe and enduring mental health problems as well as those with more common mental health problems such as mild to moderate anxiety and depression.

1.2. Two related issues are considered in this report; the needs of older, frailer people with LTC's who:

a. have severe and enduring functional mental health problem, and
b. develop common mental health problems often related to the ageing process e.g. bereavement, loneliness, loss of independence, illness and disability.

1.3. This paper does not specifically deal with dementia and cognitive impairment services. It should, however, be noted that older frailer people may have both a

cognitive impairment and a functional mental health need that also needs to be taken into account.

2. Cabinet Member introduction

NA

3. Recommendations

3.1. That the Adult and Health Overview and Scrutiny Panel include in its investigation into mental and physical health care consideration of the needs of older frail people with a functional mental health problem, many of whom also have multiple long term conditions (LTC's) and their carers.

4. Alternative options considered

NA

5. Background information

5.1. ***The National Policy context***

5.1.1. A key standard in the *National Service Framework (NSF) for Older People* is that older people who have mental health problems should have access to specialist integrated older peoples mental health services. This will help to ensure effective diagnosis, treatment and support.

5.1.2. *Everybody's Business* (Care Services Improvement Partnership 2005) re-asserted that older people's mental health spans both physical and mental health. This is the responsibility of specialist as well as mainstream or generalist services.

5.1.3. *Improving Access to Psychological Treatments (IAPT) – Older People Positive Practice* (Dept of Health 2009) describes the particular needs and issues for commissioning and providing talking therapies to the diverse population of older people experiencing common mental health problems.

5.1.4. *No Health without Mental Health (*Dept of Health 2011) explicitly states that all mental health services should be age-appropriate and non-discriminatory. The six objectives of the strategy are:

- More people will have good mental health
- More people with mental health problems will recover
- More people with mental health problems will have good physical health
- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

5.1.5. *Guidance for Commissioners of Older Peoples Mental Health* (Joint Commissioning Panel for Mental Health May 2013) asserts that older people should not be prevented from using adult (working age) mental health services where they can meet their needs. At the same time it raises the question and expresses a concern that merging older peoples and adult (working age) mental health services potentially risks causing indirect discrimination against older people. It also states that it is "essential that services sensitive to different needs continue to be provided".

5.1.6. *The Francis Report (The Final Report of the Independent Inquiry into Care Provided by Mid Staffordshire NHS Foundation Trust 2013)* found that many of the issues investigated related to the care and treatment of older people and issues of discrimination in relation to their care.

5.1.7. *A Call to Action – No Health without Mental Health:* Thirty leading health and social care organisations (including Directors of Adult Social Services, MIND, Department of Health, The Royal College of Psychiatrists, Rethink and the MH Network of the NHS Confederation) have signed a Call to Action. All recognise the urgent need for co-ordinated action to improve mental health and wellbeing and the life chances and recovery rates of people who experience mental health problems. The organisations signing the Call to Action have committed to work together to ensure a co-ordinated approach to deliver the six objectives of the *No Health without Mental Health* National Strategy.

5.2. ***Prevalence and impact of functional mental health needs on older and frailer people:***

Depression:

5.2.1. Depression is three times more common in older people than dementia. It increases in prevalence in people over 65, especially for those living alone

with poor material circumstances. Co-morbid depression incrementally worsens older people's health more than either depression alone or any combination of chronic diseases without depression. Depression in later life is a major risk factor in increased suicide, increased levels of natural mortality, and impairment of independent function which necessitates the need for long term care.

5.2.2. Treatment of depression in older people has a similar level of efficacy as for younger people. Recognition rates are lower for older people than for younger people. Only 1 in 6 older people with depression get treatment and only one third of older people are likely to discuss their depression with their GP's. Less than half of these will receive adequate treatment.

5.2.3. Up to 50% of older people in care homes have clinically severe depression and only 10-15% gets treatment. Up to 70% of acute general inpatients beds are occupied by people over 65 and around 30% of these patients also have depression.

5.2.4. The Audit Commission estimated that between 10 – 16% of older people living in cities had depression (Forget Me Not: 2000). Using these figures Table 1 below shows the estimated number of older people in Haringey who suffer from depression (based on the 2011 ONS Interim Sub National Population Projections for Haringeys 65+ population):

Table 1: Number of Haringey residents over 65, predicted to have depression.

	2011	2021
Lowest estimate of prevalence - 10%	2,246	2,692
Highest estimate of prevalence - 16%	3,594	4,308

Suicide and self harm:

5.2.5. Whilst suicide rates are declining for all age groups the rate for people over 65 is double that in younger people under 25. 80% of people over 75 who commit suicide have depression and the risk of completed suicide after self harm is much higher in older people.

5.2.6. Haringeys Mental Health JSNA estimates that around 26 Haringey residents commit suicide each year 11% of whom were retired.

Psychosis:

5.2.7. Psychosis is proportionately more common in older people than younger people. 20% of older people develop psychotic symptoms by the age of 85, most of which are not precursors to dementia. The ONS 2011 census gave a figure of 19,948 Haringey residents aged between 65 and 84. This suggests that there were approximately 3,989 people aged 65 to 84 experiencing some form of psychotic symptoms in the borough in 2011.

5.2.8. Whist schizophrenia beginning in earlier life is more common, the annual incidence of late onset schizophrenic-like psychosis increases by 11% with each 5 year increase from age 60 and up. Older people with schizophrenia include those who have grown old with the condition and those who have developed the illness later in life.

Alcohol and Substance misuse:

5.2.9. Alcohol usage generally declines with age but misuse/dependence on alcohol still affects circa 2-4% of older people. Table 2 below shows the estimated number of older people in Haringey who have problems with alcohol (based on the 2011 ONS Interim Sub National Population Projections for Haringeys 65+ population). There is evidence that there is a hidden group of older people with caring responsibilities who have drinking problems so these figures may be an under estimate. It is also suggested by some that older people who have substance misuse problems need different definitions, diagnosis and treatment to younger people.

Table 2: Number of Haringey residents over 65, predicted to have problems with alcohol.

	2011	**2021**
Lowest estimate of prevalence - 2%	449	538
Highest estimate of prevalence - 4%	899	1,077

5.2.10. Although illicit drug use is predominantly a condition affecting younger people, there is a predicted increase in older people needing treatment for substance misuse by virtue of ageing. This is based on figures emerging from America.

Black and Minority Ethnic and refuge communities

5.2.11. Different ethnic groups have different rates and experiences of mental health problems, reflecting their different cultural and socio-economic contexts and access to culturally appropriate treatments.

5.2.12. Patterns of prevalence of mental illness vary across different ethnic communities and evidence is hampered by smaller sample sizes in minority communities. The Mental Health Foundation found that in general, people from black and minority ethnic groups living in the UK are:

- more likely to be diagnosed with mental health problems
- more likely to be diagnosed and admitted to hospital
- more likely to experience a poor outcome from treatment
- more likely to disengage from mainstream mental health services, leading to social exclusion and a deterioration in their mental health.

5.2.13. There is evidence that refugees are especially vulnerable to psychiatric disorders including depression, suicidality and post-traumatic stress disorder. This group also has more complex needs and often have more difficulty accessing health services than the general population. It is estimated that between 25,000 and 30,000 refugees and asylum seekers live in Haringey.

*5.3. **Are older peoples functional mental health needs different to younger peoples?***

5.3.1. Using a needs based approach rather than a strict age related division, the evidence is that older peoples mental health needs are often different to those of younger people. The differences relate to the presentations of mental health problems, and the increased incidence physical illnesses and LTC's in older people. Poly-pharmacy, the risks associated with the use of multiple medications and over prescription of drugs, is more common in older than younger people. Older people often have specific needs relating to medication for both physical and mental health illness.

5.3.2. Differences in schizophrenic-like conditions in older people suggest doubt for some about the condition being the same in older people as in younger people. There is also evidence that older peoples functional mental health problems may need different definitions, diagnosis and treatment to younger people. The involvement of family carers with older people is also often different to carer involvement with younger people; this also requires different levels of understanding and experience.

5.3.3. The additional stresses and strains experienced by some older people as a result of aging, bereavement, isolation, and caring responsibilities may also impact more negatively on older than younger older people.

5.4. ***The key elements of a good mental and physical health care for older frail people:***

5.4.1. The Guidance for Commissioners of Older Peoples Mental Health (Joint Commissioning Panel for Mental Health May 2013) sets out some key principles that should underpin the commissioning and delivery of services for older frailer people with mental health problems. These are summarised below:

5.4.2. Mental health and emotional wellbeing are as important for older and or frailer people with LTC's as for any other person. Services need to be age appropriate and delivered on the basis of need rather than age. Older people's services should be of the same high standard as for people of working age. All services must be delivered in a culturally sensitive manner, recognising different risk factors and needs across communities.

5.4.3. Staff delivering the care need the right level of skill, knowledge and experience of working with older frailer people. Health and social care services should be aligned and able to work together to meet complex needs. The specific physical and mental health needs of carers must also be catered for.

5.4.4. Clear pathways joining up physical and mental health needs are required to stop people falling through service criteria and boundary gaps. This applies equally to both:

- ~ people with severe and enduring mental health needs getting appropriate physical health care and
- ~ older frailer people having their mental health needs recognised, diagnosed and treated.

5.4.5. Staff across all health and social care organisations working with older frailer people should be able to recognise and care for peoples mental health needs. In the same way staff in specialist mental health services must be able to recognise and care for peoples physical health needs.

5.4.6. The majority of mental and physical health care for older frailer people is delivered in primary care and community based settings by mainstream or generalist services. Partnership work between specialist teams, expert in supporting older frailer people with mental health problems and generalist mainstream services, is essential. This will help staff in generalist services develop skills in recognition, diagnosis and treatment of mental health problems and vice versa.

5.4.7. Older people with mental health problems can be among the most socially isolated and excluded groups in society. The factors that are important in reducing this isolation and the impact of poor mental health in older people include:

- ~ Reducing stigma and discrimination.
- ~ Increasing participation in meaningful activities and social involvement.
- ~ Promoting physical health, including the ability to carry out everyday tasks.
- ~ Combating poverty.
- ~ Supporting families and carers.
- ~ Helping to build and maintain relationships and community engagement.
- ~ Reducing isolation and increasing community engagement.

5.4.8. The Third Sector, community and faith groups have a unique and valuable role to play in this task along with arts, sports and leisure based organisations. The impact of small scale local community based initiatives significantly contribute to maintaining well being and reducing reliance on more specialist health and social care support services.

5.5. ***Specialist mental health services for older frailer people in Haringey:***

The Older People's Community Mental Health Team

5.5.1. The specialist mental health needs of frailer older people with LTC's and severe and enduring functional mental health problems are currently met by Barnet Enfield and Haringey Mental Health Trust (BEH MHT). BEH MHT provides an Older Peoples Community Mental Health Team that also works with people with people with cognitive impairment and dementia of all ages. Broadly speaking, this means that the specialist knowledge and expertise required to effectively support older frailer people with functional mental health problems is currently concentrated in the older people's team. The

other community based mental health services provided by BEH MHT have more expertise in working with younger less frail people of working age.

Inpatients services

5.5.2. Bed based inpatient mental health care for people over 65 who cannot be treated or supported at home or in another setting is provided by BEH MHT at Chase Farm Hospital. This inpatient service combines care for both people with functional and cognitive impairment.

The Rapid Assessment, Interface and Discharge service

5.5.3. Haringey CCG has recently commissioned a new enhanced psychiatric liaison service from BEH MHT at North Middlesex University Hospital (NMUH). The Rapid Assessment, Interface and Discharge (RAID) model provides an innovative liaison psychiatry service which will improve quality of care, drive down lengths of stay and reduce readmission rates across the whole spectrum of mental health need in the acute hospital. This service will include older and or frail people with functional mental health problems. The model was developed and implemented at Birmingham City Hospital, and has been thoroughly evaluated and accepted nationally as a benchmark platform for acute hospital liaison services.

5.5.4. The new RAID service is Consultant-Led and made up of a mix of Consultant Psychiatrists, Consultant Psychologist, Social Workers, specialist Psychiatric Nurses and Graduate Mental Health Workers. It provides:

- ~ A 24 hour nurse delivered on-site service to A&E, mainly focusing on adults of all ages with mental health presentations;
- ~ A 9am to 9pm dementia focused service to the wards;
- ~ Support for other non-dementia clinical area's such as Substance misuse and Self Harm;
- ~ An on-going programme of education and mentoring to the acute trust staff which also provides them with on-site mental health expertise to assist with any difficult decisions.

Haringey IAPT *service*

5.5.5. The Haringey Increasing Access to Psychological Therapies service (IAPT) is provided through a collaboration between Whittington Health and BEH MHT. The IAPT service provides high quality psychological therapies to help people manage and overcome anxiety and depression through the provision of:

- ~ guided self-help, stress management skills, computerised cognitive behavioural therapy and psycho-education groups;

- ~ individual and group cognitive behavioural therapy;
- ~ counseling.

5.5.6. The IAPT service offers support to all age groups but only about 3% of the Haringey users are over 65.

*5.6. **Future commissioning of services to support older and or frailer people with mental health problems:***

5.6.1. People are living longer and older people are disproportionally high users of health and social care services. The impact of older, frailer people's poor mental health is significant, not only for the person themselves but also their carers and society as a whole. Demand is likely to increase unless we can improve people's physical and mental health and wellbeing.

5.6.2. The way CCG's and Local Authorities commission health and social care is changing. In the future there will be more integrated services with pooled budgets offering joined up support and care to people with complex health (physical and mental) and social care needs. The changes will be delivered jointly by the CCG and Local Authority working together on the Department of Health driven initiatives including the allocation of the new Better Care Fund.

5.6.3. The future direction for commissioning of mental health services is based on "whole life course" planning. Ensuring that the particular needs of older and or frailer people are included within this life planning approach is essential.

5.6.4. Commissioners will continue to face the double challenge of providing specialist mental health services for older frailer people with severe and enduring mental health problems, at the same time as ensuring older frailer people with LTC's have access to high quality mental health services. These services include prevention services to support people to maintain good mental health and wellbeing. The range of services commissioners can consider commissioning include:

- ~ preventive public health awareness campaigns and early interventions targeted at older frailer people;
- ~ support and engagement with families and carers to help them maintain their mental wellbeing as well as physical health;
- ~ provision of psychological therapies (IAPT) that is equitable with those for working age adults and which meet the needs of frailer people with multiple LTC's and their carers;

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- provision of acute hospital liaison services that include expertise in older peoples mental health;
- services that are delivered in both community and inpatient settings;
- specialist mental health assessment, diagnosis and intervention services for older and of frailer people that are distinct from those for working age adults.

5.6.5. Careful consideration also needs to be given to the best model for strategic planning, commissioning and provision of specialist mental health support for frail and/or older people in Haringey. Should these functions and services remain as they are currently configured or should there be a move to all age functional mental health commissioning and service provision incorporating the needs of older frailer people alongside a separate all age cognitive impatient and dementia service. This question has not been considered in Haringey for several years and it may now be timely to consider it again particularly in the context of the emerging integration of health and social care commissioning and provision in the future.

6. Comments of the Chief Finance Officer and financial implications

NA

7. Head of Legal Services and legal implications

NA

8. Equalities and Community Cohesion Comments

NA

9. Head of Procurement Comments

NA

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10. Policy Implication

NA

11. Reasons for Decision

NA

12. Use of Appendices

NA

13. Local Government (Access to Information) Act 1985