

# Joint Commissioning Panel for Mental Health

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Guidance for commissioners of  
**older people's  
mental health services**

Practical mental health commissioning	

# Joint Commissioning Panel for Mental Health

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## Co-chaired by:



## Membership:



For better  
mental health



The British  
Psychological Society  
Promoting excellence in psychology



Royal College  
of Nursing



THE AFIYA TRUST



The New Savoy Partnership



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# Ten key messages for commissioners

- 1 **Older people will form a larger proportion of the population.** By 2035 the number of people aged 85 and over is projected to be almost 2½ times larger than in 2010. The population aged 65 and over will account for 23% of the total population in 2035<sup>1</sup>. Commissioners will need to ensure that accurate modeling of their local population is conducted as part of their Joint Strategic Needs Assessment and plan sufficient capacity in local services.
- 2 **Older people's mental health services in particular benefit from an integrated approach with social care services.** Most patients in older age mental health services have complex social needs. Commissioners should ensure service providers across agencies work together if they are to meet people's needs and aspirations effectively<sup>2</sup>. A whole system approach that draws together the expertise of health and social care agencies and those in the voluntary sector will deliver a comprehensive, balanced range of services, which places as much emphasis on services that promote independence as on care services<sup>2</sup>.
- 3 **Older people's mental health services need to work closely with primary care and community services.** Models that include primary care 'in-reach' or joint working with community physical health care services, provide more co-ordinated care and should be the norm.
- 4 **Services must be commissioned on the basis of need and not age alone.** Older people's mental health services should not be subsumed into a broader 'adult mental health' or 'ageless service'. The needs of older people with functional mental illness (for example depression) and/or organic disease such as dementia and their associated physical and social issues are often distinct from younger people.
- 5 **Older people's mental health services must address the needs of people with functional illnesses such as depression and psychosis as well as dementia.** The majority of the mental illness experienced by older people is not dementia and there is significant crossover between dementia and functional illnesses such as depression and psychosis.
- 6 **Older people often have a combination of mental and physical health problems.** Commissioners and service providers need to seek and exploit opportunities for joint working and service delivery that can address both physical and mental health needs. Older people with long-term health conditions make up the greater proportion of this care group. Having more than one long-term condition greatly increases the risk of depression<sup>3</sup>. Planning and delivering an integrated service to manage service delivery to this group through joint working protocols will be the best and most cost-effective way to manage care.
- 7 **Older people's mental health services must be multidisciplinary.** Medical doctors are important because of the complex physical and treatment issues common in older people, but given the complex needs of this group, integrated input from nurses, psychologists, physiotherapists, occupational therapists and speech and language therapists is necessary.
- 8 **Older people with mental health needs should have access to community crisis or home treatment services.** With extended hours of working and intensive crisis management, home treatment workers help to reduce the need for admission, facilitate early discharge and reduce transfer to residential care.
- 9 **Older people with mental health needs respond well to psychological input.** Evidence shows that response rates amongst older people are as good as those of younger adults. The spectrum of psychological service provision at all tiers needs to reflect this<sup>4</sup>.
- 10 **Older people should have dedicated liaison services in acute hospitals.** Over 60% of older people in acute hospital wards have a serious mental disorder which is often unrecognised and delays rehabilitation and discharge<sup>5</sup>. Commissioners must ensure appropriate specialist liaison services are in place with relevant discharge care plans and support from secondary care mental health teams.

# Introduction

The Joint Commissioning Panel for Mental Health (JCP-MH) ([www.jcpmh.info](http://www.jcpmh.info)) is a new collaboration co-chaired by the Royal College of General Practitioners and the Royal College of Psychiatrists, which brings together leading organisations and individuals with an interest in commissioning for mental health and learning disabilities. These include:

- people with mental health problems and carers
- Department of Health
- Association of Directors of Adult Social Services
- NHS Confederation
- Mind
- Rethink Mental Illness
- National Survivor User Network
- National Involvement Partnership
- Royal College of Nursing
- Afiya Trust
- British Psychological Society
- Representatives of the English Strategic Health Authorities (prior to April 2013)
- Mental Health Providers Forum
- New Savoy Partnership
- Representation from Specialised Commissioning
- Healthcare Financial Management Association.

The JCP-MH is part of the implementation arm of the government mental health strategy *No Health without Mental Health*<sup>6</sup>.

The JCP-MH has two primary aims:

- to bring together people with experience of mental health problems, carers, clinicians, commissioners, managers and others to work towards values-based commissioning
- to integrate scientific evidence, the experience and viewpoints of people with mental health problems and carers, and innovative service evaluations in order to produce the best possible advice on commissioning the design and delivery of high quality mental health, learning disabilities, and public mental health and wellbeing services.

The JCP-MH:

- has published *Practical Mental Health Commissioning*<sup>7</sup>, a briefing on the key values and principles for effective mental health commissioning
- provides practical guidance and a developing framework for mental health commissioning
- has so far published twelve other guides on the commissioning of primary mental health care services<sup>8</sup>, dementia services<sup>9</sup>, liaison mental health services to acute hospitals<sup>10</sup>, transition services<sup>11</sup>, perinatal mental health services<sup>12</sup>, public mental health services<sup>13</sup>, rehabilitation services<sup>14</sup>, forensic services<sup>15</sup>, drug and alcohol services<sup>16</sup>, community specialist mental health services<sup>17</sup>, acute care (inpatient and crisis home treatment)<sup>18</sup>, eating disorders<sup>19</sup>, and child and adolescent mental health services<sup>20</sup>.

## WHO IS THIS GUIDE FOR?

This guide has been written to provide information and practical advice on developing and delivering local plans and

strategies to commission the most effective and efficient older people's mental health services.

Based upon clinical best practice guidance and drawing upon the range of available evidence, it describes what should be expected of an older people's mental health service in terms of effectiveness, outcomes and value for money.

The guides will be of particular use to:

- Clinical Commissioning Groups
- General Practitioners (GPs) and commissioning leaders
- Commissioning Support Organisations
- wider local authority commissioners, voluntary and independent sector organisations.

## HOW WILL THIS GUIDE HELP YOU?

This guide has been developed by a group of older people's mental health professionals, people with mental health problems, and carers. The content is primarily evidence and literature-based, but ideas deemed to be best practice by expert consensus have also been included.

By the end of this guide, readers should be more familiar with the concept of effective older people's mental health services and be better equipped to:

- understand what an effective range of older people's mental health services should look like
- know the sorts of services and interventions that should be on offer
- understand how those interventions can contribute to achieving recovery outcomes and make improvements in public mental health and wellbeing.

# What are older people's mental health services?

Older people's mental health services are concerned with the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems usually relating to ageing.

These specialist mental health services aim to meet the needs of people with mental health problems and their carers in many settings including:

- primary care
- their own homes and via community-based services and inpatient facilities
- acute general hospitals
- residential care homes and nursing homes
- hospices
- prisons (this is rare but may increase given rising numbers of older prisoners)<sup>21</sup>.

Services should be person-centred, accessible, culturally appropriate and above all needs-based.

## Not just dementia

There are some misconceptions about what constitutes 'mental health'. It is often assumed to be mental ill health and in particular, with older people, just dementia. Mental health is not just about the absence of ill health but the promotion of positive health and wellbeing.

Mental ill health in older people does not just mean dementia but also other disorders such as depression, anxiety, schizophrenia, suicidal feelings, personality disorder and substance misuse. Services in health and social care should not simply be focused on those people who are known to have mental ill health and how to support them. They should also be concerned with the identification, diagnosis and appropriate treatment of older people who develop mental illness for the first time in older age, perhaps, but not necessarily, in reaction to consequences of ageing (e.g. physical issues such as stroke, Parkinson's, falls or social isolation).

Older people's mental health services should therefore provide a range of assessment and treatment services for mental disorders. These will include:

- depression
- bipolar disorders
- anxiety disorders
- schizophrenia and psychosis
- dementia
- alcohol and substance misuse disorders.

For further information on dementia, please see the JCP guide on commissioning dementia services<sup>9</sup>, as well as the resources listed on page 17.

## Who should receive old age services?

The Royal College of Psychiatrists has suggested needs-based criteria, outlining for which people the interventions provided by older people's mental health services would be most relevant. These are outlined below:

- people of any age with a *primary* dementia
- people with mental disorder and *significant* physical illness or frailty which contribute(s) to, or complicate(s) the management of their mental illness – exceptionally this may include people under 60
- 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<sup>22</sup>.

## How are old age services provided?

Older people's mental health services typically provide a community-based (i.e. seeing a substantial proportion of patients at home) multidisciplinary model. Such models are particularly useful for people who are frail or cognitively impaired and cannot easily travel to hospital or other settings. Furthermore assessing and following-up people at home provides far better scope for accurate assessment and clinical and risk management.

Access to crisis services and inpatient units that are specific to the needs of this population is also important.

## Who works in old age services?

Community mental health teams and ward-based inpatient services need to include a range of health and social care professionals. Table 1 shows the professional groups and their primary roles.

## What are older people's mental health services? (continued)

<b>TABLE 1</b>	
<b>PROFESSION</b>	<b>ROLE</b>
<b>Nurses</b>	Inpatient physical and psychiatric nursing care, community assessments and interventions, care coordination, Mental Health Act / Mental Capacity Act assessments, nurse prescribing. Clinical leadership, initial assessment; ongoing assessment; support planning, follow-up; care programme approach (CPA) coordination/case management; discharge planning.
<b>Consultant Psychiatrists</b>	Mental Health Act / Mental Capacity Act assessments, complex assessments and interventions, prescribing, supervision and advice to team members. Clinical leadership; initial assessment; advice on difficult clinical issues; monitoring of team function (including metrics). Minimal role in follow-up. Ensuring seamless transition when junior medical staff change.
<b>Other doctors</b>	Initial assessment; ongoing assessment, specialist assessment/management follow-up advice on difficult clinical issues and diagnosis.
<b>Psychologists</b>	Clinical leadership; initial assessment; specialist assessment and management follow-up; discharge planning. CPA co-ordination/case management of complex cases. Will be involved with a range of psychological interventions based on the initial formulation and activities, including neuropsychological assessment and rehabilitation; from face-to-face client work with individuals and families, group work, Mental Capacity Assessments. Co-working, skills-sharing, teaching, working with practice development facilitators, supervision, audit, research and service developments.
<b>Social workers</b>	Initial assessment; ongoing assessment, specialist assessment/management follow-up; CPA coordination, discharge planning, safeguarding, Mental Health Act assessments.
<b>Support workers</b>	Physical health care; therapeutic interventions; monitoring role functioning; providing emotional and practical support; encouraging social participation.
<b>Occupational therapists</b>	Initial Assessment; specialist assessment/management follow-up; CPA coordination; discharge planning.

Note: this is not an exhaustive list and some services may also include other professionals including speech and language therapists and physiotherapists.

# Why are older people's mental health services important to commissioners?

## 1 People are living longer, including older people

In 1901, there were just over 60,000 people aged 85 and over in the UK. Today there are 1.5 million, a 25-fold increase<sup>23</sup>.

In 2008, there were 18.3 million people aged 60 and older in UK. By 2033, the number of people in the UK aged 75 and over is projected to increase from 4.8 million to 8.7 million. For those aged 85 and over, the projected increase is from 1.5 million in 2011 to 3.3 million in the same period<sup>24</sup>. The number of people in care homes is projected to rise from 345,000 in 2005 to 825,000 in 2041<sup>25</sup>. As a result of this demographic change public expenditure on long-term care is projected to rise by more than 300% in real terms over that period<sup>24</sup>.

This demographic change is not a new phenomenon; it has been widely reported and plotted in recent years, including in the Dilnot report<sup>23</sup>. It will require commissioners to consider carefully the consequences of an ageing population.

## 2 Older people are disproportionately high users of health and social care services

Although age-related decline in mental wellbeing should not be seen as inevitable, older people form the majority of people using health and social care services. We know that mental health problems increase with age, for example, dementia affects over 5% of those aged over 65 years and 20% over 80 years<sup>26,27</sup>. Moderate to severe depression occurs in 3-4% of the older adult population<sup>28</sup>. The highest prevalence of depression is found in those over 75<sup>29</sup>. Indeed, contrary to some perceptions, the majority of the morbidity in older people is not dementia, but other

functional illnesses such as depression and psychosis though these can, and frequently do, co-exist with dementia.

Historically older people were at greater risk of suicide, but more recent data suggests a similar risk compared to younger adults<sup>30</sup>. A suicide attempt in an older person is more likely to be successful than in younger people, and must never be dismissed. Expert advice should be sought on all cases.

When it goes untreated, depression shortens life and increases health and social care costs<sup>31</sup>. It is a leading cause of suicide among older people. Depression, pain and physical disability are all associated with suicide. When older people are treated for depression, quality of life improves<sup>32</sup>. Higher suicide rates may not be a characteristic of old age depression but rather a consequence of a failure to diagnose and treat it.

There are significant co-morbidities with a range of physical health needs. For example, 50% of people with Parkinson's disease suffer depression<sup>33</sup>, 25% following stroke<sup>34</sup>, 20% with coronary heart disease<sup>35</sup>, 24% with neurological disease and 42% with chronic lung disease<sup>36</sup>. Depression is often difficult to diagnose and treat in these groups and requires sustained, expert management.

The impact of older people's mental health needs is therefore wide ranging, having an effect not only on the person themselves, but also on their family, friends and carers. The demand for services is likely to increase given the predictions of demographic changes and higher prevalence.

This will mean that commissioners and providers will continue to face the challenge of providing high quality specialised services, to a larger number of people, and within a more constrained economic environment. This will challenge

existing funding priorities for both health and local authority commissioners. They will need to consider the potential in terms of effectiveness and efficiency from joined-up, integrated services including developing partnership models that enable older people and their carers to manage their long-term conditions better.

## 3 Older people and public mental health

Older people's mental health is now recognised as a significant public health issue. The wider relationship of mental health and physical health problems and ageing upon an individual is clear:

- ageism and other forms of age and mental health related discrimination and stigma
- social isolation and loneliness – maintaining relationships with friends and family
- financial difficulties
- access to affordable, safe and secure housing
- fuel poverty
- difficulties with tasks of daily living such as cooking, cleaning, personal hygiene etc
- poor mobility
- physical illness and frailty.

Older people with high support needs place particular value on:

- personal relationships
- support/good relationships with carers
- self-determination/involvement in decision-making
- social interaction
- good environment/home
- getting 'out-and-about'
- information about services and help available
- financial resources<sup>37</sup>.



## Why are older people's mental health services important to commissioners? (continued)

The NHS Mandate provides a clear driver to assist in addressing some of the challenges that physical and mental health problems bring. It sets out five objectives for the NHS where the Government expects to see improvement:

- helping people live longer
- managing ongoing physical and mental health conditions
- helping people recover from episodes of ill health or following injury
- making sure people experience better care
- providing safe care.

The Mandate also includes some additional objectives in relation to older people and mental health:

- improving standards of care and not just treatment for adults including older people
- better diagnosis, treatment and care for people with dementia
- putting mental health on an equal footing with physical health – this means everyone who needs mental health services having timely access to the best available treatment<sup>38</sup>.

In order to achieve parity of esteem, commissioners will need to strengthen links between physical and mental health professionals, with the aim of benefitting patients by providing more integrated services that can address the twin impacts of mental and physical health issues.

### **Final Report of the Independent Inquiry Into Care Provided By Mid Staffordshire NHS Foundation Trust** (*known as the Francis Report*)

This report was published in February 2013 following Sir Robert Francis QC's public inquiry into the role of the commissioning, supervisory and regulatory bodies in the monitoring of Mid Staffordshire Foundation NHS Trust. The report made 290 recommendations for the NHS and government. Many of the issues investigated related to the care and treatment of older people and issues of discrimination in relation to their care. The Inquiry's main message was that listening to, and understanding, patients must come first, at all levels of the NHS commissioners and providers must work together to ensure the implementation of the relevant recommendations to ensure high quality services that are safe, responsive and effective.

### **Any Qualified Provider/Section 75 regulations**

Although the NHS has traditionally been the predominant provider of older people's mental health services, a number of independent and voluntary sector organisations have played a part in delivering specific services to complement those in the NHS and social care.

'Section 75' regulations place requirements on commissioners to improve the quality and efficiency of services by procuring from the providers most capable of meeting that objective and delivering best value for money<sup>39</sup>. In doing so, commissioners must be aware of the need for boundary-free integration of care pathways between providers to ensure the most seamless service possible.

Specialist older people's mental health services form an intrinsic element of the range of services that should be expected to be available. Where they are adequately invested in, and of high quality, they can achieve good outcomes, not just in mental health, but across the wider health and social system.

# What do we know about current older people's mental health services?

## SERVICE MODELS

*The National Service Framework for Older People*, published in 2001, made specific reference to the need for improvement in services in England. One of its key standards was that older people who have mental health problems should have access to specialist older people's mental health services with integrated social service elements, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them, and for their carers<sup>40</sup>.

*Everybody's Business*<sup>41</sup>, a service development guide, was published in 2005 to improve health and social care practice at the front line. It made clear that older people's mental health spans health and social care, physical and mental health and mainstream and specialist services.

In 2008, the Care Quality Commission found that there was still limited availability of good quality national data in relation to the quality of specialist older people's mental health services<sup>42</sup>. More recent moves to outcomes-based commissioning and performance management have sought to address the gaps in information about how services are performing.

Age is an important personal characteristic enshrined in law. The main tenet of parity of esteem is that all people are entitled to the best care available, whatever their diagnosis or personal characteristics (such as age or gender). Older people with mental disorders are entitled to have their care and treatment managed by professionals who have specific expertise in that area. This principle is supported by NICE, the Department of Health, the Royal College of Psychiatrists, and the British Psychological Society.

Due to differences in the nature of treatment and care needs of older people with mental health problems, and differences in what having mental health problems can mean to different age groups, older people often have different care and treatment needs from younger people with mental health problems. Meeting the complex needs of older people requires specific professional skills and an awareness of the social, familial and historical context to which that person belongs. In addition, services have to be structured in such a way that they can respond to this complex mix of social, psychological, physical and biological factors<sup>43</sup>.

*No Health without Mental Health*<sup>6</sup> expects services to be age-appropriate and non-discriminatory. A recent trend of merging old age and adult services potentially risks breaching the Equality Act by causing indirect discrimination and reducing patient choice (see page 17 for resources on addressing this risk).

Older people should not be precluded from accessing services provided for adults of working age where it can appropriately meet their needs. It is essential that services sensitive to different needs continue to be provided, and that specialist older people's mental health services (who have unique expertise in meeting a particular set of needs characteristic of later life) continue to be provided comprehensively in all commissioning areas<sup>44</sup>.

The expertise of older people's mental health services lies in the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems usually relating to ageing. Although not restricted to older people, the presence of an increasing number of these domains in an individual is characteristic of the mixture of problems associated with the ageing process. Specialist old age services are best equipped to diagnose and manage mental illness in our ageing population.

## Investment

In common with all public services, the NHS is operating within a more constrained financial environment. Twenty billion pounds of savings must be made by 2015 through a range of measures grouped under the heading of Quality, Innovation, Prevention & Productivity (QIPP). All commissioners are seeking to ensure that financial resources are deployed to deliver effective, outcome-based services that provide value for the public purse.

Investment in older people's mental health has never had parity with adult services, and if reductions are applied equally will be further disadvantaged. Nationally older people's services are currently underfunded by as much as £2.3 billion compared with services for younger adults<sup>45</sup>.

The most recent audit of investment in older people's mental health services was published in August 2012. This showed that the total reported overall cash investment in older people's mental health services fell by 1% from £2.859 billion in 2010/11 to £2.830 billion in 2011/12.

Taking inflation into account, the overall real term investment in older people's mental health services fell by 3.1% from £2.921 billion in 2010/11 to £2.830 billion in 2011/12<sup>46</sup>. This is a significant shortfall given the pre-existing funding gap, and is made worse by the fact that these reductions have taken place against a backdrop of rising demand for services.

The national investment per weighted head of population for 2011/12 was £341. Investment within Strategic Health Authorities (now disestablished) varied between £269 and £483 investment per weighted head<sup>45</sup>.

## What do we know about current older people's mental health services? (continued)

Given the fall in investment, the acceptance of the need for specialised services and rising demand means that in future, targeted investment and development is required for older people's mental health services compared to other mental health specialties. Parity of esteem with adult services remains an ambition that commissioners should be aiming to achieve, working alongside primary care and voluntary sector agencies in order to build service capacity.

### PREVALENT PRESENTING CONDITIONS

- **depression** – depression is common in people over the age of 65. There are currently up to 2.4 million older people with depression severe enough to impair their quality of life<sup>47</sup>. Recognition rates are lower than for younger people and when recognised, fewer than half can expect appropriate pharmacological treatment. Only one third of older people with depression discuss their symptoms with their general practitioner and less than half of these will receive adequate treatment<sup>48</sup>.
- **schizophrenia** – psychosis is common in older people, with 20% of people over 65 developing psychotic symptoms by age 85, and most are not a precursor to dementia<sup>49</sup>. These rates of hallucinations and paranoid thoughts remain high in people of 95 years of age without dementia. Older people with schizophrenia include those who have grown old with the condition and those who have developed the illness in later life. Paranoid ideas and delusions can also occur with a dementing illness, and people with these needs require care along the same lines as other people with dementia.

- **memory services** – approximately 800,000 people are known to be living with dementia in the UK. This is expected to almost double within 30 years, and only 40% of cases of dementia are currently diagnosed<sup>50</sup>. Memory assessment services specialise in the diagnosis and initial management of dementia and are often the single point of referral for people with a possible diagnosis of dementia<sup>51</sup>. Ideally these services should be multidisciplinary and include pre-diagnostic counselling and post-diagnostic support for the person with dementia and their family, including psychosocial interventions as well as monitored medication, if required. The RCPsych and Memory Services National Accreditation Programme resource outlining standards for memory services assessment and diagnosis is a valuable tool for commissioners to refer to<sup>52</sup>.
- **working with carers** – older people with mental health problems may have an increased requirement for care. This is often provided by family carers, the majority of whom are old themselves<sup>41</sup>. It is estimated that up to 1.5 million people care for someone with a mental health problem. Thirty percent of carers will suffer from depression at some stage, and carer breakdown has been found to be a major trigger for long-term care<sup>53,54</sup>.

The mental health and wellbeing of carers is therefore paramount in the aim of maintaining older people in the community for as long as possible. Carers want to have:

- information
- respite
- emotional support
- support to care and maintain their carers own health
- a voice<sup>55</sup>.

## 4. Demand and capacity

The rising number of older people in the population is likely to result in an increasing demand for the whole range of health and social care services.

Commissioners will need to work closely with public health colleagues in local authorities to ensure robust Joint Strategic Needs Assessment (JSNA) and demand modeling so that provision can be appropriately developed to address the rising need for services. These JSNAs need to consider data and outcomes for older people's mental health, and not data aggregated simply for mental health with no accompanying age information.

# What would a good older people's mental health service look like?

In considering what a good service might look like, there are some key principles that should underpin commissioning activity:

- older people and their carers should be able to access general and mental health promotion and education services, and information from community access points, through primary care to acute inpatient and continuing care. All should work to promote the social inclusion and independence of older people with mental health difficulties.
- the expertise of older people's mental health services lies in the care and treatment of people with complex mixtures of psychological, cognitive, functional, behavioural, physical and social problems usually related to ageing.
- older people and their carers need to feel heard, safe, engaged and respected. Services should promote and maximise opportunities for co-production. Commissioners need to meaningfully consult and involve older people, including those with mental illness and their carers in the development and planning of local services. Carers must be recognised and engaged with as partners in care delivery, as well as people who have needs of their own.
- a good service will have a strong values base. In particular, it should draw on the recently published Nursing Vision which emphasises person-centred approaches (the six C's: compassion, courage, communication, competence, care and commitment)<sup>56</sup>.
- choice should be a key element in service delivery for older people with mental health problems. The right to choice will take effect from April 2014 and commissioners should plan for this. People who are detained under the Mental Health Act will not be entitled to use the provisions of the choice policy.
- a good service will recognise that alongside specialist provision, colleagues in primary care do most of the work to support people with mental health problems, given that the majority of people with a mental health problem are seen in primary care only. Working in partnership with primary care must be seen as a central part of the way in which specialist services operate.
- services must be commissioned on the basis of need and not age. Older people are as entitled as any other group to high quality age-appropriate services. Services should ensure the same standard of care as services for younger people, including speed of response and choice<sup>57</sup>. These should be delivered in a timely way and provided comprehensively by teams of professionals specifically trained and qualified in the management of older people with the right range of knowledge and expertise in teams specifically commissioned for older people's mental health. The workforce should have equal access to high quality training in appropriate interventions.
- older people's mental health services need to be integrated with social care services. Integration is a single system of needs assessment, commissioning and/or service provision that aims to promote alignment and collaboration between the care sectors<sup>58</sup>.
- older people's mental health services need to provide care in a seamless way. There need to be clear pathways to avoid people falling between service criteria boundaries across:
  - specialist community physical health teams for older people
  - memory services
  - crisis intervention services
  - acute hospitals
  - residential care.
- staff across all health and social care organisations working with older people should have skills in recognising and caring for mental health needs, and in working with specialist mental health services.
- older people whether living independently, or in differing forms of supported, residential or nursing home accommodation, who are in need of mental health assessment or intervention should have access to intermediate and inpatient care services. These should include a full range of evidence-based psychological, social, medical and personal care interventions delivered in a culturally sensitive manner and aiming to support the individual in the most independent living circumstances possible.
- an effective older people's mental health service requires a managed network of services across a wide spectrum of care, and the exact components of the care pathway provided should be determined by local need. This need should be established through a Joint Strategic Needs Assessment that can help to determine the range of services and providers that should be in place. These could comprise:
  - information services
  - psychological interventions
  - liaison services in general hospitals
  - community-based teams
  - inpatient services.
- a good service should provide comprehensive psychiatric, psychological and social input to older people. Adequate inpatient, memory clinic and community-based teams should form the central elements of the services, complemented by a clear presence in general hospitals, primary care and care homes.

## What would a good older people's mental health service look like? (continued)

- a good service will support the development of diagnostic and management skills among GPs and act as a learning resource for practice teams, through use of attached staff, regular case reviews and readily accessible advice from senior staff.
- a good service must be appropriately and permanently staffed to allow safe, effective management in all locations in which old age mental health services are delivered.
- a good service needs to provide continuity of care for an older person, no matter what their diagnosis, needs or location might be. It will be well integrated, with no need for formal cross-referral between disciplines or agencies.
- a good service will engage in shared planning and management of an older persons needs with colleagues in medicine for old age, colleagues normally working with younger adults, and those working in sub-specialities such as substance misuse, learning disabilities, forensic psychiatry and medical psychotherapy.
- a good service will plan and respond appropriately to demographic and cultural changes in the population.

### Putting principles into practice

To achieve this, commissioners should consider commissioning a range of services to meet the needs of older people, including:

- preventive public health interventions
- support and engagement with families and carers
- provision of psychological therapies that is equitable with those for adult services
- provision of acute hospital liaison services
- services that are delivered in both community and inpatient settings
- memory assessment services
- specialist mental health assessment, diagnosis and intervention services for older people that are distinct from those for younger adults.

### Using the right levers

Commissioners should make use of the range of levers available to create and improve local services. These include CQUINs, as well as contract and service specifications. Detail of these can be found on the JCP-MH website ([www.jcpmh.info](http://www.jcpmh.info)).

### Community-based services

Co-morbidities or multi-morbidities are the *norm* in later life. A multi-agency and multi-professional approach is key to identifying and intervening early in high-risk situations where there are vulnerable people and unsupported carers under high levels of stress.

Community Mental Health Teams (CMHTs) for older people are regarded as pivotal to the delivery of an integrated service<sup>59</sup>. Delivering services through multidisciplinary CMHTs ensures that the needs of local communities are both at the forefront of service provision, and creates a service identity that can be easily recognised and accessed by patients and referring agencies. CMHTs provide continuity, and are often the lynchpin, providing coordination between other services within mental health (inpatient wards, hospital liaison, memory services) and beyond (acute geriatric medicine, Improving Access to Psychological Therapies – IAPT).

The multi-agency, multidisciplinary team membership can harness local expertise, knowledge and skills, and enable the team to network with those other relevant services that may need to be engaged in the individual care plan (e.g. housing and leisure). A single team approach to delivering services will streamline referral sources and use common assessment and care planning processes that will improve access and continuity.

The JCP-MH has also published resources for commissioners on community mental health services and acute care for adults of working age which can be accessed via [www.jcpmh.info](http://www.jcpmh.info)

It is important to state that the range and scale of challenges that older people with mental health needs and their families and carers face, means that continuity of care usually remains with the GP. Specialist services should provide support, information and advice, including education sessions not only to the patient and their carers, but also to other professionals, including those in primary care.

### Crisis resolution and home treatment

Crises amongst older people arise for different reasons than in working age adults, and intensive support may be required for longer, particularly where a person is living alone. Service configuration needs to be able to respond in these circumstances.

This guide supports the development and delivery of crisis resolution and home treatment, providing that the service can be delivered solely or in part by people with specific expertise in the problems faced by older adults.

### Psychological services

Specialist psychological (or *talking*) therapy services for older people aim to alleviate psychological distress and promote psychological wellbeing and health of older people with mental health problems and their families and carers.

People with mental health problems consistently place access to psychological therapies as an unmet need, both in early and later stages of the care pathway.

The term *talking therapies* can cover a wide range of models such as: psychodynamic, cognitive behavioural, cognitive analytic, systemic, narrative and arts-based

approaches<sup>60</sup>. Multi-professional in nature, these may be provided by psychologists, psychiatrists, nurses, counsellors, social workers and others who have undertaken appropriate training in specific models of psychological intervention.

The effectiveness of psychological (and pharmacological treatments) for older people with mental health problems is well recognised<sup>61</sup>, but these are often not fully provided or funded. Commissioners should explore the fullest range of evidence-based interventions to ensure that local services are able to provide a broad set of services across both community and inpatient settings.

An effective older people's mental health service will include access to psychological therapies across all elements of the services, from primary care (including IAPT) to inpatient wards. In particular, the IAPT programme for older people provides a key means by which to achieve improved outcomes by providing a high quality, measurable preventative service in primary care.

### Inpatient services

Inpatient services remain an integral part of any effective older people's mental health pathway. Sometimes older people will require a period of time in hospital for assessment and/or treatment of complex conditions. It is imperative that commissioners ensure that an adequate number of inpatient beds is available for their local population.

In comparison with working age adults, older people are less likely to have co-morbid substance misuse or personality disorder, but more likely to have significant physical co-morbidity, frailty and some degree of cognitive impairment. Their length of stay is likely to be longer as a consequence.

To ensure the highest standards, this guide advocates that commissioners work with providers to deliver inpatient services that best meet the needs of the local population, but that emphasis is placed on:

- inpatient services that specifically meet the needs of older people and are separate from wards for adults of working age
- where possible, separate ward space for functional and organic disorder
- gender separation guidance for inpatient services being properly applied.

### General hospital settings

Old age liaison should be provided by older people's mental health services, distinct from those provided by adult teams for working age patients (although a single point of referral may be appropriate). The profile of an older person referred to a liaison service from a general hospital is substantially different from that of a younger adult. Deliberate self-harm in older people results in a relatively greater risk of completing suicide. Depression, dementia and delirium are all common, often undetected and will delay rehabilitation, lengthen stay and increase care costs. Effective treatment of psychiatric morbidity in acute hospitals reduces length of stay and care costs<sup>62</sup>.

The Rapid Assessment Interface & Discharge (RAID) philosophy of keeping overall liaison provision as uniform as possible (e.g. single point of referral) has been successful<sup>63</sup> and provides a helpful model for commissioners to consider. The service needs of older people with mental health problems referred from general hospitals is different to that from younger adults. However, old age services providing liaison input will benefit from being co-located with other liaison services.

### Black and minority ethnic (BME) elders

Older people from BME groups who experience mental health problems are now recognised to be one of the most socially excluded groups in our society. Minority ethnic elders are under-represented as users of specialist mental health services, but there is no evidence that elders from black and minority ethnic groups have reduced mental health needs.

This form of social exclusion is not just due to the direct impact of mental illness but is a result of stigma, prejudice and a lack of access to services that could aid recovery amongst this group.

The older BME population is growing fast and was expected to increase by 170% between 2005–2012, according to the *UK Inquiry into Mental Health and Well-Being in Later Life*, a rise that if validated will have been significant and may be sustained. The same inquiry, led by Age Concern (now Age UK), warned that older BME people are among the groups most likely to experience mental health problems<sup>64</sup>. It is clear that older people from ethnic minority backgrounds with mental health problems can potentially face issues of discrimination arising from their age, their sex, their ethnicity and their psychological ill health.

Planning of services for older people from BME groups needs to begin early and there is a need to develop and improve ethnic monitoring and to disseminate evidence of good practice.

## What would a good older people's mental health service look like? (continued)

### Public health commissioning to support older people's mental health

Public health is about improving the health of the population through preventing disease, prolonging life and promoting health<sup>13</sup>. *The Foresight Report* highlighted that “the increasing prevalence of cognitive decline, particularly due to dementia will be critical. However, other mental disorders, notably depression and anxiety will also be important: addressing the relatively poor access of older adults to treatment (compared with younger adults) should be an immediate priority.”<sup>65</sup>

This highlights the need for commissioners to consider the impact of public health commissioning and its relationship to the development of services for older people with mental health problems.

According to the JCP-MH publication, *Guidance for commissioning public mental health services*, public mental health involves:

- an assessment of the risk factors for mental disorder, the protective factors for wellbeing, and the levels of mental disorder and wellbeing in the local population
- the delivery of appropriate interventions to promote wellbeing, prevent mental disorder, and treat mental disorder early
- ensuring that people at ‘higher risk’ of mental disorder and poor wellbeing are proportionately prioritised in assessment and intervention delivery.

Although there is a shortage of robust evidence for the effectiveness and cost-effectiveness of interventions to improve the mental wellbeing of older people<sup>66</sup>, particular interventions to increase social participation, physical activity, continued learning and volunteering can help prevent depression, particularly in older people.

Public health intelligence can assist in decisions about which interventions and services to commission. They must work closely with colleagues in public health in the conducting of Joint Strategic Needs Assessments and the development of commissioning strategies to ensure coherent linkages that will lead to effective and efficient services.

### Housing

Good quality, affordable, safe housing underpins mental and physical wellbeing. Without a settled place to live, access to treatment, enabling recovery and greater social inclusion can be impeded<sup>67</sup>. Housing provides the basis for individuals to recover, receive support and return to an independent life in the community<sup>68</sup>. Mental ill health is frequently cited as a reason for tenancy breakdown<sup>67</sup>, and housing problems are frequently given as a reason for a person being admitted or re-admitted to inpatient care<sup>69</sup> or in delays in leaving hospital.

Support with housing can improve the health of individuals and help reduce overall demand for health and social care services. Specialist housing and housing-related support helps people to live independently in the community, reducing the need for care and preventing poor health. Timely home adaptations and reablement services aid timely discharge and prevent hospital readmissions, helping people to recover their independence after illness<sup>70</sup>.

From specialist housing through to accessible general housing, dementia care services through to handyperson services, commissioners must ensure a full range of care and accommodation solutions are offered to enable independence for longer<sup>71</sup>.

### Long-term conditions commissioning to support older people's mental health

People with long-term conditions frequently have more than one condition. Around half of this population will have more than one major health problem, and around a quarter will have three or more problems<sup>72</sup>, with the chances of having more than one problem increasing with age. As people grow older, their health needs become more complex, with physical and mental health needs frequently being inter-related and impacting on each other. Examples include:

- both physical and mental health difficulties can affect an individual's ability to care for themselves independently, and potentially have major implications for their way of life – for example, surveys indicate that 25% of people receiving home care services are depressed<sup>73</sup>.
- physical health difficulties can both contribute to, and be compounded by, depression and anxiety, as well as acute and chronic confusion. Conditions associated with chronic pain, and those leading to the loss of independence, and possibly the loss of the family home if a move is necessary, are commonly associated with depression.
- a person's ability to look after their own health, by taking a good diet, keeping active both mentally and physically, managing medication correctly and co-operating with treatment, can be adversely affected by depression or dementia.
- many older people receive multiple types of medication. Any medication has the potential to cause adverse effects as well as benefits. Any new or changed treatment to help a physical condition can lead to, or worsen, mental health problems. Similarly, treatment for mental health problems can adversely affect physical health in vulnerable older people.

- people with diagnosable physical illnesses, especially chronic or recurrent conditions commonly show higher rates of mental health problems than the general population. Recovery from, or the management of, for example diabetes and coronary heart disease can be compromised as a consequence of mental health problems, especially depression<sup>74</sup>.
- rates of depression in severe and chronic diseases can be high. It has been shown that up to 60% of people who have suffered a stroke can be depressed, up to 40% of people with coronary heart disease, cancer, Parkinson's Disease and Alzheimer's can also be suffering from depression<sup>75</sup>.

### Personal health budgets and personalisation

A personal health budget is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between the person and their local NHS team. The vision for personal health budgets is to enable people with long-term conditions and disabilities to have greater choice, flexibility and control over the health care and support they receive<sup>76</sup>. Direct Payments are intended to create greater flexibility in the use of social care budgets, giving greater control to people who use services and enabling them to determine the nature and provision of their care. Older people and their carers, especially those living with dementia, may need support from the specialist team to use and manage personalised budgets for themselves.

These payment systems introduce the requirement for greater personal responsibility, and for individuals to use their own resources, as well as the chance for the NHS and social care to continue to reshape

their approach to both the commissioning and delivery of care services. Commissioners will need to be mindful of the increasing use of personal health budgets and direct payments when developing local strategies for service change and development, and work to overcome potential barriers for older people.

### Technology

Information technology is having an increasing impact on the delivery of mental health services to older people. The IAPT programme has shown that computerised CBT (cCBT) programmes can be used effectively by older people if they are well supported in the first instance to gain confidence in the use of the technology and materials<sup>77</sup>.

Similarly, telephone therapy and email follow-up sessions work well, provided the person and their therapist have had some initial face-to-face meetings. This can reduce need for outpatient appointments not only for therapy but also for memory clinic settings. This can de-stigmatise and normalise contact with mental health professionals and reduce anxieties about travel. It needs to be offset against the positive gains from face-to-face contact in terms of relationship building and reduction of social isolation. Although the evidence for use of telehealth and telecare is somewhat equivocal, as seen in the 'Whole System Demonstrator' site review conducted by the Nuffield Trust<sup>78</sup>, commissioners will need to explore the ways in which technology can assist in the provision of effective and responsive services.

## Special Settings

### Care homes

Depression occurs in 40% of people living in care homes and often goes undetected<sup>79</sup>. Very few care homes provide solely for the care of older people with mental health problems which are not dementia. Usually people with mental health problems are particularly isolated in the care home setting. The special needs of those in care homes need to be recognised in a commissioning process. In particular, training care staff to identify possible symptoms of depression can improve detection<sup>80</sup>. The National Mental Health Development Unit produced a resource, 'Let's Respect' which is primarily aimed at staff working in care homes who want to know about the mental health needs of older people in order to improve practice and standards of care<sup>81</sup>. It can be accessed at: [www.nmhd.org.uk/silo/files/lets-respect-toolkit-for-care-homes-.pdf](http://www.nmhd.org.uk/silo/files/lets-respect-toolkit-for-care-homes-.pdf)

### Prisons

Although the current old age population in prisons is small, sentencing policy over the last two decades will ensure that it will rise. The physical health of prisoners is poorer than the general population and they are more prone to vascular disease<sup>82</sup>. Depression and dementia are both more common in the older prison population. Commissioners of services need to recognise this in their local planning and development.

### Learning disability

Mental health problems are more common in this group than the general population. Although transition arrangements will be required for people who have been in contact with learning disability services throughout their life, service provision is required for the minority of learning disabled people who develop mental health problems for the first time in old age.



# Supporting the delivery of the mental health strategy

The JCP-MH believes that commissioning which leads to good older people's mental health services as described in this guide will support the delivery of the *No Health without Mental Health* strategy in a number of ways as set out below:

**Shared objective 1:  
more people will have good mental health**

Commissioning effective older people's mental health services will enable the identification of associated mental health problems and ensure access to appropriate assessment, diagnosis treatment and support.

**Shared objective 2:  
more people with mental health problems will recover**

Improved older people's mental health services will ensure that older people with mental health problems have their needs met so that their quality of life, choices and independence are enhanced.

**Shared objective 3:  
more people with mental health problems will have good physical health**

Ensuring the provision of effective older people's mental health services will enable those people who have co-morbid mental health problems to have their physical health needs properly assessed and treated. The identification of these needs and action to address them will result in improved physical health.

**Shared objective 4:  
more people will have a positive experience of care and support**

Older people are disproportionately higher users of health and social care. Good quality services, and especially ones that integrate and support the other health and social care services, will have a positive impact in improving people's experience of care and support.

**Shared objective 5:  
fewer people will suffer avoidable harm**

Depression in older people remains a significant issue. Effective diagnosis and treatment is likely to have a positive impact on levels of self-harm and suicide.

**Shared objective 6:  
fewer people will experience stigma and discrimination**

In the commissioning and provision of older people's mental health services it is essential to avoid both direct and indirect age discrimination.

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### Development process

This guide has been developed by a group of older people's mental health experts, in consultation with patients and carers. Each member of the Joint Commissioning Panel for Mental Health received drafts of the guide for review and revision, and advice was sought from external partner organisations and individual experts.

Final revisions to the guide were made by the Chair of the Expert Reference Group in collaboration with the JCP's Editorial Board (comprised of the two co-chairs of the JCP-MH, one user representative, one carer representative, and technical and project management support staff).

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He has held operational and strategic posts in local authorities and the NHS, with a specialist interest in the health, housing and social care needs of people with mental health problems, substance misuse needs, learning disability, older people and offender health.

## Resources

Department of Health –  
Dementia Challenge  
<http://dementiachallenge.dh.gov.uk/>

National Development Team for Inclusion (NDTI): resources on achieving age equality in mental health services  
[www.ndti.org.uk/publications/ndti-publications/a-long-time-coming](http://www.ndti.org.uk/publications/ndti-publications/a-long-time-coming)

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