Cambridgeshire

Joint Strategic Needs Assessment (JSNA)

OLDER PEOPLE'S MENTAL HEALTH

2014

This report was commissioned from Solutions for Public Health (SPH) by the Public Health Team, Cambridgeshire County Council. The contents are based upon the work undertaken by SPH, with support and contributions from the Cambridgeshire Adult and Older Peoples Mental Health JSNA Steering Group and editorial amendments and additions made by the Public Health Team at Cambridgeshire County Council.

April 2014

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1. Executive summary

This joint strategic needs assessment reviews the mental health needs of older people in Cambridgeshire, with a particular focus on dementia and depression. It is important to be clear about the differences between mental wellbeing (or general mental health), and mental illness. In this document we refer to both using the definitions below:

Mental wellbeing (or mental health): There are many different definitions of mental wellbeing but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems.

Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities eg dementia, depression, anxiety, and schizophrenia.

Over a third of older people in the UK are likely to experience mental health problems. Depression and anxiety are the most common conditions, followed by dementia. Other less common conditions include delirium (acute confusion), schizophrenia, bipolar disorder, personality disorder and autism, alcohol and drug (including prescription drug) misuse; this needs assessment focuses primarily on depression and dementia.

Dementia is a group of related symptoms associated with an ongoing decline of the brain and its abilities. This includes problems with memory loss, thinking speed, mental agility, language, understanding and judgement. People with dementia can become apathetic or uninterested in their usual activities, and have problems controlling their emotions. They may also find social situations challenging, lose interest in socialising, and aspects of their personality may change. A person with dementia may lose empathy (understanding and compassion), they may see or hear things that other people do not (hallucinations), or they may make false claims or statements. As dementia affects a person's mental abilities, they may find planning and organising difficult. Maintaining their independence may also become a problem. A person with dementia will therefore usually need help from friends or relatives, including help with decision making.

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. It affects how one feels, thinks and behaves. It may make it difficult to carry out normal day-to-day activities and make one feel that life is not worth living. Depression and dementia can co-exist and can be difficult to distinguish.

Both conditions, especially when moderate or severe, can reduce markedly the quality of life of those living with the condition. They also affect the family and friends who care for their loved ones. Depression is highly treatable, but the progressive nature of dementia can cause extensive physical, psychological, emotional and financial stresses to those with the condition, their family, carers and the wider community.

This report starts by describing the population of Cambridgeshire, with particular emphasis on the older population and the factors which contribute to mental health problems in that population. It goes on to estimate how many people in Cambridgeshire have depression and dementia, both now and in the future. The report then describes the present pattern of services available in Cambridgeshire for older people with mental health problems, and summarises relevant NICE guidance and reports findings from research about the interventions which, if used early in the course of illness, may reduce its severity. The report then summarises the results of engagement with service users, carers and providers, before setting out some conclusions and key findings.

The difficulties with securing data on NHS activity meant that the report has adopted a qualitative approach. There are also other sources of information which were not available or accessible during this project, and these mean there are limits to the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible therefore to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.

Key Facts

1. The population of Cambridgeshire will age substantially by 2026: the number of people aged over 90 years will more than double, and the number of people in their 80s rise by more than 50%. This will lead to steep rises in the number of older people with dementia and, to a lesser extent, depression.

2. Cambridgeshire's population is more affluent and less ethnically diverse than that of England, but social isolation is no less common. Most risk factors for poor mental health show similar patterns of prevalence across Cambridgeshire, though in some cases the Cambridgeshire population shows a lower risk profile. There are also areas within the county where risk factors are concentrated, such as Fenland.

3. Assuming prevalence rates remain the same as current rates, between 2012 and 2026, the number of older people with depression in Cambridgeshire is expected to rise by 12%, from approx. 11,900 to 13,360. The number of people over 65 years with dementia is expected to rise from 7,400 to 12,100, an increase of 64%. There is forecast to be a 43% increase in the number of older people with learning disability. Increases of this size over a short period will put severe strain on existing services.

4. In Cambridgeshire, many people with depression and most of those with dementia have not been diagnosed and recorded by their primary care teams, which reflects a national trend. This means they cannot receive the treatment and support they need. This suggests that there is unmet mental health need within the population.

5. Cambridgeshire apparently devotes less health service spending per head to mental health than average for England. The Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is relatively under-funded and faces a challenging financial future.

Key findings

1. **Increasing older population**
   - Due to an increasing population there is forecast to be an increase in the number of older people with dementia and, to a lesser extent, depression, within a few years.
   - However, the resources available from statutory agencies, for health services given the current financial restraints, will at best remain the same, requiring the development of new service models to meet need. A holistic approach is vital.

2. **Risk factors for depression and dementia**
   - Older people's mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers.

- Mental health needs interact in complex ways with long-term physical health problems. Adults with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems.
- Evidence-based guidelines from NICE recommend reviewing and treating vascular and other risk factors for dementia in middle-aged and older people. These include smoking, excessive alcohol use, obesity, diabetes, hypertension and raised cholesterol levels.
- NICE are also currently developing two relevant pieces of public health guidance: the first, due to be published in February 2015, focuses on mid-life approaches to prevent or delay the onset of disability, dementia and frailty in later; the second, due for publication in November 2015, considers independence and mental wellbeing (including social and emotional wellbeing) for older people.

3. **Diagnosis and assessment**
   - There is apparent widespread under-diagnosis of depression in primary care. Rates of diagnosis also vary between practices for unexplained reasons. Depression is a distressing, but highly treatable condition, so improvement in rates of diagnosis is important.
   - Dementia is also under-diagnosed in primary care, with unexplained variation in rates of diagnosis and prescribing. Early diagnosis means that patients and carers can receive appropriate information and support, so ensuring the condition is recognised promptly is beneficial.
   - Improving diagnosis in primary care is a priority, as part of an integrated approach and partnership working, to improve awareness of mental health needs in the community.

4. **Current spending**
   - The NHS in Cambridgeshire apparently spends 18% less per head on mental health services than the average for England. It is, however, less well funded than average. This information is based on programme budgets, and differences in budgetary definitions and coding behaviour may underlie these findings. More analysis of the reasons for the differences would be of value.

5. **Current service provision**
   - The JSNA full report describes acute and community mental health services available for older people and details three local clinical pathways for ‘Functional mental illness’ (includes depression, anxiety, bipolar affective disorder, psychosis, personality disorder); ‘Memory assessment’; and ‘Complex dementia’. Training programmes to raise awareness of dementia are in place across primary care, community and acute settings. Local support services are also provided by the Alzheimer’s Society and Mind. These are jointly commissioned by the CCG and Cambridgeshire County Council (CCC) and are also described in more detail in the full report.
   - There is substantial variation in the rate of referrals to the older people’s mental health service, with lower rates seen in South Cambridgeshire, and higher rates in Cambridge City, Fenland and East Cambridgeshire. The reasons for this variation are unclear, and may relate to data quality problems, but it would merit further investigation.

- No information on activity levels and expenditure patterns, by the main NHS mental health service provider in Cambridgeshire, was available within the timescale of this report. This impedes service planning and evaluation by commissioners and limits the extent to which patterns of service delivery can be reported and analysed. The routinely collected anonymised national minimum dataset should be available in a timely and accessible format to providers and commissioners of mental health services.
- There are other sources of information which were not available or accessible during this project, and these limited the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible, therefore, to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.
- The current re-procurement of older people's services is expected to lead to improvements in mental health services for older people. The re-procurement process will involve clarifying what mental health services for older people are available, where and to whom.

6. **National guidance and evidence on provision of services and standards**
   - National guidance in the form of Clinical Guidelines and Quality Standards published by NICE describe, in detail, what patients should receive from the NHS and social services.
   - A review of the evidence did not find any reliably evaluated early interventions for mental health disorders in older people that were not included in existing NICE guidance.
   - Existing service specifications from commissioners describe what should be available from NHS mental health services. The extent, to which national guidance and local service specifications are followed, in practice, was not reviewed as part of this JSNA. This could form part of a future work programme.

7. **Stakeholder feedback**
   - The main concerns of service users and carers reported to us were:
     - Service delivery
     - Organisational challenges
     - Coordination of services
     - Safeguarding of vulnerable people
     - Access to services
     - Transition between services
     - Continuity of relationships
     - Culture and equity
     - Physical health and mental health
     - Carers' needs.
   - Service improvement ideas from service users and carers, included more help with practical things, such as maintaining relationships, applying for benefits, and a focus on the positives rather than the diagnosis. Community support, and signposting for where to go for help, ideas or friendship were also considered important. Information and training for families and carers as well as those with mental health disorders, and seeing the same health professional consistently were also suggested.

8. **Further information**
Building on the findings of this JSNA, further work may be useful to:

- Establish the activity and cost levels at the main NHS mental health provider;
- Review the validity of the apparent low levels of NHS spending on mental health in Cambridgeshire;
- Audit the extent to which NICE guidance is followed and understand gaps in mental health service provision for older people;
- Investigate the apparent variation in referral rates to the older people's mental health service.

2. Introduction

This section sets out the purpose of this report, describes the nature of the mental health problems considered, provides context to the report and outlines the structure of the rest of the document.

This needs assessment reviews the mental health needs of people over the age of 65 years with dementia, depression or functional mental illness[1] living in Cambridgeshire. It is important to be clear about the differences between mental wellbeing (or general mental health), and mental illness. In this document we refer to both using the definitions below:

Mental wellbeing (or mental health): There are many different definitions of mental wellbeing but they generally include factors known to promote mental health such as: life satisfaction, optimism, self-esteem, mastery and feeling in control, having a purpose in life, and a sense of belonging and support. Good mental health is not simply the absence of diagnosable mental health problems, although good mental health is likely to help protect against the development of many such problems.

Mental illness or disorder: Mental illness or disorder refers to a diagnosable condition that significantly interferes with an individual's cognitive, emotional or social abilities eg dementia, depression, anxiety, and schizophrenia.

The aim of this JSNA is to assess whether services for people with dementia and other major mental health problems in older people are meeting current and future need.
Its objectives are to:

- Identify the prevalence of risk and protective factors for mental wellbeing.
- Identify the prevalence of common mental health conditions.
- Identify the assets and current service provision for mental health for older people in Cambridgeshire.
- Engage with service users and carers to explore the patient perspective of existing services and assets, to understand whether services are accessible and appropriate.
- Quantify local activity and spending on treatment of mental disorders in older people.
- Identify evidence-based approaches to prevention and early intervention.

Over a third of older people in the UK are likely to experience mental health problems. Depression and anxiety are the most common conditions, followed by dementia. Other less common conditions include delirium (acute confusion), schizophrenia, bipolar disorder, alcohol and drug (including prescription drug) misuse.[2]

Depression is a mood disorder that causes a persistent feeling of sadness and loss of interest. It affects how one feels, thinks and behaves. It may make it difficult to carry out normal day-to-day activities and make one feel that life is not worth living.

Dementia is a syndrome characterised by impaired cognitive functioning. It is a syndrome due to disease of the brain, usually of chronic or progressive nature, in which there is disturbance of multiple higher cortical functions, including memory, thinking, orientation, comprehension, calculation, learning capacity, language and judgement. The impairments of cognitive function are commonly accompanied, and occasionally preceded, by

[1] Functional mental illnesses are those not known to result from a structural brain abnormality.
[2] Healthcare Commission, *Equality in later life: a national study of older peoples mental health services*, 2009. Available at: http://lx.iriss.org.uk/sites/default/files/resources/equality_in_later_life.pdf

deterioration in emotional control, social behaviour or motivation.[3] Depression and dementia can co-exist and can be difficult to distinguish.

Both conditions, especially when moderate or severe, can reduce markedly the quality of life of those living with the condition. They also affect the family and friends who care for their loved ones. Depression is highly treatable, but the progressive nature of dementia can cause extensive physical, psychological, emotional and financial stresses to those with the condition, their family, carers and the wider community.

Older people are also affected by other mental health problems, but most of the impact at population level arises from dementia and depression, so it is on those conditions that the report is focussed.

2.1. National context and policy drivers

In 2012, around 800,000 people in the UK were living with a form of dementia. More than 17,000 of them were under 65. Around 11,500 were from black and minority ethnic groups. Family and friends were acting as primary carers for about 670,000 people. The cost of dementia is £23 billion a year to the NHS, local authorities and families. This is estimated to grow to £27 billion by 2018, as the number of people with dementia increases.[4]

There is a range of national policy drivers which support and provide a context for local strategies. The important policy driver was the *National Service Framework (NSF)*[5] published in 1999 by the Department of Health. The NSF was a ten-year programme designed to set consistent and measurable standards for the delivery of mental health care across England and Wales and the framework within which health and social care services were required to work.

In later years, the previous Government's mental health policy became more focused on themes which promoted social inclusion and the individual's engagement with their communities and working life, and which challenged inequality and stigma. At the end of ten years the NSF was replaced by *New Horizons: A Shared Vision for Mental Health,*[6] published in December 2009**.** *New Horizons* was a cross-government programme of action to improve the mental health and wellbeing of the population. It aimed to:

- Improve the mental health and wellbeing of the population.
- Improve the quality and accessibility of services for people with poor mental health.

New Horizons describes factors that affect wellbeing and some everyday strategies for preserving and boosting it. It also sets out the benefits, including economic benefits, of doing so.

Following the formation of the Coalition Government in May 2010, it became clear that *New Horizons* was not to be fully implemented and the Government announced that it would introduce a replacement mental health strategy that built upon the strengths of *New Horizons* but placed a clearer focus on outcomes and greater clarity on delivery. *No Health*

[3] WHO. International Classification of Diseases (ICD) 10. Available at: http://www.who.int/classifications/icd/en/
[4] NICE (2013) *Delaying the onset of disability, frailty and dementia in later life: final scope.* Scope for NICE Public Health Guidance 64. Available at: http://guidance.nice.org.uk/PHG/64/Scope/pdf/English
[5] Department of Health, *National Service Framework for Mental Health*, 1999. Available at: https://www.gov.uk/government/publications/quality-standards-for-mental-health-services
[6] Department of Health, *New Horizons: A Shared Vision for Mental Health*, 2009. Available at: http://www.recoverydevon.co.uk/download/2010-02-04-299060_NewHorizons_acc2.pdf

without Mental Health[7] was published in 2011 and replaces *New Horizons* as the main policy driver for mental health services in England.

The strategy is supported by a series of documents, including the economic case for improving efficiency and quality in mental health, an outcomes paper, a four-year action plan, to improve access to talking therapies and an impact assessment. The overall aims of the strategy are to improve outcomes for people with mental health problems, to improve the mental health and wellbeing of the population and to keep people well.

The aims and principles are underpinned by six high-level mental health objectives:

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

Each objective is supported by a series of actions. *No Health without Mental Health* is described as a cross-cutting and cross-Government strategy linked to the NHS, public health and local authority outcomes frameworks. The Government's cabinet sub-committee on public health will oversee the implementation of the strategy.

Local government will play a central role in ensuring that local partners and partnership arrangements can deliver the shared mental health objectives via the local health and wellbeing boards. The new enhanced role played by local government in delivering public health recognises that mental health is intrinsic to positive health and wellbeing.

No Health without Mental Health: Delivering better mental health outcomes for people of all ages sets out a range of local approaches to improve physical and mental health in older people. They include

- Reducing isolation, support during times of difficulty, and increasing social networks and opportunities for community engagement.[8,9]
- Providing easy access to continued learning.
- Improving support for informal carers.[10]
- Warm homes initiatives.[11]
- Promotion of physical activity and physical health.[12]

The Prime Minister launched the dementia challenge in March 2012. It highlighted three main areas for action: driving improvements in health and care, creating dementia-friendly communities and improving dementia research.

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[7] Department of Health, *The Mental Health Strategy for England*, 2011.Available at: https://www.gov.uk/government/publications/the-mental-health-strategy-for-england

[8] Netuveli G, Wiggins RD, Montgomery SM et al. Mental health and resilience at older ages: bouncing back after adversity in the British Household Panel Survey. *Journal of Epidemiology and Community Health* 2008; 62: 987

[9] Pinquart M, Sorensen S. How effective are psychotherapeutic and other psychosocial interventions with older adults? A meta-analysis. *Journal of Mental Health and Aging* 2001; 7: 207-243

[10] Sorensen S, Pinquart M, Duberstein D. How effective are interventions with caregivers? An updated meta-analysis. *The Gerontologist* 2002; 42: 35

[11] Green G, Gilbertson J. *Warm Front, Better Health: Health impact evaluation of the Warm Front Scheme.* Sheffield: Centre for Regional, economic and Social Research, Sheffield Hallam University, 2008

[12] NICE (2008) *Occupational Therapy Interventions and Physical Activity Interventions to Promote the Mental Wellbeing of Older People in Primary Care and Residential Care*. NICE Public Health Guidance 16, available at: www.nice.org.uk/nicemedia/pdf/PH16Guidance.pdf

In May 2013, the first Annual Report of Progress[13] noted that by 2015 the government wanted 'to see significant increases in research funding, diagnosis rates and the number of dementia-friendly communities.'

The improvements described in this report mirror closely the progress reported by the Cambridgeshire and Peterborough Older People's Mental Health Group. These include the recruitment of dementia friends, the implementation of the new enhanced service to reward general practices for more actively assessing patients, who may be showing the early signs of dementia, and rewarding organisations to offer better quality care for people with dementia and their carers through the commissioning for quality and innovation (CQUIN) scheme.

The G8 Dementia Summit in December 2013 brought together G8 ministers, researchers, pharmaceutical companies and charities from around the world to discuss the challenges of improving life and care for people affected by dementia and their carers, preventing and delaying dementia and social adaptation to global ageing and dementia.[14]

There was a collective commitment from all the member states to:

- Set an ambition to identify a cure, or a disease-modifying therapy, for dementia by 2025.
- Significantly increase the amount spent on dementia research.
- Increase the number of people involved in clinical trials and studies on dementia.
- Establish a new global envoy for dementia innovation, following in the footsteps of global envoys on HIV and Aids and on Climate Change.
- Develop an international action plan for research.
- Share information and data from dementia research studies across the G8 countries to work together and get the best return on investment in research.
- Encourage open access to all publicly-funded dementia research to make data and results available for further research as quickly as possible.

2.2. Health service commissioning

In 2007, the Department of Health published its *Commissioning Framework for Health and Wellbeing*, which advocated the provision of services to meet needs, not only the treatment of presenting conditions but also to enable people to maintain healthy and independent lives.

The report said that commissioning had been too focused on volume and price, rather than quality and outcomes, with much service provision being service-led rather than needs-led, and provided at the convenience of providers rather than patients. The needs of patients are now accepted as being central to the NHS.

The framework identified eight steps to effective commissioning which include:

- Putting people at the centre.
- Understanding the needs of populations and individuals.

[13] Department of Health, *The Prime Minister's Challenge on Dementia: Annual report of progress*, 2013. Available at: https://www.gov.uk/government/publications/the-prime-ministers-challenge-on-dementia-annual-report-of-progress

[14] Department of Health news story, Dec 2013. Available at: https://www.gov.uk/government/news/g8-dementia-summit

- Sharing and using information more effectively.
- Assuring high quality providers.
- Recognising the interdependence between work, health and wellbeing.
- Developing incentives for commissioning for health and wellbeing.
- Making it happen – local accountability.
- Making it happen – capability and leadership.

The framework aspired to achieve:

- A shift towards services that are personal, sensitive to individual need and that maintain independence and dignity.
- A strategic reorientation towards promoting health and wellbeing, investing now to reduce future ill-health costs.
- A stronger focus on commissioning the services and interventions that will achieve better health, across health and local government, with everyone working together to promote inclusion and tackle health inequalities.

The NHS England Commissioning framework *Everyone Counts: Planning for Patients 2014/15 to 2018/19*[15] was published in December 2013. The planning guidance seeks:[16]

- Strategic plans covering a five year period, with the first two years at operating plan level.
- An outcomes focused approach, with stretching local ambitions expected of commissioners, alongside credible and costed plans to deliver them.
- Citizen inclusion and empowerment to focus on what patients want and need.
- More integration between providers and commissioners.
- More integration with social care – cooperation with Local Authorities on Better Care Fund planning.
- Plans to be explicit in dealing with the financial gap and risk and mitigation strategies.

The framework states that there is a critical role for clinical commissioning groups and direct commissioners, to work together under the auspices of the local Health and Wellbeing Boards, to promote early diagnosis and better treatment of dementia. A key outcome measure described in the framework is to increase the dementia diagnosis rate to 67% by March 2015. To support this, GPs were asked to sign up to a new Directed Enhanced Service (DES), in 2013, to adopt a proactive case-finding approach to patients at risk of developing dementia, as part of the GP contract for 2013-14.

The framework states that if each Health and Wellbeing Board can determine its local expectation for improved diagnosis of dementia, primary care services can be commissioned in a way that secures improved diagnosis rates while clinical commissioning groups can commission services to reflect the treatment needed. It emphasises that dementia services will be a particularly important priority for better integrated health and social care services, supported by accountable professionals.

[15] NHS England, *Everyone Counts: Planning for Patients 2014-2015 to 2018/2019*. December 2013. Available at: http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf

[16] NHS England. Strategic and Operational Planning 2014 to 2019 webpage. Available at http://www.england.nhs.uk/ourwork/sop/

2.3. Carers

Carers play a vital role in supporting the health needs of adults and older people with mental health disorders. The specific mental health needs of carers and the needs of carers for individuals with mental health needs are outside of the scope of this report, but are the subject of another joint strategic needs assessment devoted to carers. This report recognises that carers can be seriously affected by mental health problems in the people for whom they care.[17] Supporting carers is vital if these patients are to be able to continue to live in the community, which has important implications for the NHS and other statutory organisations.

2.4. Report structure

This report starts by describing the population of Cambridgeshire, with particular emphasis on the older population and the factors which contribute to mental health problems in that population. It goes on to estimate how many people in Cambridgeshire have depression and dementia, both now and in the future. The report then describes the present pattern of services available in Cambridgeshire for older people with mental health problems, summarises relevant NICE guidance and reports findings from research about interventions which, if used early in the course of illness, may reduce its severity. The report then summarises the results of engagement with service users, carers and providers, before setting out some conclusions and key findings.

Needs assessment depends on understanding the present pattern of service use and how resources are directed. For NHS mental health services, the most appropriate source is the mental health minimum dataset, which contains details of each episode of care provided through the NHS, anonymised to protect patient confidentiality. No access to this dataset was possible within the four-month timescale of this project. This report therefore contains no information on the volume or cost of mental health services for older people, apart from some limited activity information from key performance indicators provided by Cambridgeshire and Peterborough Clinical Commissioning Group (CCG).

This JSNA builds on previous JSNA reports and work which relate to mental health and older people. In particular, the mental health of the population of Cambridgeshire is described in the JSNA on 'Mental Health in Adults of Working Age (2010)[18] much of which is relevant to older people. The JSNAs on 'Prevention of Ill Health in Older People (2012)[19] and 'Older People (including Dementia) 2010[20] also include specific sections relating to the mental health of older people.

Information on the use of specialist mental health services by older people in Cambridgeshire and associated costs is collected by age group and presented in the Cambridgeshire JSNA 'Older People Services and Financial Review'.[21]

[17] Available at: http://www.cambridgeshireinsight.org.uk/jsna/carers
[18] Available at: http://www.cambridgeshireinsight.org.uk/currentreports/mental-health-adults-working-age
[19] Available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013
[20] Available at: http://www.cambridgeshireinsight.org.uk/currentreports/older-people-including-dementia
[21] Available at: http://www.cambridgeshireinsight.org.uk/currentreports/jsna-older-peoples-services-and-financial-review

3. Key data: demography, prevalence and spending

This section sets out information about the current and future population of Cambridgeshire, a key determinant of future health needs. It then describes features of the population which contribute to the occurrence of mental health problems, and estimates the current and future numbers of older people with mental health problems.

Summary

The population of Cambridgeshire will age substantially by 2026: the number of people aged over 90 years is forecast to more than double, and the number of people in their 80s to rise by more than 50%. This will lead to steep rises in the number of older people with dementia and, to a lesser extent, depression. Between 2012 and 2026, the number of older people with depression in Cambridgeshire is expected to rise by 39%, from 7,700 to 10,700. The number of people over 65 years with dementia is expected to rise from 7,400 to 12,100, an increase of 64%. There is also forecast to be a 43% increase in the number of older people with a learning disability.

The resources available from statutory agencies for health services, given the current financial restraints, will at best remain the same, requiring the development of new service models to meet need.

A variety of factors are associated with the risk of mental illness. Wider determinants such as deprivation, housing, social isolation and education are described. Cambridgeshire's population is more affluent and less ethnically diverse than that of England, but social isolation is no less common. Most risk factors for poor mental health show similar patterns of prevalence across Cambridgeshire, though in some cases the Cambridgeshire population shows a lower risk profile. There are also areas within the county where risk factors are concentrated, such as Fenland.

Vascular risk factors linked to modifiable lifestyle behaviours are also related to depression and can be risk factors for both vascular dementia and Alzheimer's disease. These include smoking, high cholesterol, hypertension, physical inactivity and obesity. Mental health needs interact in complex ways with long-term physical health problems. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems. Adults with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services.

In Cambridgeshire, many people with depression and most of those with dementia have not been diagnosed and recorded by their primary care teams, which reflects a national trend. Rates of diagnosis also vary between practices for unexplained reasons. This means individuals cannot receive the treatment and support they need. This suggests that there is an unmet mental health need within the population. Improving diagnosis in primary care is a priority, as part of an integrated approach and partnership working to improve awareness of mental health needs in the community.

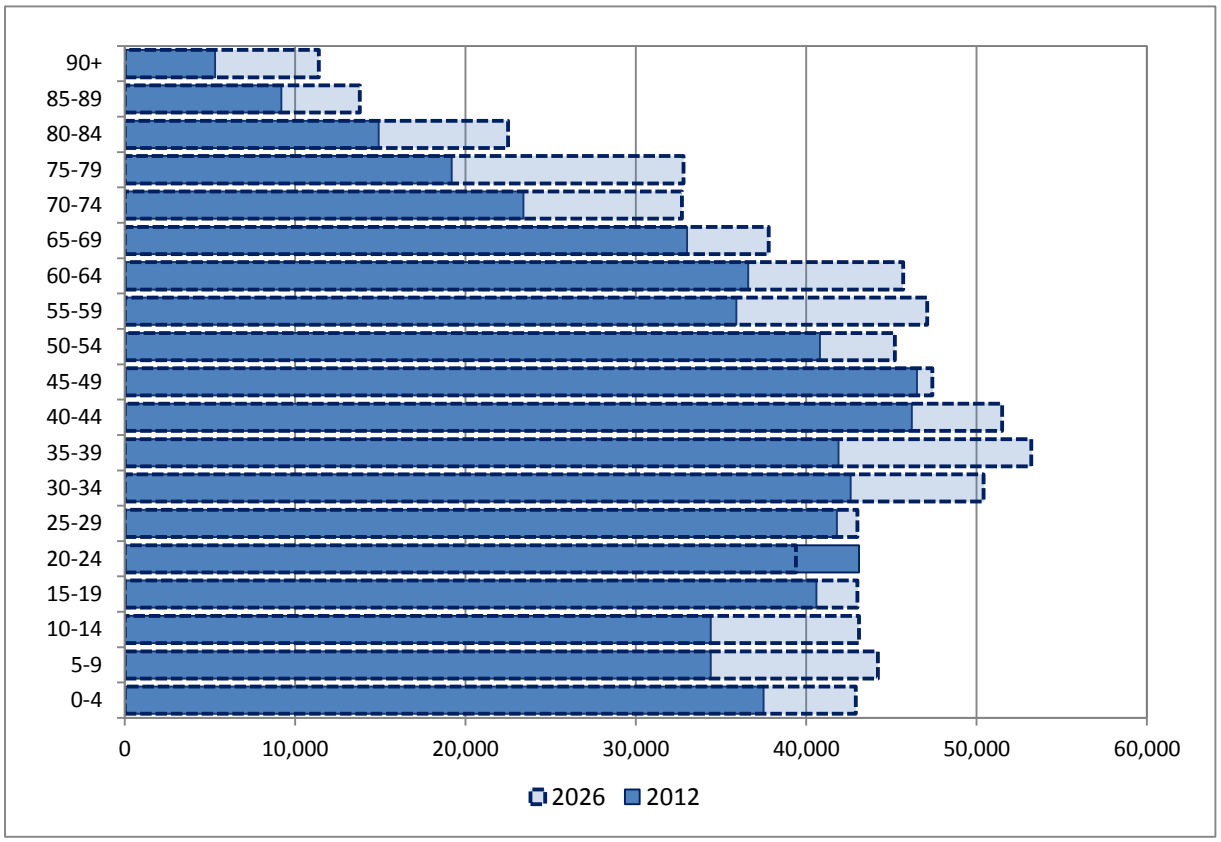
Cambridgeshire apparently devotes less health service spending per head to mental health than average for England. The CCG is relatively under-funded and faces a challenging financial future. This information is based on programme budgets, and differences in budgetary definitions and coding behaviour may underlie these findings. More analysis of the reasons for the differences would be of value.

3.1. Demography

We used population projections from Cambridgeshire County Council, based on 2011 data, to construct population projections for age-bands for each year from 2011 to 2026. Figure 1a describes population projections by numbers of people and Figure 1b presents this data as a proportion of the population. Detailed results for each district are in Appendix 1.

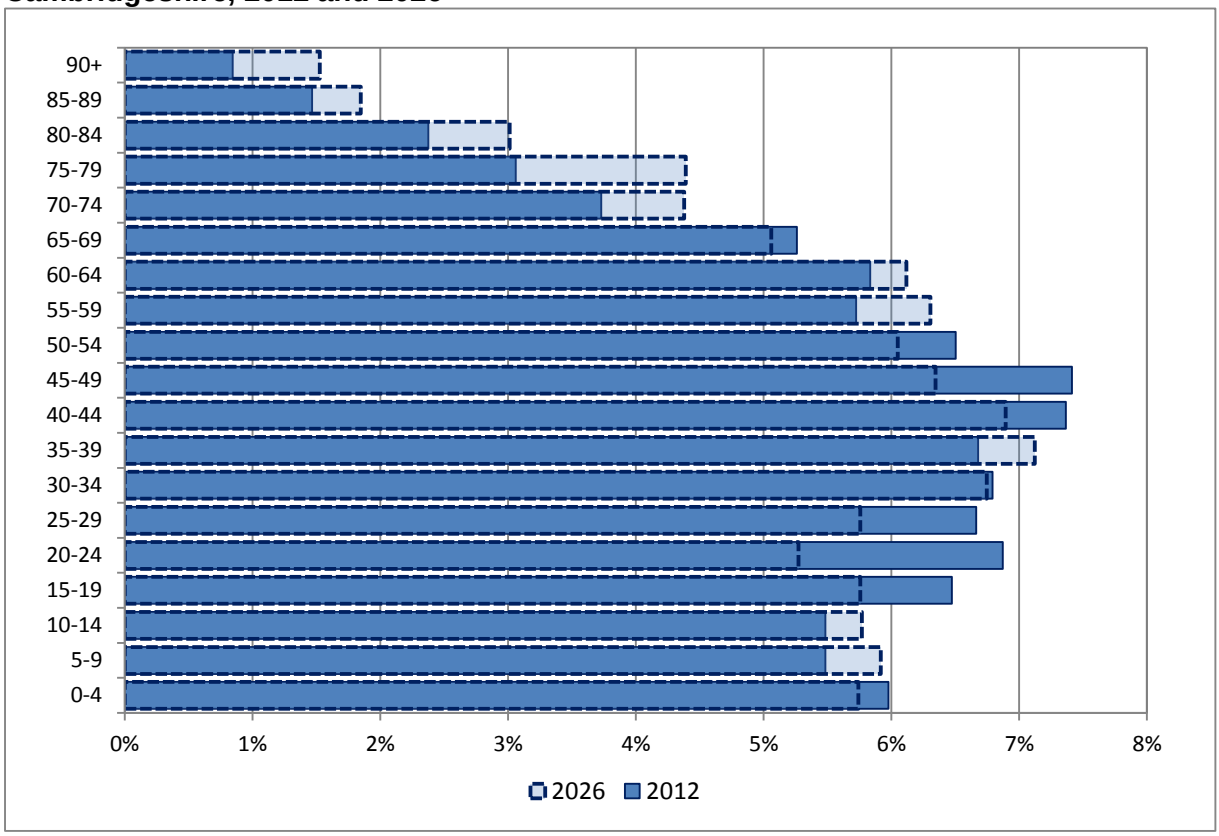
All but one age-band are expected to show increases in absolute numbers by 2026, with older adults becoming relatively more numerous (Figure 1).

Figure 1a: Population projections by age-band, numbers of people, Cambridgeshire, 2012 and 2026



Source: Cambridgeshire County Council Research & Performance Team 2011 based forecasts.

Figure 1b: Forecast population projections by age-band, proportions of population, Cambridgeshire, 2012 and 2026



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

Figure 2 shows the expected changes in the population of Cambridgeshire and its districts between 2012 and 2026. Most adult categories also show increases, though these vary between districts and age groups.

The main changes of importance to this report are the large increases in older people. The number of people aged over 90 years is forecast to more than double, and the number of people in their 80s to rise by more than 50%.

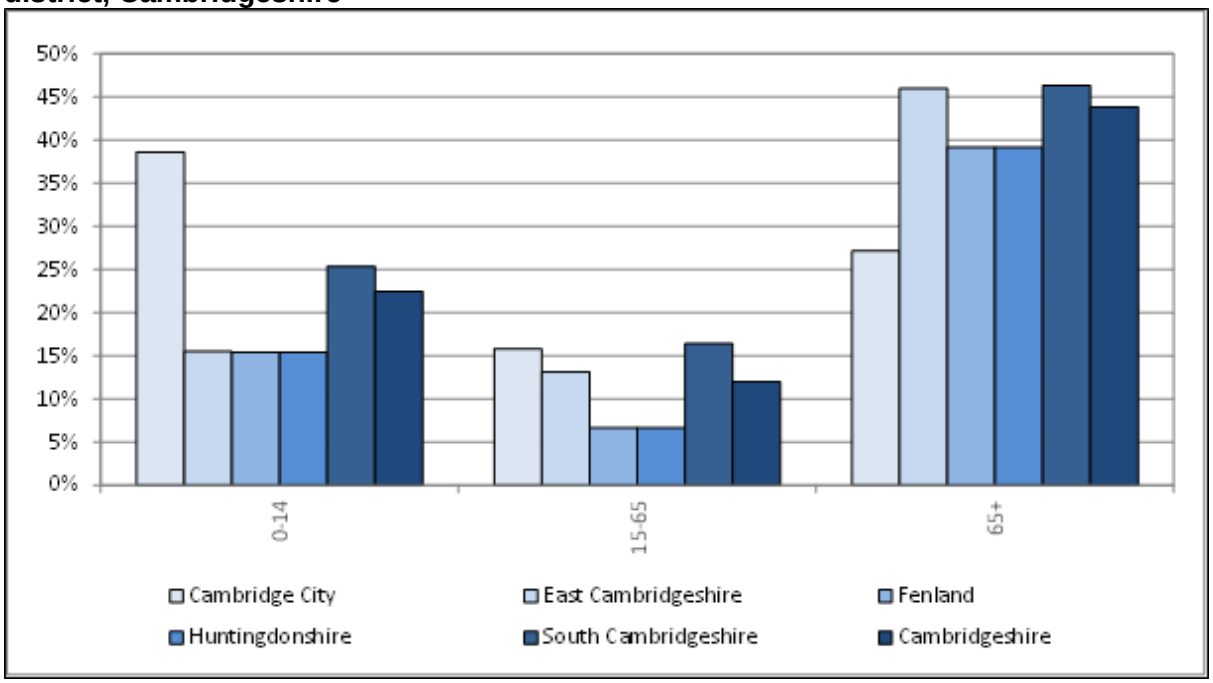
Figure 2: Forecast population changes from 2012 to 2026, by age-band and district, Cambridgeshire

Age Group	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
0-4	25%	4%	8%	12%	20%	14%
5-9	51%	18%	24%	24%	28%	28%
10-14	44%	27%	15%	19%	28%	25%
15-19	-5%	24%	-4%	6%	17%	6%
20-24	0%	-8%	-14%	-24%	-6%	-9%
25-29	-4%	2%	-2%	1%	20%	3%
30-34	20%	9%	15%	19%	23%	18%
35-39	20%	22%	27%	30%	33%	27%
40-44	53%	5%	3%	-1%	7%	11%
45-49	40%	2%	-11%	-9%	0%	2%
50-54	30%	14%	3%	2%	13%	11%
55-59	31%	36%	26%	30%	33%	31%
60-64	31%	27%	23%	23%	24%	25%
65-69	15%	17%	15%	15%	12%	15%
70-74	32%	42%	38%	41%	42%	40%
75-79	36%	75%	55%	92%	79%	71%
80-84	22%	45%	33%	78%	59%	51%
85-89	12%	46%	47%	77%	57%	50%
90+	73%	143%	144%	115%	115%	115%
Grand Total	**20%**	**19%**	**15%**	**17%**	**23%**	**19%**

Source: Cambridgeshire County Council Research & Performance Team 2011 based forecasts.

The increases are expected in all parts of the county, though will be somewhat smaller in Cambridge City (Figures 3 and 4). Increases of this size in the number of older people will lead to much greater demand for services for older people, including mental health services.

Figure 3: Forecast population changes from 2012 to 2026, by age category and district, Cambridgeshire



Source: Cambridgeshire County Council Research & Performance Team 2011 based forecasts.

Figure 4: Forecast population changes from 2012 to 2026, by age category and district, Cambridgeshire

Age Group	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
0-14	39%	15%	15%	18%	25%	22%
15-64	16%	13%	7%	7%	16%	12%
65+	27%	46%	39%	52%	46%	44%
Grand Total	**20%**	**19%**	**15%**	**17%**	**23%**	**19%**

Source: Cambridgeshire County Council

3.2. Factors affecting the risk of mental illness

A variety of factors are associated with the risk of mental illness. These associations may not be causal and in some cases are not strong, but they are reported here to provide as much information as possible.

Deprivation

The relationship between high levels of deprivation and high rates of mental ill-health is well established.[22] Studies have found an association between mental health and socio-economic status, with higher rates of psychiatric admissions and suicides in areas of high deprivation and unemployment.[23,24,25,26] Regardless of age or gender, there is an increased risk of mental ill-health for the poor when compared to the better-off.

The Index of Multiple Deprivation (IMD) 2010 produced by Department for Communities and Local Government (DCLG) combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. The domains of the IMD are:

- Income deprivation
- Employment deprivation
- Health deprivation and disability
- Education, skills and training deprivation
- Barriers to housing and services
- Living environment deprivation
- Crime

Figure 5 shows the pattern of deprivation in Cambridgeshire and districts within the County. The height of each column shows the proportion of neighbourhoods which fall into each quintile (or fifth) of deprivation for England, measured using IMD. It shows that few of the neighbourhoods in the County are in the most deprived quintile for England, and 40% are in the most affluent. South Cambridgeshire is the most affluent of Cambridgeshire's districts, and Fenland the most deprived.

[22] Payne, S. (2000) *Poverty, social exclusion and mental health: findings from the 1999 PSE survey. Working Paper no. 15.* Poverty and Social Exclusion Survey of Britain: Townsend Centre for International Poverty Research. Bristol: University of Bristol.

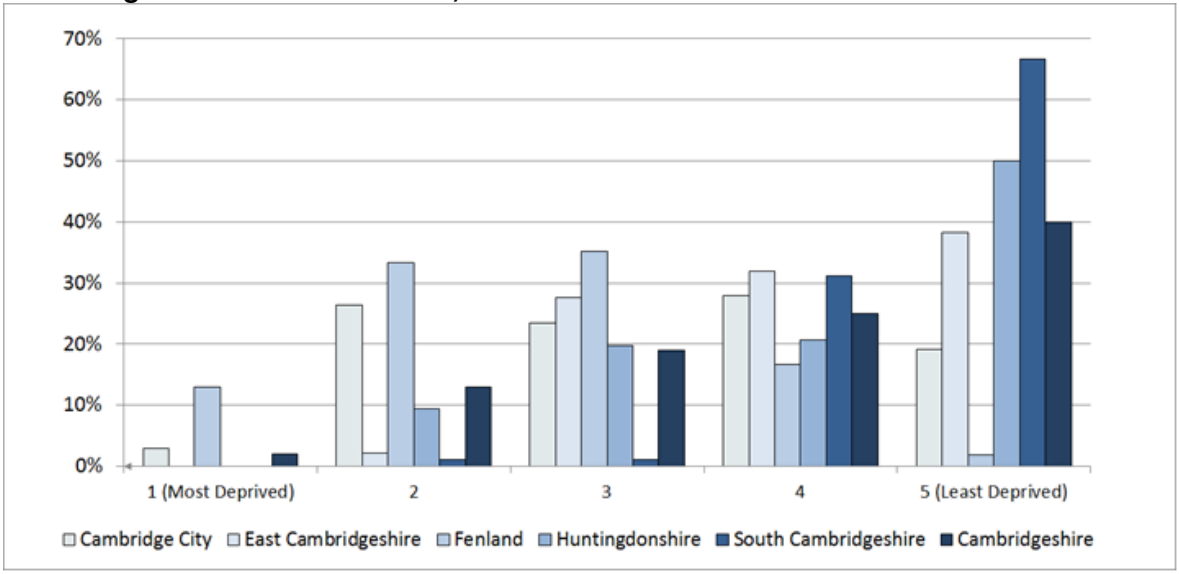
[23] Kammerling, M. and O'Connor, S. (1993) Unemployment rate as predictor of rate of psychiatric admission. *British Medical Journal,* 307, 1536 – 9

[24] Gunnell, D., Peters, T., Kammerling, M. and Brooks, J. (1995) The relationship between parasuicide, suicide, psychiatric admissions and socioeconomic deprivation. *British Medical Journal,* 311, 226 – 230

[25] Boardman, A.P., Hodgson, R.E., Lewis, M. and Allen, K. (1997) Social indicators and the prediction of psychiatric admission in different diagnostic groups. *British Journal of Psychiatry,*171, 457 – 462.

[26] Croudace, T.J., Kayne, R., Jones, P.B. and Harrison, G.L. (2000) Non-linear relationship between an index of social deprivation psychiatric admission prevalence and the incidence of psychosis. *Psychological Medicine,* 30, 177 – 185.

Figure 5: Proportion of lower super-output areas in each deprivation quintile, Cambridgeshire and its districts, 2010



Source: DCLG

Ethnicity

The relationship between ethnicity and mental health is complex with well-documented inequalities at a national and local level.

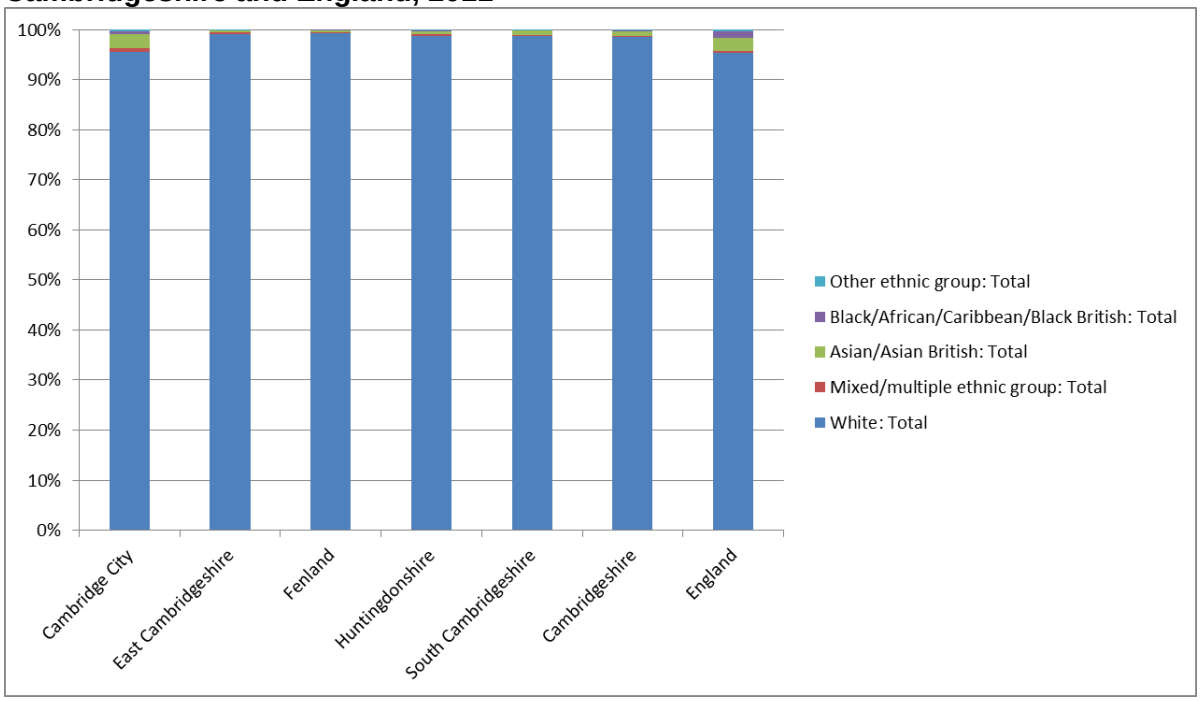
National survey findings estimate there to be little difference in prevalence rates of common mental health problems between minority ethnic groups and the white population. However, specific group differences showed that Irish men and Pakistani women had higher rates, while Bangladeshi women had lower rates.

In relation to severe mental health problems, significant variations were found. Black Caribbean people showed a two-fold excess. Pakistani people had a 60% higher and Bangladeshi people a 25% lower rate, both with no apparent gender difference. Irish people showed similar rates to the rest of the white population.[27]

Figure 6 shows the ethnic composition of the population of Cambridgeshire, districts within the county and England, and Figure 7 shows the same data with a reduced axis so that ethnic minorities are more clearly displayed. Cambridge City has a much more ethnically diverse population than other parts of the county, and has a lower white population than England as a whole, while Cambridgeshire overall and each of the other districts show much less diversity than England.

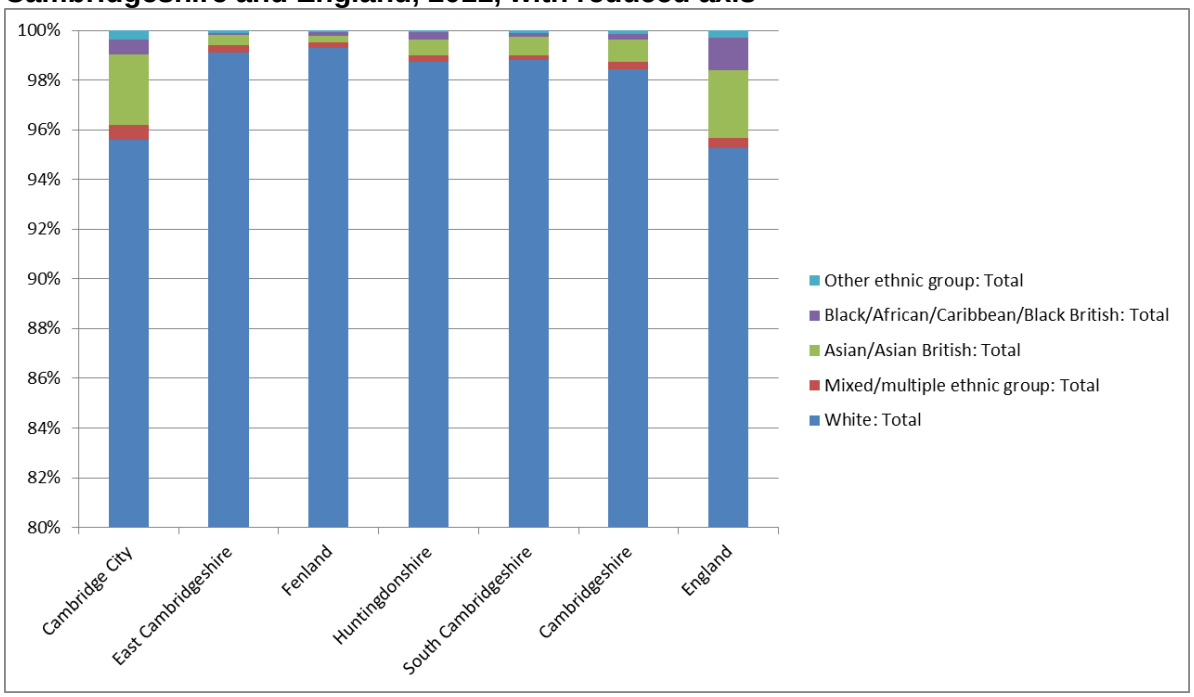
[27] Ethnic Minority Psychiatric Illness Rates in the Community (EMPIRIC) Quantitative Report, ONS, 2002. Available at: http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_4024034.pdf

Figure 6: Ethnicity, people 65 years and over Cambridgeshire, districts in Cambridgeshire and England, 2011



Source: 2011 Census

Figure 7: Ethnicity, people aged 65 years and over Cambridgeshire, districts in Cambridgeshire and England, 2011, with reduced axis



Source: 2011 Census

Housing

The provision of appropriate housing is clearly important for Cambridgeshire's growing population of older people and safe and secure housing is important to mental health. Most older people live in the community: nationally only 5% of older people live in supported sheltered schemes; 95% of older people live in the wider community.[28] From a prevention perspective, it is essential to ensure that the majority of older people in their own home are supported or have easy access to support where required, including mental health and wellbeing support. In particular, the 2009 National Dementia Strategy highlights the need to consider the potential for housing support, housing-related services and telecare to support people with dementia and their carers.[29]

Housing-related support (previously known as the 'Supporting People Programme') currently supports some of the most vulnerable and socially excluded members of society. The primary purpose is to develop and sustain an individual's capacity to live independently in their accommodation. Client groups include single homeless, homeless families and rough sleepers, Ex-offenders and those at risk of offending, people with physical or sensory disability, people suffering domestic violence, people with alcohol or drug problems, teenage parents, vulnerable older people, young people at risk/leaving care, people with HIV or AIDs, people with learning difficulties, Gypsies and Travellers, migrant workers, refugees and asylum seekers, and people with mental health problems. Housing related support is vital to many, helping them recover from a life trauma, maintain their existing housing, or continue to live at home instead of needing care.

A significant issue for Cambridgeshire is the provision of appropriate housing for the growing older population, for example, through 'floating support services', sheltered housing or extra-care housing, which are likely to reduce the need for residential care.

The 2012 JSNA on the Prevention of Ill Health in Older People[30] briefly summarises aspects of housing support and local initiatives which are particularly pertinent to the prevention of ill health and poor wellbeing of older people. More detail on housing needs and specific issues for older people with mental health issues is also described in the 'Housing and Health' JSNA (2013).[31]

Education

Spending a number of years in education, having an intellectually-challenging job, and being socially engaged as you get older, can help reduce the amount of time you live without dementia.[32],[33] A recent Cochrane review found that cognitive stimulation, which involves a wide range of activities aimed to stimulate thinking and memory generally, including discussion of past and present events and topics of interest, word games, puzzles, music and practical activities such as baking or indoor gardening, had a beneficial effect on the memory and thinking test scores of people with dementia. People were reported to communicate and interact better than previously, although, no evidence was found of

[28] National Housing Federation. *Breaking the Mould*, NHF, 2011. Available at: http://www.housing.org.uk/publications/find_a_publication/care_and_support/breaking_the_mould_re-vision.aspx.

[29] Department of Health. *National Dementia Strategy*, 2009. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058.

[30] Available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/prevention-ill-health-older-people-2013

[31] Available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports/housing-and-health-2013

[32] Dementia UK website - http://www.dementiauk.org/information-support/about-dementia/#1

[33] Carillon, MC. et al. 'Can we prevent Alzheimer's disease? Secondary "prevention" trials in Alzheimer's Disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association* 2013; 9 (2): 123-131

improvements in the mood of participants or their ability to care for themselves or function independently.[34]

Social isolation

Depression and dementia are associated with social isolation. The Government recognises social isolation as a major issue when addressing mental health:

> 'Tackling isolation is fundamental and may be the most significant area in which mental health promotion strategies can support the mental health of older people. After income and poverty, lack of social participation was the key issue'.[35]

The concept of social isolation is centred on the level of social integration of an individual, although, the specific definition varies within the literature. It is usually described as the absence of strong social networks, and therefore as an objective concept distinct from 'emotional isolation' or the subjective and negative emotional experience more usually described as 'loneliness'. However some studies conflate social isolation and loneliness, including those that have measured the health impact of this lack of social support.

Social networks are quantified as the number, frequency and density of contacts with other people. There is a strong relationship between social networks and mental health: those with few social contacts are at increased risk of mental health problems.[36] The relationship between loneliness and depression is multidirectional: loneliness can be both a cause and consequence of depression. Loneliness may affect cognitive behaviours, encouraging a more negative outlook and a greater focus on self-preservation.[37] Loneliness is often described as a vicious cycle, and these cognitive behavioural impacts may be the means of mediating this as they hamper social interaction; qualitative research suggests loneliness relating to feelings such as 'anger, sadness, depression, worthlessness, resentment, emptiness, vulnerability and pessimism'.[38] Lonely or isolated older people have an increased risk of developing dementia, specifically in developing Alzheimer's disease as self-perceived loneliness doubles the risk.[39]

Social networks can prevent problems arising from stress and research suggests that they can help women recover from depression.[40] Young people, women and some ethnic groups have better social networks, but some, for example black ethnic minority groups, have poorer networks. Other risk factors for loneliness include gender, living arrangements and marital status, health, income, being an informal carer, and sexual orientation; key

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[34] Woods B, Aguirre E, Spector AE, Orrell M. Cognitive stimulation to improve cognitive functioning in people with dementia. Cochrane Database of Systematic Reviews 2012, Issue 2. Art. No.: CD005562. DOI: 10.1002/14651858.CD005562.pub2.

[35] p25. National Institute for Mental Health in England, Making it possible: Improving mental health and well-being in England, London: NIMHE 2005. Available at: http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Publichealth/Choosinghealth/Browsable/DH_5891786

[36] Stewart-Brown, S. (2002) Interpersonal relationships and the origins of mental health. *Journal of Public Mental Health,* 4 (1) 24-29

[37] Oxfordshire Age UK. *Loneliness: the state we're in. A report of evidence compiled for the Campaign to End Loneliness*, 2012. Available at: http://www.ageuk.org.uk/brandpartnerglobal/oxfordshirevpp/documents/loneliness%20the%20state%20we%20are%20in%20-%20report%202013.pdf

[38] ibid

[39] Age UK, *Evidence review: loneliness*, 2014. Available at: http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Evidence_Review-Loneliness_2014.pdf?dtrk=true

[40] Brugha, T.S., Bebbington, T.E., MacCarthy, B., Sturt, E., Wykes, T. and Potter, J. (1990) Gender, social support and recovery from depressive disorders: A prospective clinical study. *Psychological Medicine*, 20 (1) 147 – 156.

transitions for older people such as retirement or bereavement may also act as a trigger.[41] More of the rural population is over the retirement age than those living in urban areas in the UK; this has implications for health and wellbeing, although the association between geography with loneliness and isolation is complicated as there are a variety of contributing variables including gender and community safety issues. A report by the Social Research Unit in York highlights research suggests that rural women in North Wales, living alone in sparsely populated areas were at greater risk of loneliness, whereas population density was not a predictor of loneliness for men.[42] Evidence also suggests that lonely are more likely to be lonely if they live in a deprived urban area or an area where crime is an issue.[43]

Neighbourliness relates to the percentage of adults speaking to their neighbours, the number of neighbours known and how many are trusted, as well as whether people have received favours from their neighbours in the previous week. It is considered an important aspect of social capital and can provide protection from mental health problems.[44]

Estimates of the scale of isolation and loneliness vary, though a finding that 10% of UK residents aged 65 and over are lonely most or all of the time[45] is similar to other reports. The English Longitudinal Study of Ageing (ELSA) data has shown higher rates of self-reported loneliness in those aged over 80, although higher social detachment measures in the oldest older people are not independent of living alone.[46] The proportion of adult social care users who have as much social contact as they would like is 44.7% in Cambridgeshire, similar to the 43.2% reported for England as a whole.[47] And the figure is similar for the older population: 43.9% adult social care users aged 65 or over are satisfied, yet 11.8% identified with 'I have some social contact with people, but not enough' and 4.3% indicated that 'I have little social contact with people and feel socially isolated'.[48] This information is not available at district level and it is therefore difficult to identify the distribution of those at risk of social isolation in Cambridgeshire. We have no information on where people with dementia and depression live, or how many live alone.

3.3. Mental health and life expectancy/mortality

Mental health and physical health are intricately related. The national mental health strategy, *No Health without Mental Health* states that having a mental health problem increases the risk of physical ill health.

In relation to common mental health disorders:

- Depression increases mortality by 50% and has been associated with a four-fold increase in the risk of heart disease, even when other factors are controlled for.[49]

[41] ibid
[42] Bernard, S. (2013) Loneliness and Social Isolation Among Older People in North Yorkshire, *Executive summary*, Social Policy Research Unit, University of York, York. Avaiolable at: http://php.york.ac.uk/inst/spru/pubs/2681/
[43] Age UK, *Evidence review: loneliness*, 2014. Available at: http://www.ageuk.org.uk/Documents/EN-GB/For-professionals/Research/Evidence_Review-Loneliness_2014.pdf?dtrk=true
[44] Social Exclusion Unit. *Social Exclusion and Mental Health*. London: Office of the Deputy Prime Minister. 2004
[45] Victor C. (2011) 'Loneliness in old age: the UK Perspective' *Safeguarding the Convoy: a call to action from the Campaign to End Loneliness* (Oxford: Age UK Oxfordshire)
[46] Banks, J et al. Financial circumstances, health and well-being of the older population in England: ELSA 2008 (Wave 4), October 2010. Available at: http://www.ifs.org.uk/elsa/report08/ch5.pdf
[47] http://www.cambridgeshireinsight.org.uk/health/phof
[48] 2012 Cambridgeshire adult social care survey data
[49] Mykletun A, Bjerkeset O, Overland S et al. Levels of anxiety and depression as predictors of mortality: the HUNT study. British Journal of Psychiatry 2009; 195: 118-125

- Untreated depression and anxiety disorders are associated with increased healthcare usage, not only ongoing consultations and treatment in relation to the specific mental health condition, but also increased healthcare usage more generally.[50]
- Co-morbid mental health problems have a significant impact on the costs related to the management of long-term conditions. For example, the total cost to the health service of each person with diabetes and co-morbid depression is 4.5 times greater than the cost for a person with diabetes alone.[51]

In May 2013, a BMJ editorial stated that "the gap between life expectancy in patients with a mental illness and the general population has widened since 1985 and efforts to reduce this gap should focus on improving physical health."[52] The paper highlighted that while strategies aimed at the prevention of suicides were an important component, "80% of excess deaths are associated with physical conditions" and that "multi-pronged approaches will be required to address these inequalities". Of the few studies of life expectancy in people with mental illness, some have reported a gap of 14-20 years for males and 6-15 years for females. It has been estimated that people with severe mental illness (usually conditions with psychosis, such as schizophrenia and bipolar disorder) die 10 years younger than other people because of poor physical health.

The editors of the article also stress that treating both physical health problems and risk factors "would result in improvements to both physical and mental health". Physical health and mental health should be viewed as inseparable and a holistic approach to the care of all patients with mental health problems should be sought.

3.4. Modifiable healthy behaviours as risk factors

Risk factors for dementia depend on the category of disease. The most common type of dementia is Alzheimer's disease, a physical disease in which protein 'plaques' and 'tangles' develop in the structure of the brain, leading to the death of brain cells. Vascular dementia is the second most common type, and is caused by problems in the supply of blood to the brain. Other types of dementia are less often seen. The causes of Alzheimer's disease are not well understood, so preventative interventions are less readily understood.

Barnes and Yaffe calculated the population-attributable risk for seven lifestyle risk factors that seem most promising in terms of primary prevention of dementia.[53] Worldwide, low education, smoking, physical inactivity, and depression were most strongly correlated with Alzheimer's Disease risk; in the United States, physical inactivity, depression, smoking, and midlife hypertension had the highest correlations. They concluded that up to half of Alzheimer's disease cases may be attributable to modifiable risk factors, and that even a modest reduction of 10% in all of these risk factors combined could reduce the incidence of Alzheimer's disease by over one million people worldwide.[54] Given that risk factors are largely correlated it may be that living a healthy, engaged life is the best way to prevent dementia and that one single factor is insufficient to prevent the disease.[55]

[50] Layard R et al. Cost benefit analysis of psychological therapy. Centre for Economic Performance. CEP Discussion paper No 829, October 2007

[51] Egede LE, Zheng D, Simpson K. Comorbid depression is associated with increased healthcare use and expenditures in individuals with diabetes". Diabetes Care 2002, vol 25, no 3, pp 464–70

[52] Lawrence D, Hancock K, Kisely S The gap in life expectancy from preventable physical illness in psychiatric patients in Western Australia: retrospective analysis of population based registers. *BMJ* 2013;346:f2539

[53] Barnes, DE, Yaffe, K. The Projected Impact of Risk Factor Reduction on Alzheimer's Disease Prevalence . Lancet Neurol. 2011; 10 (9): 819-828 Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647614/

[54] Carillon, MC. et al. 'Can we prevent Alzheimer's disease? Secondary "prevention" trials in Alzheimer's Disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association* 2013; 9 (2): 123-131

[55] Alzheimer's Disease International: Policy Brief –'Risk Factors for Dementia' April 2012. Available at: http://www.alz.co.uk/sites/default/files/policy-brief-risk-factors-for-dementia.pdf

People with vascular risk factors are at higher risk, not only for vascular dementia but also for Alzheimer's disease. Both share risk factors with cardiovascular disease, such as smoking, high cholesterol, hypertension, physical inactivity, obesity and diabetes. Emerging evidence has suggested that general improvements in midlife health, especially better control of vascular risk factors, may be associated with a decline in the incidence of cognitive impairment.[56] Addressing smoking, promoting physical activity and healthy eating and treating high blood pressure could all reduce the future burden of vascular dementia.

Smoking

Evidence shows that being a current smoker increases the risk of dementia with the association being stronger for those smoking a greater amount and having smoked for a longer period of time.[57] There are also suggestions that heavy smoking in middle age increases the risk of dementia.[58] Barnes and Yaffe (2011) calculated that nearly 14% (4.7 million) of Alzheimer's cases worldwide are potentially attributable to smoking.[59] Based on these figures a 25% reduction in smoking prevalence in the UK could therefore potentially lower dementia prevalence by more than 20,000 cases. However the Cognitive Function and Aging Study (2006)[60] - Brayne) found that in the cohort observed smoking (never, past and current) was neither strongly protective nor predictive of dementia. People with mental health problems are more likely to smoke, but often experience better quality of life once they quit.

Physical Activity

Physical activity is known to be associated with less depression and anxiety, better sleep, better concentration and possibly a reduced likelihood of problems with memory and dementia.[61] Structured group physical activity programmes are one of the treatment options recommended by NICE for people with mild to moderate common mental health disorders.[62]

Multiple studies show a relationship between physical activity and the development and progression of dementia. These findings suggest that midlife physical activity may be associated with a reduced risk of Alzheimer's disease or vascular dementia in later life. Even mild activities, such as walking, were found to be protective.[63] However evidence suggests more work is needed to understand this as it is still unclear how an active lifestyle could protect the brain.

Diet and obesity

The influence of diet is controversial. Thus far, insufficient evidence has been found to support the association of diet or any other modifiable risk factors with dementia.[64] However,

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[56] Carillon, MC. et al. 'Can we prevent Alzheimer's disease? Secondary "prevention" trials in Alzheimer's Disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association* 2013; 9 (2): 123-131

[57] Alzheimer's Disease International: Policy Brief –'Risk Factors for Dementia' April 2012. Available at: http://www.alz.co.uk/sites/default/files/policy-brief-risk-factors-for-dementia.pdf

[58] Ibid.

[59] Barnes, DE, Yaffe, K. The Projected Impact of Risk Factor Reduction on Alzheimer's Disease Prevalence . Lancet Neurol. 2011; 10 (9): 819-828 Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3647614/

[60] Yip, AG, Brayne C, & Matthews, FE. Risk factors for incident dementia in England and Wales: The Medical Research Council Cognitive Function and Ageing Study. A population-based nested case-control study. *Age Ageing*. 2006 Mar;35(2):154- 60. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16414964

[61] Royal College of Psychiatrists. *Physical activity and mental health*. November 2012. Available from http://www.rcpsych.ac.uk/mentalhealthinfoforall/treatments/physicalactivity.aspx (Accessed July 2013)

[62] National Institute for Health and Clinical Excellence. Common mental health disorders: Identification and pathways to care. Clinical Guidelines 123, May 2011. Available at:

[63] Alzheimer's Disease International: Policy Brief –'Risk Factors for Dementia' April 2012. Available at: http://www.alz.co.uk/sites/default/files/policy-brief-risk-factors-for-dementia.pdf

[64] Carillon, MC. et al. 'Can we prevent Alzheimer's disease? Secondary "prevention" trials in Alzheimer's Disease. *Alzheimer's & Dementia: The Journal of the Alzheimer's Association* 2013; 9 (2): 123-131

there appears to be growing evidence that midlife obesity can contribute to dementia[65] and diet is a modifiable risk factor in the context of maintaining a healthy weight.

People with mental health problems may be less able to prevent or deal with overweight and obesity. The health consequences of obesity include diabetes, heart disease, stroke, cancer, respiratory disease, reproductive disorders, osteoarthritis, stigma and mental health issues and, in the UK, some 30,000 deaths per year. Prevalence of obesity has increased in the past 25 years in every age-group, social class, ethnicity and gender. In 1986, 8% of men and 12% of women were obese. Today it is estimated that 24% of men and 26% of women are obese.

People at greater risk of being obese are people in lower socioeconomic groups, socially disadvantaged groups and women. In women, the mean body mass index (BMI) is markedly higher in black Caribbeans and black Africans than in the general population, and markedly lower in Chinese. In men, the mean BMI of Chinese and Bangladeshi origin is significantly lower than that of the general population. The average BMI is markedly higher amongst people of black Caribbean and black African ethnicity. Some mental health diagnoses are more common in people of this ethnic group, though not specifically the diagnoses of interest in this JSNA.

Alcohol

The Cognitive Function and Aging Study (2006) found that the consumption of alcohol was not strongly protective or predictive of dementia;[66] however other studies have found moderate consumption of wine to be associated with a reduced risk of subsequent dementia. Harmful effects of alcohol have also been noted.[67]

The JSNA on Primary Prevention for Older People[68] also focuses specifically on modifiable healthy behaviours in older people which impact on physical and mental health and wellbeing. This specifically describes physical activity, diet and malnutrition and smoking, and emphasises the role of mental health in influencing healthy behaviours and the impact of such behaviours on mental health.

To assess the performance of general practices in diagnosing and recording cardiovascular disease and vascular risk factors, we compared the number of people with cardiovascular disease (Figure 8), coronary heart disease (Figure 9) and hypertension (Figure 10) recorded by each practice with the number we would expect based on the age and sex of the practice's patients. A figure of less than 100% indicates that there are patients with the condition in the practice who are not diagnosed, or whose diagnosis is not recorded.

The ratios differ markedly between practices, with generally low ascertainment, especially of cardiovascular disease. Some of this variation may be because of differences in the underlying prevalence of the conditions, but there are also likely to be substantial differences in the rates of diagnosis and recording of the conditions. This has implications for the quality of prevention and care that patients receive.

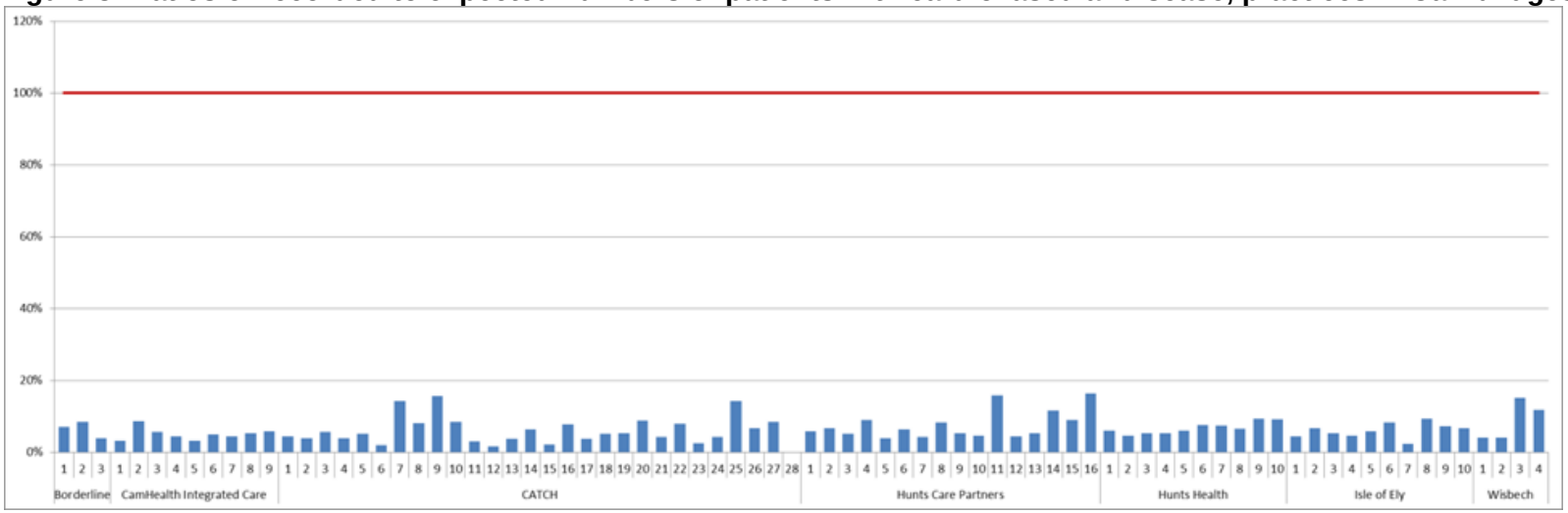
[65] Alzheimer's Disease International: Policy Brief –'Risk Factors for Dementia' April 2012. Available at: http://www.alz.co.uk/sites/default/files/policy-brief-risk-factors-for-dementia.pdf

[66] Yip, AG, Brayne C, & Matthews, FE. Risk factors for incident dementia in England and Wales: The Medical Research Council Cognitive Function and Ageing Study. A population-based nested case-control study. *Age Ageing*. 2006 Mar;35(2):154- 60. Available at: http://www.ncbi.nlm.nih.gov/pubmed/16414964

[67] Alzheimer's Disease International: Policy Brief –'Risk Factors for Dementia' April 2012. Available at: http://www.alz.co.uk/sites/default/files/policy-brief-risk-factors-for-dementia.pdf

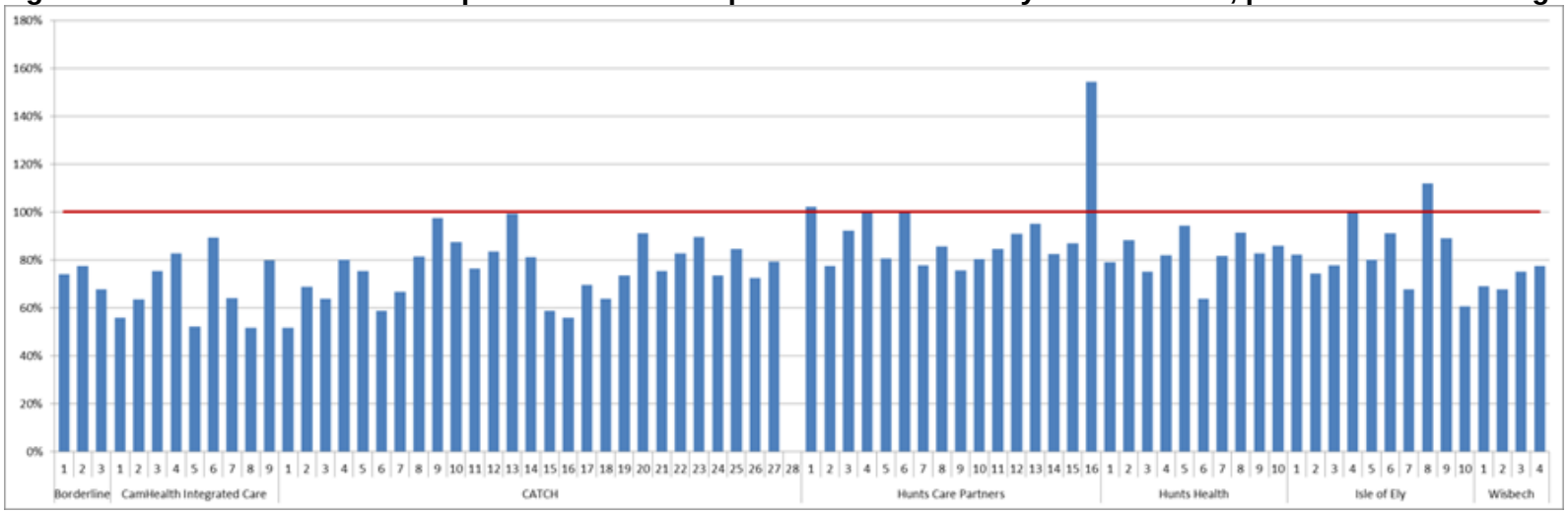
[68] Available at: http://www.cambridgeshireinsight.org.uk/joint-strategic-needs-assessment/current-jsna-reports

Figure 8: Ratios of recorded to expected numbers of patients with cardiovascular disease, practices in Cambridgeshire, 2012/13



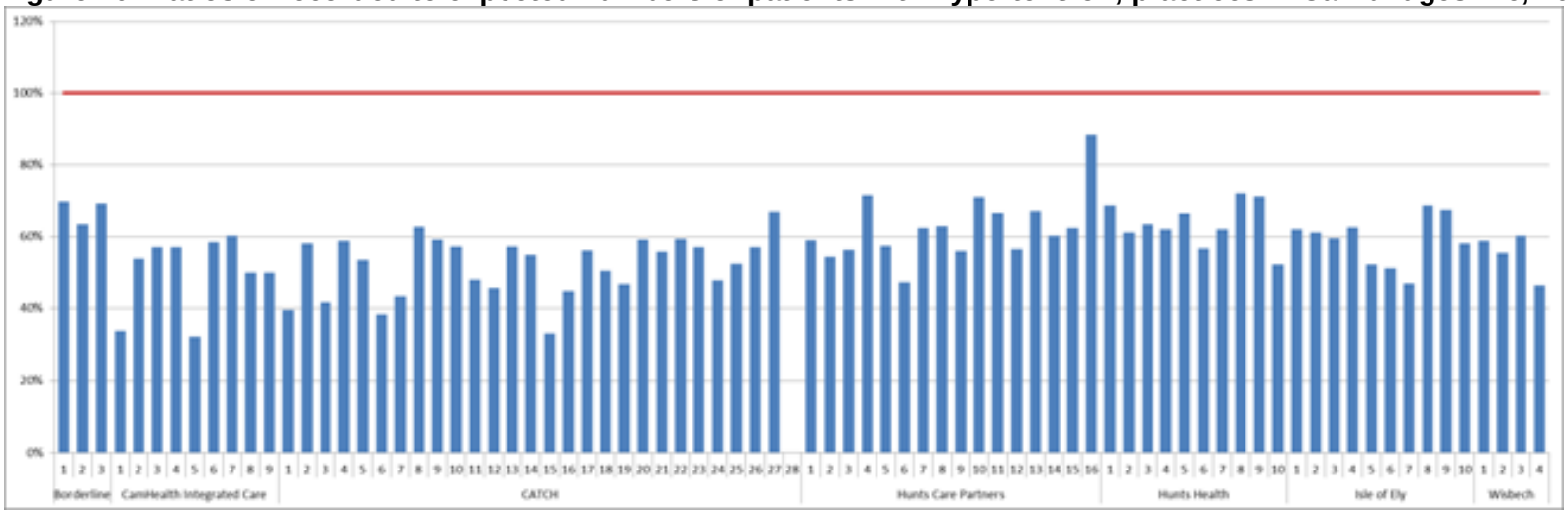
Source: Observed figures from QOF 2012/13, prevalence model from APHO

Figure 9: Ratios of recorded to expected numbers of patients with coronary heart disease, practices in Cambridgeshire, 2012/13



Source: Observed figures from QOF 2012/13, prevalence model from APHO

Figure 10: Ratios of recorded to expected numbers of patients with hypertension, practices in Cambridgeshire, 2012/13



Source: Observed figures from QOF 2012/13, prevalence model from APHO

3.5. Current prevalence of dementia and depression in older people in Cambridgeshire

Prevalence is the proportion of a population that has a condition at a specific time.

We do not know for certain how many people in Cambridgeshire have dementia, because many people living with the condition are un-diagnosed. This means that we have to use ways to estimate the number of people with dementia in the county.

The Cognitive Function and Ageing Study (CFAS) (I and II) provides contemporary estimates of dementia prevalence based on a study of dementia in six geographical areas of England (including Cambridgeshire) over the past two decades.[69] These prevalence rates for dementia can be applied to the local Cambridgeshire population to estimate the number of individuals we would expect to have dementia in the population. These are described in Table 1, column 1.

In future, the Public Health Outcomes Framework (PHOF) will include an indicator for the estimated diagnosis rate for people with dementia. The full indicator data is not yet available, but Cambridgeshire's observed prevalence of dementia among GP-registered patients is similar to that for England.[70]

Data from the Primary Care Quality and Outcomes Framework (QOF) records of each general practice can be used to describe the number of individuals in the county who have a diagnosis of dementia recorded in their medical GP records. This can be used as a proxy for the number of individuals who have been diagnosed with dementia. The data can be analysed at the level of local commissioning groups (LCGs) and by individual GP practice.

Cambridgeshire and Peterborough Clinical Commissioning Group (CCG) is made up of eight local commissioning groups which are groups of practices which have come together to commission (buy) health services for their local population.[71] Seven of these LCGs include residents of Cambridgeshire.

A total of 4,602 people in Cambridgeshire were recorded on GP IT systems in 2012/13 as having dementia, using QOF data (see Table 1, column 2). Table 1 compares the predicted estimates of individuals with dementia against those who are recorded as having a diagnosis of dementia and calculates a 'diagnosis rate'. Across Cambridgeshire, approximately half of all individuals predicted to have dementia according to national estimates are diagnosed (50.4%).

Analysis by local commissioning group (LCG) also reveals differences in dementia diagnosis rates between LCGs: this varies from 42.6% in Hunts Health to 72.8% in CamHealth. This data is not adjusted for the age structure of the LCG populations so it may be that some LCG populations have higher proportions of older people and thus higher numbers of individuals diagnosed with dementia (creating a better estimated diagnosis rate). It could also reflect different diagnostic and recording behaviour in general practices.

[69] Matthews FE, Arthur A, Barnes LE et al (on behalf of the Medical Research Council Cognitive Function and Ageing Collaboration). A two-decade comparison of prevalence of dementia in individuals aged 65 and over from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. www.thelancet.com Published online July 16 2013.

[70] http://www.cambridgeshireinsight.org.uk/health/phof

[71] http://www.cambridgeshireandpeterboroughccg.nhs.uk/local-commissioning/local-commissioning-groups.htm

Table 1: Estimated number of dementia cases based on CFAS (2013) prevalence estimates compared with QOF dementia register 2012/13 and estimated 'diagnosis' rate (%)

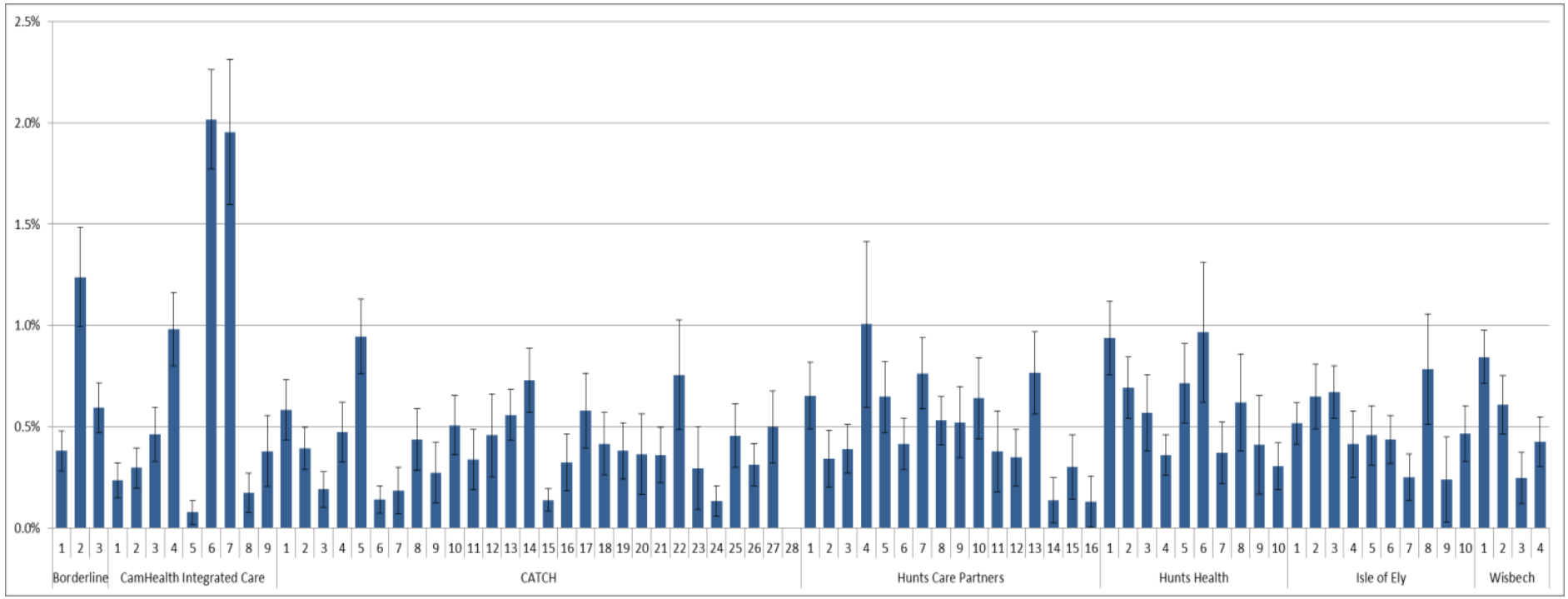
LCG	Dementia 2013		
	Estimated number of Dementia cases	QoF Register 2012/13	Register as % of estimated total ('diagnosis rate')
Borderline	1,065	634	59.5%
CamHealth Integrated Care	876	638	72.8%
CATCH	2,142	914	42.7%
Hunts Care Partners	1,402	631	45.0%
Hunts Health	906	386	42.6%
Peterborough	1,134	634	55.9%
Isle of Ely	1,023	478	46.7%
Wisbech	576	287	49.8%
Cambridgeshire and Peterborough	9,123	4,602	50.4%

Source: Prevalence estimates CFAS (2013) based on CFAS II.[72] Registered population: FHS Registration System (Exeter) April 2013

Figure 11 shows the prevalence of dementia in each practice in Cambridgeshire according to the Quality and Outcomes Framework (QOF) records of each practice for 2012/13. This presents the number of individuals in each GP practice who were recorded as having a diagnosis of dementia in this year. There is substantial variation, with the reported prevalence in some practices being seven times higher than that in others. Again, a key limitation of this data is variation in the age structure of practices; practices serving older populations will tend to have a higher prevalence of dementia and those who provide primary care services to residential or care homes may also have a higher proportion of older people in their practice population and a higher number of individuals diagnosed with dementia. While these figures may reflect variation in underlying prevalence, differences in diagnostic behaviour and recording could also have contributed.

[72] Ibid.

Figure 11: Recorded prevalence of dementia, general practices in Cambridgeshire by local commissioning group, 2012/13, with 95% confidence intervals



Source: Quality and Outcomes Framework 2012/13

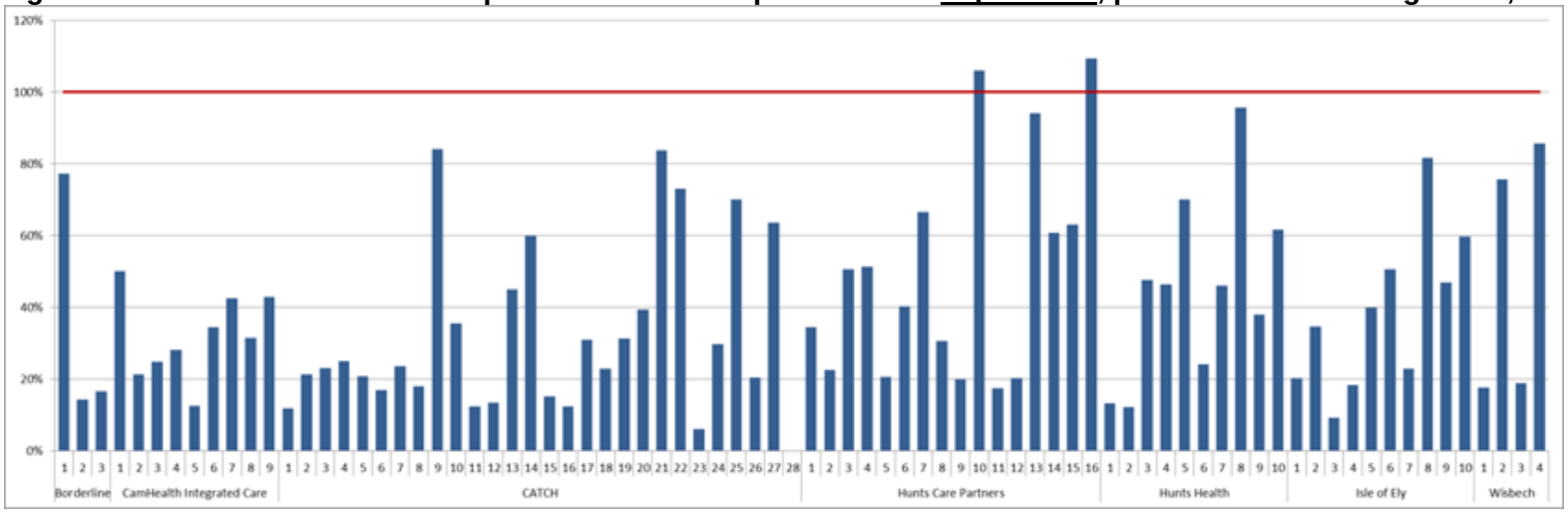
The number of people with depression and dementia recorded by each practice can also be compared with the number expected based on the age and sex of the practice's patients. To do this with adjustments for age and sex, estimates of the prevalence of mental illnesses in this model were used from sources such as the National Psychiatric Morbidity Survey to calculate expected numbers of individuals with dementia or depression. Figure 12 shows the ratio of the recorded number of people to the expected number for depression, and Figure 13 shows the same ratio for dementia. A ratio of less than one suggests that there are patients with the condition in the practice who are not diagnosed, or whose diagnosis is not recorded. The variation in recorded prevalence of depression and dementia is reflected in widely different ratios of observed to expected prevalences for both conditions.

There are wide variations between practices in the proportion of patients of all ages with depression who are diagnosed and recorded by their primary care team (Figure 12). Some practices have identified all or nearly all their patients who are estimated to have the condition according to national projections, but many have only found half, and a large number as few as a fifth. This may be an important missed opportunity to help people with a distressing but highly treatable condition.

In the case of dementia, the level of potential under-diagnosis is higher (Figure 13). Only two practices have a recorded prevalence of dementia consistent with complete case-finding if the national projections are correct, while most have ratios less than 0.5, indicating substantial under-diagnosis or under-recording. This can prevent patients having information and support. It is possible that many of the undiagnosed patients may have milder dementia, since more advanced disease is harder to miss.

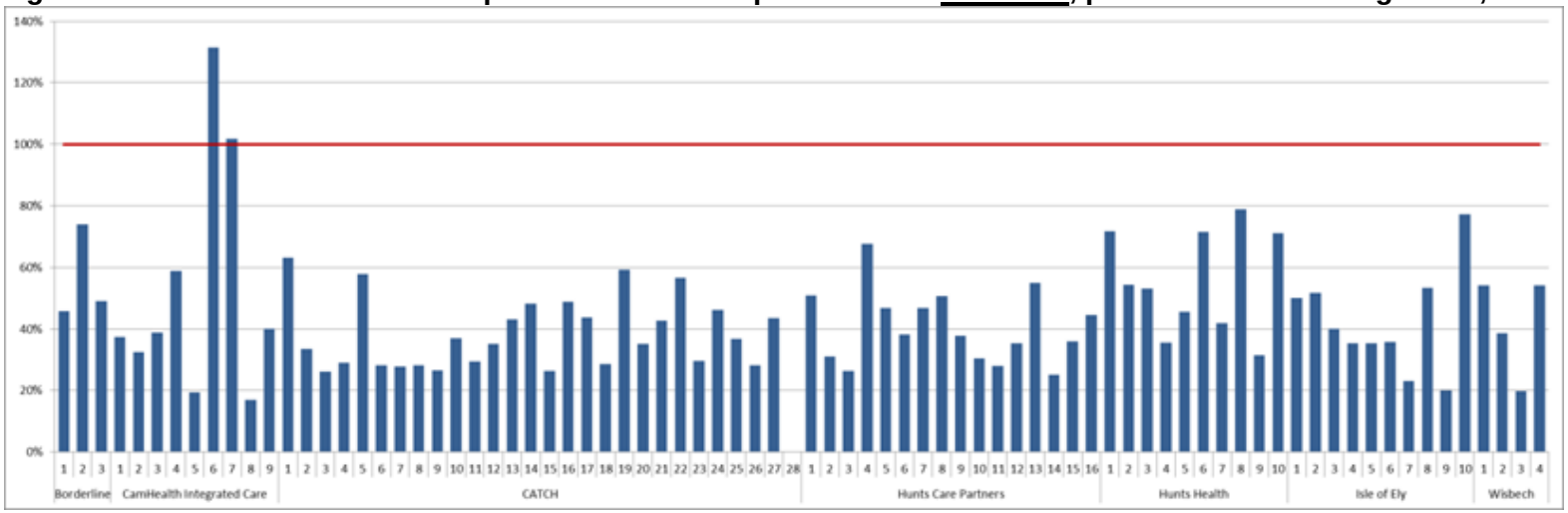
There are a number of potential reasons for under-diagnosis of dementia and depression postulated in the literature. These can range from a lack of public awareness, difficulty in picking up the symptoms, stigma about reporting problems with mental health or memory loss, unwillingness among loved ones to acknowledge the diagnosis, general practitioners' capacity to assess and the number of memory clinics or assessments available. It is also worth noting that these figures from 2012/2013 may have changed significantly for 2013/2014 due to contract incentives in the past year to improve recognition and diagnosis dementia in acute hospital settings and in primary care.

Figure 12: Ratios of recorded to expected numbers of patients with depression, practices in Cambridgeshire, 2012/13



Source: Observed figures from QOF 2012/13, prevalence model from NEPHO *Mental Health Observatory Brief 4 - Estimating the Prevalence of Common Mental health Problems*. The NEPHO model is for ages 16 to 74 years only. We have extrapolated the prevalence in people aged 70 to 74 years to people over 74 years.

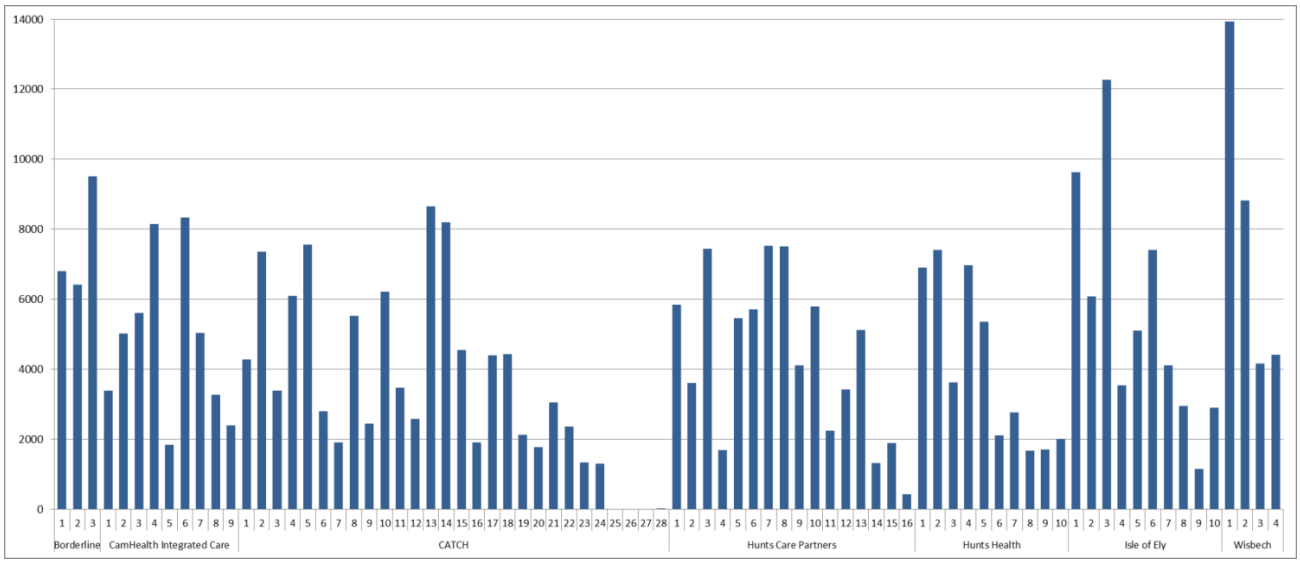
Figure 13: Ratios of recorded to expected numbers of patients with dementia, practices in Cambridgeshire, 2012/13



Source: Quality and Outcomes Framework

There are also differences between practices in the prescribing of drugs for dementia (Figure 14). Most of these drugs are prescribed only for Alzheimer's disease, so this only represents prescriptions for one type of dementia. These results, which are adjusted for differences in the age and gender profile of practices, show large and unexplained variation. This may be caused by differences between practices in the specific prevalence of Alzheimer's disease, in rates of diagnosis or in varying prescribing behaviour between GP practices. The first of these is unlikely to be large enough to explain such large variation, but we cannot determine the relative importance of the second two factors.

Figure 14: Rates of prescription for dementia per STAR-PU,[73] practices in Cambridgeshire, 2012/13



Source: Cambridgeshire and Peterborough CCG.

[73] Rates are per specific therapeutic group age-sex related prescribing unit (STAR-PU). This is a means of comparing prescribing in different practices with adjustment for differences in registered populations.

3.6. Future prevalence of dementia and depression in older people in Cambridgeshire

Dementia

The Cognitive Function and Ageing Study (CFAS) (I and II) provides contemporary estimates of dementia prevalence based on a study of dementia in six geographical areas of England (including Cambridgeshire) over the past two decades.[74] This study suggests that previous estimates of dementia have slightly over-estimated future prevalence of dementia. The authors found a 'cohort' effect whereby later-born populations seem to have a lower risk of prevalence dementia than those born earlier in the past century.

Table 2 and Figure 15 show the number of older people in Cambridgeshire expected to have dementia, calculated using these revised CFAS prevalence estimates. Of note, this assumes that current prevalence rates will not change in future years and applies the current rate to future population projections. The estimate for 2012 is 7,442, and the expected rise between 2012 and 2026 is 4,740 or 64%. The rise is greater than the expected rise of 12% for depression (see Tables 4 and 5, Figures 17 and 18). This is because, in contrast to depression, the proportion of people with dementia rises steeply with increasing age. An increase of this size over a short period is likely to put severe strain on existing services.

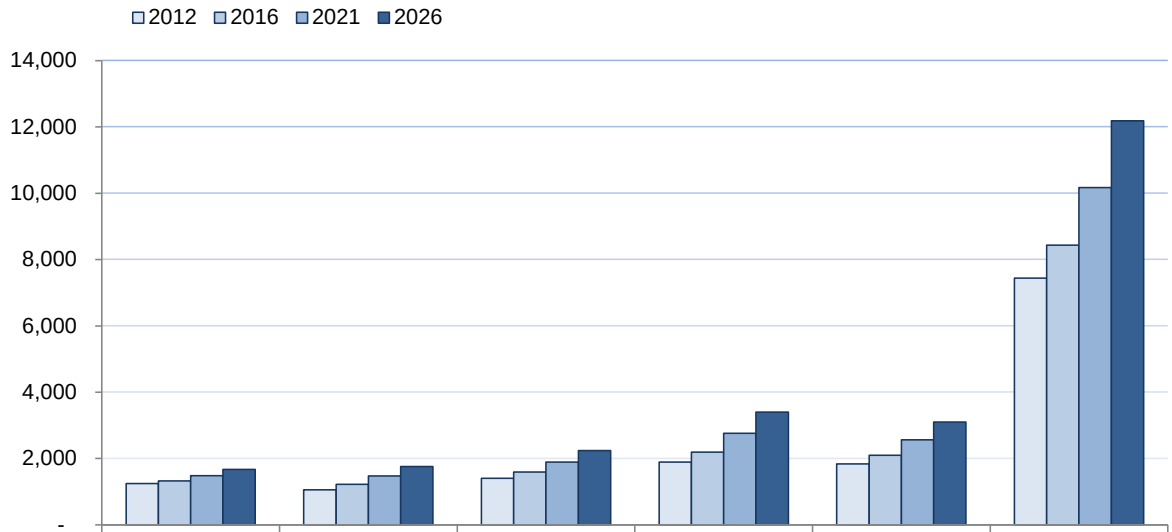
Table 2: Change in projected numbers of people with dementia compared with 2012 in people 65 and older, local authorities in Cambridgeshire, 2012 to 2026

	2012	2016	2021	2026
Cambridgeshire				
Number	7,442	8,433	10,173	12,182
Variance from 2012		+992	+2,731	+4,740
Cambridge City				
Number	1,249	1,329	1,484	1,675
Variance from 2012		+80	+235	+426
East Cambridgeshire				
Number	1,055	1,222	1,473	1,759
Variance from 2012		+168	+418	+705
Fenland				
Number	1,401	1,591	1,890	2,242
Variance from 2012		+190	+489	+841
Huntingdonshire				
Number	1,895	2,195	2,762	3,401
Variance from 2012		+300	+867	+1,506
South Cambridgeshire				
Number	1,842	2,096	2,564	3,104
Variance from 2012		+255	+722	+1,262

Source: CFAS II (2013) prevalence estimates applied to CCC Research & Performance Team population forecasts (2012 based)

[74] Matthews FE, Arthur A, Barnes LE et al (on behalf of the Medical Research Council Cognitive Function and Ageing Collaboration). A two-decade comparison of prevalence of dementia in individuals aged 65 and over from three geographical areas of England: results of the Cognitive Function and Ageing Study I and II. www.thelancet.com Published online July 16 2013.

Figure 15: Projected numbers of people aged 65 and older predicted to have dementia, local authorities in Cambridgeshire, 2012 to 2026



	Cambridge City	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
2012	1,249	1,055	1,401	1,895	1,842	7,442
2016	1,329	1,222	1,591	2,195	2,096	8,433
2021	1,484	1,473	1,890	2,762	2,564	10,173
2026	1,675	1,759	2,242	3,401	3,104	12,182

Source: CFAS II (2013) prevalence estimates applied to CCC Research & Performance Team population forecasts (2012 based

Early-onset dementia

In order to calculate future projections of early-onset dementia, depression and learning disability, estimates of the prevalence of mental illnesses from Projecting Adult Needs and Service Information (PANSI)[75] and Projecting Older People Population Information (POPPI)[76] were used. These are resources provided by the Institute of Public Care at Oxford Brookes University.

We applied the prevalence estimates to the Cambridgeshire population forecasts obtained from Cambridgeshire County Council to estimate the number of people with depression, early-onset dementia and learning disability expected in the years 2012, 2014, 2016, 2021 and 2026. The estimates are based on an assumption that there is no change in age-specific rates of these mental illnesses over this period.

POPPI uses prevalence estimates from the Dementia UK report of 2007.[77] A key issue in estimating prevalence is the selection of the population figures. Dementia prevalence tools using populations registered with general practice may produce different estimates, but the differences are not large enough to result in radically different approaches to service planning, particularly as so many cases remain undiagnosed in any case.

Table 3 and Figure 16 show the number of people of working age expected to have *early-onset* dementia, defined as onset before age 65 years. There is forecast to be a rise of approximately 20% by 2026, though the problem will remain rare.

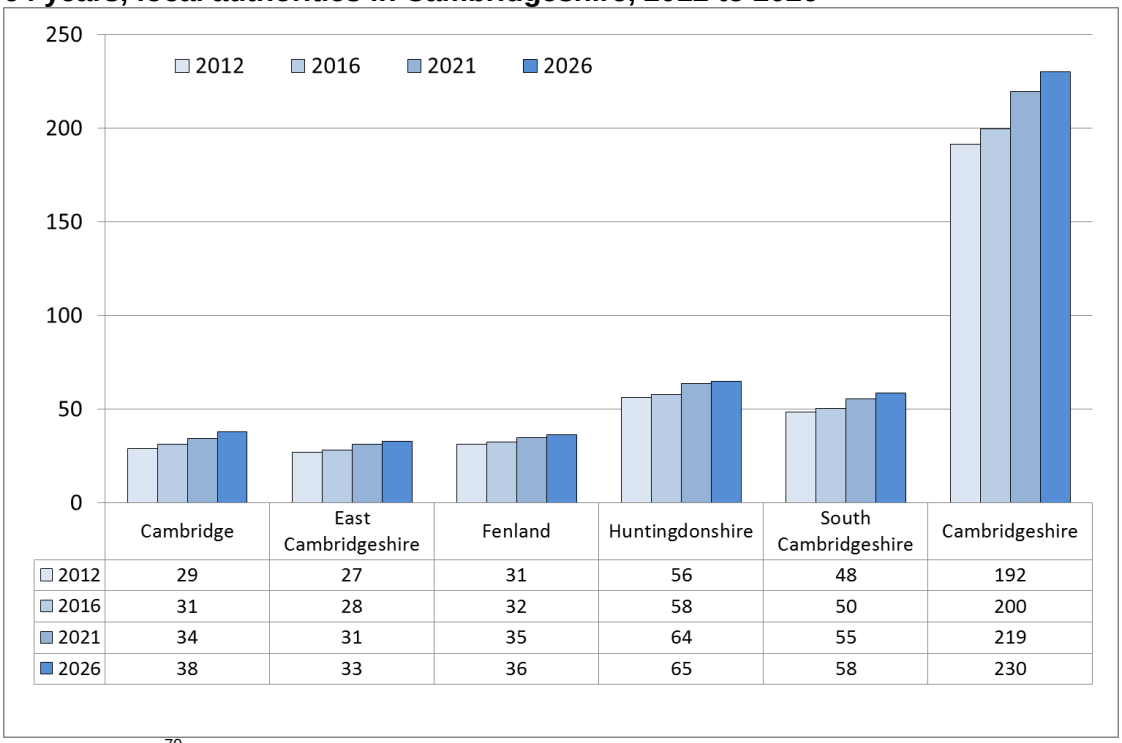
[75] Projecting Adult Needs and Service Information (PANSI). Available at: http://www.pansi.org.uk/
[76] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/
[77] Knapp M, Prince M (2007). *The Full Report*. London: Alzheimer's Society. Available at: http://alzheimers.org.uk/site/scripts/download_info.php?fileI*D=2.

Table 3: Change in projected numbers of people with early-onset dementia compared with 2012, local authorities in Cambridgeshire, 2012 to 2026

	2012	2016	2021	2026
Cambridgeshire				
Number of cases	192	200	219	230
Variance from 2012		+8	+28	+39
Cambridge				
Number of cases	29	31	34	38
Variance from 2012		+2	+5	+9
East Cambridgeshire				
Number of cases	27	28	31	33
Variance from 2012		+1	+4	+6
Fenland				
Number of cases	31	32	35	36
Variance from 2012		+1	+3	+5
Huntingdonshire				
Number of cases	56	58	64	65
Variance from 2012		+2	+7	+9
South Cambridgeshire				
Number of cases	48	50	55	58
Variance from 2012		+2	+7	+10

Source: PANSI[78] prevalence estimates applied to CCC Research & Performance Team population forecasts (2012 based)

Figure 16: Projected numbers of people with early-onset dementia, people aged 30 to 64 years, local authorities in Cambridgeshire, 2012 to 2026



	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
2012	29	27	31	56	48	192
2016	31	28	32	58	50	200
2021	34	31	35	64	55	219
2026	38	33	36	65	58	230

Source: PANSI[79] prevalence estimates applied to CCC Research and Performance Team population forecasts (2012 based)

[78] Projecting Adult Needs and Service Information (PANSI). Available at: http://www.pansi.org.uk/
[79] Projecting Adult Needs and Service Information (PANSI). Available at: http://www.pansi.org.uk/

Depression

Table 4 and Figure 17 show the number of older people predicted to have depression in 2016, 2021 and 2026, based on national prevalence estimates using POPPI. Here the predicted rise is steeper, as the ageing of the population means that more people enter the older age-groups covered by this report. Using national forecast prevalence rates, between 2012 and 2026 the number of older people with depression in Cambridgeshire is predicted to rise by 12%, from 11,908 to 13,365.

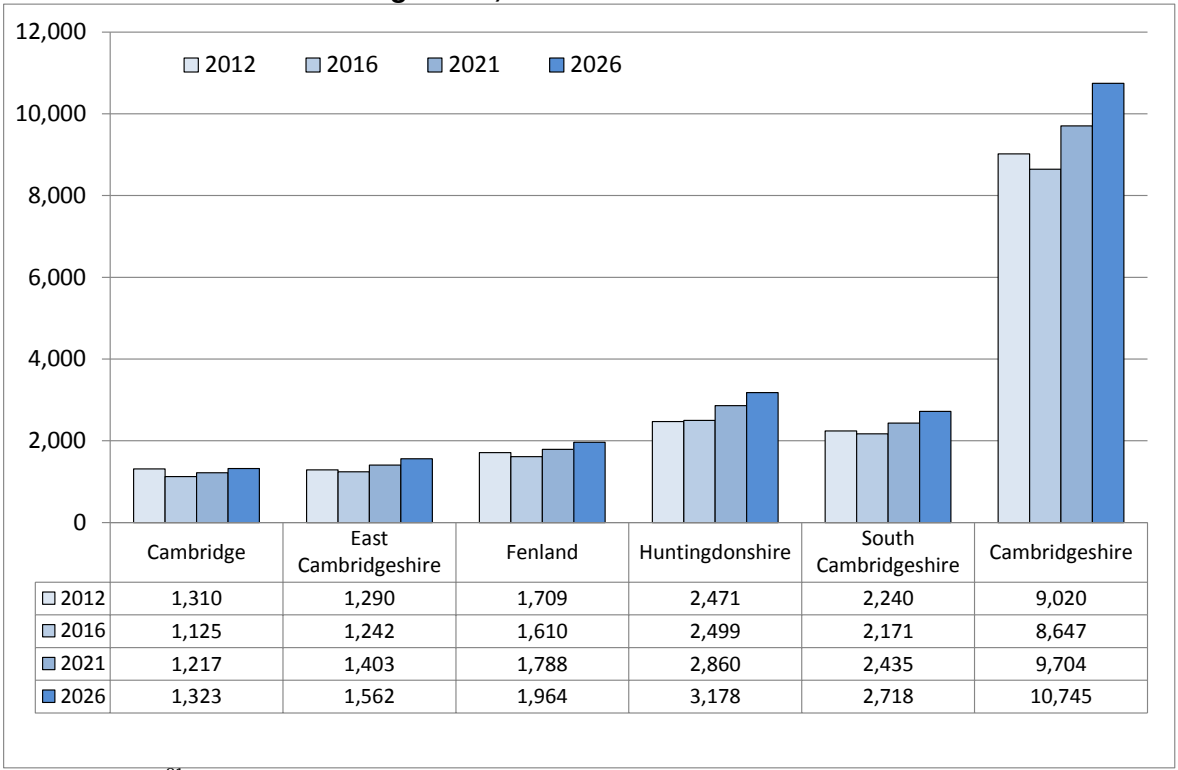
Table 4: Change in projected numbers of people with depression compared with 2012 in people 65 and older, local authorities in Cambridgeshire, 2012 to 2026

	2012	2016	2021	2026
Cambridgeshire				
Number of cases	11,908	12,296	13,218	13,365
Variance from 2012		+388	+1310	+1456
Cambridge				
Number of cases	3,542	3,850	4,222	4,117
Variance from 2012		+308	+680	+575
East Cambridgeshire				
Number of cases	1,400	1,424	1,531	1,575
Variance from 2012		+24	+130	+175
Fenland				
Number of cases	1,638	1,648	1,700	1,749
Variance from 2012		+10	+62	+111
Huntingdonshire				
Number of cases	2,890	2,901	3,067	3,125
Variance from 2012		+11	+177	+235
South Cambridgeshire				
Number of cases	2,438	2,473	2,699	2,798
Variance from 2012		+35	+261	+360

Source: POPPI[80] prevalence estimates applied to CCC Research and Performance Team population forecasts (2012 based)

[80] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/

Figure 17: Projected numbers of people with depression, people 65 years and older, local authorities in Cambridgeshire, 2012 to 2026



	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
2012	1,310	1,290	1,709	2,471	2,240	9,020
2016	1,125	1,242	1,610	2,499	2,171	8,647
2021	1,217	1,403	1,788	2,860	2,435	9,704
2026	1,323	1,562	1,964	3,178	2,718	10,745

Source: POPPI[81] prevalence estimates applied to CCC Research & Performance Team population forecasts (2012 based)

Severe depression

Table 5 and Figure 18 show the number of older people expected to have severe depression, based on national prevalence estimates using POPPI. The absolute numbers are lower, but, driven by population ageing, the predicted rise is 25% between 2012 and 2026.

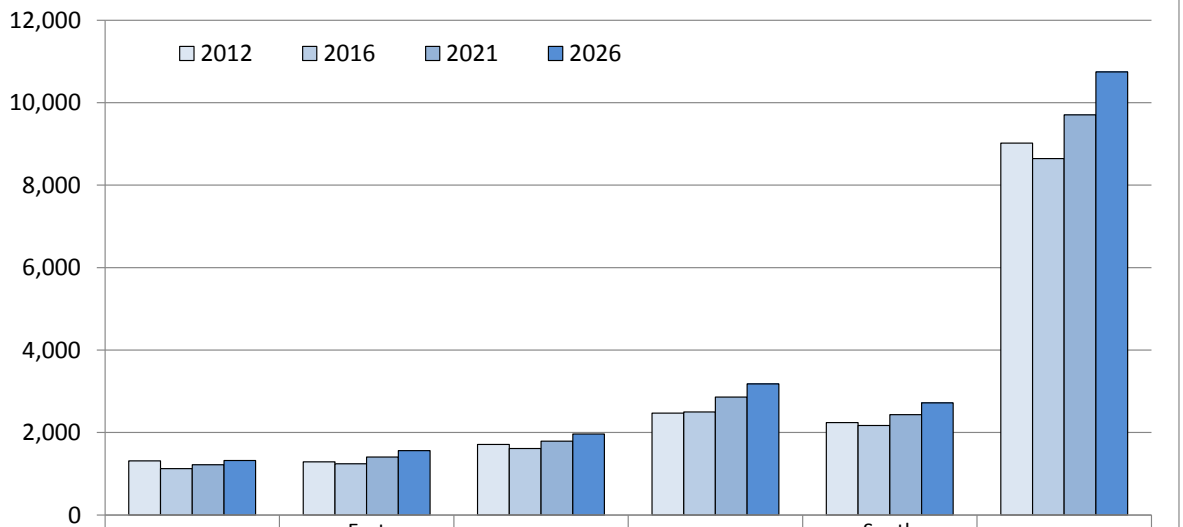
[81] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/

Table 5: Change in projected numbers of people with severe depression compared with 2012 in people 65 and older, local authorities in Cambridgeshire, 2012 to 2026

	2012	2016	2021	2026	2031
Cambridgeshire					
Number of cases	2,884	2,571	2,883	3,291	3,614
Variance from 2012		-313	-1	+407	+730
Cambridge					
Number of cases	428	335	361	400	440
Variance from 2012		-93	-67	-28	+12
East Cambridgeshire					
Number of cases	412	370	417	480	535
Variance from 2012		-42	+4	+68	+123
Fenland					
Number of cases	546	480	531	598	661
Variance from 2012		-67	-15	+52	+114
Huntingdonshire					
Number of cases	780	742	850	977	1,065
Variance from 2012		-38	+70	+197	+286
South Cambridgeshire					
Number of cases	717	644	724	836	913
Variance from 2012		-73	+7	+119	+196

Source: POPPI[82] prevalence estimates applied to CCC Research & Performance Team population forecasts (2012 based)

Figure 18: Projected numbers of people with severe depression, people 65 years and older, local authorities in Cambridgeshire, 2012 to 2026



	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
2012	1,310	1,290	1,709	2,471	2,240	9,020
2016	1,125	1,242	1,610	2,499	2,171	8,647
2021	1,217	1,403	1,788	2,860	2,435	9,704
2026	1,323	1,562	1,964	3,178	2,718	10,745

Source: POPPI[83] prevalence estimates applied to CCC Research & Performance Team population forecasts (2012 based)

[82] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/

Learning disability

Table 6 and Figure 19 show the number of older people predicted to have a learning disability in future years, based on national prevalence estimates using POPPI. The number is projected to rise from 2,164 in 2012 to 3,105 in 2026, an increase of 43%. People with some forms of learning disability, such as Down syndrome, are at increased risk of dementia, so the expected rise in the prevalence of dementia may reflect this rise in the numbers of older people with learning disability.

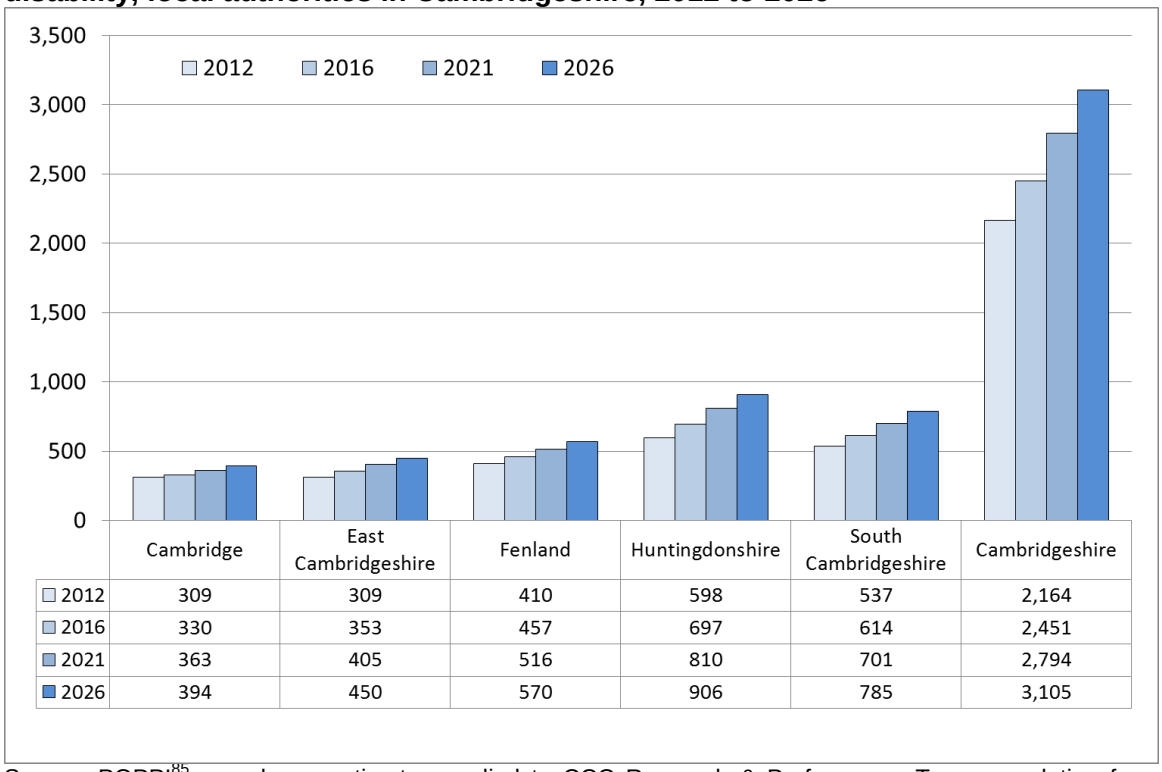
Table 6: Change in projected prevalence of learning disability compared with 2012 in people 65 and older, local authorities in Cambridgeshire, 2012 to 2026

	2012	2016	2021	2026
Cambridgeshire				
Number of cases	2,164	2,451	2,794	3,105
Variance from 2012		+287	+630	+941
Cambridge				
Number of cases	309	330	363	394
Variance from 2012		+21	+53	+85
East Cambridgeshire				
Number of cases	309	353	405	450
Variance from 2012		+44	+96	+141
Fenland				
Number of cases	410	457	516	570
Variance from 2012		+46	+106	+160
Huntingdonshire				
Number of cases	598	697	810	906
Variance from 2012		+99	+212	+308
South Cambridgeshire				
Number of cases	537	614	701	785
Variance from 2012		+77	+164	+247

Source: POPPI[84] prevalence estimates applied to CCC Research & Performance Team population forecasts (2011 based)

[83] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/
[84] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/

Figure 19: Projected number of people aged 65 and older predicted to have a learning disability, local authorities in Cambridgeshire, 2012 to 2026



	Cambridge	East Cambridgeshire	Fenland	Huntingdonshire	South Cambridgeshire	Cambridgeshire
2012	309	309	410	598	537	2,164
2016	330	353	457	697	614	2,451
2021	363	405	516	810	701	2,794
2026	394	450	570	906	785	3,105

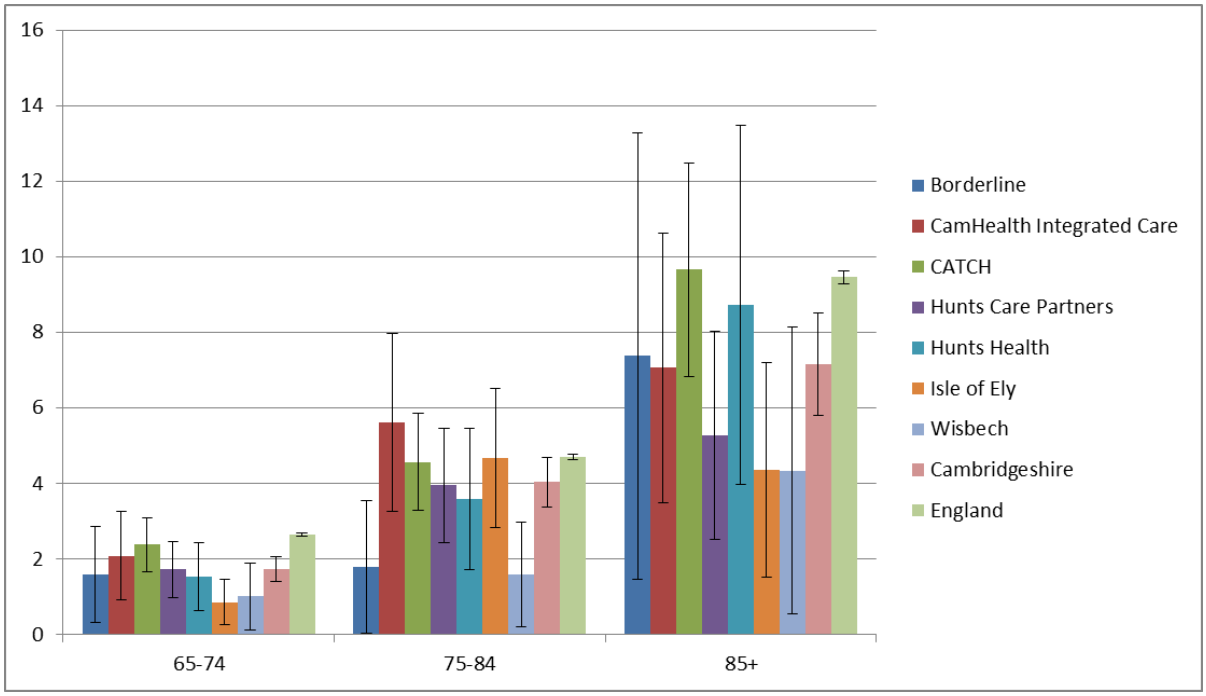
Source: POPPI[85] prevalence estimates applied to CCC Research & Performance Team population forecasts (2011 based)

3.7. Health services for older people with mental illness

Figure 20 shows rates of hospital admission of older people with mental illness of Cambridgeshire residents in each LCG to any NHS hospital. The rates rise with increasing age. They are lower in Cambridgeshire than in England. Of note, this data includes all admissions where the primary reason for admission is coded as mental health diagnosis. Individuals with mental health problems may also have been admitted under other primary codes for diagnosis if they had another physical health problem, eg for a fall. There are differences between areas, with rates in Cambridge City apparently higher, but this may be due to chance.

[85] Projecting Older People Population Information (POPPI). Available at: http://www.poppi.org.uk/

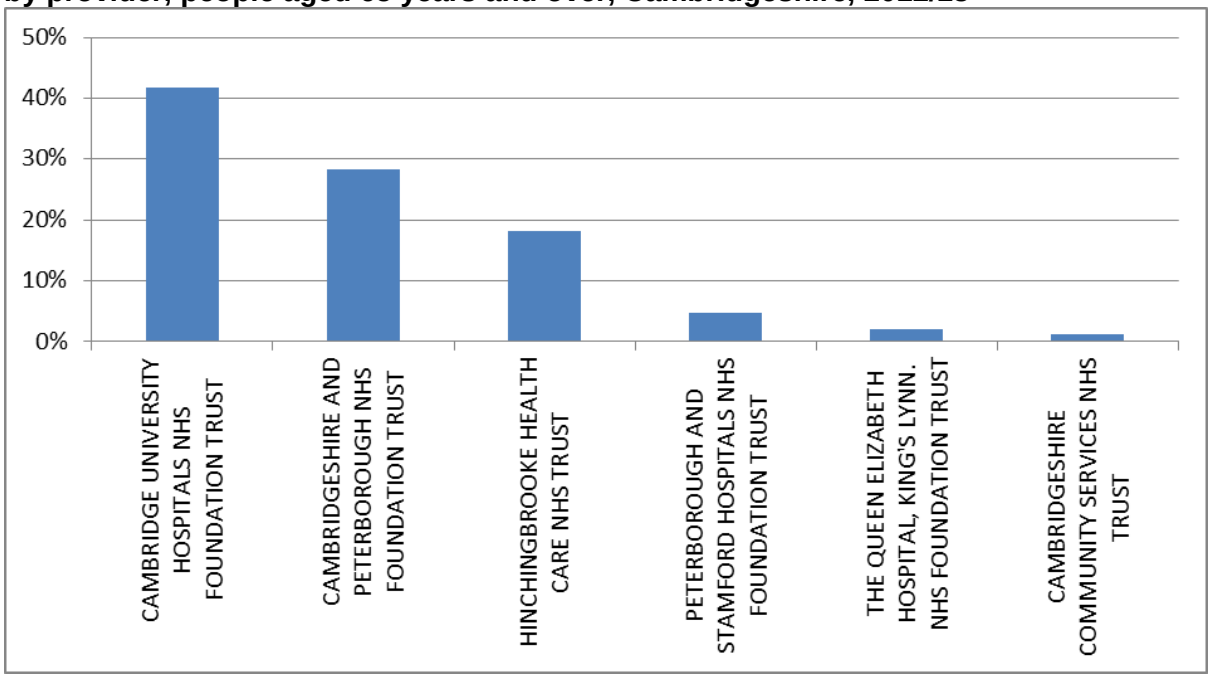
Figure 20: Rate of hospital admissions with a primary mental health diagnosis per 1,000 population, by age group and district, Cambridgeshire, 2012/13, with 95% confidence intervals



Source: HES, population figures from Cambridgeshire County Council Research & Performance Team

Figure 21 shows the rate of mental health admissions of older people in Cambridgeshire to different providers. More than 40% of admissions are to Cambridge University Hospitals Trust (CUHFT).

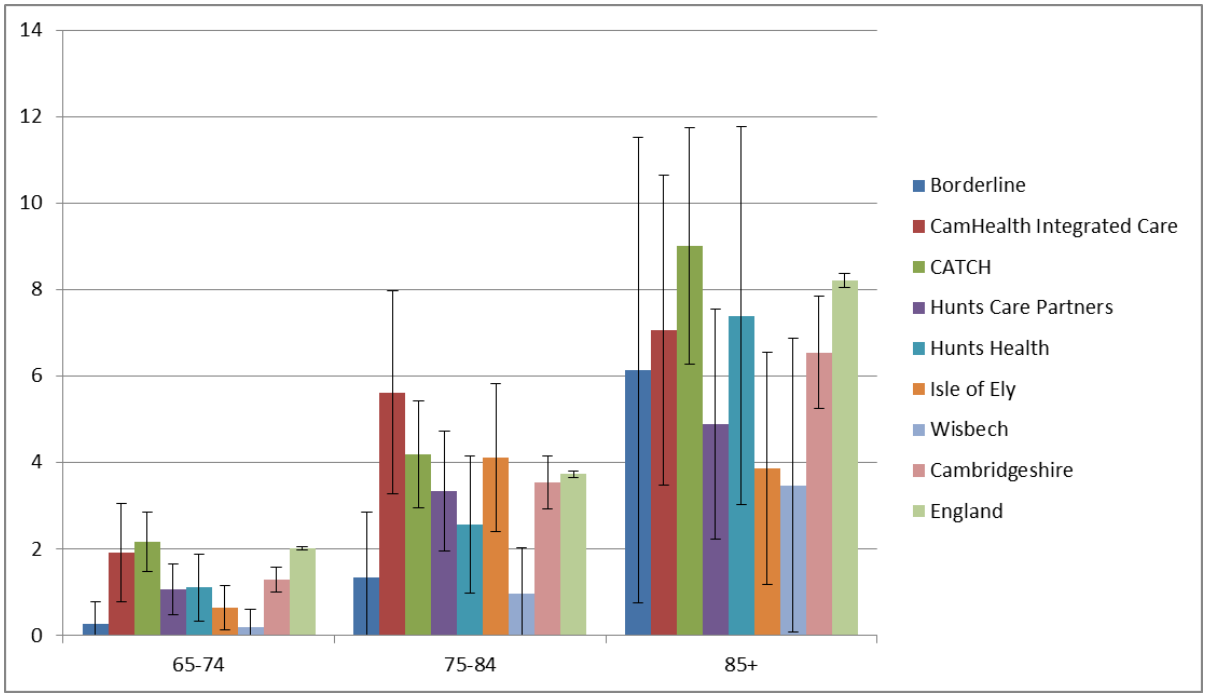
Figure 21: Proportions of hospital admissions with a primary mental health diagnosis by provider, people aged 65 years and over, Cambridgeshire, 2012/13



Source: HES

Figure 22 shows rates of emergency admission with mental illness in Cambridgeshire. Again, Cambridgeshire's rates appear to be somewhat lower than those in England, and rates in Cambridge City appear to be higher than those elsewhere in the County. Because the CCG's subdivisions are not coterminous with local authorities, no direct comparisons with need have been made.

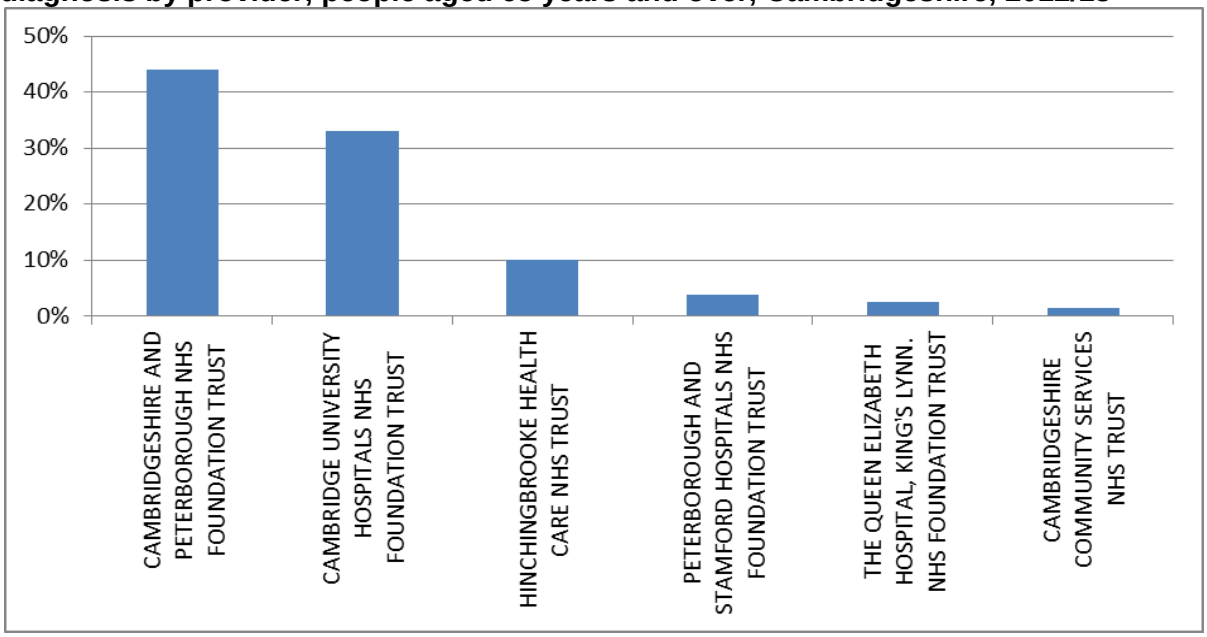
Figure 22: Rate of emergency hospital admissions with a primary mental health diagnosis per 1,000 population, by age group and district, Cambridgeshire, 2012/13, with 95% confidence intervals



Source: HES, population figures from Cambridgeshire County Council Research and Performance Team.

Figure 23 shows the rate of mental health admissions of older people in Cambridgeshire to different providers. More than 40% of admissions are to Cambridgeshire and Peterborough NHS Foundation Trust (CPFT). Again, the diagnosis recorded as the reason for admission to hospital and the coding of additional health problems limits the reliability of this data.

Figure 23: Proportions of emergency admissions with a primary mental health diagnosis by provider, people aged 65 years and over, Cambridgeshire, 2012/13

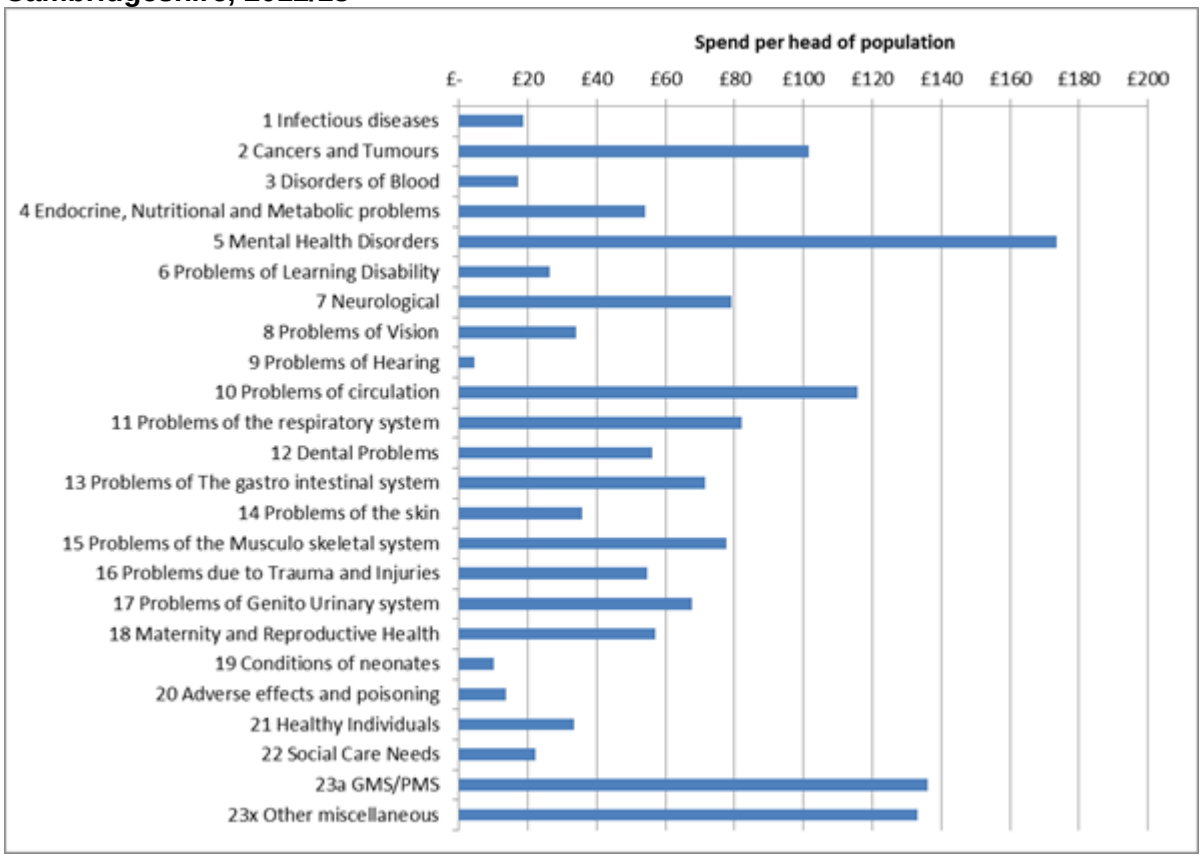


Source: HES

Figure 24 shows the spending by the NHS in Cambridgeshire per head of population on different disease areas, known as 'programme categories' in 2012/13. £174 per person per year was apparently spent on mental health programmes, 3% less than the £180 spent in 2011/12 and 18% less than the £213 per head spent on mental health programmes in England as a whole. This information is based on programme budgets. The definitions and coding practice used to compile the figures may differ between parts of the NHS and between years, with implications for the reliability of these comparisons. More analysis of the reasons for the differences would be of value.

In 2013/14, Cambridgeshire and Peterborough CCG's funding per head is £961. This is the lowest in East Anglia, 9% less than the average of £1,054 per person. It is one of the 11 health economies in England with the most severe financial challenges.

Figure 24: Spend per head of population by programme budget categories, Cambridgeshire, 2012/13

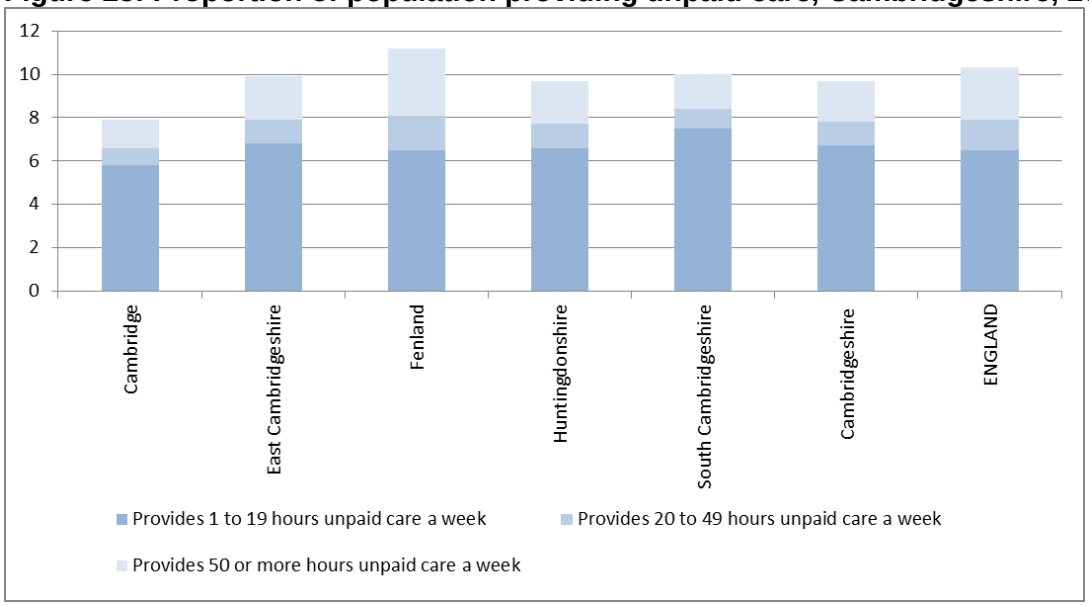


Source: Department of Health

3.8. Unpaid care

Figure 25 shows the proportion of people who provide unpaid care. Most parts of Cambridgeshire are close to the national average of 10%, but the proportion is slightly higher in Fenland and lower in Cambridge. Only some of these people are carers of older people with mental health problems.

Figure 25: Proportion of population providing unpaid care, Cambridgeshire, 2011



Source: Census 2011

Further information is available in the Cambridgeshire JSNA for Carers.[86]

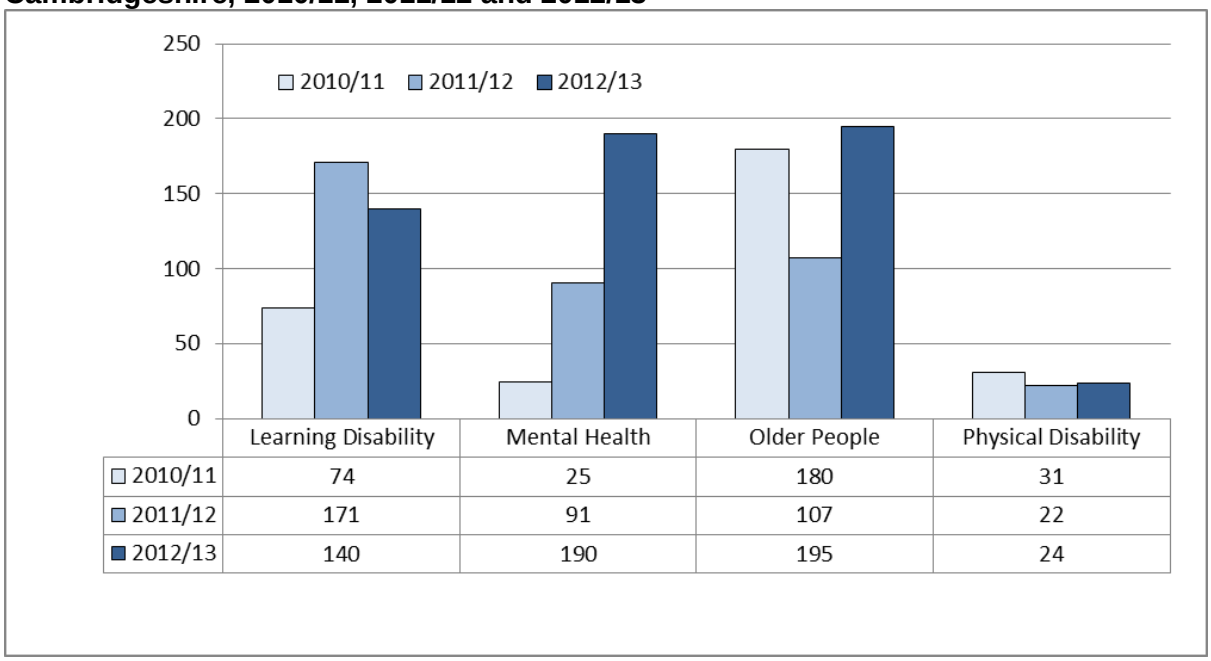
[86] Available at: http://www.cambridgeshireinsight.org.uk/jsna/carers

3.9. Adult safeguarding referrals

Adult safeguarding is the term that describes the function of protecting adults from abuse or neglect. This is an important shared priority of many public services and a key responsibility of local authorities. It is important to note that the safeguarding of vulnerable older people is a key priority which runs through all of the aspects of care, support and services described in this JSNA.

Figure 26 shows the categories of people referred to the Council's safeguarding team in whom abuse was substantiated. Mental health, learning disability and older people account for the majority of cases. This indicates the vulnerability to abuse of people with mental health issues.

Figure 26: Categories of vulnerability, number of victims of substantiated abuse, Cambridgeshire, 2010/11, 2011/12 and 2012/13



	Learning Disability	Mental Health	Older People	Physical Disability
2010/11	74	25	180	31
2011/12	171	91	107	22
2012/13	140	190	195	24

Source: Cambridgeshire County Council

4. Service map

In this section of the report, information is presented about mental health services available in Cambridgeshire for older people. Firstly, services specifically intended for people with depression and/or dementia are described, then outline information on services aimed at a wider range of people is provided, which may include those with these disorders.

Summary

This chapter describes acute and community mental health services available for older people and details three local clinical pathways for 'Functional mental illness' (includes depression, anxiety, bipolar affective disorder, psychosis, personality disorder); 'Memory assessment'; and 'Complex dementia'. Training programmes to raise awareness of dementia are in place across primary care, community and acute settings. Local support services are also provided by the Alzheimer's Society and Mind. These are jointly commissioned by the CCG and CCC and are described in more detail in section 4.3.

There is substantial variation in the rate of referrals to the older people's mental health service, with lower rates seen in South Cambridgeshire, and higher rates in Cambridge City, Fenland and East Cambridgeshire. The reasons for this variation are unclear and may relate to data quality problems, but it would merit further investigation.

There are other sources of information which were not available or accessible during this project, and these limited the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible, therefore, to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.

The current re-procurement of older people's services is expected to lead to improvements in mental health services for older people. The re-procurement process will involve clarifying what mental health services for older people are available, where and to whom.

4.1. Strategic background

In November 2012, Cambridgeshire and Peterborough Shadow Clinical Commissioning Group, Cambridgeshire County Council and Peterborough City Council published a draft Joint Commissioning Strategy for the Mental Health and Wellbeing of Older People 2013 - 2016. It included a dementia strategy.

The strategy had five themes:

1. Increasing awareness amongst those caring for older people of possible mental health problems, including cognitive impairment, affecting older people in all care settings including own home/community, care homes and hospitals:

    - Training for staff in hospitals, community services, care homes and primary care.
    - Review of the prescribing of anti-psychotic drugs for the management of dementia and awareness of alternative interventions.
    - Raising awareness of local guidelines and resources for the diagnosis and management of dementia and the prescribing of drugs used in the management of dementia.

2. Early diagnosis and improving access to effective help:

    - Introduce a single-point of access Advice and Resource Centre (ARC) to all local OPMH services.
    - Ensure that the ARC is supported by a comprehensive website.
    - Promote screening for dementia in acute and community settings, using consistent screening tools.
    - Provide access to a specialist Increasing Access to Psychological Therapy (IAPT) - accredited primary care mental health service for older people throughout Cambridgeshire and Peterborough.
    - Complete the roll-out of re-designed day therapy services to include younger people with dementia.
    - Promote the social inclusion of older people with mental health problems.
    - Maximise the independence of older people through the use of self-directed support and other opportunities to promote personalised care.
    - Implement the “Releasing Time to Care” programme in local wards.
    - Expand access to, and capacity of, local specialist accommodation for older people with mental health needs.
    - Ensure local “end-of-life” strategies reflect the needs of people with dementia.
    - Ensure that the issues faced by older people are recognised in local work to improve the response to people who may be at risk of suicide.
    - Continue to challenge stigma through mental health promotion activities.

3. The inter-relationship between physical and mental health and the need for multi-disciplinary working to better address the often complex health needs of older people in a more seamless and integrated way:

    - Design service models and care pathways that address physical and mental health needs simultaneously.
    - Explore opportunities to develop a more integrated approach to the management of older people who have both mental and physical health problems.
    - Improve integration between mental health and other providers, such as primary and secondary care services, social care and voluntary organisations, to improve health outcomes, promote independence and reduce admissions to acute care and other care settings.
    - Enhance liaison psychiatry services for older people in local hospitals.

4. Increasing access to advice and support for the carers of older people with mental health problems including cognitive impairment:

    - Ensure carers of older people with mental health problems are able to access carers’ support available throughout the wider health economy.
    - Explore potential for greater access to respite beds in local care homes, especially those patients with the most complex needs.
    - Increase access for carers to psychological therapies.

- Extend carer support volunteer service across the CCG area and identify options for long-term sustainability.
- Provide carer access to advice and support within acute hospitals.
- Implement the Alzheimer's Society carer information and support programme.

5. Improved commissioning processes to promote joint working across health and social care and voluntary organisations, allowing better use of available resources:

    - Focus on outcomes achieved for local service users as a key measure of the effectiveness of the services that are commissioned.
    - More closely monitor the quality of local services, including clinical and quality of life outcomes, service user and carer experience, safety, patient environment, and risk assessment.
    - Systematically use data from local Joint Strategic Needs Assessments to ensure equality of access to the services that are commissioned.
    - Ensure consistency between this strategy and the respective Cambridgeshire and Peterborough Commissioning Strategy for adults of working age.
    - Continue to improve the quality of data collected about local services so that this can be reliably used as the basis for future commissioning decisions.
    - Strengthen links with local carer groups, primary care and community services in order to improve feedback about local services.
    - Ensure through contract management that there is an effective multi-disciplinary partnership working between local service providers (including the voluntary sector) in order that patients receive an integrated and seamless service.
    - Continue and strengthen the already close working between the respective local commissioners of health and social care.
    - Ensure that the Transparency Challenge for information on Dementia Services is met.

The Older People Mental Health Group, chaired by the CCG GP clinical lead for older people's mental health, is responsible for monitoring progress in implementing this strategy. This multi-disciplinary working group includes commissioning, provider and patient representation. It has been active in developing strategy to improve OPMH and reviewing and coordinating operational progress across a wide range of statutory and voluntary organisations in Cambridgeshire and Peterborough. Review of the minutes showed progress against the Dementia CQUIN and local strategic objectives to improve the health and wellbeing of patients with dementia and for older people with mental health problems.

Examples of recent initiatives in the dementia field include:

- The recruitment of over 90 dementia friends' champions, who in turn have recruited nearly 900 dementia friends. These friends have attended information sessions and are able to provide support to people with dementia through small actions and by spreading awareness and understanding of the condition.
- Active recruitment to clinical trials such as the ATTILA Trial (**A**ssistive **T**echnology and **T**elecare to maintain **I**ndependent **L**iving **A**t home for people with dementia.)

- Development of a website where all the information about services is located in one place, ie a single point of access. The new website is called *Your Life, Your Choice* and has a specific dementia section.[87]
- Updated primary care pathway and protocol for dementia.[88]
- Dementia support pilot scheme run by the Alzheimer's Society in seven GP practices in Cambridge, where patients will be able to access support from the Society in the GP surgery.
- Peer-support groups and cognitive stimulation groups designed to enhance communication and listening skills and to raise self-esteem and confidence, as well as stimulating memory.
- Dementia cafes with guest speakers, with plans to establish them elsewhere in Cambridgeshire.
- The Books on Prescription scheme (now called Reading Well) is available in Cambridgeshire libraries. The scheme offers mood-boosting books, books on long-term conditions and books for carers.

The CCG is also a Dementia Action Alliance member and has an action plan to improve the way that services meet the needs of dementia patients and carers. Specific actions being led by the CCG include:

- Improving earlier diagnosis of dementia, through supporting the primary care DES and hospital CQUINs for case finding.
- Increasing staff awareness and improving the skills of dementia care workforce including primary care, care homes (development of Local Authority dementia training standards), supported housing and other partners.
- Commissioning integrated physical and mental health pathways for older people's services (through the Older People programme and procurement exercise currently underway) and implementing the Lifestyles Intervention Framework at ward level.
- Embedding liaison psychiatry into the acute hospitals.
- Supporting carers of people with dementia through the appointment of the older people's mental health service user engagement officer, consulting with the service user and carer group about services, developing the older people's mental health crisis card and hospital passport, and evaluating dementia annual reviews in primary care.

The CCG's commissioning processes coordinate the actions and contributions of a large number of organisations with an interest in older people's mental health. This is through the implementation of standardised outcome measures and quality dashboards for all service providers, ensuring the Service User Network (SUN) is at the centre of each commissioning decision and strengthening the relationships with The East of England Collaboration for Leadership in Health Research and Care (CLAHRC) and Dementias and Neurodegenerative Diseases Research Network (DeNDRoN) to improve research into dementia in Cambridgeshire and Peterborough.

[87] www.yourlifeyourchoice.org.uk
[88] http://members.cambridgeshireandpeterboroughccg.nhs.uk/Default.aspx.LocID-02dnew0a5.RefLocID-02d01u016014.Lang-EN.htm

The Collaboration's current research themes include dementia, frailty and end-of-life care. Four focus areas for the CLAHRC relevant to older people's mental health are:

- Admission avoidance.
- The effect and impact of CQUINs and dementia primary care direct enhanced service.
- Evaluation of the Addenbrooke's tool - eating and drinking well with dementia'
- Risk factors for cognitive decline and what interventions are most effective, including investigating the potential preventative role of exercise.

4.2. Services available

Many of the primary care and specialist services for people with mental illness will treat those with depression and dementia as part of a wider general service. However, this is not always specified in contract arrangements, service descriptions or budgets, and so may have a less obvious profile in reports such as this.

Older people's mental health services are delivered across two divisions:

Acute care consists of:

- Two crisis resolution and home treatment teams for older adults.
- Two functional illness admission units.
- Two dementia admission units.

Community services consist of:

- Community mental health teams including psychiatry and psychology services.
- Primary mental health.
- Day therapy services.
- Young people with dementia service.

Additionally, there is a multi-disciplinary liaison service for older people at Addenbrooke's Hospital. It provides training for staff and assessment and treatment for older people with mental health concerns in the general hospital setting, and works closely with community and acute OPMH services.

The six locality teams include mental health nurses, social workers, occupational therapists, psychologists, psychiatrists and support workers. They provide a primary mental health service, an IAPT- equivalent service for over 65s. It focuses on psychological interventions for mild to moderate common mental health problems. Secondary level psychology includes neuropsychological assessments, psychological interventions such as cognitive behaviour therapy (CBT), CAT and psychotherapy, and training and supervision of other staff.

Day therapy focuses on specific evidence-based interventions rather than long-term attendance for social support. Interventions include cognitive stimulation therapy and psychologically focused group therapy for recovery, anxiety and mood management. Some groups still take place in local centres but there is also an emphasis on outreach and supporting people to use local community activities. There has been a move away from a day hospital model.

CPFT have specific services for people with dementia diagnosed at less than 65 years old. There is a small resource and the referrals are for people with a diagnosis of a progressive dementia and exclude some other diagnosis such as alcohol-related dementia and primary brain damage.

All of the teams are integrated with local authority staff providing social care. For people suitable for case management, CPFT can commission domiciliary, residential or nursing care. There is an increased emphasis on using direct payments to enable people to develop their own personal care package. The teams also carry out statutory responsibilities such as advising on legal and financial matters, Court of Protection applications and Mental Health Act and Mental Capacity Act assessments.

Clinical pathways

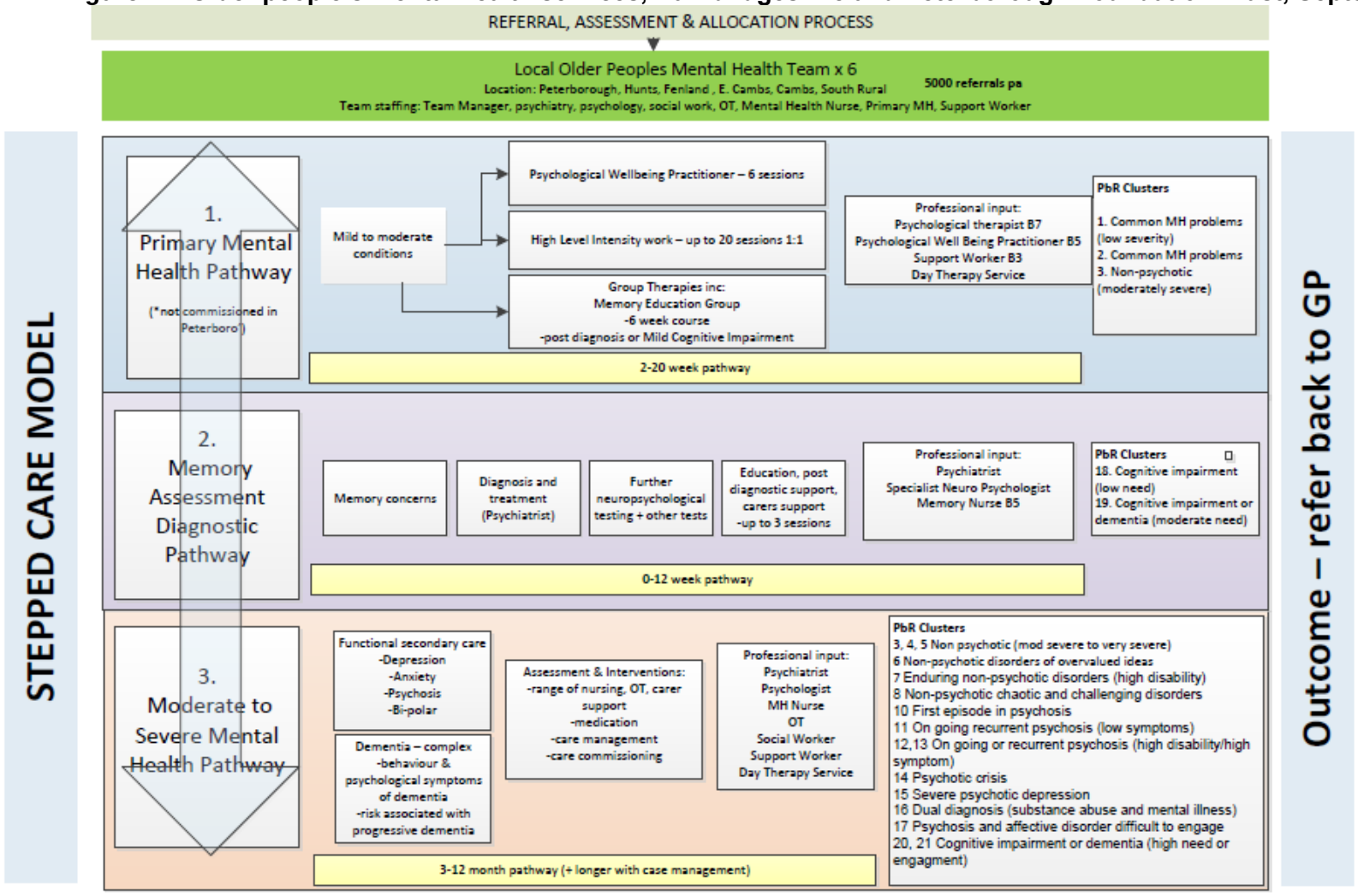
There are three clinical pathways for older people with mental health problems (Figure 29). Services include:

- Functional mental illness (includes depression, anxiety, bipolar affective disorder, psychosis, personality disorder).
- Memory assessment.
- Complex dementia.

In October 2013, about 30% of the caseload was for memory assessment, 24% was for management of complex dementia and 46% was for functional illness.

The community services deliver a stepped care model.

Figure 27: Older people's mental health services, Cambridgeshire and Peterborough Foundation Trust, September 2013



Source: CPFT

Memory clinics are for people with a suspected and/or identified memory impairment that is of an organic nature, not caused by depression or a physical illness. The referral criteria are:

- At least six months of memory problems affecting two or more domains.
- Score below 25 on standardised mini-mental state examination (SMMSE).
- Not managing activities of daily living.
- Significant carer concerns.

Memory assessment is a three month diagnostic pathway. Early assessment and diagnosis by a psychiatrist is followed up by nursing and support staff who can monitor and titrate any medication, offer post-diagnostic support and provide advice and signposting. CPFT have developed a programme of memory groups for people with a new diagnosis and their carers which focus on adjustment and education. CPFT have worked closely with the Alzheimer's Society and there are three memory support workers who work within the primary mental health and memory assessment pathways.

The number of referrals to the memory clinic is not included in quarterly key performance indicator data.

CPFT's *older people's mental health service* is for people over 65 years who:

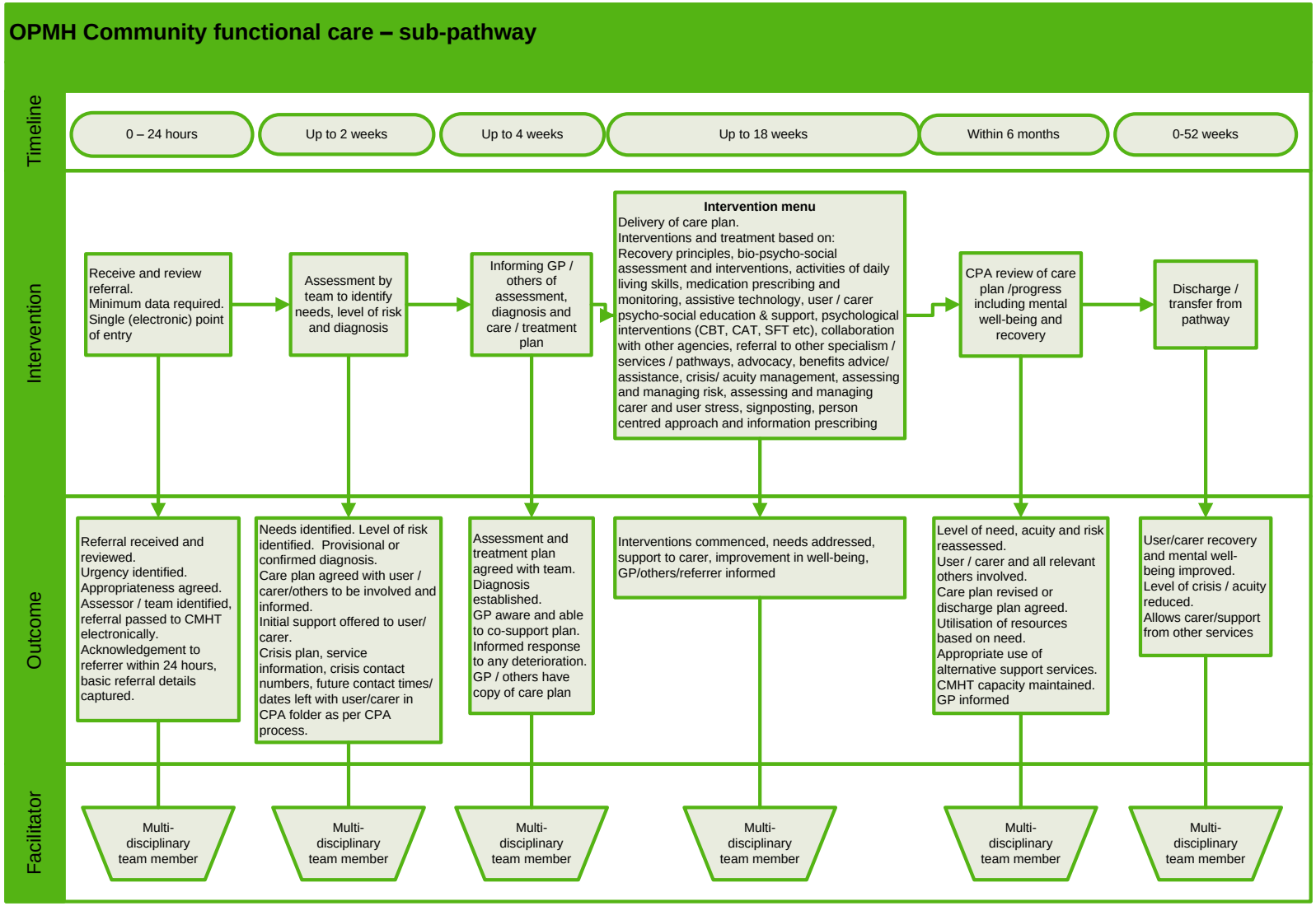
- Have a mood/affective disorder, psychotic disorder or neurosis.
- Have one or more social, behavioural or psychological needs.
- May require use of legislation.
- May be resistant to treatment.
- May present risk to self or others.
- Have complex mental health needs inter-related to physical health needs.
- Are at risk of admission to in-patient services.
- Require specialist assessment.
- Require a complex care plan integrated with other agencies.
- Require care, treatment and support from specialist mental health services for up to 12 months or more.
- Requires one or more of a range of specialist mental health interventions.

The service includes:

- Biological and physical assessments.
- Neuropsychological assessments.
- Reminiscence therapy.
- Aids to daily living skills.
- Medication prescribing and monitoring.
- Assistive technology.
- User and carer psychological education and support.
- Psychological interventions.
- Advocacy.
- Benefits advice and assistance.
- Crisis/acuity management.

This pathway describes CPFT's approach to the care of older people with functional mental health problems in the community. All the pathways shown in this report are currently under review.

Figure 28: Community Functional Care Pathway, Cambridgeshire and Peterborough Foundation Trust, September 2013



Source: CPFT

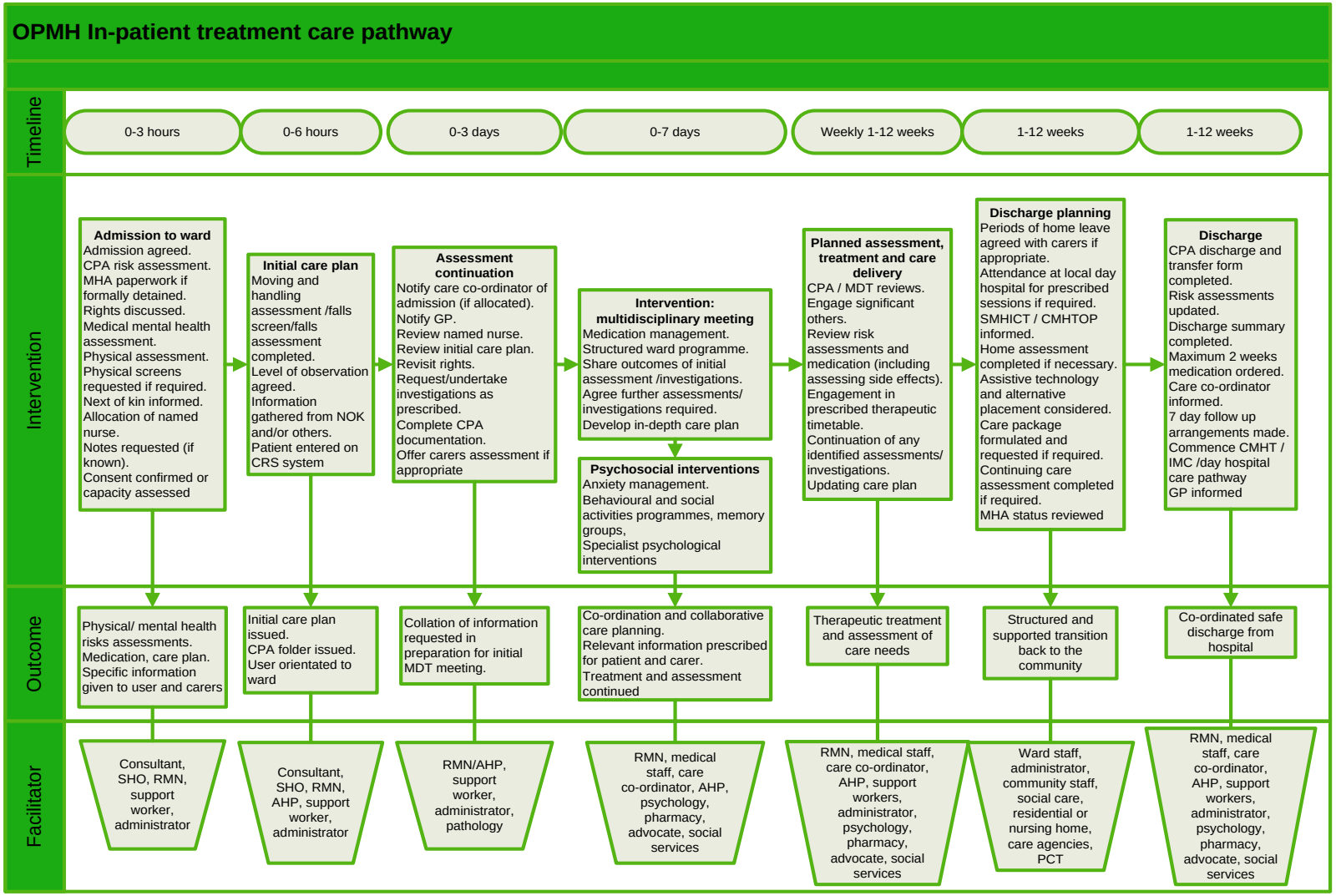
Older people meeting the following criteria may be admitted for treatment of mental health problems:

For service users of any age where specialist older people's mental health services are best placed to meet their needs.

- Acute or long-term functional illness which cannot be safely managed in the community.
- Failed first/second line treatment attempts.
- Requires intervention through use of legislation.
- Ongoing illness resistant to treatment.
- May present risk to themselves or others.
- Complex mental illness inter-related to physical health needs.
- At risk of severe neglect or death.
- Multiple social, behavioural or psychological needs.
- Requires specialist assessment and treatment within older people's mental health units.
- Likely to require multi-disciplinary team and range of interventions/care pathways.
- Assessment of continuing care needs cannot be undertaken in the community.

The treatment pathway for older people admitted with mental health problems is shown below:

Figure 29: Inpatient Treatment Care Pathway, Cambridgeshire and Peterborough Foundation Trust, September 2013



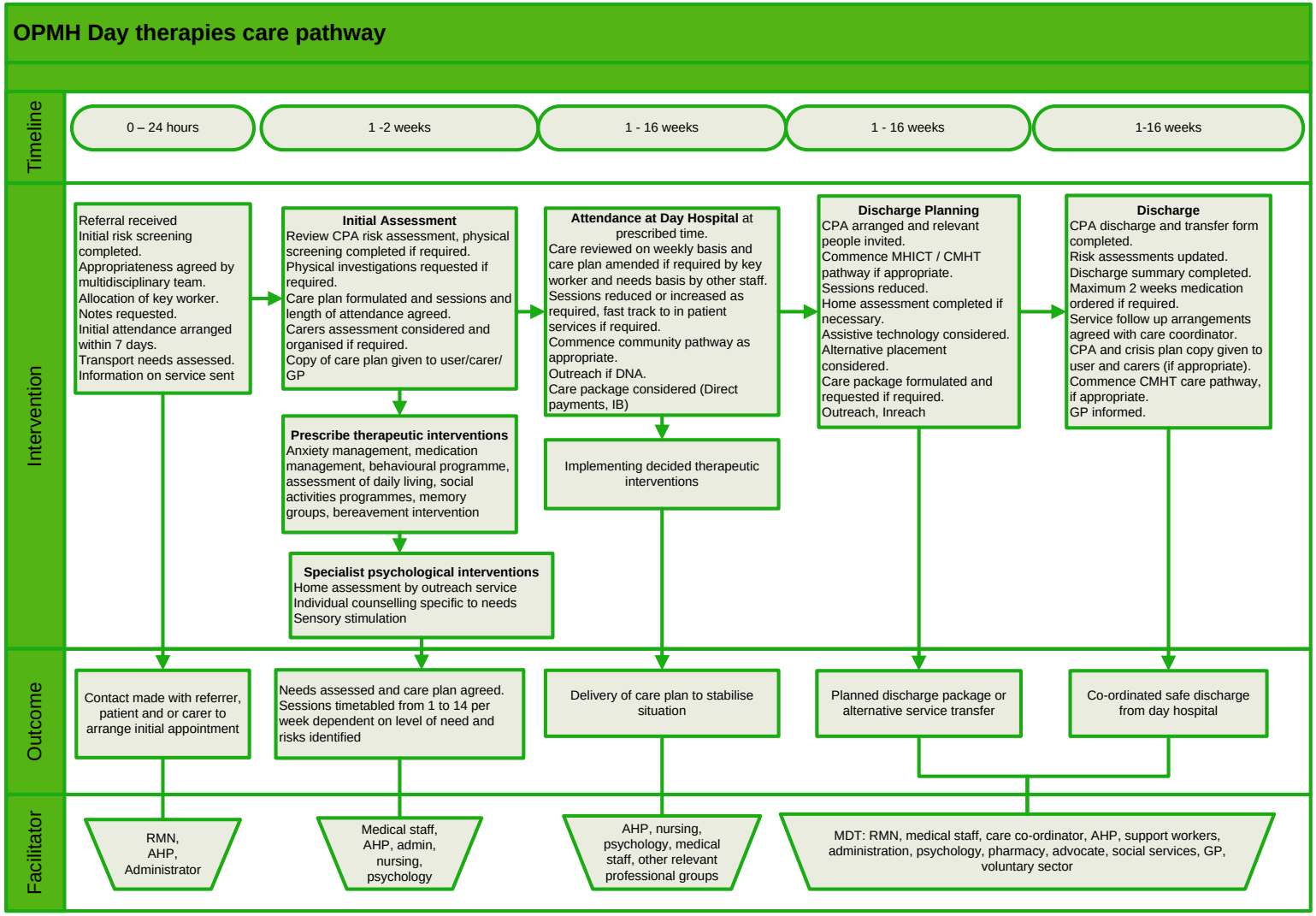
Source: CPFT

There is a day therapy service for older people with mental health problems. It includes provision of

- Psychotherapeutic group activity.
- Individual therapy.
- Arts therapies.
- Psychiatric support.
- Aid to daily living assessments.

The pathway appears below:

Figure 30: Day Therapies Care Pathway, Cambridgeshire and Peterborough Foundation Trust, September 2013



Source: CPFT

There is a *service for people with dementia under the age of 65 years,* provided by the older people's mental health team. The inclusion criteria are:

- Experiencing memory problems.
- Mild to severe dementia.
- One or more significant social, behavioural or psychological needs.
- Requires specialist assessment by older people's mental health for diagnosis of dementia.
- Requires long-term care, treatment and support from specialist mental health services.
- Presenting significant challenges in preventing deterioration in mental health.
- At risk of self-harm, harm to others or of admission to in-patient services or care home.
- Complex mental illness inter-related to social needs.
- One or more behavioural or psychological needs.
- Requires specialist assessment and complex care plan integrated with other agencies.
- Requires one or more periods in intermediate in-patient setting.
- Requires one or more of a range of specialist mental health interventions.

The service comprises:

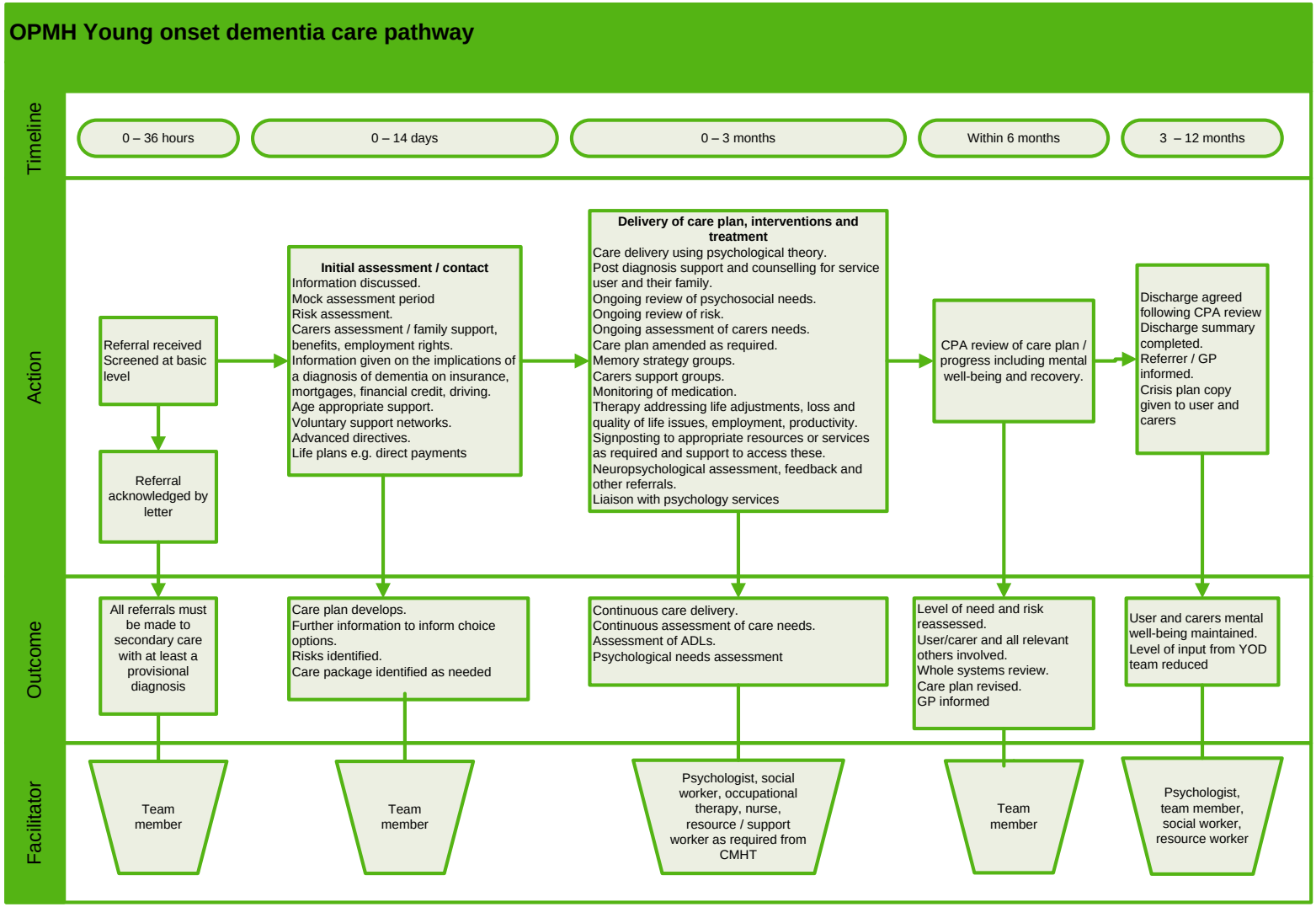
- Assessment.
- Specialist assessment.
- Care planning.
- Complex care plan.
- Carer's assessment.
- Information given on implications of diagnosis of dementia.

Interventions include:

- Neuropsychological assessment.
- Psychological therapy.
- Ongoing review of psychosocial needs.
- Medication monitoring.
- Memory strategy groups.
- Signposting to appropriate support.

The pathway for people with early onset dementia is below (Figure 33).

Figure 31: Young Onset Dementia Care Pathway, Cambridgeshire and Peterborough Foundation Trust, September 2013



Source: CPFT

Geographical areas and community teams

Table 7 below describes the services available for older people with mental health problems in different parts of Cambridgeshire.

Table 7: Older people's mental health services by locality, Cambridgeshire

Locality	Service	Base
Huntingdonshire	Integrated CMHT delivers to all three pathways. Integrated day therapy with primary and secondary care groups delivered from rented accommodation in Huntingdon.	Based at Newtown Centre, Huntingdon with many patients seen at this base. Patients can be assessed and reviewed at home.
Fenland	Integrated CMHT delivers to all three pathways. Day therapy delivered at base and in Wisbech.	Based at Alan Conway Court, Doddington with many patients seen at this base and in Wisbech. Patients can be assessed and reviewed at home.
East Cambridgeshire	Integrated CMHT delivers to all three pathways. Day therapy co-located at Princess of Wales Hospital (PoW).	Based at New Cottages at Princess of Wales Hospital, Ely. Some space to see patients at PoW and in local GP surgeries. Many assessed and reviewed at home.
South rural	Integrated CMHT delivers to all three pathways Day therapy based at Deighton Day Centre, Fulbourn.	Based at Sawston office plus sub team base at Royston. Some clinic space at Union Road, Cambridge. Many assessed and reviewed at home.
Cambridge city	Integrated CMHT delivers to all three pathways Day therapy based at Deighton Day Centre, Fulbourn.	Based at Elizabeth House, Fulbourn Hospital. Some clinic space at Nightingale Court, many assessed and reviewed at home.

Source: Dr Susan Green, CPFT

In 2013, there were 6,258 referrals to older people's community mental health services. This includes all of Cambridgeshire plus Essex psychiatry services. In 2013, there were 4,810 discharges from OPMH services.

The most recent information on activity in the older people's mental health service is shown in Table 8.

Table 8: Older people's mental health service activity, Cambridgeshire, April to December 2013

Service	Number of referrals	Number of completed care pathways
Community	2,722	2,882
Intermediate	943	968
Inpatient	192	203
Young onset dementia	42	48
Day therapies	241	400

Source: CPFT
The number of people completing care pathways exceeds the number of people referred when more patients are leaving than entering the care system – that is, caseloads are declining.

In February 2014, there were 3,762 people in contact with the service. This did not include patients under review by consultant psychiatrists.

Table 9 shows the rate of referrals to the older people's mental health service in 2013 from each district council area. There is substantial variation, with lower rates seen in South Cambridgeshire and Royston, and higher rates in Cambridge, Fenland and East Cambridgeshire. The reasons for this variation are unclear and may relate to data quality problems, but it would merit further investigation.

Table 9: Older people's mental health service referrals, by district council, Cambridgeshire, 2013

Team	Cambridge city	South Cambridgeshire and Royston	East Cambridgeshire	Huntingdon	Fenland
Bases	Cambridge	Sawston, Royston	Princess of Wales Hospital	Newtown Centre	Alan Conway Court, Doddington
Population over 65 years	15,052	29,225	15,219	29,357	20,152
Referrals/1,000 population	45.0	25.2	41.7	32.2	42.0

Source: Dr Susan Green, CPFT. Mid-2012 population estimates, based on 2011 Census, ONS

Older people's mental health training

Cambridgeshire Training Education and Development for Older People (CAMTED-OP) is a multi-disciplinary team within older people's mental health services of Cambridgeshire and Peterborough NHS Foundation Trust. The service was established in 2006 with a specific remit to provide training and practice development to care home providers in the Cambridge City, South Cambridgeshire and East Cambridgeshire. Currently, the service offers training and hands-on practice development work for staff working with people with mental health needs in care home, primary care (including GP practices), community settings and acute hospitals.

End-of-life care

End-of-life care has an important part to play in services for people with dementia. The CCG has an End of Life Programme Board who oversee their work to optimise the experience of care for patients approaching the end of their lives, and their carers, in all settings and at all times of the day and night.[89]

4.3. Other services

Primary care

Primary care plays a critical role in the care of people with mental illness. This includes diagnosing mental health problems, providing support to the patient and family, prescribing medication and referring where necessary. Primary care staff have a holistic approach which takes into account the patient's risk factors, physical and mental comorbidities and domestic and family situation. CAMTED provides them with training and they are supported by LCG mental health leads. A web tool is available to assist primary care staff with guidance and assistance with diagnosis, shared care arrangements and a primary care dementia pathway. There are plans to develop dementia services delivered by the Alzheimer's Society in pilot primary care surgeries, booked by reception staff and using a specific consulting room.

Advice and Referral Centres (ARC)

The advice and referral centres provide a single point of access into services. Referrals are received and triaged prior to signposting to the most appropriate service. If referrals are complex and cannot be processed via telephone or triaging, gateway workers undertake face to face assessments.

The ARCs provide GPs, nurses, other local medical professionals, service users and carers with advice, support and information. They are the main channel of mental health prevention information, specialist advice to GPs, self-management, signposting and initial triaging of referrals.

The service will collect a range of data regarding referrals into the service to include volume, treatment options and engagement rates, and signposting.

[89] www.cambridgeshireandpeterboroughccg.nhs.uk/end-of-life-care.htm

Care and nursing homes

There is a variety of residential care homes and nursing homes in Cambridgeshire. Some accommodate older people who have existing dementia on admission or who develop it later, while others specialise in providing care to people with dementia.

Alzheimer's Society

The following services are funded in part by Cambridgeshire County Council, in part by Cambridgeshire Clinical Commissioning Group and in part by the Society itself:

- *This is me,* a pack given to those diagnosed with dementia that they can complete and keep with them. This contains a photograph and key facts about the person such as medication and how they best communicate in case they cannot provide this information themselves.
- A campaigns team to promote professional and public referrals.
- A focus on living well with dementia: what people can do rather than what they cannot.
- Dementia group services such as cognitive stimulation groups, cafes and signing for the brain sessions.
- A carer information and support programme.
- Dementia advisors which help people with dementia navigate services. These advisors help refer people to memory clinics and obtain statutory, voluntary and community support.
- Support workers to provide initial support for newly diagnosed people.
- Statutory carers assessment.
- Primary care workers raising awareness of professionals and patients in primary care settings and also provide advice, support for dementia patients and their carers.
- Dementia friendly communities.
- Dementia friend training
- Dementia Action Alliance to help organisations support people with dementia.

Mind

Mind provides several services in Cambridgeshire funded by the NHS. They include:

- Changing Lives Service

This service is linked to the Improving Access to Psychological Therapies programme. The services provided reflect the focus of the programme in helping people with mental health problems improve their general health and wellbeing and promotes social inclusion and economic productivity. The particular focus of the service is people who struggle to access mainstream mental health services provided by NHS statutory providers.

- Counselling Service

Mind provides a counselling service in the Cambridge and Huntingdon areas, complementing other local provision for people with mental health problems for whom counselling would be a beneficial intervention.

- Service user engagement worker

Mind hosts a service user engagement worker on behalf of four local voluntary organisations providing mental health services. This individual co-ordinates representative service user input into local commissioning work streams.

- Groups for people with personality disorders

These have been available since 2006, and operate without specific external funding. Referrals have increased by 60% in the last 18 months.

The CCG's expenditure on older people's mental health is divided between the NHS and the third sector. In 2013/14, the CCG's expenditure on NHS services was £16,570,000 and the expenditure on third sector providers was £475,000 (for services specifically for older people). This excludes primary care costs such as general practitioners' time, accident and emergency services and prescribing expenditure.

5. Activity analysis

Needs assessment depends on understanding the present pattern of service use and how resources are directed. For NHS mental health services, the most appropriate source for these is the mental health minimum dataset, which contains details of each episode of care provided through the NHS, anonymised to protect patient confidentiality. No access to this dataset was possible within the four-month timescale of this project. This report therefore contains no information on the volume or cost of mental health services for older people.

This impedes service planning and evaluation by commissioners and limits the extent to which patterns of service delivery can be reported and analysed. The routinely collected anonymised national minimum dataset should be available in a timely and accessible format to providers and commissioners of mental health services.

6. Evidence-based recommendations for prevention and care

6.1. Summary of NICE Guidance

Relevant NICE guidance (clinical guidelines, public health guidance and quality standards) for prevention, treatment and care for individuals with dementia and/or depression is summarised in Table 10. In addition, the remainder of the chapter attempts to summarise the key points from the most pertinent guidelines. However, for reasons of brevity, this does not capture the very detailed content of each guideline such as which diagnostic tests to use, or the sequence and type of psychotherapy that should be offered and by whom.

Table 10: Relevant NICE Guidance	**Areas covered by recommendations**
General: Adults	
Behaviour change: individual approaches PHG49, 2014 http://guidance.nice.org.uk/PH49	1. Local behaviour change commissioning policy, strategy, interventions and programmes. 2. Organisation policies, strategies, resources and training all support behaviour change. 3. Commission high quality, effective behaviour change interventions. 4. Deliver very brief, brief, extended brief and high intensity behaviour change interventions and programmes. 5. Ensure behaviour change is maintained for at least a year. 6. Training for all staff involved in helping to change people's behaviour. 7. Monitoring and evaluation of behaviour change interventions.
Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services CG136, 2011 http://www.nice.org.uk/CG136	• Care and support across all points on the care pathway. • Access to care. • Assessment. • Community Care. • Assessment and referral in a crisis. • Hospital care. • Discharge and transfer of care. • Assessment and treatment under the Mental Health Act.
Service user experience in adult mental health: Quality Standard QS14, 2011 http://www.nice.org.uk/guidance/QS14	Covers improving the experience of people using adult NHS mental health services (excluding mental health service users using NHS services for physical health problems, or the experiences of families or carers of people using NHS services specifically).

Violence: the short-term management of disturbed/violent behaviour in in-patient psychiatric settings and emergency departments. CG25, 2005 http://www.nice.org.uk/CG25	• Environment and alarm systems. • Prediction: antecedents, warning signs and risk assessment. • Training. • Working with service users. • De-escalation techniques. • Observation. • Physical interventions. • Seclusion. • Rapid tranquillisation. • Post-incident review. • Emergency departments. • Searching.
Older People: Dementia	
Dementia: supporting people with dementia and their carers in health and social care. CG42 2006/2012 http://guidance.nice.org.uk/CG42	• Principles of care for people with dementia. • Integrated health and social care. • Risk factors, prevention and early identification. • Diagnosis and assessment of dementia. • Promoting and maintaining independence of people with dementia. • Interventions for cognitive symptoms and maintenance of function for people with dementia. • Interventions for non-cognitive symptoms and behaviour that challenges in people with dementia. • Interventions for co-morbid emotional disorders in people with dementia. • Inpatient dementia services. • Palliative care, pain relief and care at the end of life for people with dementia. • Support and interventions for the carers of people with dementia.
Commissioning Guide: Support for **commissioning dementia care** CMG48, April 2013 http://www.nice.org.uk/usingguidance/commissioningguides/dementia/home.jsp	Summarises the key commissioning issues and the resource impact that will arise from implementing the recommendations in NICE guidance and other NICE accredited guidance, to support improvements in the quality of care for people with dementia, in line with the statements and measures that comprise the NICE quality standards for dementia. The commissioning tool that accompanies this guide enables commissioners to show how well they are performing against a range of outcome measures that together demonstrate how well the whole system is working. Where data is available, the tool also demonstrates where improvements against outcome measures have prevented or reduced avoidable expenditure in the health and social care system.

Dementia: Quality Standard QS1, 2010 http://www.nice.org.uk/guidance/QS1	Includes the care provided by health and social care staff in direct contact with people with dementia in hospital, community, home-based, group care, residential or specialist care settings.
Supporting People to live well with dementia: Quality Standard QS30, 2013 http://www.nice.org.uk/guidance/QS30	This quality standard covers the care and support of people with dementia. It applies to all social care settings and services working with and caring for people with dementia.
End of life care for adults: Quality Standard 13 QS13, 2011 http://guidance.nice.org.uk/QS13	Covers all settings and services in which care is provided by health and social care staff to all adults approaching the end of life.
Older People: depression	
Depression: the treatment and management of depression in adults. CG90, 2009 http://www.nice.org.uk/CG90	• Care of all people with depression. • Stepped care. • Step 1: recognition, assessment and initial management. • Step 2: recognised depression-persistent sub-threshold depressive symptoms or mild to moderate depression. • Step 3: persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions, and moderate and severe depression. • Treatment choice based on depression subtypes and personal characteristics. • Enhanced care for depression. • Sequencing treatments after initial inadequate response. • Continuation and relapse prevention. • Step 4: complex and severe depression.
Depression in adults with a chronic physical health problem: treatment and management, CG91, 2009 http://www.nice.org.uk/CG91	• Principles of care for adults with depression and a chronic physical health problem (such as cancer, heart disease or diabetes). Guideline includes sub-threshold depressive symptoms. • Stepped care for adults. • Step 1: identification, assessment and initial management. • Step 2: Low-intensity psychological/psychosocial interventions, medication and referral for further assessment and interventions. • Step 3: Medication, high-intensity psychological interventions, combined treatments,

	collaborative care and referral for further assessment and interventions. • Step 4: intensive combined treatment, multi-professional care and inpatient services. • Risk Assessment.
Older People: improving mental wellbeing	
Mental wellbeing of older people in care homes: Quality Standard QS50, 2013 http://publications.nice.org.uk/mental-wellbeing-of-older-people-in-care-homes-qs50	This quality standard covers the mental wellbeing of older people (65 years and over) receiving care in all care home settings, including residential and nursing accommodation, day care and respite care. It uses a broad definition of mental wellbeing, and includes elements that are key to optimum functioning and independence, such as life satisfaction, optimism, self-esteem, feeling in control, having a purpose in life, and a sense of belonging and support.
Occupational therapy and physical activity interventions to promote the **mental wellbeing of older people in primary care and residential care** PH16, 2008 http://guidance.nice.org.uk/PH16	This guidance is for all those involved in promoting older people's mental wellbeing. It focuses on practical support for everyday activities, based on occupational therapy principles and methods. This includes working with older people and their carers to agree what kind of support they need. Key recommendations include: • Offer regular sessions that encourage older people to construct daily routines to help maintain or improve their mental wellbeing. The sessions should also increase their knowledge of a range of issues, from nutrition and how to stay active to personal care. • Offer tailored, community-based physical activity programmes. These should include moderate-intensity activities (such as swimming, walking, dancing), strength and resistance training, and toning and stretching exercises. • Advise older people and their carers how to exercise safely for 30 minutes a day on 5 or more days a week, using examples of everyday activities such as shopping, housework and gardening. (The 30 minutes can be broken down into 10-minute bursts.) • Promote regular participation in local walking schemes as a way of improving mental wellbeing. Help and support older people to participate fully in these schemes, taking into account their health, mobility and personal preferences. • Involve occupational therapists in the design of training offered to practitioners.
Older People: other mental health problems	
Generalised anxiety disorder and panic disorder in adults CG113, 2011 http://www.nice.org.uk/guidance/CG113	This offers evidence-based advice on the care and treatment of adults with generalised anxiety disorder or panic disorder (with or without agoraphobia).

Anxiety disorders: Quality Standard QS53, 2014 http://publications.nice.org.uk/anxiety-disorders-qs53	This quality standard covers the identification and management of anxiety disorders in primary, secondary and community care for children, young people and adults. It covers a range of anxiety disorders, including generalised anxiety disorder, social anxiety disorder, post-traumatic stress disorder, panic disorder, obsessive–compulsive disorder and body dysmorphic disorder.
Self-harm: the short-term physical and psychological management and secondary prevention of self-harm in primary and secondary care CG16, 2004 http://www.nice.org.uk/CG16 Self-harm (QS34), 2013	• Respect, understanding and choice. • Staff training. • Activated charcoal. • Triage. • Treatment. • Assessment of needs. • Assessment of risk. • Psychological, psychosocial and pharmacological interventions.
Self-harm (longer term management) CG133, 2011 http://guidance.nice.org.uk/CG133	
Relevant Social Care Institute for Excellence (SCIE) publications	Black and minority ethnic people with dementia and their access to support and services SCIE Research briefing 35, 2011 Assessing the mental health needs of older people SCIE Guide 3, 2006

6.2. Evidence-based guidance for individuals with dementia

6.2.1. NICE Clinical Guideline for dementia – diagnosis, treatment and service provision

The NICE Clinical Guideline CG42[90] (reviewed for update in May 2012) makes recommendations on all types of dementia including Alzheimer's disease, dementia with Lewy bodies (DLB), frontotemporal dementia, vascular dementia and mixed dementias. The guideline includes detailed information about all aspects of diagnosing and caring for people with dementia:

- Principles of care.
- Diagnosis and assessment.
- Promoting independence and maintaining function.
- Interventions for cognitive symptoms and maintenance of function.
- Interventions for non-cognitive symptoms and behaviour that challenges.
- Interventions for comorbid emotional disorders.
- Palliative and end-of-life care.
- Support for carers.
- Integrated and coordinated care.
- Accommodation and hospital care.
- Staff training.

As well as highlighting important principles of care, such as person-centred care, taking into account each person's individual needs and preferences, involvement and communication with carers and relatives, informed decision making, the guideline addresses issues of equality, to ensure that services are accessible and appropriate for all regardless of age, diagnosis, learning disability or communication barriers.

Diagnosis and assessment
The guideline recommends that specialist memory assessment services provided by a memory assessment clinic or community mental health teams should be the single point of referral for people with possible dementia. They should provide:

- A full range of assessment, diagnostic, therapeutic and rehabilitation services to accommodate different types and all severities of dementia and the needs of families and carers.
- Integrated care in partnership with local health, social care, and voluntary organisations.
- Following a diagnosis of dementia, make time available to discuss the diagnosis with the person with dementia and, if the person consents, with their family. Both may need ongoing support.

At the time of diagnosis, and regularly afterwards, people with dementia should be assessed for medical and psychiatric comorbidities including depression and/or anxiety and psychosis and should be considered for psychosocial therapy including cognitive behavioural therapy (possibly involving carers) or tailored interventions, such as reminiscence therapy, multisensory stimulation, animal-assisted therapy and exercise.

[90] http://guidance.nice.org.uk/CG42

Pharmacological interventions for comorbid depression should be offered in line with the NICE guideline on depression.

The NICE guideline aims to promote and maintain the independence, including mobility, of people with dementia and that services should support people with dementia in the community as far as possible. This should include supporting the needs of carers of people with dementia with psychological support, as well as providing practical living support.

Key elements of the guideline aimed at supporting this include:

- Care plans which address and support activities of daily living and minimise need for support, offering pharmacological treatment in line with NICE guidance.
- Offering people with dementia the opportunity to participate in a structured group cognitive stimulation programme irrespective of drug treatment for cognitive symptoms.
- Access to occupational therapy.
- Environmental modifications to aid independence, including assistive technology, with advice from an occupational therapist and/or clinical psychologist.
- Support to undertake physical exercise, with assessment and advice from a physiotherapist when needed.

Carers
The NICE guideline recognises the need to provide support for carers. They should be assessed to seek to identify any psychological distress and the psychosocial impact, care plans for carers which include tailored interventions, such as individual or group psycho-education, access to peer-support groups, telephone and internet information and support and training courses about dementia, services and benefits, dementia-care problem solving and access to psychotherapy.

Practical support, including transport and respite or short-break services, should be offered to enable carer participation in interventions and to support them in their caring role.

Training
The guideline recommends that all staff working with older people in the health, social care and voluntary sectors have access to dementia-care training and skill development that is consistent with their roles and responsibilities.

People with dementia in acute hospitals
The guideline recommends that acute and general hospital trusts should plan and provide services that address the specific personal and social care needs as well as the mental and physical health of people with dementia who use acute hospital facilities for any reason. In particular, the guideline requires that people with suspected or known dementia using inpatient services are assessed by a liaison service that specialises in the treatment of dementia. Care should be planned jointly by the trust's hospital staff, liaison teams, relevant social care staff and the person with suspected or known dementia and carers.

Integrated and coordinated health and social care
Multi-agency planning, implementation and delivery of services needs to be coordinated and this should result in all individuals having a combined care plan, with appropriately timed formal reviews, agreed by health and social services that takes into account the changing needs of the person with dementia and his or her carers.

People with dementia and their carers should be given up-to-date information on local arrangements including inter-agency working for health and social care, including the independent and voluntary sectors, and on how to access such services.

6.2.2. Dementia NHS Quality Standards

The Dementia Quality Standard[91] lists the standards of care that the NHS should aim to provide for people with dementia, related closely to the clinical guideline:

1. People with dementia receive care from staff appropriately trained in dementia care.
2. People with suspected dementia are referred to a memory assessment service specialising in the diagnosis and initial management of dementia.
3. People newly diagnosed with dementia and/or their carers receive written and verbal information about their condition, treatment and the support options in their local area.
4. People with dementia have an assessment and an ongoing personalised care plan, agreed across health and social care that identifies a named care co-ordinator and addresses their individual needs.
5. People with dementia, while they have capacity, have the opportunity to discuss and make decisions, together with their carer/s, about the use of:
    - Advance statements.
    - Advance decisions to refuse treatment.
    - Lasting Power of Attorney.
    - Preferred Priorities of Care.
6. Carers of people with dementia are offered an assessment of emotional, psychological and social needs and, if accepted, receive tailored interventions identified by a care plan to address those needs.
7. People with dementia who develop non-cognitive symptoms that cause them significant distress, or who develop behaviour that challenges, are offered an assessment at an early opportunity to establish generating and aggravating factors. Interventions to improve such behaviour or distress should be recorded in their care plan.
8. People with suspected or known dementia using acute and general hospital inpatient services or emergency departments have access to a liaison service that specialises in the diagnosis and management of dementia and older people's mental health.
9. People in the later stages of dementia are assessed by primary care teams to identify and plan their palliative care needs.
10. Carers of people with dementia have access to a comprehensive range of respite/short-break services that meet the needs of both the carer and the person with dementia.

[91] http://guidance.nice.org.uk/QS1/PublicInfo/pdf/English

The more recently published quality standard from NICE (QS30)[92] focuses on standards to support people with dementia to live well with dementia:

- Statement 1. People worried about possible dementia in themselves or someone they know can discuss their concerns, and the options of seeking a diagnosis, with someone with knowledge and expertise.
- Statement 2. People with dementia, with the involvement of their carers, have choice and control in decisions affecting their care and support.
- Statement 3. People with dementia participate, with the involvement of their carers, in a review of their needs and preferences when their circumstances change
- Statement 4. People with dementia are enabled, with the involvement of their carers, to take part in leisure activities during their day based on individual interest and choice.
- Statement 5. People with dementia are enabled, with the involvement of their carers, to maintain and develop relationships.
- Statement 6. People with dementia are enabled, with the involvement of their carers, to access services that help maintain their physical and mental health and wellbeing.
- Statement 7. People with dementia live in housing that meets their specific needs.
- Statement 8. People with dementia have opportunities, with the involvement of their carers, to participate in and influence the design, planning, evaluation and delivery of services.
- Statement 9. People with dementia are enabled, with the involvement of their carers, to access independent advocacy services.
- Statement 10. People with dementia are enabled, with the involvement of their carers, to maintain and develop their involvement in and contribution to their community.

Other related quality standards for people with dementia are:

- Patient experience in adult NHS services. NICE quality standard 15 (2012).
- End of life care for adults. NICE quality standard 13 (2011).

6.2.3. Medication for Alzheimer's disease

In March 2011, the NICE clinical guideline (CG42) was amended to incorporate the updated NICE technology appraisal of drugs for Alzheimer's disease. The review and re-appraisal of donepezil, galantamine, rivastigmine and memantine for the treatment of Alzheimer's disease resulted in a change in the guidance. Specifically:

- Donepezil, galantamine and rivastigmine are recommended as options for managing mild as well as moderate Alzheimer's disease.
- Memantine is now recommended as an option for managing moderate Alzheimer's disease for people who cannot take AChE inhibitors, and as an option for managing severe Alzheimer's disease.

These drugs are not licensed or recommended for use in the management of other types of dementia.

[92] http://www.nice.org.uk/guidance/QS30

6.3. Evidence-based guidance for individuals with depression

6.3.1. NICE Clinical Guideline on Depression in Adults

The NICE guideline on depression in adults (CG90)[93] was last updated in 2009. It makes recommendations on the identification, treatment and management of depression including subclinical depressive symptoms in adults aged 18 years and older, in primary and secondary care.

Depression is characterized by depressed mood and/or loss of pleasure in most activities. The severity of the disorder is determined by the number and severity of symptoms, and the degree of functional impairment. Some people may experience sub-threshold depressive symptoms which fall below the criteria for major depression, and are defined as at least one key symptom of depression but with insufficient other symptoms and/or functional impairment to meet the criteria for full diagnosis.

NICE recommends that the key goal of an intervention should be complete relief of symptoms (remission), which is associated with better functioning and a lower likelihood of relapse. The stepped-care model promoted by NICE provides the framework in which to organise the provision of services, and support patients, carers and practitioners in identifying and accessing the most effective interventions (see below). It advocates the least intrusive, most effective intervention is provided first; if a person does not benefit from the intervention initially offered, or declines an intervention, they should be offered an appropriate intervention from the next step.

Focus of the intervention	Nature of the intervention
STEP 4: Severe and complex depression; risk to life; severe self-neglect.	Medication, high-intensity psychological interventions, electroconvulsive therapy, crisis service, combined treatments, multi-professional and inpatient care.
STEP 3: Persistent sub-threshold depressive symptoms or mild to moderate depression with inadequate response to initial interventions; moderate and severe depression.	Medication, high-intensity psychological interventions, combined treatments, collaborative care and referral for further assessment and interventions.
STEP 2: Persistent sub-threshold depressive symptoms; mild to moderate depression.	Low-intensity psychosocial interventions, psychological interventions, medication and referral for further assessment and interventions.
STEP 1: All known and suspected presentations of depression.	Assessment, support, psycho-education, active monitoring and referral for further assessment and interventions.

[93] http://www.nice.org.uk/CG90

Priorities for implementation identified in the guideline are:

- *Principles for assessment:* When assessing a person who may have depression, conduct a comprehensive assessment that does not rely simply on a symptom count. Take into account both the degree of functional impairment and/or disability associated with the possible depression and the duration of the episode.

- *Effective delivery of interventions for depression:* All interventions for depression should be delivered by competent practitioners. Psychological and psychosocial interventions should be based on the relevant treatment manual(s), which should guide the structure and duration of the intervention.

- *Case identification and recognition:* Be alert to possible depression, particularly in people with a past history of depression or a chronic physical health problem with associated functional impairment.

- *Low-intensity psychosocial interventions:* For people with persistent sub-threshold depressive symptoms or mild to moderate depression, consider offering one or more of the following interventions, guided by the person's preference:

    - Individual guided self-help based on the principles of cognitive behavioural therapy (CBT) computerised cognitive behavioural therapy (CCBT).
    - A structured group physical activity programme.

- *Drug treatment:* Do not use antidepressants routinely to treat persistent sub-threshold depressive symptoms or mild depression, because the risk–benefit ratio is poor. Consider them for people with:

    - A past history of moderate or severe depression.
    - Initial presentation of sub-threshold depressive symptoms that have been present for a long period (typically at least two years).
    - Sub-threshold depressive symptoms or mild depression that persist(s) after other interventions.

    When prescribing antidepressants for older people, prescribe at an age-appropriate dose taking into account the effect of general physical health and concomitant medication on pharmacokinetics and pharmacodynamics and carefully monitor for side effects.

- *Treatment for moderate or severe depression:* For people with moderate or severe depression, provide a combination of antidepressant medication and a high-intensity psychological intervention (CBT or IPT).

- *Continuation and relapse prevention:* For a person whose depression has not responded to either pharmacological or psychological interventions, consider combining antidepressant medication with CBT.

    For people with long-standing moderate or severe depression who would benefit from additional social or vocational support, consider befriending as an adjunct to pharmacological or psychological treatments.

    Support and encourage a person who has benefited from taking an antidepressant to continue medication for at least six months after remission of an episode of depression.

- *Psychological interventions for relapse prevention:* People with depression who are considered to be at significant risk of relapse, including those who have relapsed despite antidepressant treatment or who are unable or choose not to continue antidepressant treatment, or who have residual symptoms should be offered one of the following psychological interventions:

    - Individual CBT for people who have relapsed despite antidepressant medication and for people with a significant history of depression and residual symptoms despite treatment.
    - Mindfulness-based cognitive therapy for people who are currently well but have experienced three or more previous episodes of depression.

6.3.2. NICE Quality Standards for adults with depression

The NICE Quality Standard[94] for depression in adults comprises thirteen statements:

- Statement 1. People who may have depression receive an assessment that identifies the severity of symptoms, the degree of associated functional impairment and the duration of the episode.
- Statement 2. Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression receive regular supervision that ensures they are competent in delivering interventions of appropriate content and duration in accordance with NICE guidance.
- Statement 3. Practitioners delivering pharmacological, psychological or psychosocial interventions for people with depression record health outcomes at each appointment and use the findings to adjust delivery of interventions.
- Statement 4. People with persistent sub-threshold depressive symptoms or mild to moderate depression receive appropriate low-intensity psychosocial interventions.
- Statement 5. People with persistent sub-threshold depressive symptoms or mild depression are prescribed antidepressants only when they meet specific clinical criteria in accordance with NICE guidance.
- Statement 6. People with moderate or severe depression (and no existing chronic physical health problem) receive a combination of antidepressant medication and either high-intensity cognitive behavioural therapy or interpersonal therapy.
- Statement 7. People with moderate depression and a chronic physical health problem receive an appropriate high-intensity psychological intervention.
- Statement 8. People with severe depression and a chronic physical health problem receive a combination of antidepressant medication and individual cognitive behavioural therapy.
- Statement 9. People with moderate to severe depression and a chronic physical health problem with associated functional impairment, whose symptoms are not responding to initial interventions, receive collaborative care.
- Statement 10. People with depression who benefit from treatment with antidepressants are advised to continue with treatment for at least 6 months after remission, extending to at least 2 years for people at risk of relapse.

[94] http://publications.nice.org.uk/depression-in-adults-quality-standard-qs8/list-of-statements

- Statement 11. People with depression whose treatment consists solely of antidepressants are regularly reassessed at intervals of at least 2 to 4 weeks for at least the first 3 months of treatment.
- Statement 12. People with depression that has not responded adequately to initial treatment within 6 to 8 weeks have their treatment plan reviewed.
- Statement 13. People who have been treated for depression who have residual symptoms or are considered to be at significant risk of relapse receive appropriate psychological interventions.

6.4. Prevention and addressing risk factors for dementia

NICE does not recommend general population screening for dementia. However, the guideline recommends reviewing and treating vascular and other risk factors for dementia in middle-aged and older people. These include smoking, excessive alcohol use, obesity, diabetes, hypertension and raised cholesterol levels.

No prevention measures are recommended. In fact, the guideline lists specific treatments which should not be used for the primary prevention of dementia: statins, vitamin E, hormone replacement therapy, and non-steroidal anti-inflammatory drugs.

For the secondary prevention of dementia, NICE recommends that patients should be reviewed and treated for vascular and other risk factors in people with the condition

NICE are developing two relevant pieces of public health guidance related to prevention and supporting older people to be independent and well:

1. Disability, dementia and frailty in later life – mid-life approaches to prevent or delay the onset of these conditions,[95] due for consultation in July to September 2014 and to be issued in February 2015.
2. Independence and mental wellbeing (including social and emotional wellbeing) for older people.[96] This is scheduled for consultation in May to June 2015, with publication expected in November 2015.

The guidance will complement NICE guidance on dementia and other non-communicable chronic conditions.

The guidance on mid-life approaches to prevent or delay the onset of disability, dementia and frailty in later life will include adults aged 40 to 64 years, with a particular focus on people at increased risk of frailty, dementia, disability or other non-communicable chronic conditions due to health-related behaviour and lifestyle factors. The guidance will also include adults aged 39 and younger from disadvantaged populations, as they are at increased risk of ill health and more likely to develop multiple morbidities.

[95] http://guidance.nice.org.uk/PHG/64/Scope/pdf/English
[96] http://guidance.nice.org.uk/PHG/65/Scope/pdf/English

Interventions to increase the uptake and maintenance of behaviours to prevent or delay frailty, disability, dementia and other non-communicable chronic conditions, such as cardiovascular diseases, diabetes, chronic obstructive pulmonary disease, and some cancers will be the focus of this review. These include:

- Interventions to encourage less sedentary behaviour, increase physical activity, improve diet, lose weight, quit smoking and reduce alcohol use.
- Interventions delivered at individual, family, community, subnational or national level. These may be targeted at specific groups, particularly those who are at increased risk, or who are from disadvantaged groups.
- Interventions carried out in a range of settings including primary and secondary care, and workplace and community settings in the private, public, voluntary or commercial sectors.

The guidance will seek to address:

1. Which mid-life lifestyle factors are associated with successful ageing and the primary prevention or delay of dementia, non-communicable chronic conditions, frailty and disability? How strong are the associations? How does this vary for different subpopulations?

2. What are the most effective and cost-effective mid-life interventions for increasing the uptake and maintenance of healthy lifestyle behaviours?

    - To what extent do the different health behaviours prevent or delay dementia?

    - To what extent do the different health behaviours prevent or delay frailty and disability related to modifiable lifestyle risk factors?

    - To what extent do the different health behaviours prevent or delay non-communicable chronic diseases?

3. What are the key issues for people in mid-life that prevent or limit their uptake and maintenance of healthy behaviours and to what extent do they have an effect? How does this differ for subpopulations, for example by ethnicity, socioeconomic status or gender?

4. What are the most effective models of delivery of interventions that increase the uptake and maintenance of healthy lifestyle behaviours in mid-life? For example, how do interventions targeting single versus multiple behaviours compare? How does effectiveness and cost effectiveness vary in relation to the recipient's demographic variables?

The second relevant publication is the public health guidance being developed on "Independence and mental wellbeing (including social and emotional wellbeing) for older people.[97]"

[97] http://guidance.nice.org.uk/PHG/65/Scope/pdf/English

This guidance will address the following questions:

1. What are the most effective and cost effective ways that local authorities, other services and communities can raise awareness of the importance of older peoples' mental wellbeing and independence?

2. What are the most effective and cost effective ways that local government, other services and communities can identify older people who are at high risk of a decline in their mental wellbeing or independence? This includes the following subsidiary questions:

    - What are the key identifiable risk factors?
    - What factors help reduce the risk of a decline in mental wellbeing or independence?

3. What are the most effective and cost effective ways to improve or protect the mental wellbeing and/or independence of older people? This could include the following subsidiary questions:

    - What information is needed by, or available to, those responsible for services for older people?
    - What is the role of services (such as transport and care support in the home), and technologies (such as alarm systems, electronic communication and information systems) in improving or protecting the mental wellbeing and independence of older people?
    - Are some interventions more effective for some target groups than others? What are the barriers and facilitators to assessing suitability for, and uptake of, interventions or services to improve or protect the mental wellbeing and/or independence of older people?

4. What links are there between the mental wellbeing and independence of older people and their: mental and physical health, capability, quality of life, isolation and participation in community, civil and family activities?

7. Evidence review

Summary

A review of the evidence did not find any reliable evaluated early interventions for mental health disorders in older people that were not included in existing NICE guidance.

7.1. Literature review: Primary prevention for older people mental health

A literature review was conducted to explore the evidence base for primary prevention or early interventions for mental health in older people. Secondary interventions or treatments for people who are already known to have a mental illness were not included in this review. This was not a systematic review seeking to identify and assess all the studies that have been published in this area, rather a search for high-level evidence from systematic reviews, meta-analyses and health economic studies that could be used to inform the delivery and targeting of interventions to groups at higher risk of mental ill-health in Cambridgeshire. Full details of the search strategy are given in the Appendix 2.

Generally the authors of the systematic reviews felt that the quality of the published studies in this area varied considerably. Some good quality randomised controlled studies were identified in some areas but many studies were lower quality observational studies. Common weaknesses of studies included a small number of participants, short duration of interventions, short follow-up periods and poor reporting of interventions or outcomes. In many cases weaknesses in the evidence base limited the strength of the conclusions that the systematic review authors were able to make about the effectiveness of different interventions.

In the tables we have summarized the literature relating to the effectiveness of interventions for adults and older people separately. The focus of the different systematic review varied, with some focusing on interventions based in a particular setting, for example the workplace, for any mental health issues, and other reviews focusing on specific interventions to prevent a particular mental health condition.

7.2. General and home-visit based interventions (Tables 10 and 11)

The authors of a general review comparing the effectiveness and costs of two or more interventions to promote mental health and wellbeing and/ or prevent the onset of mental health problems across all age groups concluded that one area where there was a strong case for action and investment for older people was group and home visiting activities eg group-based exercise and psychosocial interventions (McDaid & Park 2011[98] – see Table 10). We also identified a systematic review on the effect of home visits for older adults living in the community which found statistically significant improvements in functionality for programmes that included a clinical examination, and in mortality for programmes with younger study populations (Huss et al 2008[99] – see Table 11). However, no significant impact on admission to nursing homes was observed.

[98] McDaid D. Park A. Inventing in mental health and well-being: findings from the DataPrev project. Health Promotion International 2011, 26(S1): i108-i139

[99] Huss A. Stuck AE. Rubenstein LZ. Egger M. Clough-Gorr KM. Multi-dimensional preventative home visit programs for community-dwelling older adults: a systematic review and meta-analysis of randomized controlled trials. Journal of Gerontology 2008, 63A(3): 298-307

7.3. Interventions targeting particular mental health issues (Table 12)

Suicide

A systematic review on preventing suicide in the elderly found positive effects for interventions on level of patient's suicidal ideation, suicide rates of participating communities and depression. Interventions included support, education and/or treatment for depression, close monitoring, screening, telephone counselling, clinical treatment of depression, and reduction of social isolation. When gender was considered women seemed to benefit more than men. The authors concluded that preventative interventions were useful although no particular intervention stood out from the others (Lapierre et al 2011[100] – see Table 12).

Depression

Two systematic reviews were identified on the prevention of depression in older people, both focusing on non-pharmacological interventions. These reviews differed in the populations included with Lee et al 2012[101] (see Table 12) focusing on randomised controlled trials (RCTs) of adults aged at least 50 years and Forsman et al 2011[102] (see Table 12) focusing on RCTs and other studies involving adults aged 65 or older. However, both reviews concluded that non-pharmacological intervention can reduce depressive symptoms, although less evidence was identified for an impact on quality of life. The effect sizes observed were smaller in Forsman et al's review which included older populations.

Cognitive decline or cognitive impairment

We identified a number of systematic reviews on different approaches to preventing cognitive decline. A few interventions were considered to be promising although these results should be treated with caution as they were all drawn from lower quality observational studies:

- The majority of studies identified reported a positive effect for cognitive leisure activities during mid or late life (Stern & Munn 2010[103])
- An association was found between vegetable consumption and lower risk of dementia or slower rate of cognitive decline (Loef & Walach 2012[104])
- A slight protective effect for the prevention of dementia was found from taking statins (Wong et al 2013[105])
- The use of nonsteroidal anti-inflammatory drugs was associated with a decreased risk of Alzheimer's disease (Szekely et al 2004[106])

[100] Lapierre S. Erlangsen A. Waern M. et al. A systematic review of elderly suicide prevention programs. Crisis 32(2): 88-98

[101] Lee SY. Franchetti MK. Imanbayev A. Gallo JJ. Spira AP. Lee HB. Non-pharmacological prevention of major depression among community-dwelling older adults: a systematic review of the efficacy of psychotherapy interventions. Archives of Gerontology and Geriatrics 2012, 55: 522-529

[102] Forsman AK. Schierenbeck I. Wahlbeck K. Psychosocial interventions for the prevention of depression in older adults: systematic review and meta-analysis. Journal of aging and Health 2011, 23(3): 387-416

[103] Stern C. Munn Z. Cognitive leisure activities and their role in preventing dementia: a systematic review. International Journal of Evidence Based Healthcare 2010, 8: 2-17

[104] Loef M. Walach H. Fruit, vegetables and prevention of cognitive decline or dementia: a systematic review of cohort studies. The Journal of Nutrition, Health and Aging 2012, 16(7): 626-630

[105] Wong WB. Lin VW. Boudreau D. Devine EB. Statins in the prevention of dementia and Alzheimer's disease: a meta-analysis of observational studies and an assessment of confounding. Pharmacoepidemiology and Drug Safety 2013, 22: 345-358

[106] Szekely CA. Thorne JE. Zandi PP. et al. Nonsteroidal anti-inflammatory drugs for the prevention of Alzheimer's disease: a systematic review. Neuroepidemiology 2004, 23: 159-169

It should be noted however that the 2012 NICE Clinical Guideline for Dementia[107] specifically stated that statins and non-steroidal anti-inflammatory drugs should not be used for primary prevention of dementia.

We also identified several reviews that did *not* recommend the intervention considered as a means of preventing cognitive decline or dementia based on current evidence. These included:

- Screening community-dwelling older adults for cognitive impairment (Lin et al 2013[108]).
- Omega-3 fatty acid for cognitively healthy older adults (Sydenham et al 2012[109]).
- B-vitamins or fatty acids as single nutrients or in combination for healthy older people (Dangour et al 2010[110]).
- Fruit consumption was also not found to be associated with the prevention of dementia or cognitive decline (Loef & Walach 2012[111]).
- Blood pressure lowering interventions for people with hypertension, although there was significant bias within the studies which make it difficult to draw firm conclusions (McGuiness et al 2009[112]).

The evidence on physical leisure activities was considered to be insufficient to either recommend or rule out a benefit for preventing dementia (Stern & Konno 2009[113]).

[107] http://guidance.nice.org.uk/CG42

[108] Lin JS. O'Connor E. Rossom RC. Perdue LA. Exkstrom E. Screening for cognitive impairment in older adults: a systematic review for the US Preventative Services Task Force. Annals of Internal Medicine 2013, 159: 601-612

[109] Sydenham E, Dangour AD. Lim WS. Omega 3 fatty acid for the prevention of cognitive decline and dementia. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD005379. DOI: 10.1002/14651858.CD005379.pub3

[110] Dangour AD. Whitehouse PJ. Rafferty K. Mitchell SA. Smith L. Hawkesworth S. Vellas B. B-vitamins and fatty acids in the prevention and treatment of Alzheimer's disease and dementia: a systematic review. Journal of Alzheimer's Disease 2010, 22: 205-224

[111] Loef M. Walach H. Fruit, vegetables and prevention of cognitive decline or dementia: a systematic review of cohort studies. The Journal of Nutrition, Health and Aging 2012, 16(7): 626-630

[112] McGuinness B. Todd S. Passmore P. Bullock R. Blood pressure lowering in patients without prior cerebrovascular disease for prevention of cognitive impairment and dementia. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD004034. DOI: 10.1002/14651858.CD004034.pub3

[113] Stern C. Konno R. Physical leisure activities and their role in preventing dementia: a systematic review. International Journal of Evidence Based Healthcare 2009, 7: 270-282

General review papers

Table 11: Primary prevention in mental health: interventions across all populations

Study and Aim:	Population	Interventions	Key findings	Author's conclusions
McDaid & Park 2011,[114] systematic review of 47 studies **comparing the effectiveness and costs of two or more health-focused interventions** to promote mental health and wellbeing and/or prevent the onset of mental health problems.	All age groups	The review focused on early years and parenting interventions, actions set in school and workplaces and measures targeted at older people.	Areas where the authors felt there was a strong case for action and investment included: • Childhood and targeted at mothers eg health visiting and parenting programmes • Workplace interventions eg health promotion and stress management programmes • Group and home visiting activities for older people eg group-based exercise and psychosocial interventions	The case for investment in parenting and health visitor-related programmes was most strong. Benefit was also observed in workplace interventions and for group and home visiting activities for older people.

[114] McDaid D. Park A. Inventing in mental health and well-being: findings from the DataPrev project. Health Promotion International 2011, 26(S1): i108-i139

Older people

Table 12: Primary prevention in mental health: interventions targeted at older people in community/ family settings

Study and Aim:	Population	Intervention	Key findings	Author's conclusions
Huss et al 2008,[115] systematic review of 21 trials examining the effect of **home visit programmes** on mortality, nursing some admissions and functional status decline.	Older adults (mean age >70 years) living in the community (n=14,603)	Multi-dimensional preventative home visit programmes. The median number of home visits was 4.3 (maximum 12) ranging from four months to four years in duration.	The trial results were heterogeneous. Overall the improvements observed were not statistically significant for effects on nursing home admissions, functional status or mortality. Meta-regression investigating characteristics that might affect the impact showed some statistically significant results: • Programmes including a clinical examination showed a beneficial effect on functional status (OR 0.64, 95%CI 0.48 to 0.87) • Trials whose participants had a younger mean age showed a greater positive effect on mortality (OR 0.74, 95%CI 0.58 to 0.94) compared to trials with an older mean age More intensive programme (≥3 visits per year) did not result in fewer hospital admissions than programme with fewer visits (<3 per year).	Multi-dimensional preventative home visits have the potential to reduce disability burden among older adults when based on multi-dimensional assessment with clinical examination.

[115] Huss A. Stuck AE. Rubenstein LZ. Egger M. Clough-Gorr KM. Multi-dimensional preventative home visit programs for community-dwelling older adults: a systematic review and meta-analysis of randomized controlled trials. Journal of Gerontology 2008, 63A(3): 298-307

Table 13: Primary prevention in mental health: interventions for older people targeting particular mental health issues

Study and Aim:	Population	Intervention	Key findings	Author's conclusions
Lapierre et al 2011,[116] systematic review of 19 studies on **preventing suicide in the elderly**	Older people (aged at least 60 years)	Any intervention aimed at reducing suicidal ideation, suicidal behaviour or death by suicide. Interventions included support, education and/or treatment for depression, close monitoring, screening, telephone counselling, clinical treatment of depression, and reduction of social isolation.	• Six/nine interventions assessed were associated with a reduction in the level of patients' suicidal ideation or in the suicide rates of participating communities. • Two/three studies assessing depression found a significant reduction. • Where gender was considered, women seemed to benefit more than men. • Most studies focused on the reduction of risk factors. Programmes aiming at improving protective factors were rare.	All types of preventative interventions were useful for the population they reached however none stood out from the others with regard to their effect on the various outcome variables.
Lee et al 2012,[117] systematic review of 5 trials of **non-pharmacological interventions for the prevention of depression**	Community-dwelling older adults (aged at least 50 years at study entry) with depressive symptoms but who do not meet DSM-IV criteria for depression.	Non-pharmacological interventions to prevent depression. Interventions included psychotherapy, social and behavioural activation, life-review and reminiscence, CBT and internet CBT. Intervention duration ranged from 11 weeks to 12 months.	• Four/five interventions were associated with statistically significant greater reduction in depressive symptoms compared to controls (ES ranged from 0.25 to 1.22) • The largest effect size achieved was for internet CBT (1.22) • One trial also showed a statistically significant improvement in quality of life and emotional wellbeing.	Overall, older adults assigned to intervention conditions tended to have lower depressive symptoms, higher remission rates and lower incidence of major depression at 12-month follow- up, compared to control conditions.

[116] Lapierre S. Erlangsen A. Waern M. et al. A systematic review of elderly suicide prevention programs. Crisis 32(2): 88-98

[117] Lee SY. Franchetti MK. Imanbayev A. Gallo JJ. Spira AP. Lee HB. Non-pharmacological prevention of major depression among community-dwelling older adults: a systematic review of the efficacy of psychotherapy interventions. Archives of Gerontology and Geriatrics 2012, 55: 522-529

Forsman et al 2011,[118] systematic review of 30 studies, including meta analysis of 19 trials, on **psychosocial interventions for preventing depression**	Older adults aged 65 years or older, or studies with an average participant age of 70 years, who did not meet diagnostic criteria for depression.	Any intervention emphasizing psychological or social factors rather than biological factors. Interventions with a physiological component in addition to a psychosocial component (eg exercise groups) were also included.	Meta-analysis results: • A small but statistically significant benefit for psychosocial intervention on depressive symptoms from 17 trials (SMD = -0.17, 95%CI -0.31 to -0.03). • No statistically significant effect on quality of life from three trials (SMD = -0.09, 95% CI -0.37 to 0.19). • No statistically significant effect on overall functional ability outcomes from two trials (SMD -0.28, 95%CI -0.70 to 0.13). Individual interventions: • Significant reduction in depressive symptoms for social activities from two studies (SMD -0.41, 95%CI -0.72 to -0.10). • Small, but non-statistically significant benefit for physical exercise, reminiscence, skills training and multi-component interventions.	Psychosocial interventions focusing on primary prevention of depressive symptoms among older adults show either a small positive effect or no effect.

[118] Forsman AK. Schierenbeck I. Wahlbeck K. Psychosocial interventions for the prevention of depression in older adults: systematic review and meta-analysis. Journal of aging and Health 2011, 23(3): 387-416

Stern & Munn 2010,[119] systematic review of 13 observational studies (cohort and case-control) on **cognitive leisure activities** for preventing Alzheimer's disease and other dementias.	Adults aged at least 60 at follow-up, living in the community or a care setting, with or without a clinical diagnosis of dementia.	Cognitive leisure activities – requiring a mental response from the individual eg reading. Follow-up period for the eight cohort studies ranged from a mean of 2.9 years to 10 years.	No RCTs were identified. Meta-analysis was not performed due to heterogeneity. The effect of cognitive leisure activities on the development of dementia or Alzheimer's disease was examined for different life stages: • Five/six studies reported a positive effect for the cognitive leisure activities during early and middle adulthood (commonly 20-60 years) • Six/seven studies reported a positive effect for cognitive leisure activities during later life (commonly 65 years and over)	Participating in cognitive leisure activities during mid or late life may be beneficial. However, the evidence is not strong enough to infer a direct causal relationship or to recommend one activity over another.
Loef & Walach 2012,[120] systematic review of 9 cohort studies examining the association between **fruit and vegetable consumption and cognitive decline or dementia**	Adult cohort population. Cohort size ranged from 1,233 to 13,388	All nine studies used food frequency questionnaires to assess the dietary intake of vegetables and fruit. All studies had follow-up periods of at least six months	Meta analysis was not performed due to study heterogeneity. • Five/six studies reported an association between increased intake of vegetables and lower risk of dementia or slower rate of cognitive decline • No studies found an association between fruit intake and dementia or cognitive decline • Four/four studies assessing combined fruit and vegetable intake found an association between increased intake and decreased incidence of mild cognitive impairment, dementia and	The majority of studies found an association between vegetable consumption and dementia, however evidence for an association with fruit consumption was lacking.

[119] Stern C. Munn Z. Cognitive leisure activities and their role in preventing dementia: a systematic review. International Journal of Evidence Based Healthcare 2010, 8: 2-17

[120] Loef M. Walach H. Fruit, vegetables and prevention of cognitive decline or dementia: a systematic review of cohort studies. The Journal of Nutrition, Health and Aging 2012, 16(7): 626-630

			Alzheimer's disease. There was no association with cognitive decline.	
Wong et al 2013,[121] meta-analysis of 20 observational studies on **statins for the prevention of dementia**	No specific population group defined	Interventions that assessed the effectiveness of statins compared to placebo or no statin use for the prevention of all-type dementia or Alzheimer's disease. Follow-up ranged from three to 25 years.	Meta analysis using random effects modelling found that statin use was associated with a lower relative risk of dementia (RR 0.82, 95%CI 0.69 to 0.97) and Alzheimer's disease (RR 0.70, 95%CI 0.60 to 0.83) compared to non-statin use.	Longitudinal studies demonstrated a slight protective effect for statins in the prevention of Alzheimer's disease and all-type dementia. However, this conclusion should be treated with caution due to the risk of bias in observation studies.
Szekely et al 2004,[122] meta-analysis of 11 articles (describing eight studies) on **nonsteroidal anti-inflammatory drugs (NSAIDs) for the prevention of Alzheimer's disease**	Participants from a range of studies designed to assess a variety of medical and environmental exposures in relation to dementia or cognitive aging (n= 31,366).	Exposure to nonsteroidal anti-inflammatory drugs (NSAIDs) Seven articles related to non-prospective studies (case-control and cross-sectional); 4 articles related to prospective studies.	Meta-analysis results for risk of Alzheimer's disease: • Lifetime exposure to NSAIDs from non-prospective studies: combined OR = 0.51 (95%CI 0.40 to 0.66) (a 49% reduction in risk) • Lifetime exposure to NSAIDs from prospective studies: RR = 0.74 (95%CI 0.62 to 0.89) (a 26% reduction in risk) • ≥2 years of exposure to NSAIDs from prospective studies: combined RR = 0.42 (95%CI 0.26 to 0.66) (a 58% reduction in risk)	There was evidence from secondary analysis of prospective and non-prospective observational studies to suggest that NSAID exposure is associated with a decreased risk of Alzheimer's disease. The temporal relationship between exposure and protection needs further exploration.

[121] Wong WB. Lin VW. Boudreau D. Devine EB. Statins in the prevention of dementia and Alzheimer's disease: a meta-analysis of observational studies and an assessment of confounding. Pharmacoepidemiology and Drug Safety 2013, 22: 345-358

[122] Szekely CA. Thorne JE. Zandi PP. et al. Nonsteroidal anti-inflammatory drugs for the prevention of Alzheimer's disease: a systematic review. Neuroepidemiology 2004, 23: 159-169

Lin et al 2013[123] systematic review of **screening for cognitive impairment**	Older adults living in the community[124]	Screening for cognitive impairment in older adults	• There are suitable instruments to screen for cognitive impairment that can adequately detect dementia • It is unclear whether interventions for patients or carers have a clinically significant effect in persons with earlier detected cognitive impairment	There are screening tools that could detect cognitive impairment, but there is no empirical evidence that screening improves decision making and it is unclear whether providing interventions earlier is beneficial
Sydenham et al 2012,[125] systematic review of 3 trials on the effects of **omega-3 fatty acid for the prevention of cognitive decline and dementia**	Cognitively healthy older adults (aged over 60 years) (n=4,080)	Omega-3 fatty acid, taken for at least six months.	All studies compared omega-3 fatty acid to placebo. The key findings were: • No significant difference between groups for mini-mental state examination score (Mean difference =-0.07, 95CI -0.25 to 0.10) from two trials at final follow-up of 24 or 40 months. • No significant difference between groups for other tests of cognitive function such as word learning, digit span and verbal fluency from two trials. • None of the trials explored the impact on the incidence of dementia.	These trials did not demonstrate any benefit on cognitive function from giving omega-3 fatty acid to cognitively healthy older people. Studies looking at changes in cognitive function over a longer period of time were recommended.

[123] Lin JS. O'Connor E. Rossom RC. Perdue LA. Exkstrom E. Screening for cognitive impairment in older adults: a systematic review for the US Preventative Services Task Force. Annals of Internal Medicine 2013, 159: 601-612

[124] Community-dwelling older adults were defined as adults who live at home or in senior living communities, assisted living, adult foster care, or residential care facilities. It excludes institutionalized people who reside in intermediate care facilities (ie rehabilitation centres or skilled nursing facilities)

[125] Sydenham E, Dangour AD. Lim WS. Omega 3 fatty acid for the prevention of cognitive decline and dementia. Cochrane Database of Systematic Reviews 2012, Issue 6. Art. No.: CD005379. DOI: 10.1002/14651858.CD005379.pub3

Dangour et al 2010,[126] systematic review of 33 studies on **B-vitamins and fatty acids** for preventing Alzheimer's disease and dementia	Healthy older people (for studies on preventing Alzheimer's disease).	B-vitamins and fatty acids given as single nutrients or in simple nutrient combinations.	• Results from 6 trials found that folic acid supplementation, either alone or in combination with other B-vitamins, had limited or no effect on measures of cognitive function. • Results from two of four trials found no effect of fatty acid supplementation on cognitive function tests. One small trial (n=20) did report an improvement in cognitive function and another trial reported an improvement in quality of life. However the statistical analysis of this treatment effect was not clearly reported.	The evidence available is insufficient to draw conclusions about whether B vitamins or fatty acids are associated with cognitive decline or dementia
McGuinness et al 2009,[127] systematic review of four trials on **blood pressure lowering for the prevention of cognitive impairment and dementia**	Patients with hypertension but without prior cerebrovascular disease (n=15,936) Age range – 60 to 89 years	Pharmacological or non-pharmacological interventions to lower blood pressure that had been administered for more than six months. Average follow up ranged from two years to 4.5 years.	Pooled analysis of the trials showed: • No significant difference on the incidence of dementia between treatment and placebo (OR =0.89, 95%CI 0.74 to 1.07) from four trials. • No benefit from treatment indicated for tjree trials reporting change in MMSE (although blood pressure was significantly reduced) NB: A complication of the analysis was that many control subjects received antihypertensive treatment because their blood pressure exceeded pre-set values. This made the comparison more of an intervention vs usual antihypertensive routine rather than intervention vs no intervention	Significant sources of bias within the analysis which makes it difficult to draw conclusions eg patients lost to follow-up and placebo patients receiving active treatment for hypertension. However, from the trials identified there was no convincing evidence that lowering blood pressure in patients with hypertension prevents the development of dementia or cognitive impairment

[126] Dangour AD. Whitehouse PJ. Rafferty K. Mitchell SA. Smith L. Hawkesworth S. Vellas B. B-vitamins and fatty acids in the prevention and treatment of Alzheimer's disease and dementia: a systematic review. Journal of Alzheimer's Disease 2010, 22: 205-224

[127] McGuinness B. Todd S. Passmore P. Bullock R. Blood pressure lowering in patients without prior cerebrovascular disease for prevention of cognitive impairment and dementia. Cochrane Database of Systematic Reviews 2009, Issue 4. Art. No.: CD004034. DOI: 10.1002/14651858.CD004034.pub3.

Stern & Konno 2009,[128] 17 observational studies **on physical leisure activities for preventing dementia**	Adults aged 60 years or older at follow-up, without a clinical diagnosis of dementia	Activities included those that required active movement of the body such as gardening or playing sports, but were not occupation-related or activities of daily living	The effect of physical exercise on the development of dementia or Alzheimer's disease was examined for different life stages: • Lack of studies on the effects of physical exercise during early adulthood. • Conflicting evidence from five studies of varying quality about the effect of physical activities during midlife. • Equivocal evidence from 12 studies about the effect of physical activities in later life, with some studies showing statistically significant benefits and others not. Some studies on individual physical activities suggested that activities such as gardening, walking, travelling and dancing may be beneficial.	Overall, the evidence was insufficient to either recommend or rule out a benefit for physical leisure activities on dementia.

CBT = cognitive behavioural therapy; ES = effect size; OR = odds ratio; PTSD = post-traumatic stress disorder; RCT = randomized controlled trial; RR = relative risk; SMD = standardized mean difference

[128] Stern C. Konno R. Physical leisure activities and their role in preventing dementia: a systematic review. International Journal of Evidence Based Healthcare 2009, 7: 270-282

7.4. Early interventions to reduce older people's dependence upon specialist mental health services and promote independent living in the community

This section describes evidence about interventions which could prevent older people's mental health problems progressing.

Keeping older people as healthy and independent as possible is good for everyone. One of the aims of this report is to identify and review opportunities for commissioners and providers to prevent mental health problems in older people, and to intervene early to alter their course. We need services that are sustainable and keep patients as well as possible for as long as possible, without the need for specialist mental health services.

We conducted a literature search to identify high-quality evidence of effective early interventions in peer-reviewed journals published subsequent to the relevant NICE guideline publications. We excluded studies which examined specific clinical types of treatment, for instance pharmacological therapy, nutritional supplements, psychological therapies as these have been included in the NICE publications in the form of either guidelines or technology appraisal guidance.

We found few relevant additional evaluations. Many were small case series of insufficient quality, and did not evaluate interventions which were effective at reducing demand on specialist mental health services.

We then widened our search for effective early intervention service delivery models. We searched for reviews from the Cochrane Library as well as grey literature publications such as The Kings Fund, The Mental Health Foundation, Centre for Mental Health, Mind and ReThink for publications published subsequent to the NICE guidelines.

Most of the service delivery interventions that we identified have not been evaluated and published in a peer-reviewed journal. They are simply case studies of initiatives elsewhere in the UK with only high-level, descriptive information and published on the website. Some of these case studies state that they are effective, but the evaluation was not reported. A few case studies have been evaluated and in some cases these evaluation reports provide moderate evidence that the model may be effective. The review of integrated care models undertaken in November 2013[129] was a useful start to try to identify alternative service delivery models, and is the basis of this updated review. We have excluded any studies found which concluded that the intervention/initiative was ineffective, or where the intervention could not be shown to be clinically effective.

We found no new health economic studies about the cost effectiveness of the alternative models of service delivery.

A number of the reports do not refer directly and specifically to the patient groups that this JSNA is concerned with, but we have included them where there is a strong likelihood that the intervention is relevant.

The most useful report that we found was published in October 2013 by the Kings Fund.[130] It identified the key components from five UK programmes delivering co-ordinated care for people with long-term and complex needs. People with multiple health and social care needs often receive a very fragmented service, resulting in less than optimal care experiences, outcomes and costs; the report called for improvements to care coordination.

[129] Author: Katharine Hartley, SpR Public Health. November 2013

[130] Nick Goodwin, Lara Sonola, Veronika Thiel (2013) Co-ordinated care for people with complex chronic conditions: Key lessons and markers for success. The Kings Fund

None of the five case studies specifically included early interventions for older people's mental health, though one considered an advanced dementia service.

The case studies from the King's Fund report that are relevant to older people's mental health needs were:

1. Developing community resource teams in Pembrokeshire, Wales: Integration of health and social care in progress
2. South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model
3. Oxleas Advanced Dementia Service: Supporting carers and building resilience
4. The Esteem Team: Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service

The King's Fund report had a number of conclusions:

- A holistic focus is needed to support patients and carers to become more functional, independent and resilient.
- Communities must be aware of and trust in care co-ordination programmes.
- Effective communication is critical for developing good working relationships between members of the multidisciplinary team.
- Care co-ordination programmes should be localised so that they address the priorities of specific communities.
- Leadership and commitment (from commissioners and providers alike) is vital to establish a shared vision and challenge silo-based working.

Across the five sites common challenges included:

- Funding.
- Lack of GP engagement.
- Inability of the wider health systems to see innovation as core business.
- A lack of integrated IT systems.
- Problems caring for people in remote and rural locations.

Important policy points based upon learning from all five pilots were that:

- Care co-ordination innovations can take some years to mature and to build legitimacy and acceptance.
- Successful approaches are very context-specific; care models cannot be transported 'en bloc' from one setting to another.
- Care co-ordination should primarily be a quality improvement strategy rather than one aimed at reducing costs.
- Models of care co-ordination are likely to be more effective when operating as 'fully - integrated' provider teams with some operational autonomy.

Intervention (all evidence is weak unless specifically highlighted as otherwise)	Impact
Developing community resource teams in Pembrokeshire, Wales: Integration of health and social care in progress[131] This case study looked at integrated teams of health and social care professionals, known as community resource teams (CRTs), who worked to co-ordinate care for people living at home in the largely rural county of Pembrokeshire. The main goals of this programme were to improve or restore the quality of life and confidence for people with complex health and social care needs, and to reduce avoidable admissions to hospital. Four community-based teams brought together professionals from health, social care and the third sector to provide care for patients with complex needs at home. Care co-ordinators act as the main point of contact for patients and work with the team, patients and carers to tailor individual care packages that enable people to manage their long-term conditions and avoid unnecessary hospital admissions. Professionals in the CRTs include social workers, occupational therapists, physiotherapists, district nurses, voluntary sector service brokers and specialist nurses. The voluntary sector service brokers arrange for additional services from local charities, such as befriending, dog walking or gardening, while the CRT can also call on the services of dieticians, speech and language therapists, and other health and social care professionals.	Reduced admissions Operationally challenging to implement Relied on common goals across all organisations and team members It takes time to develop the CRT so that there is an appreciation of roles and contributions. No information about cost effectiveness available
South Devon and Torbay: Proactive case management using the community virtual ward and the Devon Predictive Model[132] Community virtual wards were introduced by Devon Primary Care Trust in 2010 to proactively identify those at high risk of emergency admissions using a predictive risk tool and to manage their care through a multidisciplinary approach and virtual wards. Each month, the multidisciplinary team, including professionals from health, social care and the voluntary sector, identified and addressed patients' needs across health and social care to put in place a case management plan to prevent crises from occurring. High risk patients were admitted to the virtual ward for intensive assessment and care co-ordination from staff in the team – which is led by a case manager – who provide ongoing	GP/practice brings knowledge of patients into the process Predictive modeling was a more effective way to target patients Case manager provides continuity of care and point of contact for patient and carers. No information about cost effectiveness available

[131] http://www.kingsfund.org.uk/projects/co-ordinated-care-people-complex-chronic-conditions/pembrokeshire-patient-stories

[132] http://www.kingsfund.org.uk/projects/co-ordinated-care-people-complex-chronic-conditions/south-devon-and-torbay-patient-stories

care and support in their home. Each patient has a personalized case management. Once their condition has stabilised they are discharged from the virtual ward and continue to receive 'usual' care.	
Oxleas Advanced Dementia Service: Supporting carers and building resilience Oxleas Advanced Dementia Service provides care co-ordination, and specialist palliative care and support to patients with advanced dementia living at home in the last year of their life. There is a consultant in old-age psychiatry working alongside specialist nurses, CPN, Bexley, an advanced practice nurse and a social worker specialising in dementia. The team liaises with community mental health services and general practitioners to provide care in patients' own homes, focusing on supporting the carer and/or family to provide palliative care for the patient to prevent hospital or care home admission. The Oxleas service works with family and carers, navigating through the complex health and social care system as patients' needs and their entitlements to support change. The model relies on building resilience among carers, case finding and relationship building a holistic care assessment and a personalised care plan, having dedicated care coordination and access to support in the event of crisis.	Supports and allows patient to die in their home setting Insufficient information to estimate the numbers for Cambridgeshire Potentially useful model, especially in more rural areas No information about cost effectiveness available
The Esteem Team: Co-ordinated care in the Sandwell Integrated Primary Care Mental Health and Wellbeing Service[133] The aim of the Esteem Team is to support people with mild to moderate mental health conditions and complex social needs, at an early stage to prevent deterioration and admission to secondary care services. In this model, Link workers act as patients' navigators through the health and social care system and typically have a social worker background and/or personal experience with mental health conditions. The Esteem Team can refer patients to a wide variety of statutory and voluntary sector services including: social services, debt advice agencies, substance abuse counselling, therapeutic services and peer support groups. They also visit patients at home and accompany them to appointments if required. The service is not time limited.	No information about cost effectiveness available
Personalised befriending support for older people.[134] This study raises awareness of the many benefits associated with older people accessing befriending services and the need to increase the quantity that are set up and commissioned, regardless of what type of mental illness they have. It concludes that befriending services can be used to support older people: as a personalised form of care for those who may	Medium quality evidence that befriending is an effective intervention. No information about cost effectiveness available

[133] http://www.kingsfund.org.uk/publications/esteem-team

[134] Mulvihill, Joe (2011) **Personalised befriending support for older people.**Quality in Ageing and Older Adults. 12(3) 180. 180-183

be isolated or lonely; to prevent the onset of dementia; to lead more active lives; and to increase the quality of their lives. Befrienders can help to spot illnesses which can prevent costly health conditions before they progress and help to reduce the burden on the National Health Service (NHS).	

NICE describe one practical case study from Mersey Care NHS Trust in relation to their integrated whole system services for people with dementia

This case study is about keeping people with dementia independent for longer so they do not need more costly care; and where this is not possible, to ensure people are provided with appropriate support to get them back into the community quicker so they can regain their quality of life. The proposal for the whole system integration initiative requires extensive planning and programme management. A key factor in the success of the initiative is stakeholder support and commitment. If successful, they estimate net savings of £2.1 million or £246,000 per 100,000 population, providing all service changes are implemented across North Mersey. This initiative is in the very early stages of implementation. There is therefore no information about its effectiveness.

8. Stakeholder engagement

This section describes the results of engagement with stakeholders in mental health services for adults and older people.

Summary

The main concerns of service users and carers reported to us were:

- Service delivery.
- Organisational challenges.
- Coordination of services.
- Safeguarding of vulnerable people.
- Access to services.
- Transition between services.
- Continuity of relationships.
- Culture and equity.
- Physical health and mental health.
- Carers' needs.

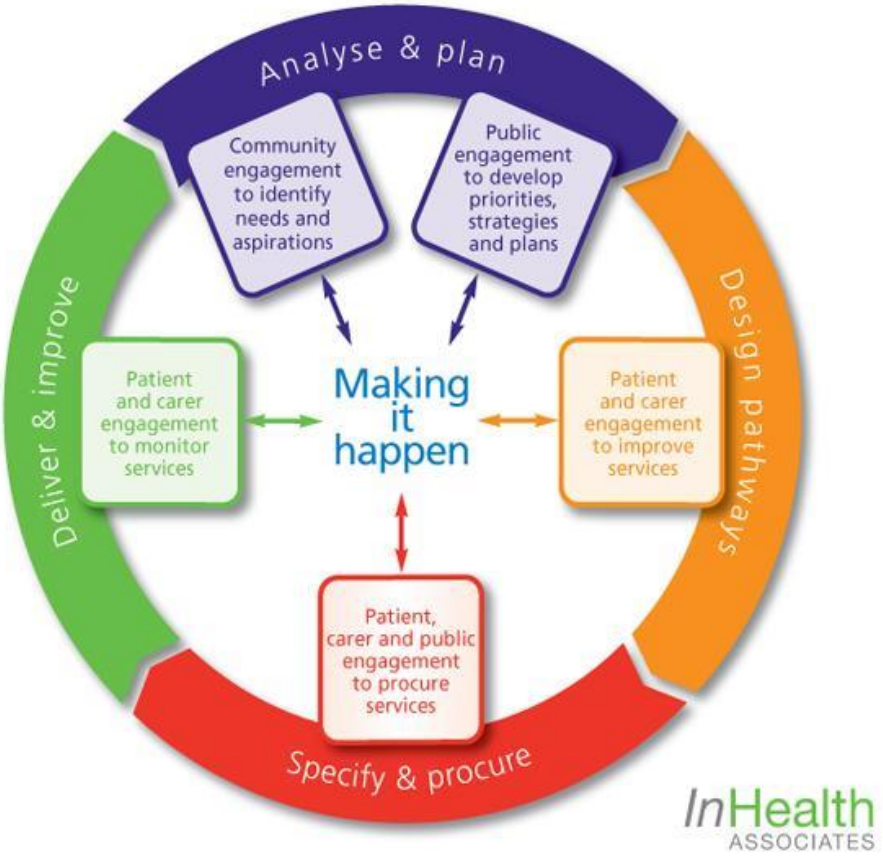
Service improvement ideas from service users and carers included more help with practical things, such as maintaining relationships, applying for benefits, and a focus on the positives rather than the diagnosis. Community support and signposting for where to go for help, ideas or friendship were also considered important. Information and training for families and carers as well as those with mental health disorders, and seeing the same health professional consistently were also suggested.

8.1. The engagement cycle

The engagement cycle (diagram below) was developed on behalf of the Department of Health in 2009. It was based on work carried out with Croydon PCT and developed and tested with national stakeholders and five additional PCTs. The engagement cycle offers a way of approaching Patient and Public Engagement in planning and commissioning and highlights the role of stakeholder engagement at different stages of the commissioning cycle.

The JSNA is part of analysing and planning services. In accordance with the engagement cycle model, part of the process of developing the JSNA is to identify needs and aspirations of the relevant patient or client groups, by asking those familiar with using or delivering those services. The qualitative information gathered is an important additional source of information for triangulation with quantitative data about need and activity, and information about commissioned services.

Figure 32: Diagram showing the Engagement Cycle model[135]



Our approach to eliciting qualitative information to inform this adult JSNA was to engage with steering group members and service providers, as well as service users (SUs) including people with the relevant mental health disorders and/or their carers. We:

1. Conducted workshop sessions with steering group members in order to gain a better understanding of what their perception was of the services that are commissioned and the key problem areas that they consider need to be addressed.

2. Invited written feedback from steering group members and relevant colleagues about their services, the key issues and how they might be resolved.

3. Listened to a range of SUs, their carers or their representatives about their experiences of accessing and using mental health or support services in Cambridgeshire, and their views on what support they needed in order to help them live as well as they could. In practice, we conducted a number of one to one telephone interviews with SUs/carers and held one all-day meeting in Cambridge as four out of the five workshop days had only very low numbers of registered participants.

[135] www.engagementcycle.org

8.2. Conversations with service users (SUs), carers and other stakeholders

In January and February 2014, Solutions for Public Health arranged five service user events, in Wisbech, Huntingdon and Cambridge. Four of these events were cancelled due to very low response rates, but those people who had expressed an interest in events were asked if they would take part in a telephone interview instead. All those invited agreed to be telephoned by Solutions for Public Health. The telephone interviews lasted approximately 45 minutes.

The aim of both the telephone interviews and the meetings with SUs/carers was to find out from a service user perspective:

- What services they used and found helpful.
- The key challenges that they faced.
- What suggestions they had for improving services in a way that would have a positive impact on their (or their relative's) wellbeing.

In total, we spoke to 24 carers or SUs of both adult and older people's mental health services, some of whom were also providing support for mentally ill adults or older people through voluntary or paid work. No-one worked for a statutory funded agency. Of note, eight of the 24, were concerned with older people's mental health services only.

The JSNA steering group remit included both adult and older people mental health issues. The membership was made up of 26 people including clinical, housing, public health, statutory commissioners, third sector agencies and provider representatives. In addition we sought input from the Chief Executive of the Police and Crime Commissioners office in Cambridgeshire.

Common themes

There were a number of common themes that were identified by SUs, carers and by steering group members and staff involved in providing services. Given the limited response rates and the qualitative nature of all of the information received, we only identified themes that had been raised by both the steering group members and the service users. Some of these were common to both older people and to adults with mental ill health. They included issues relating to:

- Service delivery
- Organisational challenges
- Coordination of services
- Safeguarding of vulnerable people
- Access to services
- Transition between services
- Continuity of relationships
- Culture and equity
- Physical health and mental health
- Carers needs.

Service delivery

A number of service users (SUs) commented on the **complexity of the services that they interface with**, and the fact that they sometimes seem fragmented "even when within the NHS", with different organisations or teams being involved. These might include the GP, housing officer, community health team, specialist mental health professionals, social services, the police and support from third sector organisations. There was agreement that caring for people with mental health is demanding upon family, friends and professionals alike but "there are a lot of different people involved over time and everyone knows different things, but often they have no idea if information is being acting on outside of their own team or organisation". Some clients who receive health or personal care at home either for their mental health condition or for physical health needs, said that they found that uncertainty and change was a contributing factor in how well they felt. Not knowing when to expect a home care visit or having lots of different carers with whom they were unfamiliar caused them to feel more confused and anxious. Both SUs and staff commented, "Services on the ground would sometimes benefit from **better coordination and cooperation between organisations and teams**."

Safeguarding of both adults and older people was raised as an important multi-agency issue, both in the context of keeping the patient or client safe, but also because occasionally the carers were vulnerable as well and they need help and support. The complexity of different service providers and commissioners was raised as being a challenge.

Access to services

Some SUs reported that they 'fell between' different parts of the NHS and could not get treatment or support, as they 'didn't fit into the right box' or have one clear 'label'. This was because they had **more than one mental health condition, had both mental and physical ill-health** or straddled the mental health services for adults and older people. SUs felt that there needed to be more flexibility and sensitivity in deciding which services should be available for people with mental illness who were older. For example, in cases where patients felt isolated and lonely and that this contributed to their mental illness, for instance depression, the view was that they should have access to local, community support and advice which is available for older people, even if they were under 65 years old. In other instances, especially where patients had other functional mental illness which they had already been diagnosed with during adulthood, it was thought that **the transition to older people's mental health services was artificial** and that continuity of care would be more important than simply their age. One client told us that "Services are mainly historical: surely they need to be configured around the needs of the patients who use them, not around the organisations who deliver them".

Other factors which mattered to older people included the constraints of **public transport** or **caring/working commitments impacting on their abilities to access** mental health support. If support is difficult to access because of the time of day or because of where it is located, then SUs felt that they were disadvantaged. This was an important factor for people living in rural areas in particular. Older people often continue to be employed even after normal retirement age.

Continuity of relationships, variation and informed choice

SUs told us that they had a variable experience of services, but that in general, they needed mental health services to be **accessible and consistent.**

Some people told us that their GPs were keen to refer them to talking therapies, whilst others were not offered the opportunity for referral to IAPT services, rather they were given a prescription. In both of these instances, the SUs told us that they got better.

It was also apparent that for those older people who were offered talking therapies, there was variation in how they could be accessed; either the therapist visited the client at home and they had individual CBT sessions, or they were invited to attend a group in the city. Some clients found that the group therapy was helpful, others told us that it had an adverse effect on their health as they "took on the problems of the other people in the group".

The SUs were keen to point out that they did not always feel that they had a choice of prescription or talking therapy, nor did they have a choice of whether they would prefer to be treated individually or to take part in group therapy. They felt that being able to be properly involved in the decisions about their health was an important factor in improving attendance and compliance, achieving a positive outcome and managing expectations. Some SUs reported that they would prefer that their treatment was not "dictated or prescribed by the medical profession", and that social and psychological interventions should be available options for all older people. Having a good relationship with professional carers in the home setting, or with health or other care professionals in primary or secondary care was important for their confidence and reassurance, and "limiting avoidable stress related flare-ups".

Culture, equity and attitude

Some older people reported that they are very aware of the **stigma** associated with having mental illness or looking after a spouse or family member with a mental illness. This affected them in that they felt reluctant to go to group therapy, or even to go to the GP in the first place. Because of the perception of stigma, those that were in work said that it affected their relationship with their employer and their work colleagues as their illness was "unmentioned" and no-one would "ask after you, offer to come and visit you at home or even organise and send a get-well card". This was "completely at odds" to being off work due to a physical illness where people know what to expect, how long you might be unwell for and how to help you. In addition to self-imposed isolation due to embarrassment about being unwell, the uncertainty of family, friends and colleagues of how to help or behave would often result in further **isolation**.

SUs of both adult and older people mental health services spoke about the **inequity** between physical and mental health, in terms of funding as well as the way that it is portrayed in society as being something to fear. There was a perception that the empathy and understanding of mental health conditions varied widely amongst different GP practices and that this created variation in what intervention or support patients were offered.

Physical health

Both adults and older people often have mental health and other co-morbidities including long-term conditions such as diabetes, arthritis and heart disease. SUs were keen to point out that their mental health and their physical health was inextricably linked and that living with chronic pain or suffering from another long term chronic condition such as irritable bowel syndrome could be the cause of depression and anxiety, as well as a factor that might even exacerbate the symptoms of the long-term chronic condition. They highlighted the need for all people with mental illness to be considered as a whole person rather than having their symptoms and diagnoses managed separately.

SUs also expressed a strong appreciation of the relationship that they have with their own doctor or their practice, where they are familiar with the patient, their history and both their physical and mental health needs. Some expressed frustration about GP appointments at which time they saw a doctor who did not know them, and who could not address more than one problem in the patient consultation due to time constraints.

Carers' needs

Family and carers of adults and older people told us that they needed a whole family approach from support services in order to be able to cope with looking after their relative as well as possibly at home or in the community. This needs to recognise the impact of caring on the carers' own physical and mental health, and take into account their own pre-existing health conditions and increasing age. There was a general concern that as the elderly population increased, there would need to be additional provision and alternative infrastructure to be able to support the carers and their mentally ill family members.

8.3. Service improvement ideas

When asked about how services could be improved in a way that would make a difference to SUs or their carers, the following suggestions were made:

- Provide information, training and workshops for families and carers as well as those with mental health disorders to help them be involved in their relatives care and to avoid carers themselves becoming isolated and lonely or frightened that they might be 'doing it wrong'. (This supports the work currently commissioned as part of the 'CRiSP service provided by the Alzheimer's Society in Cambridgeshire).
- Rather than see a different GP every visit, some SUs suggested that seeing another health care professional, who has an interest in mental health, when they go to the GP might be an alternative way of overcoming the issues about confidence and continuity of care.
- Help with practical things like maintaining personal relationships despite having a mental illness, making a will and knowing how to apply for benefits. (This resonates with the introduction of dementia support workers, advisors, and carer peer support service currently in place).
- "Need to send out a strong message that people 'can recover' and focus on the positives and treat the circumstances rather than just the diagnosis for instance, solve the loneliness rather than give pills for the depression". (This resonates with the 'Dementia Friends' and 'Dementia-Friendly communities' initiatives).
- Support to develop and strengthen communities and neighbourhoods in order to help older people with mental health problems and their carers live at home, without being 'isolated, and lonely with nothing to do"
    - Eg 'find creative solutions in the community' such as singing groups, animal care, gardening, exercise, dancing and other community centred support.
    - Signposting where to go for help or ideas and for friendship. There are community navigators – but even the navigators also need some practical help with things like communication and computer access so they can help others.
    - Stakeholders suggested time needed to be allowed for the initiative to get started, for people to learn how to make it work and for the community to get used to taking advantage of it.

8.4. Follow up consultation with providers and third sector organisations

To complement our engagement with service users and steering group representatives, we organised a meeting with organisations providing services to people with mental health problems; both statutory and third sector. All invitees were funded by statutory organisations to deliver services to adults with mental health disorders. The purpose of this meeting was to confirm the findings so far and to elicit realistic and pragmatic ideas for service improvement and service user outcomes. Of note, these meetings were held jointly discussing the needs of older people (especially with dementia and/or depression) and of adults with autism, personality disorder or dual diagnosis for the JSNA focussed on Adult Mental Health. It is also important to note that the numbers who took part in the providers meeting was limited and this information represents only the views of those who participated.

The information received from providers contributed to the overall picture of the needs of adults and older people, alongside quantitative data, patient and carers perspectives and national guidelines for best practice in delivering mental health services for these people.

The main points made by the 12 service providers who attended this meeting were that:

1. There is a perception that GPs and other health care professionals may often miss depression and anxiety in older people with long-term physical illness. This correlates with a national trend for under-diagnosis and may be due to various factors.

2. Although GPs or other health care professionals review people with dementia annually, in the past it was not specified what that review should comprise. CPFT have been working with GPs on developing a specification of these reviews. There is now a dementia annual review computerised template 'aide memoire' which was developed collaboratively between Primary Care (to which the CCG and LCG GP Mental Health Leads contributed) and specialist OPMH colleagues. It is being evaluated by the SUN OP engagement worker.

3. Sharing of information has been perceived in a number of areas as problematic. For example:

    a. Third sector and specialist housing providers did not feel able to contribute effectively to the care of patients whom they knew well, because of problems with communication with CPFT staff and confidentiality. Sheltered accommodation providers are often not allowed, by NHS staff, to receive information or to carry out assessments on inpatients, so they may not be willing to accept suitable people.

    b. There is poor integration between Addenbrooke's (an acute hospital) and Fulbourn (mental health hospital), which can disrupt care for some patients moving between the two facilities, where clinical information is not shared effectively.

4. Availability and capacity of community support was raised in relation to a number of areas:

    a. Cambridgeshire has relatively high rates of residential and nursing home care for older people with mental health problems. There was a suggestion that increasing the level of community support available would enable more individuals to remain independent or cared for at home.

b. Where domiciliary care costs more than 80% of the cost of residential care, the client may be transferred to residential care unless the client can pay all of the costs of domiciliary care themselves. This carries a risk of encouraging older people to enter residential care prematurely, sometimes against their wishes.

c. Cambridgeshire County Council did provide funding to sheltered housing providers to employ staff to support residents, including those with mental health problems. This funding was withdrawn from April 2014, to be replaced by floating workers not tied to sheltered housing schemes. As a result, there is a perceived increased risk that crises may occur and emergency services will be activated.

d. Day centre care was perceived as a positive support which could relieve the burden on carers and slow progression towards residential care. A concern was raised however that increasingly the clientele of older people's day centres have higher or more intensive needs. This raises several problems relating to the resources and capacity of the centre and staff to meet demand. There was also a perception that the recent Cambridgeshire County Council review of day care focussed more on service rationalisation, and less on mental health needs.

e. Concerns about ongoing, co-ordinated support following transitions from acute care were raised, after input from CPFT has ended. Long-term follow-up from mental health services seems to focus on a small proportion of individuals who have the most complex and enduring illness. In some cases third sector providers are able to provide some ongoing support, but some issues had been observed especially for individuals entering residential care or sheltered accommodation where their ongoing low level mental health needs were no longer met.

5. Local suggestions for early interventions which might improve prognosis included:

    a. Regular visits for at risk individuals (eg monthly) to detect and identify early deterioration.

    b. Assign a mental health nurse to each residential home to work with staff to provide better support to residents.

6. Early planning and support for end of life care for those with mental health problems could be improved:

    a. Palliative care for people with dementia is dependent on better care planning. Earlier consideration of end of life needs has been included in the Primary Care annual review dementia template.

    b. People with advanced dementia are sometimes admitted to hospital unnecessarily or at the end of their life. A better response would be easier rapid access to emergency support for this group at home and in institutional care.

9. Summary of key findings

Increasing older population

- Due to an increasing population there will be an increase in the number of older people with dementia and, to a lesser extent, depression, within a few years.
- However, the resources available from statutory agencies for health services given the current financial restraints will at best remain the same, requiring the development of new service models to meet need. A holistic approach is vital.

Risk factors for depression and dementia

- Older people's mental health needs are complex. They cause substantial impact on wellbeing and the ability to lead a normal life. They have wider impacts on the family and other carers.
- Mental health needs interact in complex ways with long-term physical health problems. Adults with severe mental illness have a substantially reduced life expectancy due to both mental and physical ill health. There is often inequality of access to health services for physical illness for people who use mental health services. Physical health and mental health are inseparable and demand a holistic approach to the care of all patients with mental health problems.
- Evidence-based guidelines from NICE recommend reviewing and treating vascular and other risk factors for dementia in middle-aged and older people. These include smoking, excessive alcohol use, obesity, diabetes, hypertension and raised cholesterol levels.
- NICE are also currently developing two relevant pieces of public health guidance: first due to be published in February 2015 focuses on mid-life approaches to prevent or delay the onset of disability, dementia and frailty in later life these conditions; the second due for publication in November 2015 considers independence and mental wellbeing (including social and emotional wellbeing) for older people.

Diagnosis and assessment

- There is apparent widespread under-diagnosis of depression in primary care. Rates of diagnosis also vary between practices for unexplained reasons. Depression is a distressing, but highly treatable condition, so improvement in rates of diagnosis is important.
- Dementia is also under-diagnosed in primary care, with unexplained variation in rates of diagnosis and prescribing. Early diagnosis means that patients and carers can receive appropriate information and support, so ensuring the condition is recognised promptly is beneficial.
- Improving diagnosis in primary care is a priority, as part of an integrated approach and partnership working to improve awareness of mental health needs in the community.

Current spending

- The NHS in Cambridgeshire apparently spends 18% less per head on mental health services than the average for England. It is however less well funded than average.

This information is based on programme budgets, and differences in budgetary definitions and coding behaviour may underlie these findings. More analysis of the reasons for the differences would be of value.

Current service provision

- The JSNA full report describes acute and community mental health services available for older people and details three local clinical pathways for 'Functional mental illness' (includes depression, anxiety, bipolar affective disorder, psychosis, personality disorder); 'Memory assessment'; and 'Complex dementia'. Training programmes to raise awareness of dementia are in place across primary care, community and acute settings. Local support services are also provided by the Alzheimer's Society and Mind. These are jointly commissioned by the CCG and CCC and are also described in more detail in the full report.
- There is substantial variation in the rate of referrals to the older people's mental health service, with lower rates seen in South Cambridgeshire, and higher rates in Cambridge, Fenland and East Cambridgeshire. The reasons for this variation are unclear and may relate to data quality problems, but it would merit further investigation.
- No information on activity levels and expenditure patterns by the main NHS mental health service provider in Cambridgeshire was available within the timescale of this report. This impedes service planning and evaluation by commissioners and limits the extent to which patterns of service delivery can be reported and analysed. The routinely collected anonymised national minimum dataset should be available in a timely and accessible format to providers and commissioners of mental health services.
- There are other sources of information which were not available or accessible during this project, and these limited the conclusions we are able to draw. These include details of where people with mental health problems live, the exact nature of all clinical and social care services provided locally and the outcomes of service interventions. It has not been possible therefore to assess the degree of correlation between needs and access to services, and whether services are delivered to national standards.
- The current re-procurement of older people's services is expected to lead to improvements in mental health services for older people. The re-procurement process will involve clarifying what mental health services for older people are available, where and to whom.

National guidance and evidence on provision of services and standards

- National guidance in the form of Clinical Guidelines and Quality Standards published by NICE describe in detail what patients should receive from NHS and social services.
- A review of the evidence did not find any reliably evaluated early interventions for mental health disorders in older people that were not included in existing NICE guidance.
- Existing service specifications from commissioners describe what should be available from NHS mental health services. The extent to which national guidance and local service specifications are followed in practice was not reviewed as part of this JSNA. This could form part of a future work programme.

Stakeholder feedback

- The main concerns of service users and carers reported to us were:
    - Service delivery
    - Organisational challenges
    - Coordination of services
    - Safeguarding of vulnerable people
    - Access to services
    - Transition between services
    - Continuity of relationships
    - Culture and equity
    - Physical health and mental health
    - Carers' needs.
- Service improvement ideas from service users and carers, included more help with practical things, such as maintaining relationships, applying for benefits, and a focus on the positives rather than the diagnosis. Community support, and signposting for where to go for help, ideas or friendship were also considered important. Information and training for families and carers as well as those with mental health disorders, and seeing the same health professional consistently were also suggested.

Further information

Building on the findings of this JSNA, further work may be useful to:

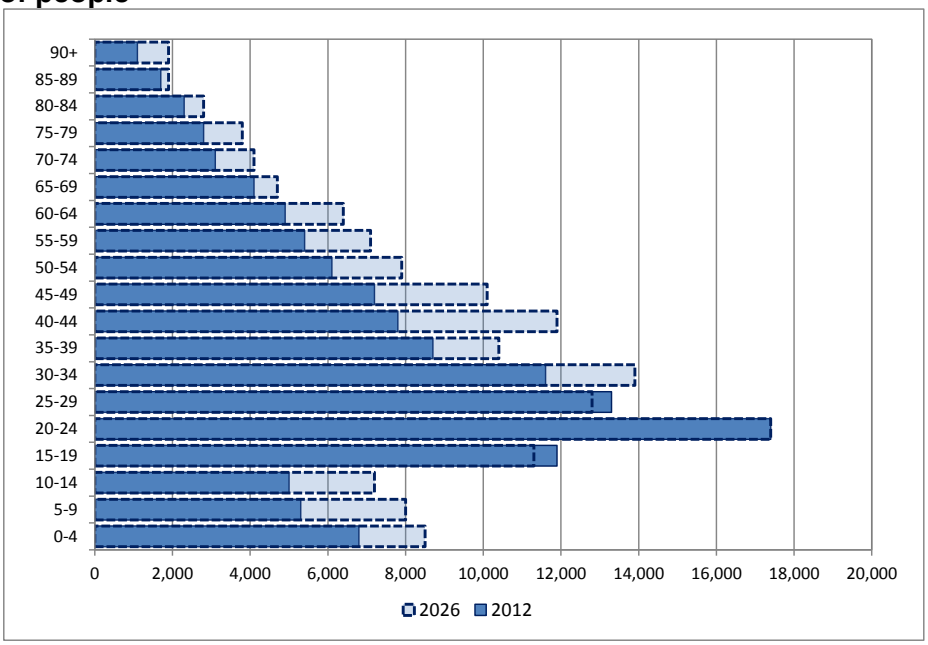
- Establish the activity and cost levels at the main NHS mental health provider.
- Review the validity of the apparent low levels of NHS spending on mental health in Cambridgeshire.
- Audit the extent to which NICE guidance is followed and understand gaps in mental health service provision for older people.
- Investigate the apparent variation in referral rates to the older people's mental health service.

Appendix 1: Details of population projections

Cambridge City shows an unusual demographic pattern, with a large number of people of younger working age and fewer children and older people. This reflects the influence of the City's educational institutions. These differences are projected to become less apparent by 2026, though this is subject to trends which are hard to anticipate.

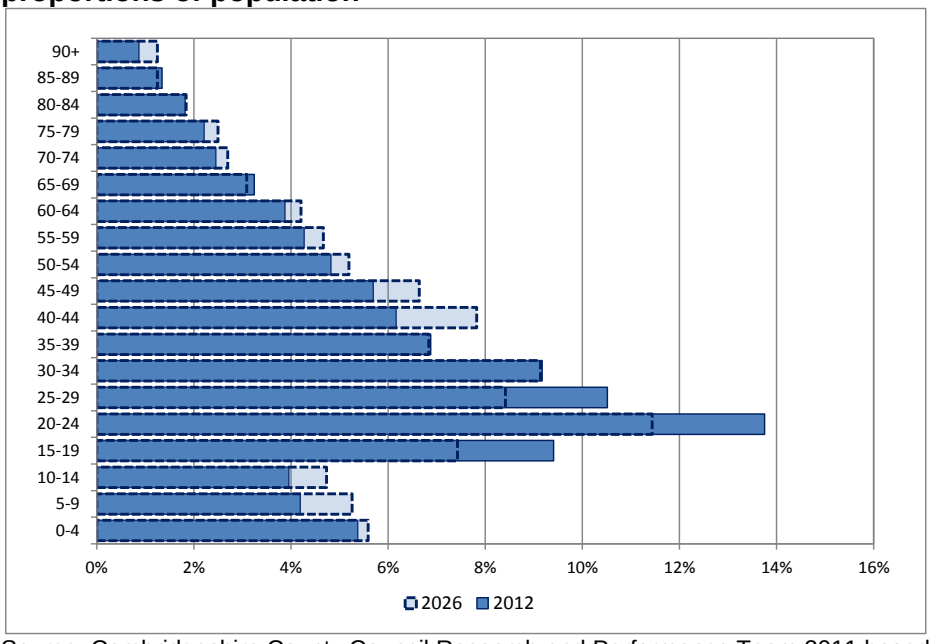
Like all parts of the County, Cambridge's population shows increases in the older age bands with time.

Figure 33: Population projections by age band, Cambridge, 2012 and 2026: numbers of people



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

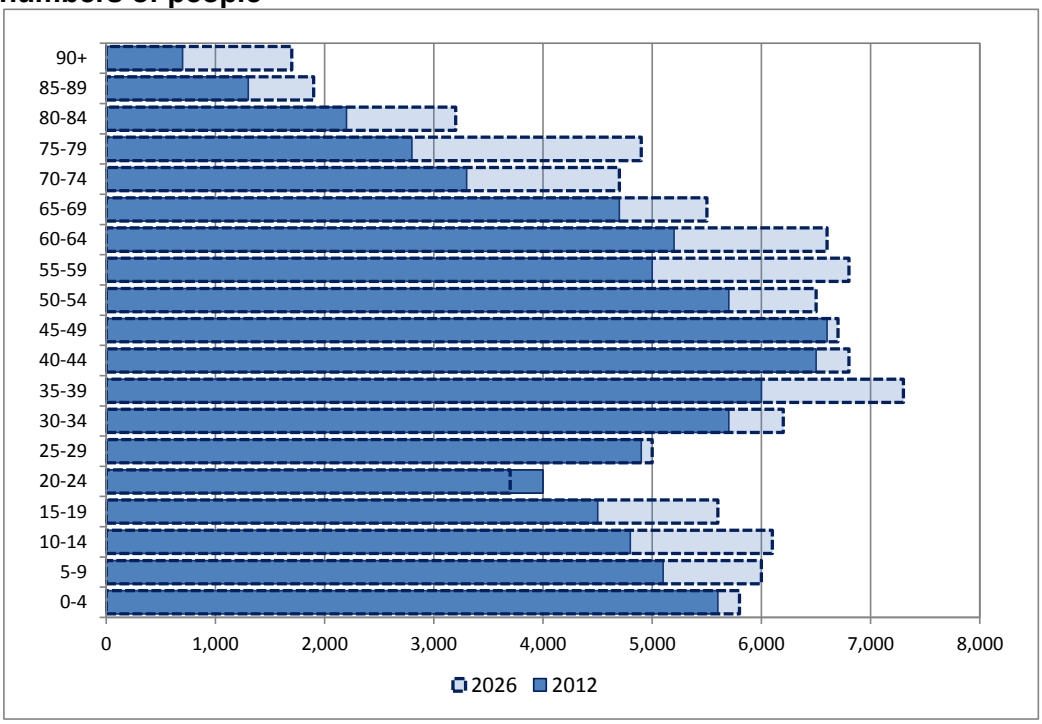
Figure 34: Population projections by age band, Cambridge, 2012 and 2026: proportions of population



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

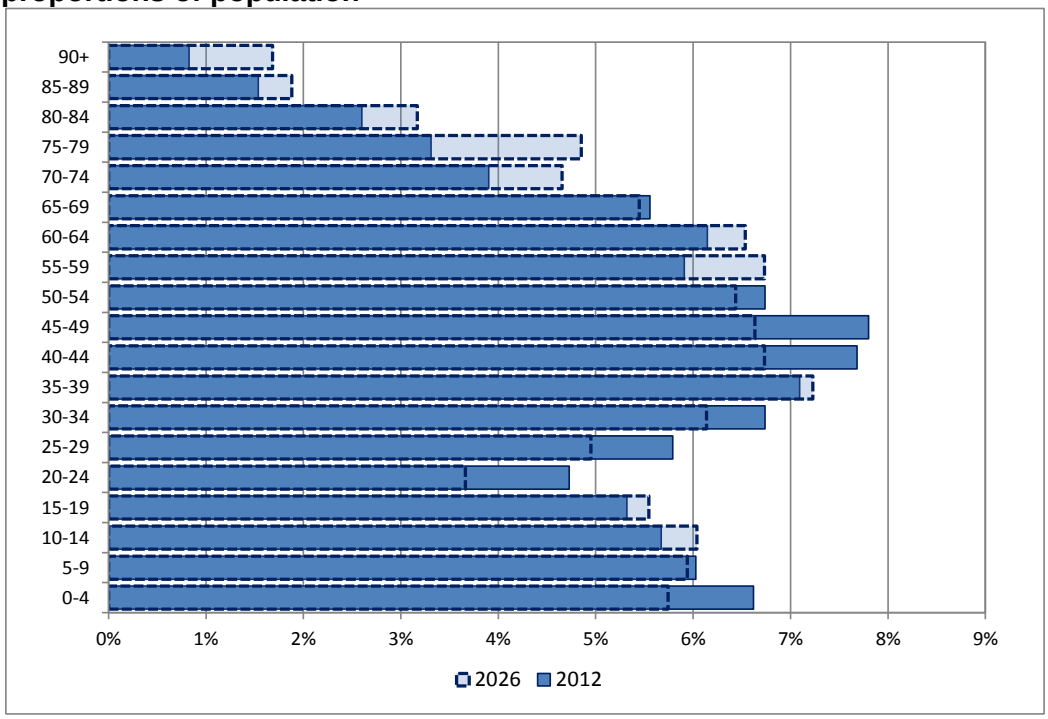
East Cambridgeshire has a more typical population profile, though with relatively few people between 20 and 40 years. The profile is expected to become more even over time, with growth in all age groups except 20 to 24 years.

Figure 35: Population projections by age band, East Cambridgeshire, 2012 and 2026: numbers of people



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

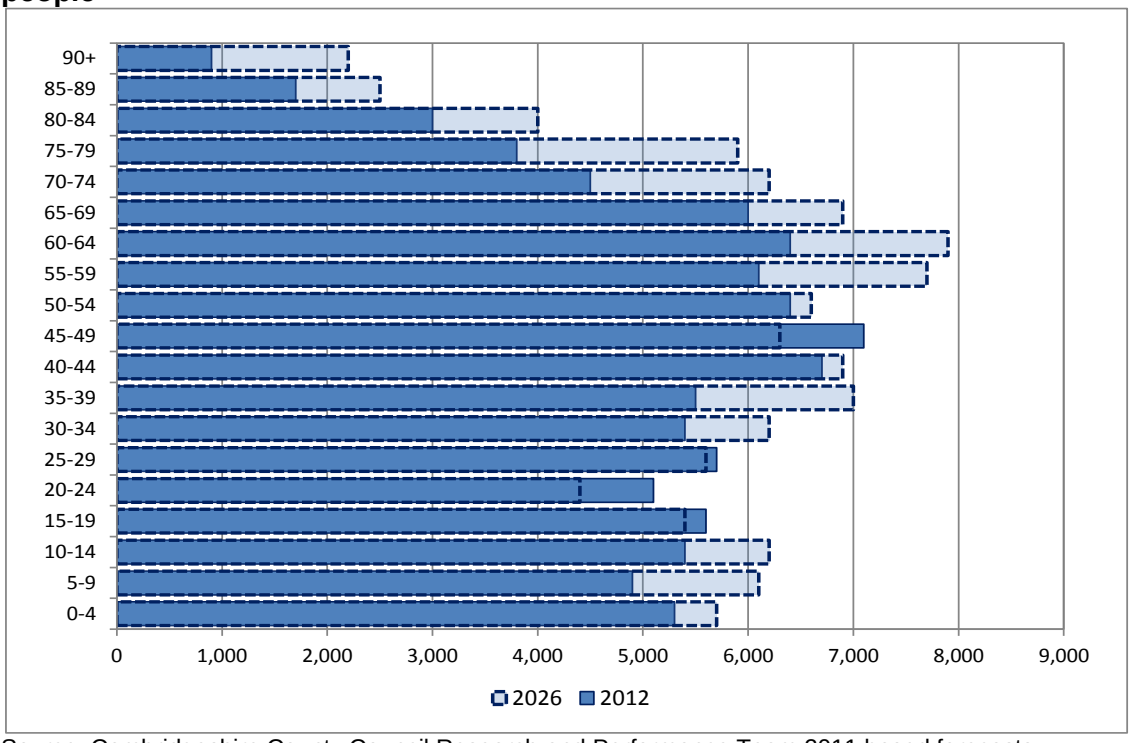
Figure 36: Population projections by age band, East Cambridgeshire, 2012 and 2026: proportions of population



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

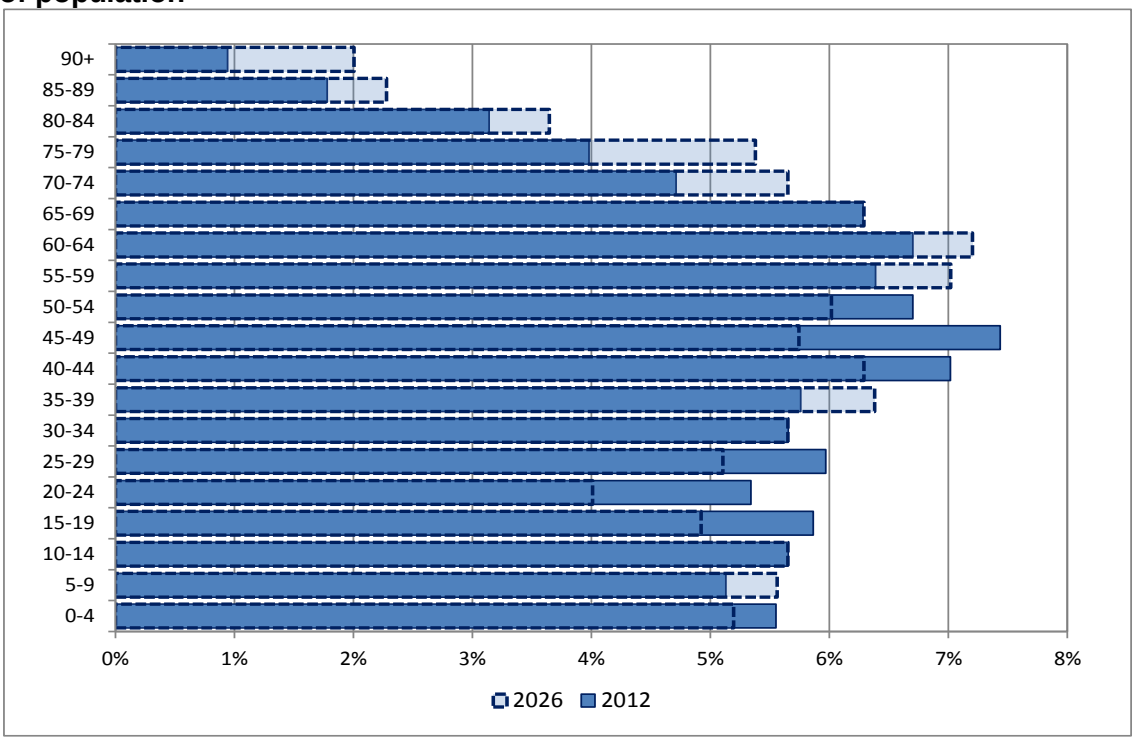
Fenland's demographic profile is fairly even across the main age categories and shows growth in most age groups.

Figure 37: Population projections by age band, Fenland, 2012 and 2026: numbers of people



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

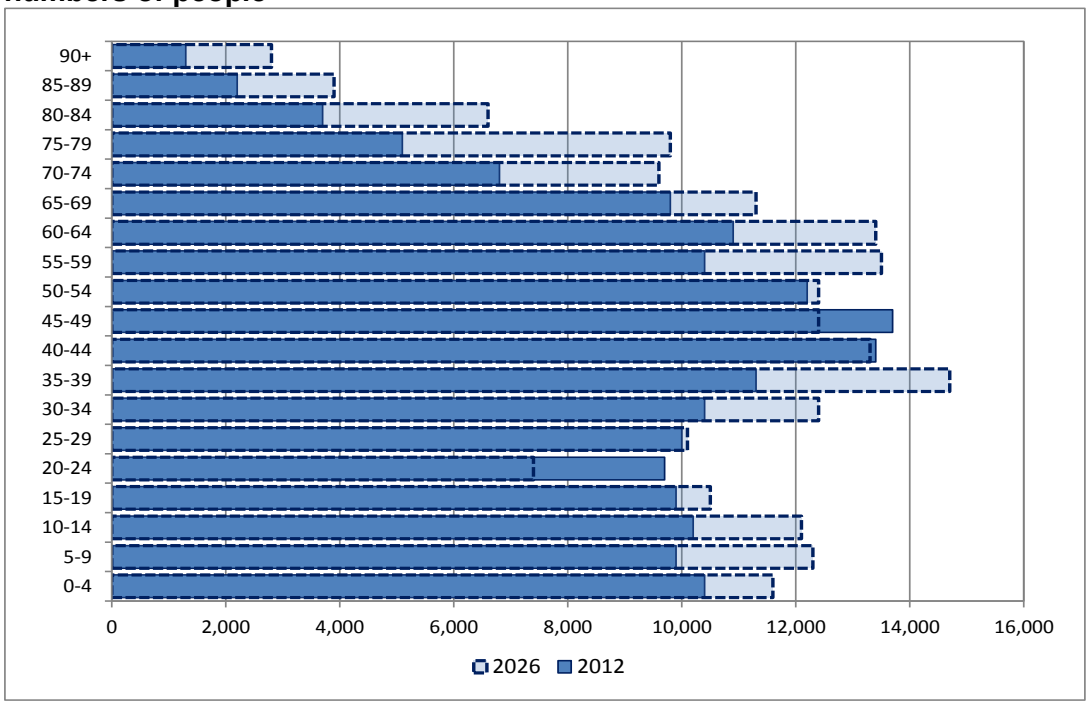
Figure 38: Population projections by age band, Fenland, 2012 and 2026: proportions of population



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

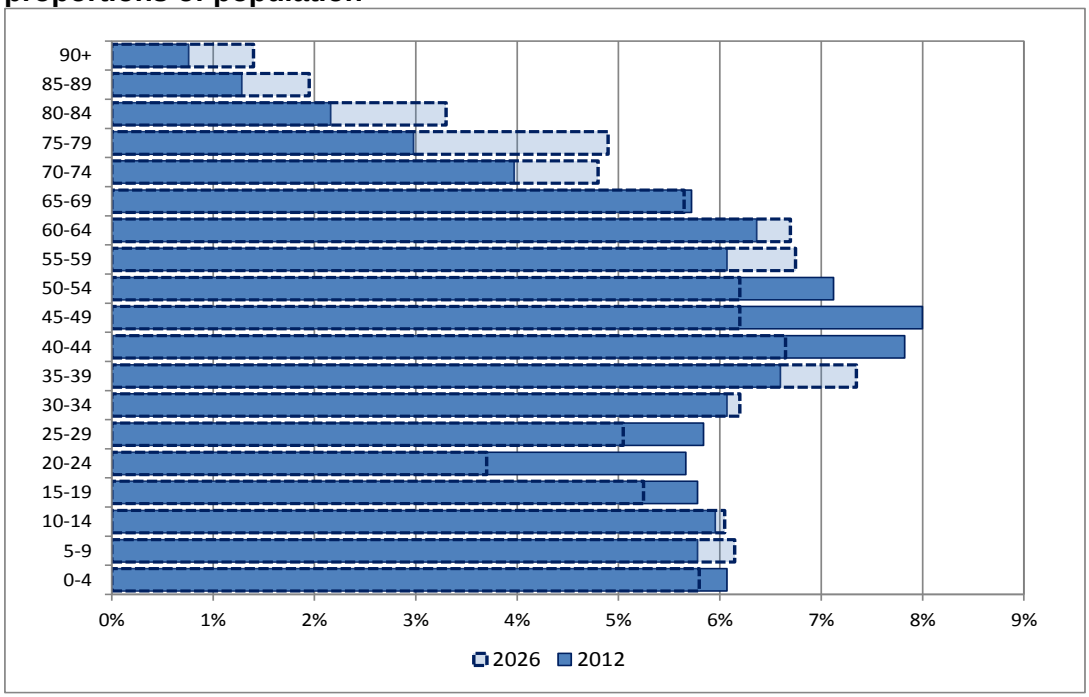
The demographic position and projections in Huntingdonshire are similar to those in Fenland, though with less, or no, growth in some adult working age categories.

Figure 39: Population projections by age band, Huntingdonshire, 2012 and 2026: numbers of people



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

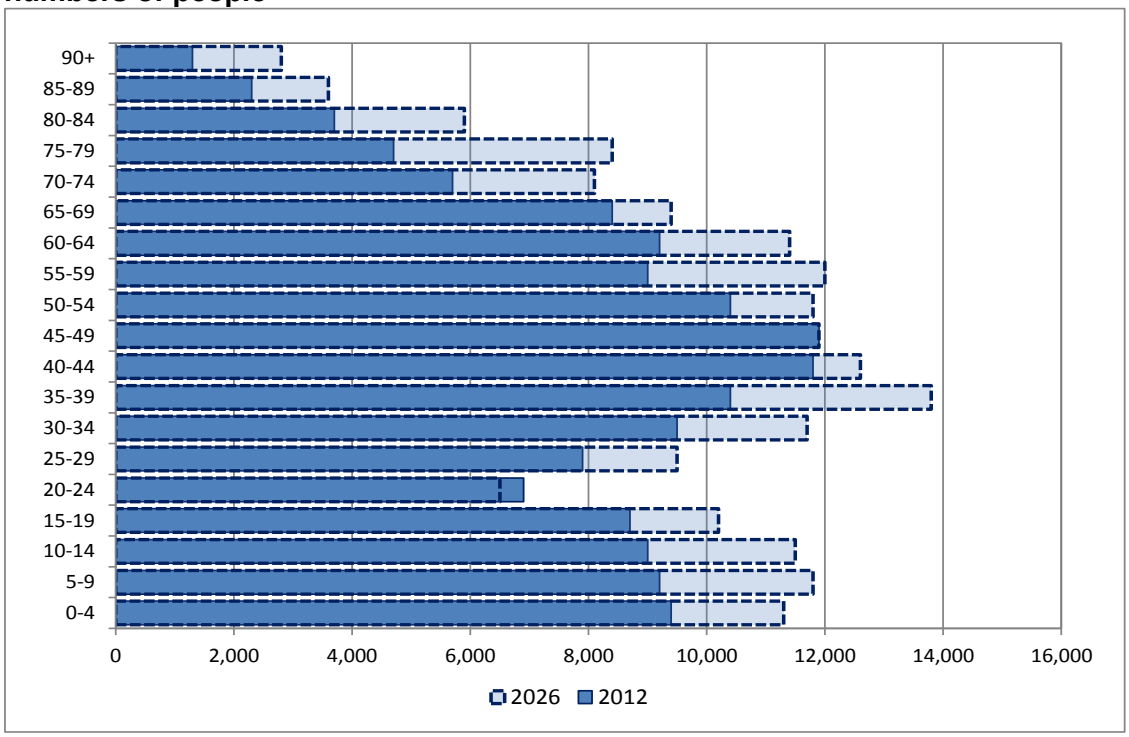
Figure 40: Population projections by age band, Huntingdonshire, 2012 and 2026: proportions of population



Source: Cambridgeshire County Council Research and Performance Team 2011 based forecasts.

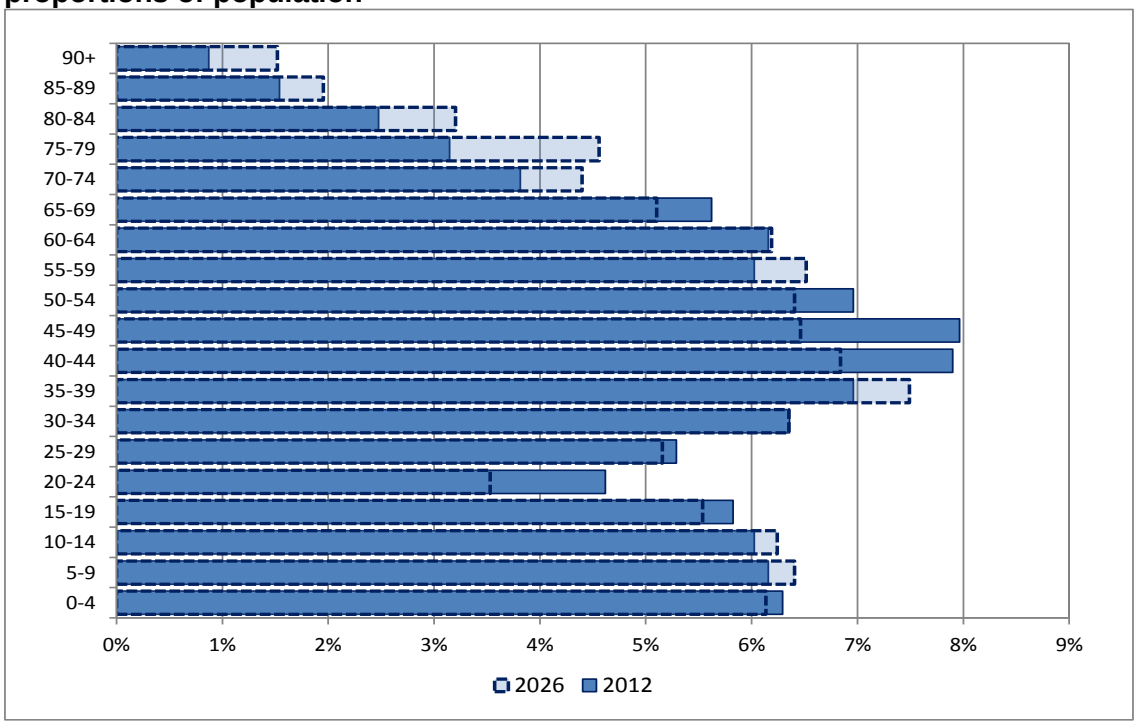
South Cambridgeshire has relatively few people in the younger adult age bands. Increases are expected in all age-groups except 20 to 24 year olds by 2026.

Figure 41: Population projections by age band, South Cambridgeshire, 2012 and 2026: numbers of people



Source: Cambridgeshire County Council Research & Performance Team 2011 based forecasts.

Figure 42: Population projections by age band, South Cambridgeshire, 2012 and 2026: proportions of population



Source: Cambridgeshire County Council Research & Performance Team 2011 based forecasts.

Appendix 2: Search strategies

1. *Depression/
2. *mood disorders/ or *depressive disorder/ or *depressive disorder, major/ or *depressive disorder, treatment-resistant/ or *dysthymic disorder/ or *seasonal affective disorder/
3. depress*.ti.
4. ((mood or dysthymic) adj2 disorder?).ti.
5. 1 or 2 or 3 or 4
6. Primary Prevention/
7. preventive health services/ or secondary prevention/
8. "early intervention (education)"/ or exp health education/ or exp health promotion/
9. prevent*.ti,ab.
10. ((patient or health or consumer) adj3 educat*).ti,ab.
11. (health adj3 promot*).ti,ab.
12. ((early or multifacet* or multi-facet* or non-pharmacolo* or nonpharmacol*) adj2 intervention*).ti,ab.
13. 6 or 7 or 8 or 9 or 10 or 11 or 12
14. 5 and 13
15. depressive disorder/pc or depressive disorder, major/pc or depressive disorder, treatment-resistant/pc or dysthymic disorder/pc or seasonal affective disorder/pc
16. depression/pc
17. 14 or 15 or 16
18. exp Aged/
19. (elder* or older? or old age? or geriatric? or veteran?).ti.
20. ((elder* or older? or old or aged or geriatric) adj2 (adult? or people or person? or patient?)).ti,ab.
21. 18 or 19 or 20
22. 17 and 21
23. limit 22 to (english language and yr="2003 -Current")
24. limit 23 to "reviews (maximizes specificity)"
25. limit 23 to "therapy (best balance of sensitivity and specificity)"
26. limit 23 to "therapy (maximizes specificity)"

1. *Depression/
2. *mood disorders/ or *depressive disorder/ or *depressive disorder, major/ or *depressive disorder, treatment-resistant/ or *dysthymic disorder/ or *seasonal affective disorder/
3. depress*.ti.
4. ((mood or dysthymic) adj2 disorder?).ti.
5. 1 or 2 or 3 or 4
6. *disease progression/
7. (progress* adj3 (disease* or disorder* or symptom*)).ti,ab.
8. ((reduc* or slow* or low* or chang* or modif* or improv*) adj3 incidence).ti,ab.
9. ((reduc* or alleviat* or improv* or chang*) adj3 symptom*).ti,ab.
10. *"Activities of Daily Living"/
11. "activities of daily living".ti,ab.
12. exp *Self-Injurious Behavior/
13. *Mortality/

14. *Survival/ or *Survival Rate/
15. (suicide or suicidal).ti.
16. (mortality or survival).ti.
17. 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16
18. 5 and 17
19. (mood disorders/th or depressive disorder/th or depressive disorder, major/th or depressive disorder, treatment-resistant/th or dysthymic disorder/th or seasonal affective disorder/th) and exp *Psychotherapy/
20. 18 or 19
21. exp Aged/
22. (elder* or older? or old age? or geriatric? or senior? or veteran?).ti.
23. 21 or 22
24. 20 and 23
25. (depress* adj5 (elder* or older? or old or aged or geriatric) adj2 (adult? or people or person? or patient?)).ti,ab.
26. 17 and 25
27. 24 or 26
28. limit 27 to (english language and yr="2003 -Current")
29. limit 28 to "reviews (maximizes specificity)"
30. limit 28 to "therapy (maximizes specificity)"

1. *dementia/ or *alzheimer disease/ or exp *dementia, vascular/
2. (dementia* or alzheimer*).ti.
3. 1 or 2
4. Primary Prevention/
5. preventive health services/ or secondary prevention/
6. "early intervention (education)"/ or exp health education/ or exp health promotion/
7. prevent*.ti,ab.
8. ((patient or health or consumer) adj3 educat*).ti,ab.
9. (health adj3 promot*).ti,ab.
10. ((early or multifacet* or multi-facet* or non-pharmacolo* or nonpharmacol*) adj2 intervention*).ti,ab.
11. 4 or 5 or 6 or 7 or 8 or 9 or 10
12. 3 and 11
13. dementia/pc or alzheimer disease/pc or exp dementia, vascular/pc
14. 12 or 13
15. limit 14 to (english language and yr="2003 -Current")
16. limit 15 to "reviews (maximizes specificity)"

1. *dementia/ or *alzheimer disease/ or exp *dementia, vascular/
2. (dementia* or alzheimer*).ti.
3. 1 or 2
4. *disease progression/
5. (progress* adj3 (disease* or disorder* or symptom*)).ti,ab.
6. ((reduc* or slow* or low* or chang* or modif* or improv*) adj3 incidence).ti,ab.
7. ((reduc* or alleviat* or improv* or chang*) adj3 symptom*).ti,ab.

8. *"Activities of Daily Living"/
9. "activities of daily living".ti,ab.
10. *Mortality/
11. *Survival/ or *Survival Rate/
12. (mortality or survival).ti.
13. ((psycholog* or psychosoc* or social* or educat* or behavio* or nonpharma* or non-pharma*) adj2 (intervention* or therap* or treatment*)).ti,ab.
14. ((cognitive or cognition) adj2 (decline or improv* or function or impair*)).ti,ab.
15. 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
16. 3 and 15
17. (*dementia/ or *alzheimer disease/ or exp *dementia, vascular/) and exp *psychotherapy/
18. 16 or 17
19. limit 18 to (english language and yr="2003 -Current")
20. limit 19 to "reviews (maximizes specificity)"