Falling Off A Cliff: Discussion Paper and Evidence

January 2020

Introduction

During 2019 VHS collaborated with Support in Mind Scotland and colleagues from across the third and public sectors, to scope what happens to people with mental health conditions other than or alongside dementia once they become 65. Issues we have been exploring include under-diagnosis, under-provision, poor transitions from 'adult' services to 'older people' services, discrimination and flouting of human rights. It is said that for some people with serious mental health issues, their 65th birthday is like 'falling off a cliff' in terms of service provision. We have been gathering evidence in order to raise awareness of the issues faced by people and to try and improve policy and practice.

We have developed a background briefing, held two round table meetings and commissioned two evidence reports on this topic. This document is a compilation of the background briefing, the notes from these meetings and the evidence reports.

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VHS Briefing: Mental Health in Later Life
April 2018

Introduction

Mental wellbeing is defined by the World Health Organisation as a state of well-being in which every individual realises their own potential, can cope with the stresses of life, can work productively, and is able to make a contribution to their community. So, it is much more than simply the absence of mental health problems such as anxiety or depression. Mental wellbeing is an important indicator of quality of life. Positive mental wellbeing encourages healthier lifestyles, better physical health and improved recovery from illness, better social relationships, and higher educational attainment3.

It is estimated that people over the age of 65 make up around 19% of the population, around 1 in 5 people in Scotland, and this figure is expected to rise to over 25% by 2041[1]. People aged 75 and over are projected to be the fastest growing age group in Scotland. The number of people aged 75 and over is projected to increase by 27% over the next ten years and by 79% over the next 25 years.

Mental illness is one of the major public health challenges in Scotland. Around one in three people are estimated to be affected by mental illness in any one year. With an ageing population predicted we can rightly assume that there will be a larger number of people aged of 65 suffering from mental ill health. Therefore, our health and social care services and community projects need to be geared to support older people suffering from mental health issues often alongside a range of multi-morbidities.

In a 2010–11 UK survey measuring national wellbeing across people aged 16 and older depression or anxiety was noted to be highest among those aged 50–59 and those of 80 years and older[2]. The Royal College of General Practitioners reports that fewer than one in six older people with depression discuss their symptoms with their GP, Furthermore, only half receive suitable treatment[3], across the UK. It is estimated that up to 40% of older adults living in a care home experience depression, and it often remains undetected[4]. It is estimated that up to 60% of older adults who have had a stroke may experience depression, as well as up to 40% of those will also suffer from coronary heart disease, cancer,

[1] Mid-2017 Population Estimates Scotland
[2] Beaumont, J., & Loft, H. (2013). Measuring National Wellbeing: Health, 2013. London: ONS.
[3] Royal College of General Practitioners. (2014). Management of Depression in Older People: Why this is Important in Primary Care.
[4] Godfrey, M. (2005). Literature and policy review on prevention and services. UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern, & MentalHealth Foundation.

Parkinson's, and Alzheimer's disease[5]. Anecdotal evidence positions old age alongside feelings of depression and low mood as a natural phenomenon and *part and parcel of growing old*.

According to research conducted by Support in Mind Scotland with older people who use their services, they found a 75% reduction in access to Community Psychiatric Nurse support for people on reaching the age of 65. The research also highlighted the lack of community mental health services and projects for people 65 and over, due to restrictions applied by funders. There is also a lack of joined up care for people suffering from a range of multi-morbidities which can be the case for people as they age and experience physical and mental health issues.

A key issue is that the focus of services and support for older adults tends to be on dementia and not on other forms of mental ill health which can be experienced for example, depression, anxiety, schizophrenia, bipolar disorder, autism among others. This means that a large cohort of older adults are left without support to manage their mental health issues and this can also impact on the physical health outcomes they experience.

Policy Review

Good Mental Health For All

Good Mental Health For All[6] published in 2016 set the foundations for taking a life course approach to tackling mental ill health from birth to old age. There is a specific focus on early years and childhood and adolescence with only a single direct action relating to older people, "to encourage work and productivity among older people".

The report calls for actions to improve mental health by addressing the wider environmental causes (such as the availability of quality work, housing and education) and individual experiences, risks and lifestyles, as well as for more upstream prevention through, for example, fiscal policies, such as changes in the tax and benefits system.

At a local level the report focusses the attention of Health and Social Care Partnerships and Community Planning Partnerships to; provide comprehensive, integrated and responsive mental health and social care services in community-based settings, to design and implement strategies for promotion and prevention in mental health and to strengthen information systems, evidence and research into mental health.

These actions can have a positive outcome for the delivery of services and support for older adults, especially the focus on equitable access to services and the application of this to a range of areas from healthcare to housing and public services, all of which contribute to improving mental health and wellbeing.

[5] Age UK. (2016). Later life in the UK.
[6] NHS Health Scotland. (2016). Good Mental Health For All.

Mental Health Strategy

The Scottish Government is now in the second year of delivering the 10 year Mental Health Strategy: 2017-2027[7] which also takes a life course approach to tackling mental health issues in Scotland. It tries to ensure that people are able to start well, live well, age well and die well through 40 actions spread across 5 broad themes which include, prevention and early intervention, access to treatment and joined-up, accessible services, the physical wellbeing of people with mental health problems, rights, information use, and planning as well as data and measurement . Although there are no actions in the strategy that relate specifically to older people there are commitments and ambitions that can resolve a number of issues that older people with mental health issues can face. For example, the emphasis on access to treatment, and joined up accessible services and better diagnosis of mental health issues.

The following actions can have a significant impact on the mental health and wellbeing of older adults as well as the wider population.

Action 10 – Support efforts through a refreshed Justice Strategy to help improve mental health outcomes for those in the justice system. The former HM Chief Inspector of Prisons David Strang's report, Who Cares? Lived Experience of Older Prisoners in Scotland's Prisons[8], illustrates the issues that older prisoners face. The report identifies a number of issues, including isolation with older prisoners expressing fears about ageing and dying alone in prison as well as inadequate accommodation which is not designed for elderly prisoners and long waiting times to for prescribed medication, all of which impacts negatively on mental health and wellbeing. The report makes a number of recommendations, including that the Scottish Prison Service and the Scottish Government work together to produce a strategy for dealing with Scotland's ageing population. It also recommends that accommodation and activities available to prisoners should be based on their health and social care needs and that older prisoners should have a health and social care plan that goes with them if they move to a different prison.

Action 11 - Complete an evaluation of the Distress Brief Intervention (DBI) by 2021 and work to implement the findings from that evaluation. The DBI approach[9] refers to time-limited contact with an individual in distress to provide support and problem solving. It is a two-level approach. DBI level 1 is provided by front line staff and involves a compassionate response, signposting and offer of referral to a DBI level 2 service. DBI level 2 is provided by commissioned and trained third sector staff who would contact the person within 24-hours of referral and provide compassionate community-based problem solving support, wellness and distress management planning, supported connections and signposting for a period of up to 14 days. This type of support is available for anyone over the age of 18 and is currently being tested in A&E, Police Scotland, Scottish Ambulance

[7] Scottish Government. (2017). Mental Health Strategy: 2017 – 2027.

[8] https://www.prisonsinspectoratescotland.gov.uk/publications/who-cares-lived-experience-older-prisoners-scotlands-prisons?page=4

[9] https://www.dbi.scot/

Services and primary care settings. This could act as a strong preventative measure supporting older adults get the help they need at the right time in an accessible manner, if implemented properly.

Action 12 - Support the further development of the National Rural Mental Health Forum[10] to reflect the unique challenges presented by rural isolation. The Rural Mental Health Forum is run by Support in Mind Scotland and supported by the Scottish Government. The Forum has a number of members including government departments, mental health organisations, third sector organisations, Police Scotland and NHS 24. The forum aims to raise awareness of rural mental health issues on a range of platforms and works in partnership with a range of organisations. In rural areas people over the age of 65 face a number of barriers to accessing support and services (for example, transport, a lack of services, lack of anonymity of services in close knit communities, stigma among others) that can impact on their mental health and wellbeing and it is important for organisations to come together in a collaborative way to tackle these barriers and provide joined up support.

Action 13 - Ensure unscheduled care takes full account of the needs of people with mental health problems and addresses the longer waits experienced by them. And **Action 14 - Work with NHS 24 to develop its unscheduled mental health services to complement locally-based services.** There needs to be support available for vulnerable older people with mental and physical health issues when they present to out of hours services as well as services within their communities. It is also important to have a range of support available within a community to reduce barriers for older people with mental health issues who may face access issues.

Action 23 - Test and evaluate the most effective and sustainable models of supporting mental health in primary care, by 2019. Primary care can often be the first port of call for a range of people trying to access mental health support and services. It is therefore important that primary care services are geared towards identifying older people with mental health issues and any complex co-morbidities and be able to offer the best tailored support.

Action 24 - Fund work to improve provision of psychological therapy services and help meet set treatment targets. Evidence suggests that psychological interventions with older people are effective despite this, older people do not have access to appropriate psychological approaches and treatments. Data shows that as many as 80% of older people with depression do not get any treatment at all, either medication or psychological therapy[11]. A report by the Older People's Psychological Therapies Working Group, showcases seven principles of good psychological care for older people. These are;

1. A psychologically- and age-aware workforce across all services,

[10] https://www.ruralwellbeing.org/

[11] http://www.gov.scot/resource/0039/00392671.pdf

2. Specialist older people's psychological services are based on need not age,
3. Access for older people to general non-age related services where appropriate,
4. A matched care approach is used that meets the needs of older people,
5. Sufficient numbers of highly trained staff are available to undertake low and high intensive therapy, plus training, research and service development,
6. Trained staff will have reserved and protected time to undertake such work and,
7. There will be ongoing clinical support, clinical supervision and reflective practice opportunities.

Action 30 - Ensure equitable provision of screening programmes, so that the take up of physical health screening amongst people with a mental illness diagnosis is as good as the take up by people without a mental illness diagnosis. According to the report, The Challenge of Delivering Psychological Therapies for Older People in Scotland, there is a bi-directional relationship between mental and physical health where one exacerbates the other. The co-morbidity of physical illness and psychological factors in older people has a negative impact on outcome: long-term conditions increase depression and anxiety which in turn slows recovery. Psychosocial factors, such as loneliness and poverty also play a major part in exacerbating illness.

Action 37 - Explore innovative ways of connecting mental health, disability, and employment support in Scotland. Joined up, accessible support at all stages throughout one's health care journey. It is important that older adults are able to access joined up care and support in an accessible manner and that both mental and physical health needs of people can be tended to. This can act as a preventative measure supporting both mental and physical recovery and management of conditions. It is also important to move away from the assumption of hard to reach demographics and gear services and activities up to being more accessible.

While there are a range of actions in the mental health strategy that can improve outcomes for older adults as well as the wider population, the focus of more specific actions remains to be children and young people and older people with dementia.

A Fairer Scotland for Older People: Framework for Action

A Fairer Scotland for Older People: Framework for Action[12] has recently been launched and it comments on improving access to Mental Health Services for older adults. The framework offers to support NHS boards to ensure there is consistent provision of mental health and psychological therapy services, and improved levels of access to psychological therapies for people over the age of 65, across the country. While this is a positive step and will help older adults who often lose support and services as they get older there is a need for recognition of older adults with other mental health issues aside from dementia.

[12] https://www.gov.scot/publications/fairer-scotland-older-people-framework-action/

Conclusion

While there are a number of key policy areas that can improve outcomes for older adults and the wider population suffering from mental ill health there needs to be more specific actions and policies that support people over the age of 65 that are relevant to their circumstances.

Support in Mind Scotland have asked for support to increase spending for older adults experiencing mental illness and conditions other than dementia as well as an increase in the number of residential/nursing care beds suitable for older adults with co-existing mental and physical health conditions.

A lot of the research to support people with mental health issues highlights areas of good practice where staff and workers have taken it on themselves to deliver appropriate support – this needs to be enhanced. Staff need to be confident enough to make decisions and support people in the best way possible – through continuous training and support.

Falling Off a Cliff at 65: Mental Health in Later Life: Note of the round table discussion held on 29th April 2019

VHS and Support in Mind Scotland held this round table on 28th April at the Royal College of Physicians Edinburgh. The round table was predicated on the recognition that people over the age of 65 with poor mental health face a wide range of barriers, particularly in accessing appropriate care and other services. The focus was on older people with mental health conditions other than (or in addition to) dementia.

Participants
Fiona Benton, Scottish Association for Mental Health
Lauren Blair, Voluntary Health Scotland
Julie Breslin, Addaction (Drink Wise Age Well)
Katherine Byrne, Chest Heart and Stroke Scotland
Julie Cameron, Mental Health Foundation
Dr Adam Daly, Royal College of Psychiatrists and NHS Lanarkshire
Dr David Hall, Mental Welfare Commission
Maureen O'Neill, Faith in Older People (and VHS Board member)
Lindsay Paterson, Royal College of Physicians Edinburgh
Simon Ritchie, Age Scotland
Frances Simpson, Support in Mind Scotland
Paul Southworth, NHS Health Scotland
Claire Stevens, Voluntary Health Scotland (chairing)
Kathleen Taylor, Mental Welfare Commission
Kiren Zubairi, Voluntary Health Scotland

Apologies
Alison Cairns Bipolar Scotland
Dr Donald Macaskill, Scottish Care
Dr Stuart Mercer, Edinburgh University

Introductions

Claire Stevens invited everyone to introduce themselves and share their interest in the topic.

Maureen O'Neill then set out her concerns as follows:

- Transition points from adult to older age services are weak.

- The attention paid to dementia is positive but it is pushing other mental issues that affect older people into the background
- The workforce in older people's care home staff is not trained or well-equipped to support older residents competently or safely if they have serious mental health problems such as schizophrenia
- Churches have a role to play as a community resource, but in practice often ignore mental health or lack confidence in how to support people
- How well-equipped are our prisons to support older prisoners' mental health?
- A 1999 literature review on older age and mental health (Edinburgh University) highlighted the issues under scrutiny today: nothing has really changed in the intervening period.
- We need to think about the reality of the life-course in policies and challenge assumptions being made about older people and mental health

Frances Simpson described Support in Mind Scotland's position on the topic, as a provider of services to people affected by serious mental health conditions:

- Support in Mind has no upper age limit and a growing number of their service users are aged 65+. The charity is increasingly concerned about such people's access to services and rights.
- Support in Mind had prepared a policy paper to discuss with the then Cabinet Secretary for Health Shona Robson, but the Cabinet reshuffle in 2018 meant the planned meeting never took place.
- The lack of data and evidence on older people with mental health issues has been a concern for some time, and several years ago Support in Mind had conducted a short piece of research with their own service users. The research established that a large cohort of people lost access to a range of services on reaching 65, including a 75% reduction in access to Community Psychiatric Nurse support. The research highlighted the lack of community mental health services and projects for people 65+ due to restrictions applied by funders. A lack of joined up care for those people also suffering from a range of multi-morbidities was identified.

Adam Daly highlighted:

- Changes in older adult psychiatry that have taken place in England in recent years. There, the Equalities Act has led to the disbandment of older people specific services, out of concern that age restrictions contravene the Act.
- The move towards 'equally good services' for all adults is designed to remove barriers (but are there unintended consequences…). People need tailored assessments regardless of an arbitrary age bracket: older people are individuals, not a homogenous group.
- The complex interplay between dementia and other mental health conditions. A prior mental health condition like schizophrenia can be a risk factor for dementia.
- There is admittedly greater recognition of dementia as a condition than previously, but services are still not great. There is a lack of joined up

care for older people experiencing poor mental and physical health: psychological health care is largely community based, whereas physical health care is still hospital dominated.
- There are useful lessons that could be adopted from the model used to transition young people from CAMHs to adult services.
- NHS Lanarkshire has five CPNs whose sole role to provide follow-through for people going into care homes.

David Hall said that 'the aspirations are clear', the question was 'how to get there': local NHS managers decide where to direct resources. Paul Southworth pointed out that mental health is one of the new National Public Health priorities that Public Health Scotland will coordinate effort around. The creation of the new agency through the merger of ISD, NHS Health Scotland and Health Protection Scotland should be an opportunity for data to become more robust and accessible. Lindsay Paterson said RCPE was aware of older people being admitted to hospital [for an unrelated condition] with a mental health diagnosis emerging only as a result of their hospital stay. Katherine Byrne said that GPs can lack the confidence to raise mental health with their patients.

Kathleen Taylor said that as a Mental Welfare Commission visitor she observes that patients with dementia and those with functional mental health illnesses (e.g. depression) are not well catered for in mixed units. [Note: in October 2015 the Mental Welfare Commission published a visit and monitoring report called Making progress: older adult functional assessment wards which looked at wards providing acute assessment for older people with functional mental illness, as opposed to dementia]

Julie Breslin drew on the experience of Drink Wise Age Well:

- Highlighting parallels between the issues being discussed today and those facing older people with alcohol problems, also an under-recognised, under-diagnosed issue that is ignored by policy makers, data gatherers (including ISD) and leaves older people facing discrimination and with poor access to appropriate services..
- Drink Wise Age Well is a UK wide, Big Lottery funded, seven year programme developing evidence around alcohol use in later life, in order to support better policy making.
- The report Calling Time, Addressing Ageism and Age Discrimination in alcohol policy, practice and research examines issues faced by older people, including arbitrary age limits for alcohol rehabilitation services and the prioritisation of younger people for treatment programmes.
- Evidence clearly shows that older people's consumption of alcohol is rising in the UK whilst younger people's is reducing, yet policy continues to focus on young people.
- The programme's UK wide advocacy group developed an Alcohol Charter as a means of trying to influence policy in a constructive and pragmatic way.

- Longer term outcomes that Drink Wise Age Well want to see are service redesign, older people's alcohol services embedded in commissioning, and new practice/NICE guidelines.

Summary of key issues explored

- Age discrimination: too many older people with serious mental health conditions are denied their rights and access to appropriate services
- Transition points between adult services and older people's services are a pinch-point – this is where people can 'fall off the cliff'. Do we need a Task Force? (there was a Task Force on CAMHs to adult services transitions)
- The general older people's workforce (e.g. care homes) has not been trained to support people with serious mental health issues
- What specialist services are needed?

But above all, the lack of hard data and evidence is impeding efforts to influence policy, practice and commissioning. This is the priority to address first.

Where are the levers for change?

Participants asked:

- Where does the policy agenda sit for older people and mental health?
- Who within Scottish Government is leading on A Fairer Scotland for Older People: A Framework for Action (published April 2019)?
- Who is the key Minister with responsibility?
- How can we persuade the Scottish Government to take ownership of this issue and commit to change?
- Where does this fit with the CMO's Realistic Medicine agenda?

Intelligence was pooled about who we need to influence:

- Minister for Older People and Equalities is Christina McKelvie
- Cabinet Secretary for Social Security and Older People is Shirley-Anne Somerville
- Cabinet Secretary for Communities and Local Government is Aileen Campbel
- The Framework sits within the Local Government and Communities Directorate
- Lead Scottish Government official for the Framework is Karen Mechan: karen.mechan@gov.scot
- Mental Health Division in Scottish Government is headed by Donna Bell

Other groups that we may wish to engage and influence:

- Cross Party Group on Older People
- Cross Party Group on Mental Health
- Equalities Committee (NB there is no Committee on older people)
- Royal College of Physicians Edinburgh's older people's faculty

Opportunities identified for gathering data:

- Take up Adam Daly's offer to help gather intelligence, ie pose key questions to Royal College of Psychiatrists – get the questions to him, especially regarding transition points and service gaps.
- Mental Welfare Commission can flag the issues in its visits, to help gather data
- Julie Breslin will talk to the International Centre for Longevity [academic partner with Drink Wise Age Well] about what data they may have
- Fiona Benton will talk to MIND [cross-border partner to SAMH], as they may have research/evidence that is relevant
- UK Research Institute: supports research with eight UK wide Networks, collaborates with third sector and provide resources for research. Two Networks are particularly relevant:
    - Closing the Gap Network – looks at closing the mortality gap; led by Professor Simon Gilbody
    - MARCH Network (Assets for Resilient Communities lie at the centre of Mental Health (M-ARC-H)); led by Dr Daisy Fancourt

Programmes and groups that participants are actively involved in and that may be useful:

- Scottish Patient Safety Programme – Frances Simpson
- Distress Brief Interventions evaluation group – Julie Cameron
- Screening Network– Julie Cameron
- See Me – SAMH
- Scottish Mental Health Arts Festival – Mental Health Foundation
- New Scots strategy: health and wellbeing sub group – Mental Health Foundation and Scottish Recover Consortium co-chair
- CPG on Health Inequalities – VHS

Other people/groups/organisations that may useful for the round table to engage with in future:

- Equalities and Human Rights Commission
- Scottish Recovery Consortium
- Dr John Mitchell, Principal Medical Officer and Psychiatric Adviser to the Mental Health and Protection of Rights Division of Scottish Government

Other points raised and explored

The focus of the round table was firmly on serious mental health issues in later life, and in particular pre-existing mental health issues. However, the question of prevention and community based approaches was raised at one point and participants made a range of contributions. Participants also shared useful intelligence about their own organisations' areas of work in relation to keeping older people well.

Simon Ritchie talked about Age Scotland's work to influence policy around transport and older people, because of the impact transport has on mental health and wellbeing. They are helping the Scottish Government to develop the National Transport Strategy to reflect the needs of older adults and the importance of mobility. Age Scotland also provides a Community Connecting service that supports older adults to access services and support within their local communities, to improve their mental health and wellbeing.

Kathleen Byrne explained how Chest Heart and Stroke Scotland was very aware of how stroke, respiratory and heart conditions affect people's mental health and wellbeing. These are often devastating and life changing events and community support is a vital part of rehabilitation. It is estimated that up to 60% of older adults who have had a stroke may subsequently experience depression.

SAMH provides over sixty services in communities across Scotland, including social care, support for homelessness, addictions and employability to people with poor mental health and wellbeing. Around 6% of their service users are over the age of 65. SAMH has increasing numbers of community link workers, including 20 generic link workers in Aberdeen City, a service designed in part with geriatric services.

Conclusions and next steps

Maureen O'Neill offered the following conclusions:

- We need better data- 'we don't know what we don't know'. Can we work with ISD to get better and appropriate data?
- Can we map and understand the different approaches happening in different localities in Scotland? Who can help with this? Is it a research project? Survey?
- Can we map transitions and how this happens across age ranges and across Scotland?
- Can we better understand role of GP- what services are signposted and what GPs currently do for older people?

The questions we want to send to Adam Daly to share with his RCP colleagues:

- What currently happens to someone who has a previous mental health diagnosis when they turn 65?
- What currently happens to someone who is diagnosed with a mental health illness after 65?
- What are your local health and social care partnership transition arrangements for people aged 65+ with mental health issues?

It was agreed that there is merit in this group meeting again, to ensure momentum is maintained. Everyone gave permission for VHS to share their contact details.

Actions:

- VHS to share everyone's contact details
- VHS to do a Doodle Poll for next meeting
- Claire Stevens to liaise with Frances Simpson to get the questions to Adam Daly finalised and sent to him.
- Claire and Frances to review these notes and consider other practical next steps.

Falling Off a Cliff at 65: Mental Health in Later Life
Note of the round table discussion held on 30th October 2019

Attending
Alison Cairns, Bipolar Scotland
Grant Donaghy, Knowledge Services, NHS Health Scotland
Becca Gatherum, Scottish Care
Simon Ritchie, Age Scotland
Jillian Matthew, Audit Scotland
Maureen O'Neill, Faith in Older People
Frances Simpson, Support in Mind Scotland
Alison Thomson, Mental Welfare Commission
Chris White, Mental Welfare Commission
Lindsay Paterson, Royal College of Physicians of Edinburgh
Claire Stevens, Voluntary Health Scotland
Lauren Blair, Voluntary Health Scotland
Kiren Zubairi, Voluntary Health Scotland

Apologies

Dr Adam Daly, Royal College of Psychiatrists
Kathleen Taylor, Mental Welfare Commission

Introduction

Claire Stevens welcomed everyone to this second round table, the first having been held on 29th April. As some participants today were new, she invited everyone to share their interest in the topic.

Frances Simpson set the scene and noted that the first round table started from a narrow perspective focusing on what the issues are; for example, losing access to a CPN after 65. However, discussion uncovered wider issues such as loneliness and isolation, recovery and prevention. It was agreed at the last meeting that more evidence needed to be gathered and that and that there was a need for policy makers to reflect on the issues.

Comments from people new to the round table included: Alison Cairns corroborated the issues older people face in relation to access to mental health services and how she heard these from their members anecdotally on many occasions. She highlighted the importance of work to tackle these issues.

Becca Gatherum highlighted a Scottish Care study conducted in 2017, Fragile Foundations which explores older people's mental health needs.

Jillian Matthews commented on the Audit of Mental Health services conducted 10 years ago which showed similar issues around transition points (i.e. transitioning from child to adult services or from adult to older adult services) and observed that nothing much has changed in the last 10 years. She highlighted work Audit Scotland is undertaking with Healthcare Improvement Scotland on older people and said that the work of the round table could feed into that.

Chris White raised the point that middle-aged men between 45 and 54 are at the highest risk of suicide – what happens when they approach 65 and still have poor mental health? How can older men be supported in residential care?

Evidence Summary: Mental health diagnosis of people aged 65 and over

Claire Stevens explained that, after the first round table, VHS had commissioned Grant Dongahy, of NHS Health Scotland's Knowledge Services, to investigate and report on the evidence and data concerning older people's mental health. VHS had provided a number of key questions for Grant to address, all arising from the first round table, and was grateful to him for the resulting Evidence Summary report.

Grant Donaghy then presented the findings set out in the Evidence Summary.

One of the main findings of the research was that while depression is more common in old age than dementia, it remains under-diagnosed and under-treated. Patients aged 60 and over were identified as less likely to seek medical help for their mental health as well as being less likely to receive adequate treatment if they do, compared to younger adults.

Statistics from the Information and Statistics Division (ISD) show that there has only been a slight increase in the prescribing of anti-psychotic medication to those over 65 across Scottish health boards since 2010. However, the prescribing of dementia related medicines over the same period has more than doubled. There has been a slight decrease in discharges from psychiatric hospitals for those aged 65 and over since 2015 and those discharged with a diagnosis of psychosis have also slightly decreased, across all Scottish health boards.

The Evidence Summary also speculated that mental health services providing hospital and community care to older adults are likely to have increased demand as a result of an ageing population with greater comorbid mental health disorders.

The process of conducting the review also confirmed that dedicated studies concerning older adults' mental health are scarce.

The round table discussed a number of issues identified in the Evidence Summary, including the lack of accessible ISD data detailing the patient journey. Maureen O'Neill mentioned that it wasn't enough to just have data on discharges as it does not explain the full whole patient journey, including how many times a

person has been admitted, length of admission, where, what issues they have and what treatment they received.

Jilian Matthew explained how Audit Scotland receives very limited and patchy data from ISD in relation to this particular topic. She remarked that data on mental health is collected in a very limited and out of date manner, in terms of the language and coding used. Lindsay Paterson expanded on this and explained how a UK wide census of consultants conducted by Royal College of Physicians was published without Scottish data in 2017, due to discrepancies between RCPE and ISD data. She explained that the discrepancies were down to the way in which ISD categorise and code data.

Frances Simpson questioned how IJBs can make decisions without clear and consistent data on health needs.

Mental Welfare Commission colleagues highlighted the problem of over-simplified diagnoses of patients, whereby an over-arching diagnosis of, for example, dementia, becomes the focus of medical attention, regardless of whether the patients has multiple or additional mental and/or physical health needs.

Survey of Consultant Old Age Psychiatrists' views of "graduate" arrangements

In the absence of Dr Adam Daly (who had been called to a hospital emergency earlier in the day and sent his apologies), Claire Stevens presented the report he had produced for the round table's attention. Dr Daly is Chair of the Faculty of Old Age Psychiatrists at the Royal College of Psychiatrists. He conducted a survey of consultants in old age psychiatry during the Faculty's bi-annual meeting in Aberdeen, May 2019.

23 of 47 potential participants responded to the survey, giving representation from 8 out of the 14 territorial health boards. This means 8 out of the potential 11 boards who are likely to have an old age psychiatry service (Western Isles, Shetland and Orkney do not have specialist services) gave a response. The survey follows the patient transition from adult to old age psychiatry services. Key findings show that five boards have a discussion regarding transfer to old age psychiatry once a person turns 65, and four have an agreed protocol for transfer. When asked to describe the local process for transition from general adult services to old age five boards gave conflicting answers and three boards responded by saying they either submit a letter alone, have a doctor to doctor discussion, or have a multi-disciplinary team discussion between services.

Only two boards said that the patient was consulted regarding transfer between general adult and old age services, although six boards said that this was sometimes the case. Most boards were unsure about the local transitions arrangements for older adults regarding social work and two boards said they did not know what these arrangements were.

Round table discussion picked up issues regarding the lack of discussion with patients regarding transition from adult to old age services and felt that this

needed to be improved so that people knew what to expect and could be partners in their own health.

The Evidence Summary discussed earlier showed that discharges with a diagnosis of psychosis have decreased and Dr Daly's survey shows that there is uncertainty around how to use processes for transition between adult to old age services and a lack of clarity around whether or not such processes exist. Maureen O'Neill commented on the disparity of approaches across boards, evidenced in both papers.

Next steps

It was agreed that both papers were very useful additions to our knowledge about the arrangements and the gaps facing older people with serious mental health issues. Sincere thanks were recorded to Grant Donaghy and Adam Daly for the work they had undertaken for the round table.

Discussion followed, with suggested actions to take forward: for example, finding out how local data is used for local decision making and local planning. Jillian Matthew said she could talk to her Audit Scotland colleagues regarding their last report on Health and Social Care Integration to see if there are any IJBs that are using data well, what relationship IJBs have with ISD and what the audit has found in terms of information governance.

Other suggestions were to seek to engage the interest of:

- The Cross Party Group on Older People
- Jack Cairs, an A&E consultant at Glasgow Royal Infirmary seconded to the Scottish Government to look at distress intervention
- John Scott, the independent chair of the review of mental health legislation
- Donna Bell, Director of Mental Health, Scottish Government
- The Equalities Unit, Scottish Government
- Mental Health Strategy Annual Forum (November 2019)

It was noted that a Mental Health Collaborative is likely to be established, and that any opportunity to get the issues included in the mental health strategy should be taken. It was agreed that obtaining a meeting with Donna Bell was a priority and that Claire Stevens, Frances Simpson and Maureen O'Neill would collaborate to take that forward, together with other potential actions. VHS offered to produce a single document combining the two round table notes, the two reports presented today, and VHS's original briefing paper, for ease of reference when engaging with other stakeholders.

Survey of Consultant Old Age Psychiatrists' views of "graduate" arrangements

Dr Adam Daly, Chair of the faculty of Old Age Psychiatry, Royal College of Psychiatrists in Scotland, October 2019

Background

Old Age Psychiatry was accepted as an NHS specialty in the 1980s, marking it as one of the first countries to acknowledge that older adults with mental health problems had a specific set of requirements and needs. The adoption of the speciality took place during the 80s and 90s and now all but the smallest of health boards in Scotland have an "Old Age Psychiatry" Service, as opposed to the "General Adult Psychiatry" services that treat younger adults.

There is perception that the transition between services can be difficult, that there are marked variations between regions and that experiences of the transition to an older adult service can be difficult. Such transitions are not unusual in services and signifigant positive work has recently been undertaken regarding the transfer from child and adolescent mental health services to general adult psychiatry services.

Services are resourced differently, and it is often felt that older adult services are not as well resourced as the general adult service in an area.

The reasons for transfer between services are also not well articulated. Some services use age, usually 65, despite the fact that this is a protected characteristic under equality legislation. Some use the Royal College of Psychiatry Criteria:

1. People of any age with a primary dementia.
2. People with mental disorder and physical illness or frailty that contributes to, or complicates, the management of their mental illness. This may include people under 65 years of age.
3. People with psychological or social difficulties related to the ageing process, or end-of-life issues, or who feel their needs may be best met by a service for older people. This would normally include people over 70 years of age.

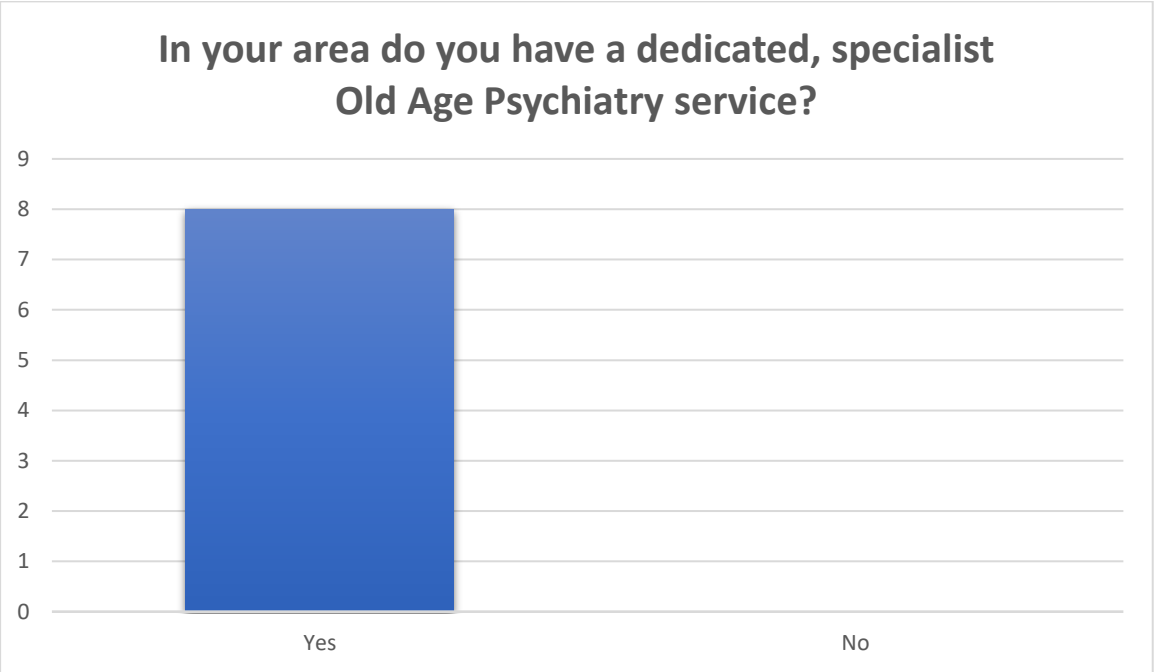
A series of discussions organised by Support in Mind and VHS have begun to examine this issue in a Scottish context, and this paper has been written to further inform the discussion.

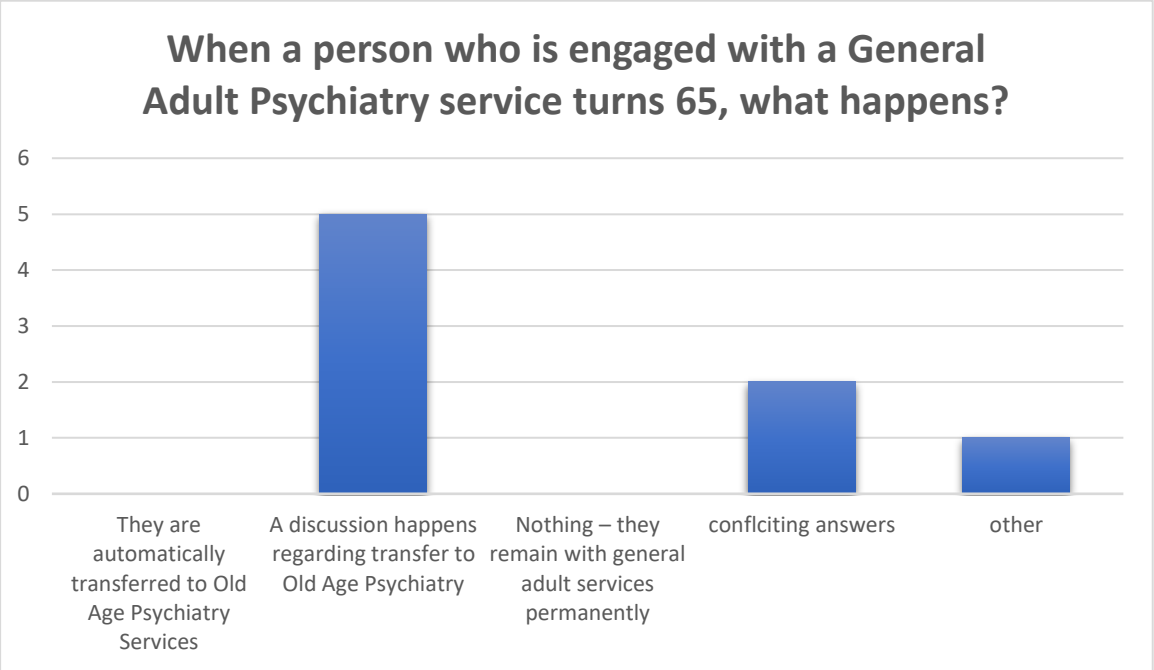
Method

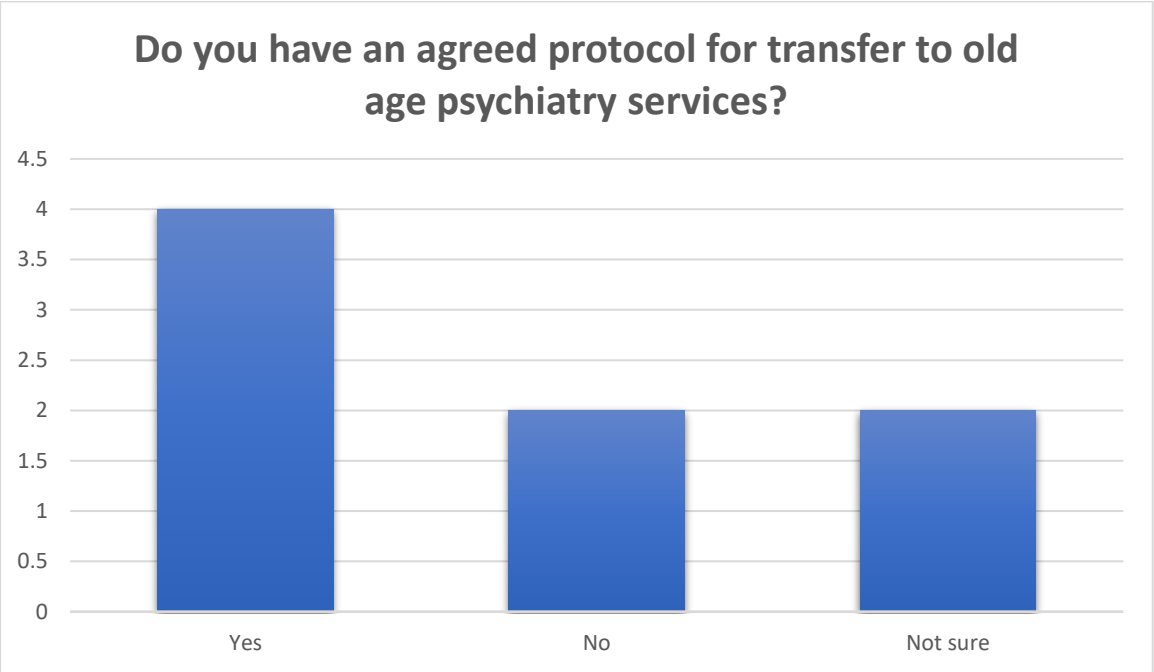
A survey of consultants in old age psychiatry took place during one of the bi-annual meetings held by the Old Age Faculty of the royal college of Psychiatrists in Scotland. This meeting was hosted in Aberdeen in May 2019. A paper survey was delivered in packs to all attendees, most of whom are consultants in Old Age Psychiatry. As the purpose of this paper is to highlight practice and variation, Health Boards are not mentioned by named.

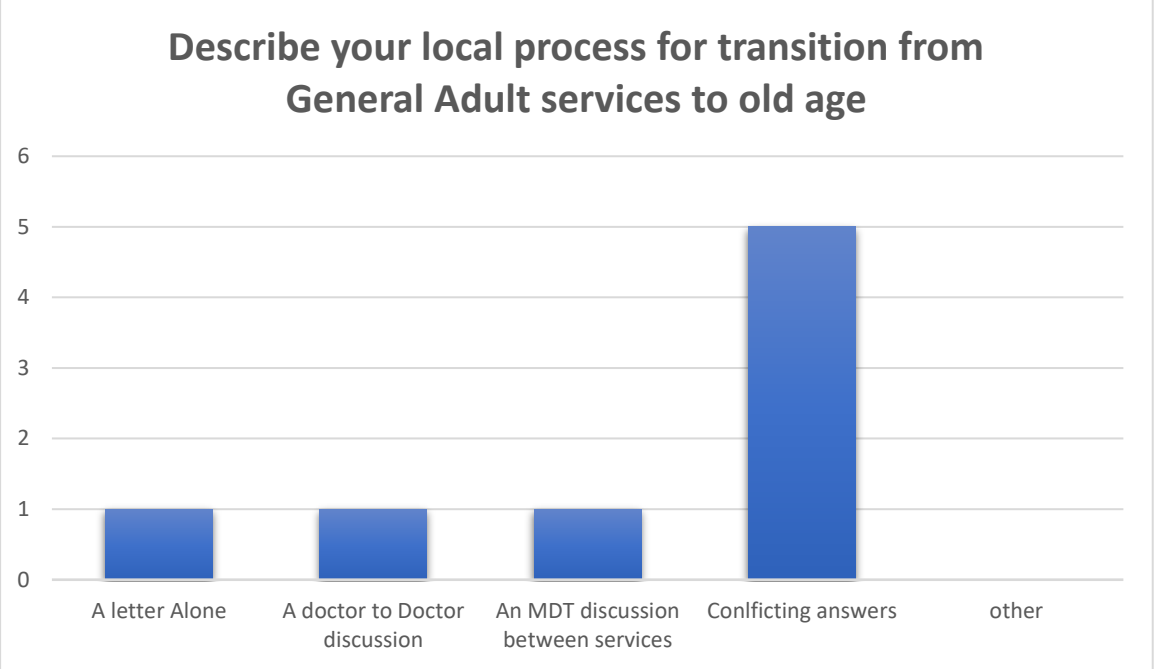
Results

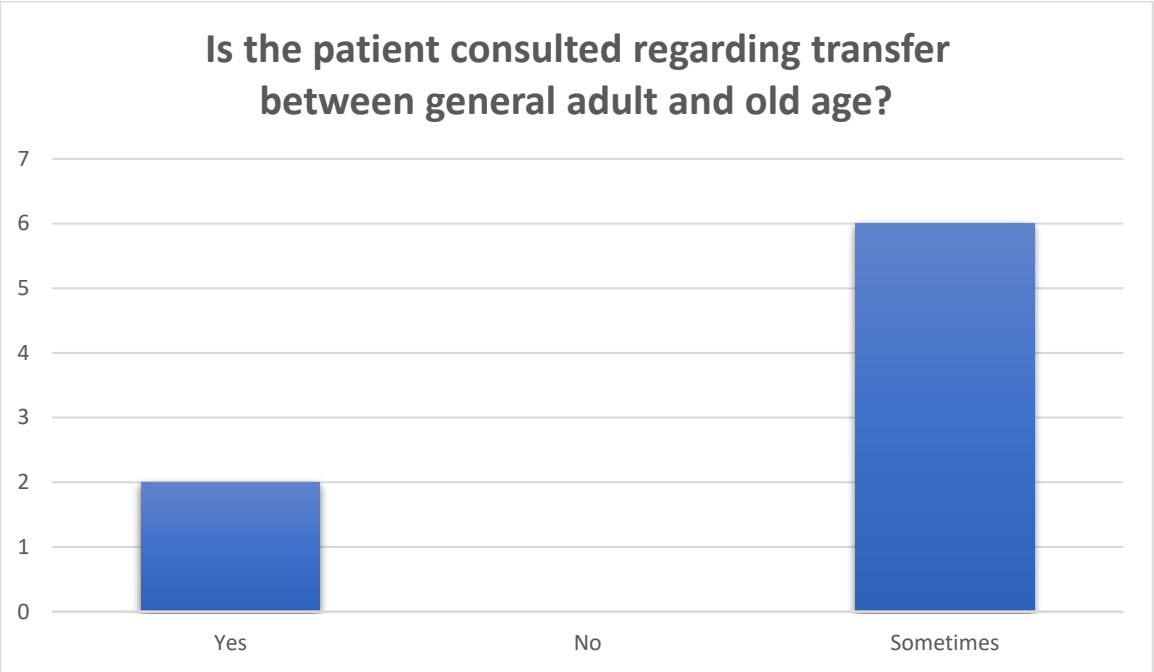
23 of 47 participants responded to the survey, giving representation from 8 of the 14 territorial boards. As the Western Isles, Shetland and Orkney do not have specialist Old Age Psychiatry services, this puts the total at 8 out 11 potential boards who are likely to have an old age pscyhaitry service.

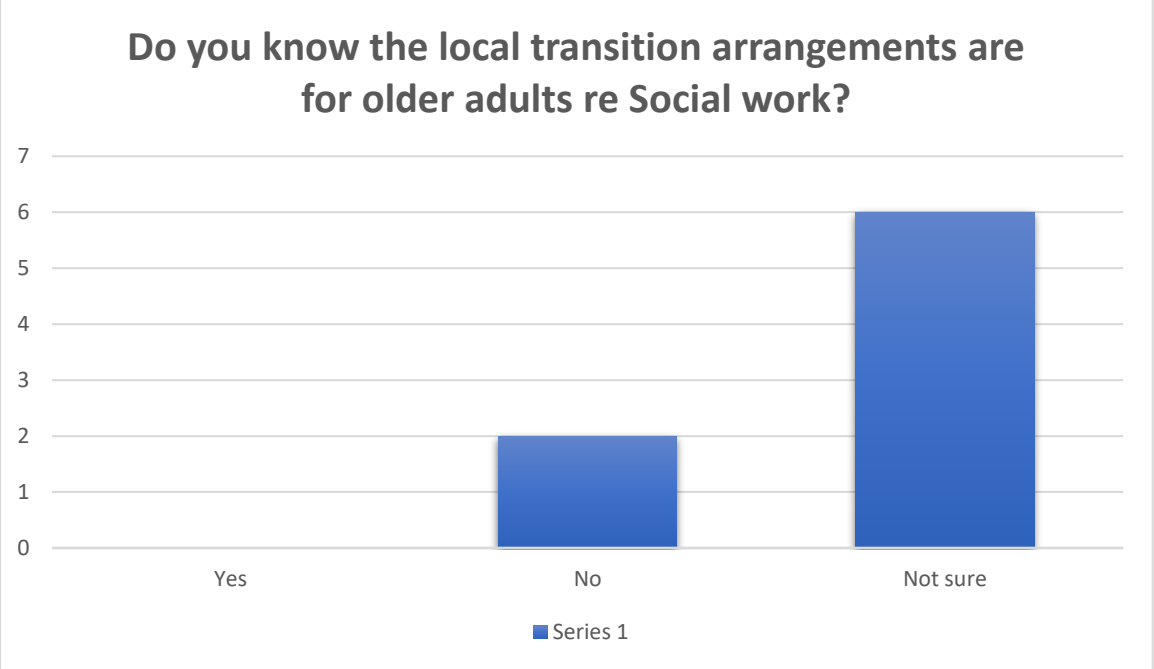

In your area do you have a dedicated, specialist Old Age Psychiatry service?
9
8
7
6
5
4
3
2
1
0
Yes
No

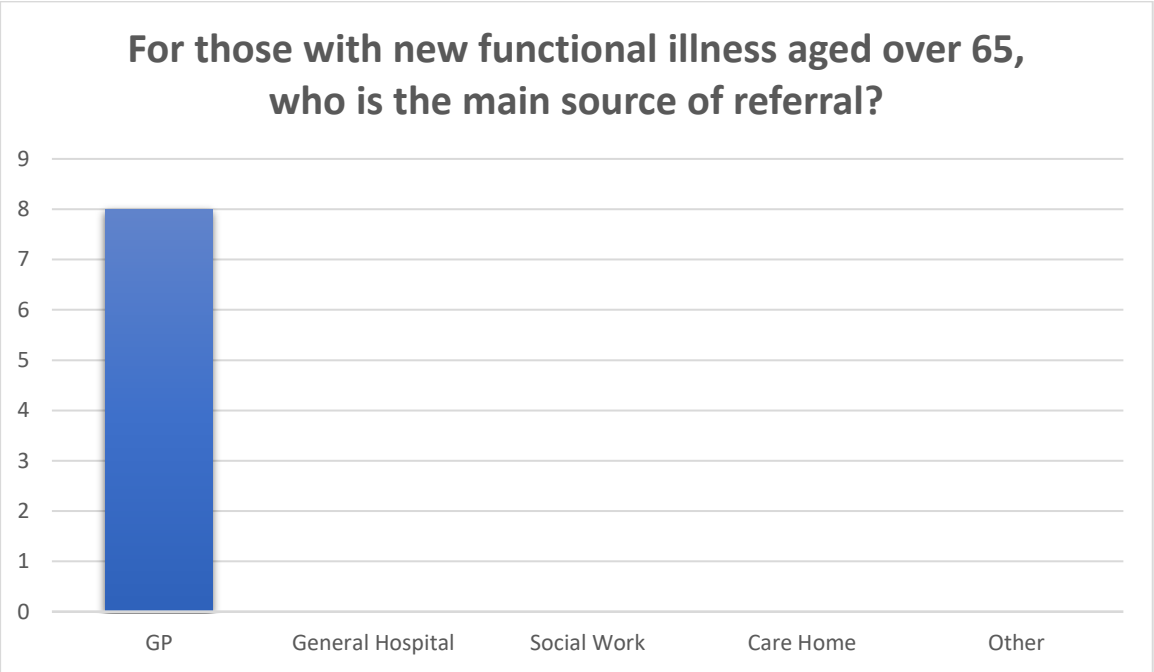

When a person who is engaged with a General Adult Psychiatry service turns 65, what happens?
6
5
4
3
2
1
0
They are automatically transferred to Old Age Psychiatry Services
A discussion happens regarding transfer to Old Age Psychiatry
Nothing – they remain with general adult services permanently
conflciting answers
other


Do you have an agreed protocol for transfer to old age psychiatry services?
4.5
4
3.5
3
2.5
2
1.5
1
0.5
0
Yes
No
Not sure


Describe your local process for transition from General Adult services to old age
6
5
4
3
2
1
0
A letter Alone
A doctor to Doctor discussion
An MDT discussion between services
Conlficting answers
other


Is the patient consulted regarding transfer between general adult and old age?
7
6
5
4
3
2
1
0
Yes
No
Sometimes


Do you know the local transition arrangements are for older adults re Social work?
7
6
5
4
3
2
1
0
Yes
No
Not sure
Series 1



Discussion

The results show that the most common scenario is for a process to be in place which involves a discussion regarding transfer between the general adult and old age psychiatry services. However, the results show variation in most areas, with uncertainty about the processes used and even whether or not policies exist.

There are limitations to this work – those surveyed represent only a sample of Old Age Psychiatrists working in Scotland presently. The results also do not reflect the views of the General Adult Psychiatrists, and thus there is a degree of bias.

Knowledge Services
Scotland's public health information service

Knowledge Services Evidence Summary

Mental health diagnosis of people aged 65 and over.

Author	Grant Donaghy Knowledge Services NHS Health Scotland
Enquirer	Claire Stevens Chief Executive Voluntary Health Scotland
Date of Search	July 2019
Search Type	Evidence summary
Disclaimer	This evidence summary contains a selection of material gathered from a search of the evidence base. It is not intended to be comprehensive and has not been critically appraised. Written by a qualified information professional, the content is based upon informed prioritisation of the search results based upon the criteria supplied by the requestor. The summary is not a substitute for clinical or professional judgement and the information contained within does not supersede national and local NHS policies and protocols.

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NHS Health Scotland

1. Introduction

This report describes the evidence search request, provides a brief thematic analysis of the findings and details the included references. The question asked was:

What happens to the mental health diagnosis of a person once they reach the age of 65?

2. Search Overview

The searches for this evidence summary were conducted during July 2019. The search strategy is included in Appendix 4. The results were then de-duplicated and screened using date/title/abstract.

The following criteria were applied:

- Limits applied to search:
    - Language: [English]
    - Period: [2014-2019]
    - Geography: [UK, EU, USA, AUS]
    - Population: [65+]
- Inclusion criteria:
    - [Psychosis]
- Exclusion criteria:
    - [Dementia]

3. Key Messages

● Depression in older people is under-diagnosed and under-treated [1, 2, 6]

● There are several diagnostic assessment tools available for use with elderly patients [2]

● Evidence shows that older people are less likely to be referred to specialist services compared with younger people [1, 3]

● Patients aged 60 and over are identified as being less likely to seek medical help for their mental health as well as being less likely to receive adequate treatment if they do, in comparison to younger adults [3]

● There is limited evidence on the treatment of older people's mental health beyond dementia and depression suggesting that further research in this area is required [5]

4. Findings

Brief literature review

Allen et al [1] in their article on the under-diagnosis of depression in older people state that even though depression is more common in old age than dementia it remains both under-diagnosed and under-treated [1, 2, 6]. They suggest the reasons for this may be due to the over-lapping of presenting symptoms or to a lack of recognition of the impact of depression by clinicians, patients and their families. For this reason it is suggested that consideration of depressive illness as a differential diagnosis is required. Morichi et al [2] note that, from a clinical perspective, depression in older people is associated with:

- Functional decline
- Greater morbidity
- Increased risk of hospital admission
- Institutionalisation
- Increased mortality (due to risk of suicide as well as other causes)
- Higher healthcare costs

In diagnosing depression, Allen et all [1] note that organic disorders such as anaemia, B12 and folate deficiency and hypothyroidism should first be excluded before considering cognitive assessment. They reiterate that in an elderly patient with

depression, cognitive assessment scores are likely to have significant overlap in scores with mild cognitive impairment and even dementia.

For this reason screening tools should be used to identify key symptoms and to evaluate their severity [1]. Morichi et al [2] list the following diagnostic assessment tools for use with elderly patients:

- The Geriatric Depression Scale (GDS)
- The Patient Health Questionnaire (PHQ)
- The Cornell Scale for Depression in Dementia (CSDD)
- The Beck Depression Inventory Scale
- The Older American Resources and Services (OARS) Depression Scale
- The Hamilton Rating Scale for Depression
- The Geriatric Mental State

Yet it is noted that some of the assessment scales have varying success with the oldest old due to comorbidities and the effects of old age, e.g. frailty.

Valkanova et al [6] note that depression and dementia are common in older people and frequently happen together. However, they highlight that depression can be an independent risk factor, a prodromal symptom or a consequence of dementia. For this reason disentangling the temporal relationship between the two can be challenging. Depression can be seen as a psychological response to receiving a diagnosis of dementia. They reiterate that studies have found high rates of anxiety and depression, particularly early in the course of dementia.

Allen et al [1] state that many older people resist the use of antidepressants for the treatment of depression and express a preference for a psychological treatment. Despite this, the evidence shows that older people are less likely to be referred to specialist services compared with younger people [1, 3]. However, Morici et al [2] acknowledge that clinical presentation of late-life depression is usually different from that in younger people. Additionally to this, patients aged 60 and over are identified as being less likely to seek medical help for their mental health as well as being less likely to receive adequate treatment if they do, in comparison to younger adults [3]. Referral to specialist mental health services is recommended [1, 2] where:

- There is diagnostic difficulty
- There is poor response to treatment
- There are psychotic symptoms
- There is significant psychiatric comorbidity
- There is a risk of self-neglect or suicide

The evidence shows that antidepressants are effective in older people and that the principles of prescribing are the same as those for younger people [1]. NICE guidelines [CG90] make recommendations and state that the choice of antidepressant should be guided by comorbidities, which are more common in the elderly.

Scogin and Presnell [4] in their analysis of geriatric depression acknowledge that barriers for the elderly to seek mental health therapy can include:

- Stigmatisation of mental health treatment
- Believing depression is part of old age
- Culturally specific shame
- Lack of acculturation

They suggest some therapeutic techniques for application with the elderly:

- Behaviour therapy techniques including Cognitive Behaviour therapy (CBT)
- Cognitive bibliotherapy
- Problem-solving therapy (PST)
- Brief psychodynamic psychotherapy
- Reminiscence therapy

Searby et al [5] in their review of dual diagnosis in older adults state the dedicated studies concerning older mental health populations are scarce and as such further research in this area is required. They speculate that mental health services providing hospital and community care to older adults are likely to experience increased demand as a result of ageing generations with greater comorbid mental health disorders.

Scottish statistics (based on available data)

Figures show that that whilst there has only been a slight increase in the prescribing of anti-psychotic medication to those over 65 across all health boards in Scotland since 2010, the prescribing of dementia related medicines in the same period has more than doubled [Appendix 2].

Figures also show that there has been a slight decrease in discharges from psychiatric hospitals for those aged 65 plus across all Scottish health boards since 2015. The number of patients aged 65 plus discharged from a psychiatric hospital where their diagnosis was psychosis has also decreased slightly since 2015 [Appendix 3].

5. References

[1] Allan, Charlotte E.; Valkanova, Vyara; Ebmeier, Klaus P.
Depression in older people is underdiagnosed. Practitioner 2014;258(1771):19-22 2014

[2] Morichi V.; Dell'Aquila G.; Trotta F.; Belluigi A.; Lattanzio F.; Cherubini, A.
Diagnosing and treating depression in older and oldest old. Current pharmaceutical design 2015;21(13):1690-1698

[3] Sanglier .; Saragoussi D.; Milea D.; Tournier, M.
Depressed older adults may be less cared for than depressed younger ones. Psychiatry research 2015;229(3):905-912

[4] Scogin, Forrest; Presnell, Andrew; Floyd, Mark R.
Chapter: Geriatric depression. Translating psychological research into practice 2014; 193-199

[5] Searby, Adam; Maude, Phil; McGrath, Ian
Dual diagnosis in older adults: a review. Issues in Mental Health Nursing 2015;36(2):104-111

[6] Valkanova V.; Ebmeier K.P.; Allan, C. L.
Depression is linked to dementia in older adults. The Practitioner 2017;261(1800):11-15

Appendix 1: Evidence matrix of identified publications with priority listing

Table 1: Publications (Listed Alphabetically by author)

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
1	Allan, Charlotte E.; Valkanova, Vyara; Ebmeier, Klaus P. Depression in older people is underdiagnosed	Practitioner 2014;258(1771):19-22 2014	Depression is more common in old age than dementia yet is underdiagnosed and undertreated. It is important to recognise that patients may not always present in a typical way, features that may indicate depression include anxiety, a preoccupation with somatic symptoms, and a change in function.	• Focus on eliciting current features of depression, which have been present for at least two weeks, and are associated with a significant change in function.	Article
2	Bendixen A.B.; Engedal, K. Anxiety among older psychiatric patients: a hidden comorbidity?	Aging & mental health 2016;20(11):1131-1138 2016	The aims were to explore prevalence of anxiety among patients admitted to departments of geriatric psychiatry for treatment of various diagnoses and to examine how often anxiety was registered as a previous or ongoing diagnosis.	• Anxiety is common in geriatric psychiatric patients, regardless of the primary diagnosis. The findings suggest that anxiety is often a hidden comorbidity in various psychiatric disorders.	Article
3	Bennett, Courtney Identifying delirium in older adults with pre-existing mental illness.	Nurse Practitioner 2017;42(6):39-44 06 16 201	The ability to distinguish key signs and symptoms of delirium in the presence of multiple medical comorbidities and mental illness allows the practitioner to intervene appropriately and improve care outcomes. It is critical that NPs promptly recognize, diagnose, and correct modifiable causes of delirium in	• Early recognition and diagnosis of delirium, in lieu of medical comorbidities and pre-existing mental illness, are crucial to improve care outcome and quality of life in older adults. In the case study, upon recognizing the symptoms of delirium, appropriate treatment was	Case Study

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
			older adults. Timely and appropriate intervention reduces the risk of death and life-threatening medical conditions.	implemented and the prognosis improved for the patient. Delirium should be considered in all cases of sudden changes in cognitive status, especially in older adults.	
1	Chew-Graham, Carolyn A. Chapter: Anxiety and depression in older people: Diagnostic challenges.	Mental health and older people: A guide for primary care practitioners 2016; 45-55	This chapter considers the presentation of anxiety and depression in older people and explores the challenges clinicians face in making a diagnosis in the face of multiple health problems. Depression is a major global public health threat, and by 2030, depressive disorders are predicted to be the second leading cause of disease burden and disability worldwide.	• Reducing the burden of depressive disorders is recognised as a major public health priority. Anxiety and depression commonly overlap or coexist.	Book chapter
2	Colligan, Erin M.; Cross-Barnet, Caitlin; Lloyd, Jennifer T.; McNeely, Jessica Barriers and facilitators to depression screening in older adults: a qualitative study.	Aging & Mental Health 2018;1-8(Journal Article): 2018	The objective of this qualitative study was to better understand facilitators and barriers to depression screening for older adults.	• Findings indicate that using person-centered approaches to build positive communication and trust between beneficiaries and providers could be an effective strategy for improving depression screening. Better screening can lead to higher rates of diagnosis and treatment of depression that could enhance quality of life for older adults.	Qualitative study
2	Dols, Annemiek; Chen, Peijun; Jurdi, Rayan K. Al; Sajatovic, Martha	Bipolar disorder in older age patients	This chapter on clinical assessment of older adults with bipolar disorder will discuss the differential diagnosis of	•	Book chapter

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
	Chapter: Clinical assessment of older adults with bipolar disorder.	2017;(Journal Article):21-41 Cham, Switzerland 2017	manic presentation in older individuals as well as the elements of a clinical evaluation appropriate for the older adult who may have bipolar disorder. This includes the psychiatric clinical interview, history-taking, risk assessment, application of standardized techniques in the assessment of mood symptoms, and that of cognition as well as the assessment of medical and psychiatric comorbidities.		
3	Harrawood A.M.; Perkins A.J.; Fowler N.R.; Boustani, M. A. Mental health outcomes for a large cohort of older primary care patients who were screened for dementia	Alzheimer's and Dementia 2017;13(7):P875 Alzheimer's and Dementia. Conference Alzheimer's Association International Conference, AAIC 2017. United Kingdom. 13 (7) (pp P875); Elsevier Inc. 2017	Dementia frequently coexists with negative psychosocial symptoms such as depressive symptoms and anxiety. Strong social support has been associated with better mental health outcomes for older adults. We examined the relationship between performance on cognitive screening, social support, depression and anxiety in a large cohort of primary care patients age 65 and older.	• There was no difference in rates of depression or anxiety between the group that screened positive for dementia compared to those who screened negative for dementia. Higher social support was positively associated with less depression and anxiety for both groups, regardless of whether they screened positive or negative for dementia.	Conference abstract
2	John A.; Patel U.; Rusted J.; Richards M.; Gaysina, D. Affective problems and decline in cognitive state in older adults: a systematic review and meta-analysis.	Psychological medicine 2019;49(3):353-365	Evidence suggests that affective problems, such as depression and anxiety, increase risk for late-life dementia. However, the extent to which affective problems influence cognitive	• Results of the present study improve current understanding of the temporal nature of the association between affective problems and decline in cognitive state. They also suggest that	Systematic review

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
			decline, even many years prior to clinical diagnosis of dementia, is not clear. The present study systematically reviews and synthesises the evidence for the association between affective problems and decline in cognitive state (i.e., decline in non-specific cognitive function) in older adults.	cognitive function may need to be monitored closely in individuals with affective disorders, as these individuals may be at particular risk of greater cognitive decline.	
3	Kennedy G.J.; Ceide, M. E. Screening Older Adults for Mental Disorders.	Clinics in geriatric medicine 2018;34(1):69-79	Avoidable disability associated with depression, anxiety, and impaired cognition among older adults is pervasive. Incentives for detection of mental disorders in late life include increased reimbursement, reduced cost, and less burden for patients and families. However, screening not aligned with diagnosis, intervention, and outcome assessment has questionable utility. The link between screening, treatment, and outcomes is well established for depression, less so for anxiety and impaired cognition.	• This article details the use of common instruments to screen and assess depression, anxiety, and cognitive impairment.	Article
1	KujawskaDanecka H.; NowickaSauer K.; Hajduk A.; Wierzba K.; Krzeminski W.; Zdrojewski, Z. The prevalence of depression symptoms and other mental	Family Medicine and Primary Care Review 2016;18(3):274-277	Mental disorders, especially depression, are common problems among the elderly. This article determines the prevalence of symptoms of mental disorders, with emphasis on symptoms	• 1. In the studied group symptoms of sleep disorders and depressive disorders were the most frequent problems.	Case study

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
	disorders among patients aged 65 years and older - screening in the rural community.		of depressive disorders, in patients aged 65 years and older. Material and methods. The study involved 93 patients (59 women, 34 men, median age 70).	• 2. The severity of symptoms of depressive disorders correlated positively with the number and severity of somatic complaints. • 3. Only 1/3 of the patients presenting symptoms of mental disorders were treated with pharmacotherapy. • 4. Depression screening should be carried out among the elderly who report somatic problems and sleep disorders.	
1	Morichi V.; Dell'Aquila G.; Trotta F.; Belluigi A.; Lattanzio F.; Cherubini, A. Diagnosing and treating depression in older and oldest old.	Current pharmaceutical design 2015;21(13):1690-1698	Depression is very common in older people and it is associated with negative consequences such as functional decline, increased morbidity and mortality and higher healthcare costs. Despite this, it is still under diagnosed and undertreated and the issue is particularly relevant for people older than 80 years. The main reasons for under-diagnosis are: atypical presentation, concomitant cognitive decline, inadequate diagnostic tools, and prejudice that depression is a normal part of ageing.	• In light of the heterogeneity of people aged 80 years and over, with multiple and different medical, functional, socioeconomic problems, a multidimensional approach is probably the most suitable both for diagnosis and treatment, in order to develop an individualized care plan.	Article
2	Pocklington C.; Gilbody S.; Manea L.; McMillan, D.	International journal of geriatric psychiatry 2016;31(8):837-857	Depression in older adults is often under recognised despite it being the most	• Results suggest the possibility of selective reporting of cut-off scores,	Systematic review

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
	The diagnostic accuracy of brief versions of the Geriatric Depression Scale: a systematic review and meta-analysis.		common mental health illness in this age group. An increasing older adult population highlights the need for improved diagnostic rates.	and therefore, findings should be approached cautiously	
2	Rhee T.G.; Capistrant B.D.; Schommer J.C.; Hadsall R.S.; Uden, D. L. Effects of the 2009 USPSTF depression screening recommendation on diagnosing and treating mental health conditions in older adults: A difference-in-differences analysis.	Journal of Managed Care and Specialty Pharmacy 2018;24(8):769-776	To examine the effects of the 2009 USPSTF depression screening recommendation on the 3 following outcomes: diagnoses of mental health conditions, antidepressant prescriptions (overall and potentially inappropriate), and provision of nonpharmacological psychiatric services in office based outpatient primary care visits made by adults aged 65 or older.	• While there are mixed findings about efficacy and effectiveness of depression screening in the existing literature, more population-based observational research is needed to strengthen and support current USPSTF depression screening recommendation statements in the United States.	Difference-in-differences analysis
1	Sanglier .; Saragoussi D.; Milea D.; Tournier, M. Depressed older adults may be less cared for than depressed younger ones.	Psychiatry research 2015;229(3):905-912	The aim of the study was to investigate depression treatment use, either psychotherapy (PT) or antidepressant drugs (ADT) in the older and younger depressed population.	• Elderly persons were less often treated than the younger adults either by ADT (25.6% vs. 33.8%) or by PT (13.0% vs. 34.4%). ADT dispensing occurred later in the elderly group (51 vs. 14 days). ADT was associated with comorbid chronic conditions or polypharmacy in the elderly and younger adults. Although depressed elderly commonly presented with comorbidity, this age group was at higher risk of untreated illness or later treatment.	Article

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
2	Schluter P.J.; Lacey C.; Porter R.J.; Jamieson, H. A. An epidemiological profile of bipolar disorder among older adults with complex needs: A national cross-sectional study.	Bipolar disorders 2017;19(5):375-385	Research on bipolar disorder (BD) among community-living older adults is scant and often suffers from important methodological limitations. Using a national database, this study presents an epidemiological profile of BD in older community residents within New Zealand.	• BD among older adults is not uncommon, and numbers will increase as populations age. Increasingly, health services are moving to home-based integrated models of care. Clinicians and decision-makers need to be aware in their planning and service delivery that significant deficits in environment quality and exposure to stressful living circumstances remain for older adults with BD.	Article
1	Scogin, Forrest; Presnell, Andrew; Floyd, Mark R. Chapter: Geriatric depression.	Translating psychological research into practice 2014;(Journal Article):193-199	Depression in late life is one of the most common psychological disorders faced by older adults. Many controlled investigations have examined the treatment of the disorder, providing for a rich foundation for determining the best course of treatment. Central to the issues of treatment is the diagnosis of the disorder in this population.	• Older adults are more likely to focus complaints on somatic concerns, such as sleep problems or loss of appetite, fatigue, and cognitive concerns, than to present affective complaints. Older adults may also have a variety of medical issues that complicate treatment. These special issues make the treatment of depression in late life nuanced and therefore require techniques specifically studied within the population for best practices to be established.	Book chapter
1	Searby, Adam; Maude, Phil; McGrath, Ian Dual diagnosis in older adults: a review	Issues in Mental Health Nursing 2015;36(2):104-111	A comprehensive review of the contemporary literature examining this issue was conducted, finding a paucity	• Several recurring themes emerge from the literature, including the notion of a statistically small population that, in	Article

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
			of literature concerning dual diagnosis in older adults.	absolute terms, represents a sizeable number of individuals coming to the attention of aged mental health services in the future. Additionally, the potential for under-diagnosis in this cohort is highlighted, potentially creating a hidden population of older adults with dual diagnosis.	
3	Sohn N.; Cummings C.; Kreider, T. R. A Case of Very-Late-Onset Schizophrenia-Like Psychosis, an Under-Recognized and Distinct Syndrome	American Journal of Geriatric Psychiatry 2019;27(3 Supplement):S118-S119	Schizophrenia is classically viewed as a neurodevelopmental disorder that manifests at an early age. However, geriatric presentations of schizophrenia-like illness have been described, suggesting a distinct syndrome and warranting a diagnosis of very-late-onset schizophrenia-like psychosis (VLOSLP).	• The case of Ms. L illustrates a rare presentation of first episode of psychosis at advanced age with relative sparing of cognitive and functional status. This syndrome has been called very-late-onset schizophrenia-like psychosis.	Case report / Conference abstract
1	Valkanova V.; Ebmeier K.P.; Allan, C. L. Depression is linked to dementia in older adults.	The Practitioner 2017;261(1800):11-15	Depression and dementia are both common conditions in older people, and they frequently occur together. Late life depression affects about 3.0-4.5% of adults aged 65 and older. Depression occurs in up to 20% of patients with Alzheimer's disease and up to 45% of patients with vascular dementia. Rather than a risk factor, depression with onset in later life is more likely to be either prodromal to dementia or a condition	• Older people with depression are at raised risk of dementia and this risk is increased if they have had symptoms for a long time, if their symptoms are severe, where there are multiple (vascular) comorbidities, and where there are structural brain changes including hippocampal atrophy and white matter abnormalities.	Article

Priority 1. Must know 2. Should know 3. Could know	Author / Title	Publication, reference & date	Aim / Methods	Conclusion / Key Points	Notes / Study Type
			that unmasks pre-existing cognitive impairment by compromising cognitive reserve.		
1	Weisenbach, Sara; Carns, Danielle Chapter: Cognitive impairment and older age bipolar disorder.	Bipolar disorder in older age patients 2017;(Journal Article):107-126	Many older adult patients seen in psychiatric settings exhibit a clinical presentation that involves mixed affective and cognitive disturbances. These disruptions typically take one of two forms: either a primary mood disturbance with secondary cognitive impairment, or a primary neurodegenerative illness with secondary mood disorder, such as depression. The former pattern, also known as cognitive impairment with depression, involves cognitive impairment that may improve with adequate treatment of depression, while the latter does not.	• This differentiation highlights the importance of accurate and quick diagnosis, which is a process that begins with being able to effectively screen for impairments and knowing when to refer for neuropsychological evaluation.	Book chapter

Appendix 2: Scottish psychiatric prescribing for 65 and over figures

ISD Reference Number: IR2018-01802

Description: The number of paid items for Dementia and Antipsychotics for patients aged 65+, 2010/11 - 2017/18, by Health Board

Data source: Prescribing Information System, ISD Scotland (extracted 26/11/2018)

Please note that previous releases of this report have used existing BNF section classifications for reporting of drugs used in mental health. Since the report of October 2017 the structure of BNF medicines classification has changed and the section descriptions used are no longer applicable to the new structure. In order to maintain consistency and comparability with previous years this report uses the "legacy BNF" structure, consistent with what has been used in previous years for data for 2017/18. The "legacy BNF" is not publically available to view online, however the medicines attributed to the relevant BNF sections (BNF 4.2.1, and 4.11) are available in the "Legacy BNF" tab of this workbook. Up to date information on the availability and therapeutic uses of medicines can be found on the British National Formulary website: www.bnf.nice.org.uk

Notes

1. Includes items prescribed and dispensed in Scotland
2. Excludes items prescribed or dispensed in England
3. Split by NHS Board of prescribing
4. Excludes private prescriptions (other than control drugs), hospital and direct supply of medicines to patients; i.e. excludes prescriptions supplied though clinics
5. Includes all prescriber types
6. Includes all dispenser types
7. Data shown is for that dispensed within the community only
8. Data captured from paid items
9. Paid items are based on items which have been prescribed, dispensed and subsequently submitted for payment by a dispensing contractor
10. The paid date is the date the contractor was paid for dispensing the drugs, this is always defaulted to the end of the month
11. The frequency of items by patient is based on a count of the number of paid items for each valid CHI number.
12. Includes only items where a valid CHI has been captured. The CHI capture rates are:

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
Dementia	*87.33%*	*86.95%*	*88.27%*	*92.17%*	*93.58%*	*94.71%*	*95.37%*	*96.14%*
Antipsychotics	*93.52%*	*93.98%*	*94.77%*	*96.18%*	*96.79%*	*96.99%*	*97.18%*	*97.41%*

13. Age band is based on the patient's age as at 30th September for the financial year in question, for example the age band for financial year 2011/12 is based on 30th September 2011.

NHS National Services Scotland

The number of paid items for Dementia (4.11) and Antipsychotics (4.2.1) for patients aged 65+, 2010/11 - 2017/18 [1, 2]

ISD SCOTLAND

Prescribing NHS Board	Dementia (4.11)								Antipsychotics (4.2.1)							
	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18
NHS SCOTLAND	**112,918**	**128,857**	**154,644**	**192,321**	**216,180**	**229,563**	**243,859**	**250,438**	**184,770**	**186,645**	**189,502**	**197,228**	**205,181**	**210,886**	**219,215**	**228,280**
NHS AYRSHIRE & ARRAN	906	825	665	2,689	5,727	7,931	9,542	9,614	11,921	12,171	12,226	12,686	12,894	13,157	13,601	13,685
NHS BORDERS	2,975	3,557	4,196	5,707	7,136	8,160	8,886	9,027	3,739	3,840	3,820	3,909	3,788	3,906	4,094	4,301
NHS DUMFRIES & GALLOWAY	4,742	5,201	5,913	6,656	7,524	8,537	9,346	9,587	7,052	6,626	6,147	6,232	6,374	6,627	7,166	7,404
NHS FIFE	12,073	14,628	18,304	22,214	25,649	27,837	29,413	29,549	11,529	11,071	10,809	10,375	10,989	11,880	12,758	13,096
NHS FORTH VALLEY	2,018	1,626	2,924	9,846	11,566	11,715	11,982	13,320	8,606	9,249	9,601	10,301	10,551	11,419	12,253	13,832
NHS GRAMPIAN	15,493	17,365	19,680	22,235	23,286	22,856	23,264	23,377	20,366	20,891	21,159	22,267	23,465	24,285	25,129	25,335
NHS GREATER GLASGOW & CLYDE	24,825	28,077	34,160	40,238	41,460	43,875	45,148	43,496	46,072	46,437	46,773	48,177	48,260	49,259	49,776	51,042
NHS HIGHLAND	8,531	9,884	10,964	12,634	13,910	14,751	15,384	16,084	14,866	14,726	14,735	15,507	16,311	16,790	16,968	17,535
NHS LANARKSHIRE	19,286	22,590	27,135	31,092	35,121	35,358	36,473	35,892	20,739	20,603	21,320	22,497	26,348	27,013	27,955	29,389
NHS LOTHIAN	16,409	19,389	22,219	27,255	31,579	33,426	35,902	38,773	20,190	20,770	22,039	23,288	24,288	24,584	26,568	27,836
NHS ORKNEY	591	626	674	690	642	540	530	461	656	638	585	629	657	661	728	751
NHS SHETLAND	171	335	639	967	1,042	991	1,022	1,088	471	472	550	671	763	776	831	964
NHS TAYSIDE	4,077	3,875	5,970	8,947	10,243	12,277	15,787	19,078	17,251	17,739	18,059	18,806	18,635	18,758	19,596	21,187
NHS WESTERN ISLES	821	879	1,201	1,151	1,295	1,309	1,180	1,092	1,312	1,412	1,679	1,883	1,858	1,771	1,792	1,923

Notes:

1. Age is based on the patient's age as at 30th September for the financial year in question. For example 2010/11 data the age is based on 30th September 2010.
2. The number of items paid is where there is valid CHI only.

NHS National Services Scotland

ISD SCOTLAND

"Legacy" BNF classification - approved drug names allocated to BNF sections 4.2.1 and 4.11

Section BNF	Sub-Section BNF	Approved Name
0402 - DRUGS USED IN PSYCHOSES & RELATED DISORDERS	040201 - ANTIPSYCHOTIC DRUGS	AMISULPRIDE
		ARIPIPRAZOLE
		BENPERIDOL
		CHLORPROMAZINE HYDROCHLORIDE
		CLOZAPINE
		FLUPENTIXOL
		FLUPENTIXOL DECANOATE
		FLUPHENAZINE HYDROCHLORIDE
		HALOPERIDOL
		LEVOMEPROMAZINE
		LURASIDONE HYDROCHLORIDE
		OLANZAPINE
		PALIPERIDONE
		PERICYAZINE
		PERPHENAZINE
		PIMOZIDE
		PROMAZINE HYDROCHLORIDE
		QUETIAPINE
		RISPERIDONE
		SULPIRIDE
		THIORIDAZINE
		TRIFLUOPERAZINE
		ZOTEPINE
		ZUCLOPENTHIXOL
0411 - DEMENTIA	041100 - DEMENTIA	DONEPEZIL HYDROCHLORIDE
		GALANTAMINE
		MEMANTINE
		RIVASTIGMINE

Appendix 3: Scottish psychiatric discharges for 65 and over figures

This table shows all discharges from psychiatric hospitals for those aged 65 plus by diagnosis grouping and also by health board.

For the financial years ending 31 March 2015/16 - 2017/18
By health board of residence

	Financial Year		
Health Board of Residence	2015/16	2016/17	2017/18
NHS Ayrshire & Arran	173	218	205
NHS Borders	109	76	84
NHS Dumfries & Galloway	141	172	161
NHS Fife	322	232	247
NHS Forth Valley	264	277	294
NHS Grampian	368	340	364
NHS Greater Glasgow & Clyde	732	731	784
NHS Highland	233	197	197
NHS Lanarkshire	395	374	379
NHS Lothian	581	555	609
NHS Tayside	549	551	428
Island Boards	19	23	31
Total	**3,886**	**3,746**	**3,783**

Notes:
Source: ISD SMR04 August 2019
No diagnosis codes have been excluded from this analysis.
Each spell of treatment is counted i.e. individual patients with more than one spell of treatment would be counted for each spell of treatment within the time frame.
Due to small numbers, the island boards NHS Orkney, NHS Shetland and NHS Western Isles have been combined.

This table shows the number of patients discharged from a psychiatric hospital where their diagnosis was psychosis broken down by health board of residence.

Number of patients discharged from a psychiatric hospital with a psychosis diagnosis for those aged 65 and over
For the financial years ending 31 March 2015/16 - 2017/18
By health board of residence

	Financial Year of Discharge		
Health Board of Residence	2015/16	2016/17	2017/18
NHS Ayrshire & Arran	48	46	58
NHS Borders	*	17	17
NHS Dumfries & Galloway	29	33	32
NHS Fife	68	52	43
NHS Forth Valley	58	52	54
NHS Grampian	75	97	82
NHS Greater Glasgow & Clyde	203	177	186
NHS Highland	50	43	42
NHS Lanarkshire	87	101	99
NHS Lothian	156	151	155
NHS Tayside	96	107	85
Island Boards	*	10	13
Total	**897**	**886**	**866**

Notes:
Source: ISD SMR04 August 2019
Psychosis has been defined as schizophrenia, bipolar disorder and/or severe depression.
ICD10 codes F105, F106, F107, F20-F29, F30, F31, F322, F323, F332, F333, F39X and F431 have been used to select psychosis patients.
It should be noted that learning disability and personality disorder codes have not been used to select psychosis patients.
All six discharge diagnosis positions have been used to identify patients with a psychosis diagnosis.
Each patient is counted only once in each financial year however, if they are discharged in more than one financial year then they will be shown for each financial year.
* denotes values which have been suppressed to protect patient confidentiality.

Appendix 4: Search Strategy

Bibliographic Databases	**Search strategy** (inc. limits and filters)
Ovide Medline, Embase & Psycinfo	***1. "mental disorder*".ti.*** ***2. *Psychotic Disorders/*** ***3. *Schizophrenia/*** ***4. schizophren*.ti.*** ***5. *Bipolar Disorder/*** ***6. "bipolar disorder".ti.*** ***7. *Depression/*** ***8. depress*.ti.*** ***9. *Anxiety/*** ***10. anxiety.ti.*** ***11. *Cognition Disorders/*** ***12. "subjective cognitive impairment".ti,ab.*** ***13. *Mental Health/*** ***14. *Mental Disorders/*** ***15. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14*** ***16. older.ti.*** ***17. elder.ti.*** ***18. "senior citizen*".ti.*** ***19. pension*.ti.*** ***20. geriatric*.ti.*** ***21. gerontol*.ti.*** ***22. 16 or 17 or 18 or 19 or 20 or 21*** ***23. 15 and 22*** ***24. *Diagnosis/*** ***25. diagnosis.ti,ab.*** ***26. 24 or 25*** ***27. 23 and 26*** ***28. limit 27 to (english language and yr="2014 -Current")***