Coimisiún Meabhair-Shláinte | Mental Health Commission

MENTAL HEALTH SERVICES FOR OLDER PEOPLE

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EXECUTIVE SUMMARY

Ireland's population of older people continues to increase and with it the number of older people with mental illness. Central Statistics Office (CSO) figures predict that those aged 65 years and over will increase significantly: from 629,800 in 2016 to almost 1.6 million by 2051. This demographic change is not a new phenomenon and has been widely reported and plotted in recent years.

Approximately 15% of adults aged 60 and over suffer from a mental illness, including depression, dementia, anxiety, alcohol dependence, and schizophrenia. In this age group, physical illness is more common and includes heart disease, loss of mobility, lung disease, chronic pain, and frailty. Other considerations include lack of appropriate accommodation, loneliness, bereavement, and financial difficulties. It is, therefore, obvious that mental health service for older people cannot operate out of a silo; there must be an integration of all services for older people. Integration is a single system of needs assessment and service provision that aims to promote alignment and collaboration between the care sectors. The HSE has committed to the integration of services with primary care, social care, and acute hospital care. Currently, however, this integration varies widely across the country, resulting in the duplication of services and a lack of access to healthcare and support services.

Despite the increasing elderly population, we are currently not providing a nation-wide, comprehensive mental health service for older people. We have highly-trained and committed specialist clinicians, yet we have only 66% of the recommended number of specialist teams, which themselves are only staffed at an overall level of 54%. Day hospitals assist in maintaining people living at home while providing assessment and treatment, but there are only 0.26 day hospital places per 10,000 population over 65. Lack of community supports, such as respite care and home care packages, increase the probability of dependence on costly residential care. There are 1.2 dedicated acute mental health beds for older people per 100,000, compared with 6 per 100,000 in England and 9.7 in Northern Ireland. The delivery of in-patient mental health care to older people in general adult mental health units, rather than in dedicated units, constitutes a risk to their safety and does not meet their therapeutic needs.

The presence of mental illness in elderly general hospital admissions is common and includes depression, delirium, and dementia. Liaison psychiatry services in acute general hospitals are needed to address the mental health needs of people being treated primarily for physical health problems and symptoms. Apart from two areas in Dublin, there are no liaison teams and the needs of this population are met by already stretched community teams.

The COVID-19 pandemic presents a perfect storm for the mental health of older people. In addition to carrying the highest mortality and morbidity risk from COVID-19, they also experience social distancing, isolation, and a heightened perception of the risk of death and illness. Isolation is strongly linked to depression, anxiety, and cognitive decline, and reduces resilience factors such as self-worth, sense of purpose, and feeling valued. Access to appropriate mental health services and other supports is essential. Given the congregate nature of in-patient and residential units, elderly residents are at high risk of being affected by respiratory pathogens like COVID-19. A strong infection prevention and control program is critical to protect both residents and healthcare personnel. Mental health services must endeavour to provide adequately staffed community teams and supports to enable older persons to stay at home as long as possible, as well as enhanced technology to allow virtual assessments and contacts, and more single en suite accommodation in residential and acute mental health care to prevent progression of the disease.

Older people and their carers need to feel that they are being listened to; they need to feel safe; they need to feel respected; and they need to feel that they are being engaged with. An effective mental health service for older people requires a managed network of services across a wide spectrum of care, with the exact components of the care pathway determined by need. Improved older people's mental health services will ensure that older people with mental health problems have their needs met so that their quality of life, choices, and independence are enhanced now and into the future.

INTRODUCTION

While most older people are in good mental health, a significant number suffer from a mental disorder at any one time. The majority of those with a mental disorder will continue to function independently in the community, but others will require support from community care services to do so. In addition, some older people, particularly those with severe dementia, will require institutional care.

National Council on Ageing and Older People

By now, warnings about the impact of an ageing population on the nation's health care system have become familiar. As is the case internationally, Ireland's population is ageing. The Economic and Social Research Institute (ESRI), in a 2017 report, projected that by 2030 the population aged 80 or above will increase by between 89% and 94%. A spending review by the Department of Public Expenditure found that by 2031 more than a quarter of a million inhabitants in the State will be aged over 80 years. Central Statistics Office (CSO) figures predict that those aged 65 years and over will increase significantly: from 629,800 in 2016 to up to nearly 1.6 million by 2051. This growth will have considerable implications for public policy, Government finances, and for the health service in the years ahead.

Older adults, those aged 60 or above, make important contributions to society as family members, volunteers and as active participants in the workforce. Older people are no less prone to mental health problems than younger adults, although such difficulties often manifest differently in older age. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems, as well as other health conditions such as diabetes, heart disease, arthritis, hearing loss, and sight loss. Furthermore, as people age, they are more likely to experience several conditions at the same time. Mental health problems are often under-identified by healthcare professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help[1]. In fact, older people who experience a mental health problem or illness may face a "double dose" of stigma: the stigma of being older in addition to the stigma of mental illness.

Depression is the most common mental health problem in this age group. It is estimated that it affects 22% of men and 28% of women aged 65 or over and 40% of older people in care homes[2]. The prevalence of anxiety disorder in the community ranges from 1.2% to 15%, and in clinical settings from 1% to 28%. The prevalence of anxiety symptoms is much higher, ranging from 15% to 52.3% in community samples.[3] Less commonly, patients present to services with psychosis due to bipolar disorder or a psychotic disorder. Their psychotic illness may have been long-standing, but it may also present for the first time in later life.

Another area to consider is the impact of frailty. Frailty has been defined as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves'.[4] It is often, although not exclusively, present in people with more than one long-term illness. Around 10% of people aged 65 and over currently live with frailty, rising to between 35% and 50% of those aged over 85. Older people with frailty are at risk of dramatic changes in their physical and mental well-being after what may be an apparently minor health problem, for example an infection or a fall. Several frailty syndromes have been identified and all can complicate the identification and holistic care of mental illness.

Mental health problems carry high costs, both personal and economic. Many disorders are subject to relapse or of long duration, and every aspect of a person's functioning can be affected, leading to increased resource use. However, mental illness is not a normal consequence of ageing and can be prevented, treated and managed.

1 Mental Health of Older Adults World Health Organisation 2017
2 Age UK (2016) *Hidden in Plain Sight: The Unmet Mental Health Needs of Older People*. Age UK
3 The prevalence of anxiety in older adults: Methodological issues and a review of the literature. Journal of Affective Disorders 2008 109(3):233-50
4 British Geriatrics Society (2014) *Fit for Frailty*. British Geriatrics Society.

BACKGROUND

By the start of the 21st century, countries aimed to offer comprehensive, accessible, responsive, individualised, multi-disciplinary, accountable, and systematic mental health care for older people via integrated health and social care services. Multi-disciplinary Community Mental Health Teams (CMHTs) were given a central role in providing support for people with severe or complex mental health problems in the community.[5] [6] It is generally agreed that there will always be a significant minority of older people who need hospital admission, with the intensive levels of assessment, monitoring, and treatment this offers. That said, there is considerable concern about the extent of variation in investment and practice, for although in-patient admission can offer a safe haven, it can also be a traumatic experience, exacerbating disorientation and behavioural disturbance, and upsetting usual routines. It also accounts for a large proportion of specialist mental health expenditure.

Key Facts

- Globally, the population is ageing rapidly. Between 2015 and 2050, the proportion of the world's population over 60 years will nearly double, from 12% to 22%.
- Mental health and well-being are as important in older age as at any other time of life.
- Mental and neurological disorders among older adults account for 6.6% of the total disability adjusted life years (DALYs) for this age group.
- Approximately 15% of adults aged 60 and over suffer from a mental disorder.
- Mental and neurological disorders in older people account for 17.4% of Years Lived with Disability (YLDs).
- The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively.
- Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1% and around a quarter of deaths from self-harm are among people aged 60 or above.

Mental Health of Older Adults World Health Organisation 2017

Older people may experience life stressors common to all people, but also stressors that are more prevalent in later life, such as bereavement, a drop in socioeconomic status with retirement, significant ongoing loss in capacities, and a decline in functional ability. For example, older adults may experience reduced mobility, chronic pain, frailty, or other health problems. Some or all of these stressors can result in isolation, loneliness or psychological distress in older people, for which they may require long-term care.

Mental health has an impact on physical health and vice versa. For example, older adults with physical health conditions such as heart disease have higher rates of depression than those who are healthy. Additionally, untreated depression in an older person with heart disease can negatively affect its outcome.[7]

Older adults are also vulnerable to elder abuse - including physical, verbal, psychological, financial, and sexual abuse; abandonment; neglect; and serious losses of dignity and respect. Current evidence suggests that 1 in 6 older people experience elder abuse. Elder abuse can lead not only to physical injuries, but also to serious, sometimes long-lasting psychological consequences, including depression and anxiety.

Key International Facts

- Around 1 in 6 people 60 years and older experienced some form of abuse in community settings during the past year.
- Rates of elder abuse are high in institutions such as nursing homes and long-term care facilities, with 2 in 3 staff reporting that they have committed abuse in the past year.
- Elder abuse can lead to serious physical injuries and long-term psychological consequences.
- Elder abuse is predicted to increase as many countries are experiencing rapidly ageing populations

World Health Organisation Elder Abuse Fact Sheet June 2020

Against this background, recent years have seen the development of a series of initiatives designed to shift resources from institutional to community care, predicated on grounds of cost-effectiveness. However, most of these plans have focused on the use of care home and general

[5] Burns A, Dening T, Baldwin R. Care of older people: Mental health problems. Br Med J. 2001;322:789–91.

[6] A Vision for Change

[7] Naylor C, Parsonage M, McDaid D, Knapp M, Fossey M, Galea A (2012). Report. Long-term conditions and mental health.
The cost of co- morbidities The King's Fund and Centre for Mental Health

hospital beds, and surprisingly little attention has been paid to the demand for specialist mental health inpatient services, despite their very high cost.[8] Forty percent of older people in GP clinics have a mental health problem, rising to 50% of older people in general hospitals and 60% of those in care homes.[9]

Dementia

Dementia is a syndrome, usually of a chronic or progressive nature, in which there is deterioration in memory, thinking, behaviour, and the ability to perform everyday activities. It mainly affects older people, although it is not a normal part of ageing.

It is estimated that 50 million people worldwide are living with dementia, with nearly 60% living in low- and middle-income countries. The total number of people with dementia is projected to increase to 82 million in 2030 and 152 million in 2050.[10]

Over 90% of older adults with dementia experience behavioural and psychological symptoms of dementia (BPSD) at some point in the course of their illness.[11] These symptoms include: anxiety, depression, aggression, hallucinations or paranoia and, if not correctly managed, are one of the most common reasons why family members are not able to continue caring for their relatives at home.[12]

There are significant social and economic issues in terms of the direct costs of medical, social and informal care associated with dementia, and physical, emotional and economic pressures can cause great stress to families and carers. Support is needed from the health, social, financial, and legal systems for both people with dementia and their carers.

There are three main areas of treatment in dementia care (irrespective of patient age) with evidence of effective interventions - cognitive decline, BPSD, and care-giver stress. Systematic reviews and meta-analyses of random controlled trials (RCTs) have concluded that cholinesterase inhibitor therapies have a significant but modest effect in the treatment of cognitive decline associated with Alzheimer's disease and Dementia with Lewy bodies.[13] In the treatment of BPSD, there is evidence of the effectiveness of psychosocial interventions, such as behaviour therapy, activity programs, and music therapy.[14] Pharmacological interventions have a limited role in the management of BPSD as they are associated with a range of serious adverse effects in older people and the indications for which they are effective is relatively limited.[15] There is strong evidence that interventions for dementia care-givers that include education, skills training and emotional support are effective in reducing care-giver stress and may delay placement into institutional care.[16] [17]

While there is no medication currently available to cure dementia, much can be done to support and improve the lives of people with dementia and their caregivers and families, such as:

- early diagnosis, in order to promote early and optimal management;
- optimizing physical and mental health, functional ability, and well-being;
- identifying and treating accompanying physical illness;
- detecting and managing challenging behaviour;
- providing information and long-term support to carers.

[8] Tucker, S., Brand, C., Wilberforce, M. et al. Identifying alternatives to old age psychiatry inpatient admission: an application of the balance of care approach to health and social care planning. BMC Health Serv Res 15, 267 (2015).
[9] Social Care Institute for Excellence (2006) Assessing the Mental Health Needs of Older People (SCIE Guide 3)
[10] Dementia. World Health Organisation 2019
[11] Steinberg M, Shao H, Zandi P, Lyketsos CG, Welsh-Bohmer KA, Norton MC, et al (2008) Point and 5-year period prevalence of neuropsychiatric symptoms in dementia: the Cache County Study. International Journal of Geriatric Psychiatry, 23: 170–7.
[12] Gallagher, D., Ni Mhaolain, A, Crosby, L, Ryan, D, Lacey, L, Coen, R.F. Walsh, C., Coakley, D., Walsh, J.B. Cunningham, C. and Lawlor, B.A., 2011b. Determinants of the desire to institutionalize in Alzheimer's caregivers. American journal of Alzheimer's disease and other dementias, 26(3), pp. 205-211.
[13] Knight R, Khondoker M, Magill N, Stewart R, Landau S: A Systematic Review and Meta-Analysis of the Effectiveness of Acetylcholinesterase Inhibitors and Memantine in Treating the Cognitive Symptoms of Dementia. Dement Geriatr Cogn Disord 2018;45:131-151.
[14] Abraha I, Rimland JM, Trotta FM, et al Systematic review of systematic reviews of non-pharmacological interventions to treat behavioural disturbances in older patients with dementia. The SENATOR-OnTop series BMJ Open 2017;7
[15] National Institute for Health Care Excellence (NICE). Decision aid: Antipsychotic medicines for treating agitation, aggression and distress in people living with dementia. 2018.
[16] Bourgeois MS. Caregiving for Persons with Dementia: Evidence-based resources for SLPs. Top Lang Disord. 2019;39(1):89-103.
[17] Dementia: assessment, management and support for people living with dementia and their carers NICE guideline Published: 20 June 2018 www.nice.org.uk/guidance/ng97

Depression

Depression can cause great suffering and leads to impaired functioning in daily life. Unipolar depression occurs in 7% of the general older population and it accounts for 5.7% of Years Lived with Disability (YLDs) among those over 60 years old. Depression is both underdiagnosed and undertreated in primary care settings. Symptoms are often overlooked and untreated because they co-occur with other problems encountered by older adults.

Older people with depressive symptoms have poorer functioning compared to those with chronic medical conditions, such as lung disease, hypertension or diabetes. Depression also increases the perception of poor health, the utilization of health care services and costs.[18]

Depression in later life is the major risk factor for suicide – 80% of people over the age of 74 who die by suicide have depression.[19] [20] It also doubles, and can sometimes treble, natural death rates,[21] impair the ability to function independently, increase the likelihood of admission to long-term care, and worsen the outcome of other medical conditions.[22] In primary care, patients aged 55 or more with depression have a poor prognosis. Using readily available prognostic factors (for example, severity of the index episode, a family history of depression, and functional decline) could help direct treatment to those at highest risk of a poor prognosis. Prompt recognition, assessment, and treatment of depression in older adults is essential.

Anxiety

It is increasingly acknowledged that anxiety disorders are frequent disorders in later life and have a significant prognostic impact as an under-recognized cause of mental and physical disability as well as a potential catalyst of the mortality risk in the elderly, requiring a heightened awareness and improved diagnostic methods among clinicians. Among older people, anxiety disorders are associated with reduced physical activity and functional status, poorer self-perceptions of health, decreased life satisfaction, increased loneliness, decreased quality of life, increased service use, poor compliance with treatments, and the overall greater cost of care. Anxiety disorders are also a risk factor for Alzheimer disease and vascular dementia.[24] Ageing is associated with age-specific psychosocial risk factors for anxiety (i.e. living alone, physical illness and disability, or cognitive decline).

[18] Mental health of Older Adults. World Health Organisation 2017

[19] Conwell Y, Duberstein P, Cox C, Herrmann J, Forbes N, Caine ED (1998) Age differences in behaviours leading to completed suicide. American Journal of Geriatric Psychiatry, 6: 112–26.

[20] Hawton K, Harriss L (2006) Deliberate self-harm in people aged 60 years and over: characteristics and outcome of a 20 year cohort study. International Journal of Geriatric Psychiatry, 21: 572–81.

[21] Ryan J, Carriere I, Ritchie K, Stewart R, Toulemonde G, Dartigues JF, et al (2008) Late life depression and mortality: influence of gender and antidepressants. British Journal of Psychiatry, 192: 12–8

[22] Wanless D et al. Securing good care for older people Taking a long-term view. Kings Fund 2006

[23] Licht-Strunk E, Van Marwijk H, Twisk J, De Haan M (2009) Outcome of depression in later life in primary care: longitudinal cohort study with three years follow up. BMJ, 3079: 338

[24] Becker E, Orellana Rios CL, Lahmann C, et al. Anxiety as a risk factor of Alzheimer's disease and vascular dementia. Br J Psychiatry. 2018;213:654-660.

Strategy for Ageing and Health

The Global Strategy and Action plan on Ageing and Health was adopted by the World Health Assembly in 2016. One of the objectives of this global strategy is to align health systems to the needs of older populations, for mental as well as physical health.

Key actions include:

- orienting health systems around intrinsic capacity and functional ability
- developing and ensuring affordable access to quality older person-centred and integrated clinical care
- ensuring a sustainable and appropriately trained, deployed, and managed health workforce

In May 2017, the World Health Assembly endorsed the *Global Action Plan on the Public Health Response to Dementia 2017-2025*. The plan provides a comprehensive blueprint for action – for policy-makers, international, regional and national partners and the World Health Organisation (WHO) – in areas such as increasing awareness of dementia and establishing dementia-friendly initiatives; reducing the risk of dementia; diagnosis, treatment and care; research and innovation; and support for dementia carers. It is heavily embedded in rights-based principles (focus on choice, autonomy and self-determination) and there is a commitment to the values of personhood and social citizenship,[25] timely diagnosis, community awareness, and to improving quality of care[26] and quality of life. The aim is to improve the lives of people with dementia, their carers and families, while decreasing the impact of dementia on individuals, communities, and countries. As part of efforts to operationalise the plan, an international surveillance platform - the Global Dementia Observatory - has been established for policy-makers and researchers to facilitate monitoring and sharing of information on dementia policies, service delivery, epidemiology, and research.

WHO's Global Action Plan on the Public Health Response to Dementia identifies seven priority actions areas, sets out parallel targets for countries to achieve and provides governments with the required framework to develop their own national dementia plans. This means that countries must ensure that their policies, legislation and programmes are sensitive to the human rights of people with dementia as set out in the UN Convention on the Rights of Persons with Disabilities (UNCRPD). Today, some 32 nations around the world have developed their own National Dementia Strategies, including Ireland.[27]

[25] O'Shea &Carney, 2016 O'Shea, E., & Carney, P. (2016). Dementia paying dividends: A report on the Atlantic Philanthropies investment in dementia in Ireland. Nui Galway: Centre for Economic and Social Research on Dementia. [Google Scholar])

[26] Fortinsky, R., & Downs, M. (2014). Optimizing person-centred transitions in the dementia journey: A comparison of national dementia strategies. Health Affairs, 33(4), 566–573.[Crossref], [Web of Science ®] , [Google Scholar])

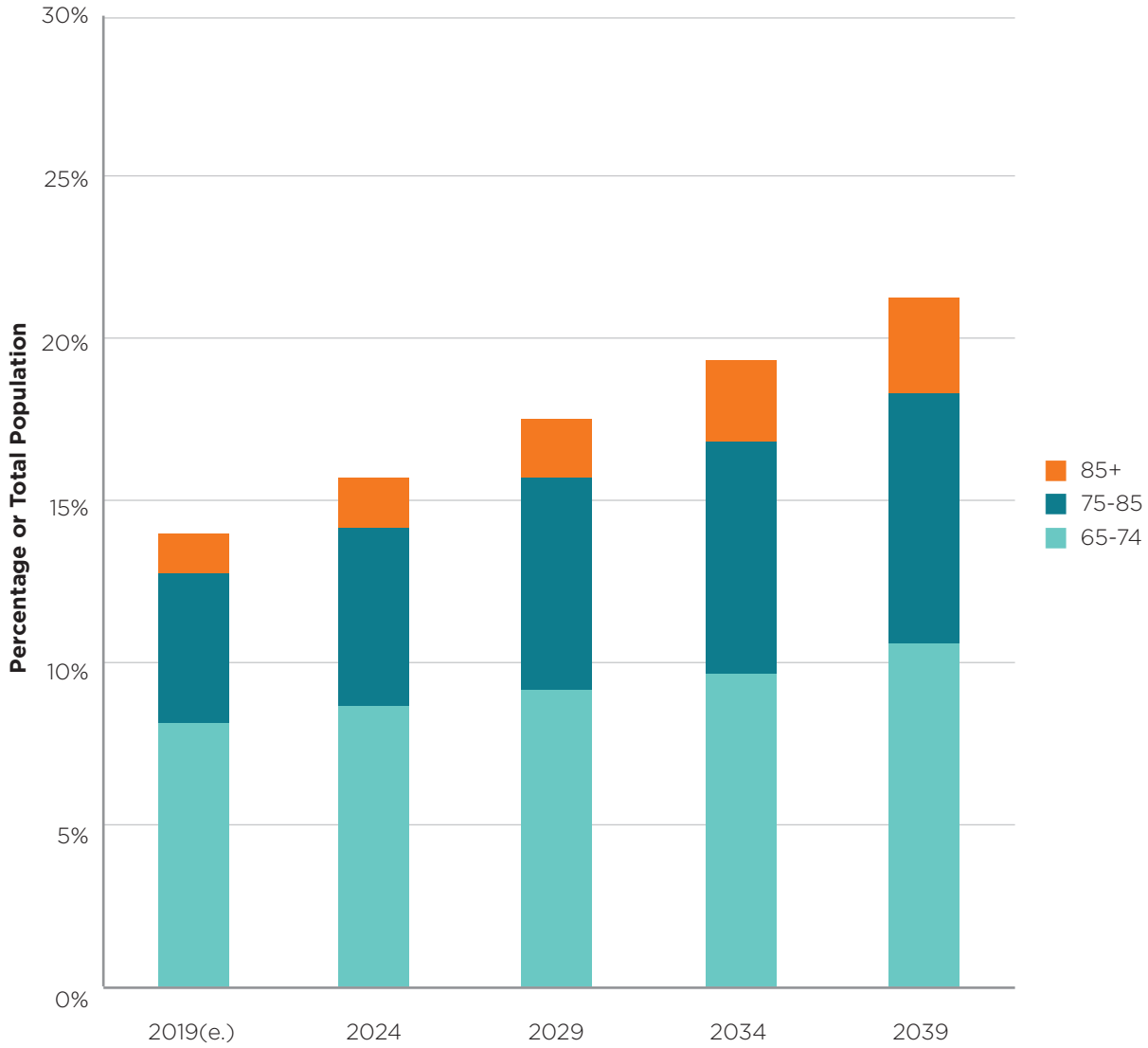
[27] ADI, Alzheimer's Disease International. (2018). From plan to impact: Progress towards targets of the global action plan on dementia. [Google Scholar]

MENTAL HEALTH SERVICES FOR OLDER PEOPLE IN IRELAND

Population increase

Central Statistics Office (CSO) figures predict that those aged 65 years and over will increase significantly: from 629,800 in 2016 to almost 1.6 million by 2051, with over 470,000 of those aged over 80.[28] Approximately 4.5% of older people currently live in a congregated setting or residential care settings. This is approximately 40% higher than the current European average.[29]

Older Age Groups: Population 2019 and Projected Population 2024-2039



From Health in Ireland Key Trends Department of Health (2019)

[28] Central Statistics Office (2013). Population and Labour Force Projections 2016-2046. Dublin: Government of Ireland

[29] Donnelly, S., O'Brien, M., Begley, E. and Brennan, J. (2016). "I'd prefer to stay at home but I don't have a choice" Meeting Older People's Preference for Care: Policy, but what about practice? Dublin: University College Dublin. Available at http://www.dementia-neurodegeneration.ie/sites/default/files/publications/staying_at_home_-_older_peoples_preference_for_care_2016.pdf [accessed 23/06/2017]

Dementia in Ireland

The prevalence of dementia in Ireland is projected to rise from approximately 38,000 in 2006 to in excess of 100,000 by 2036.[30] The majority of people with dementia are currently cared for at home by family members, with little input from formal services. Institutional care is the most costly phase of care and without adequate community supports for older adults with dementia there will be an increased and unsustainable demand for inpatient and long-term care beds. Pharmacological and psychosocial interventions help improve patient function, manage behavioural symptoms, and help to maintain older adults in their own home environment for longer.[31]

The Irish National Dementia Strategy was published by the Department of Health in December 2014. Six Priority Areas for Action have been identified in the strategy, as follows:

- Better awareness and understanding
- Timely diagnosis and intervention
- Integrated services, supports and care for people with dementia and their carers
- Training and education
- Research and information systems
- Leadership

The National Dementia Strategy is implemented under the leadership of the HSE's National Dementia Office. The strategy emphasises the need for a "whole community response" to dementia, as the majority of people with dementia live in their own communities and wish to avail of services in their local area.

Estimated and projected number of people with dementia in Ireland and living in the community, 2011-2046

Prevalence and Projections of Dementia in Ireland, 2011 – 2046 Dr. Maria Pierce, Prof. Suzanne Cahill and Prof. Eamon O'Shea

[30] Prevalence and Projections of Dementia in Ireland, 2011 – 2046 Dr. Maria Pierce, Prof. Suzanne Cahill and Prof. Eamon O'Shea

[31] Herrmann N, Lanctot K Pharmacologic Management of Neuropsychiatric Symptoms of Alzheimer Disease 2007 Canadian journal of psychiatry. Revue canadienne de psychiatrie 52(10):630-46

Functional Mental Illness

Depression is the most common mental health problem in this age group. It is estimated that it affects 22% of men and 28% of women aged 65 or over and 40% of older people in care homes.[32] The prevalence of anxiety disorder in older people in the community ranges from 1.2% to 15%, and in clinical settings from 1% to 28%.[33] Less commonly, patients present to services with psychosis due to bipolar disorder or a psychotic disorder. Their psychotic illness may have been long-standing, but it may also present for the first time in later life. Results from the Irish Longitudinal Study on Ageing (TILDA)[34] in 2011 showed that 10% of older adults in Ireland (people over 50 years of age) report clinically significant depressive symptoms and 18% have 'sub-threshold' levels of depression. It was also found that 13% of participants had clinically significant anxiety symptoms, and 29% had 'sub-threshold' levels of anxiety. TILDA research has shown that there is is under-diagnosis and under-treatment of depression and anxiety among older adults. People over 75 years of age with depression visit their GP on average seven times per year, this compares to four visits per year for people without depression.

In 2019, the HSE published a Model of Care for Specialist Geriatric Services Part 2 which is part of the National Clinical Programme for Older People.[35] This document concerns itself with the provision of specialist mental health services for older people. The Model of Care outlines the key role of specialist mental health services for older people, care pathways and interfaces with other services, the role of multi-disciplinary team members, training and education, research, governance, and performance management, and makes a number of recommendations covering these areas.

A national overview of community based Mental Health Services for Older People (MHSOP) from the Inspectorate of Mental Health in 2010 showed that there were difficulties in accessing acute and long-stay beds.[36] At the time, only 36% of services had access to acute designated beds. The review found there was a high demand on MHSOP to provide liaison services to general hospitals for patients over 65 years of age and to nursing homes. One of the recommendations from this overview was there should be one MHSOP community team providing home and community-based care per 10,000 population of 65 years of age and over (based on Royal College of Psychiatrists findings) which was an increase on the recommendation of one team per 100,000 general population in a *Vision for Change*.

The provision of health and social care services for older people and people with dementia faces significant challenges in line with demographic projections. This challenge is recognised in the 2018 Health Services Capacity Review, which concludes that *"community-based services for older people appear to be operating at capacity both in terms of residential and home care provision"*. It further outlines that: *"capacity requirements for home care is set to experience significant growth to 2031, with an additional 11,000 (70%) home care packages, 130 (70%) intensive home care packages, and 7.2 million (69%) home help hours anticipated."*[37]

[32] Later Life in the United Kingdom 2019 Age UK

[33] Bryant C , Jackson H, Ames D. The prevalence of anxiety in older adults: Methodological issues and a review of the literature 2008 Journal of Affective Disorders 109(3):233-50

[34] O'Regan, C., Cronin, H., Kenny, R.A., 2011. Mental Health and Cognitive Function. As in Barrett A, Burke H, Cronin H, Hickey A, Kamiya Y, Kenny RA, Layte R, Maty S, McGee H, Morgan K, Mosca I, Normand C, O'Regan C, O' Sullivan V, Savva G, Sofroniou N, Timonen V, Whelan B. Fifty plus in Ireland 2011: First results from The Irish Longitudinal Study on Ageing (TILDA). Dublin: Trinity College Dublin, 2011.

[35] Specialist Mental Health Services for Older People National Clinical Programme for Older People: Part 2

[36] National Overview of Mental Health Services for Older People. Mental Health Commission 2010.

[37] Health Service Capacity Review 2018: review of health demand and capacity requirements in Ireland to 2031

Decision making for Older People

Decision-making capacity is the ability to make a specific decision for oneself at a specific time. In some cases, an older person may experience impaired decision-making capacity. This may be temporary, recurring and remitting, or it may be indefinite.

A collaborative research project to investigate how the health and social care system is responding to the care needs, required supports, and preferences of older people found that there were inconsistencies in how older people were involved in decision-making about their care and that there were stark variations reported between and within CHO areas. Social workers reported that many older people with a mental health issue and or/cognitive impairment/dementia were excluded from the decision-making process regardless of their level of functional capacity. It found that older people living with dementia were more likely to be excluded due to:

- A status approach to dementia, where people were deemed to lack capacity
- Their family didn't want them involved
- Communication difficulties which impacted on their involvement
- No opportunity to be involved
- Their expressed preference was that they didn't wish to be involved.

In some cases, their involvement in decision-making was deemed to be tokenistic and the attitudes of Health and Social Care Professionals (HSCP), treating Consultants/GPs, and families played a crucial influencing role in whether or not older people were involved.[38]

The Assisted Decision-Making (Capacity) Act 2015 provides a modern statutory framework supporting decision-making by adults who have difficulty in making decisions unaided. The introduction of this legislation by the Irish Government was to enable Ireland to meet its obligations under Article 12 of the United Nations Convention on the Rights of Persons with Disabilities. It causes the Lunacy Regulation (Ireland) Act 1871 to cease to have effect and repeals the Marriage of Lunatics Act 1811. The Act provides for the replacement of the Wards of Court system for adults, which is the existing mechanism for managing the affairs of persons whose capacity is impaired. The Act has a range of legal options on a continuum of intervention levels to support people in maximising their decision-making capability.

Part 2 of the Act sets out nine guiding principles to safeguard the autonomy and dignity of the person who may require support to make decisions, either now or in the future. These guiding principles are as follows:

- Presume every person has the capacity to make decisions about their life
- Support people as much as possible to make their own decisions
- Don't assume a person lacks capacity just because of an unwise decision
- Only take action where it is really necessary
- Any action should be the least restriction on a person's rights and freedoms
- Give effect to the person's will and preferences, values and beliefs
- Consider the views of other people
- Think about how urgent the action is
- Use information appropriately[39] [40].

In addition, section 3 of the Act puts the functional assessment of capacity on a statutory basis. In a situation where a person's capacity is questioned, capacity will be assessed based on their ability to make a specific decision at a specific time. A person will be considered to have the capacity to make a decision if they can:

- Understand the information relevant to the decision
- Remember the information long enough to make a choice
- Use or weigh up the information to make a decision
- Communicate their decision (this may be with assistance)

[38] Donnelly, S., O'Brien, M., Begley, E. and Brennan, J. (2016). "I'd prefer to stay at home but I don't have a choice" Meeting Older People's Preference for Care: Policy, but what about practice? Dublin: University College Dublin.

[39] The Alzheimer's Society of Ireland Position Paper on the Assisted Decision Making (Capacity) Act 2015

[40] https://www.mhcirl.ie/DSS/asm221216/

The Assisted Decision-Making (Capacity) Act 2015 provides a legal framework for Advance Healthcare Directives (AHDs) in Ireland. In general AHDs can be defined as a statement about the kind and extent of medical or surgical treatment that a person wants in the future, on the assumption that they would not be able to make that decision at the relevant time. Importantly, an AHD allows a person to record any treatment they wish to refuse.

Despite the signing into law in December 2015 of the Assisted Decision-Making (Capacity) Act 2015, this legislation has not yet been commenced. As a result, Ireland continues to operate a Ward of Court system under the aforementioned *Lunacy Regulations (Ireland) Act, 1871*. A person taken into wardship loses the ability to make any decisions about their lives, no matter how big or small. This current legal framework for substituted decision making for people deemed of "unsound mind" amounts to a denial of a vulnerable adult's human rights, and can impact people with reduced capacity due to dementia, intellectual disability, mental health disorder or acquired brain injury.

The Assisted Decision-Making (Capacity) Act 2015 provides a modern statutory framework supporting decision-making by adults who have difficulty in making decisions unaided.

Acute Mental Health Services for Older People

Acute mental health beds for older people should be in a separate unit close to the general adult acute mental health unit. This allows specialist staff to treat and care for older people in a safer environment. *A Vision for Change* recommends that there should be eight acute beds for older people per 30,000 population.[41] International guidance specifies one to two acute beds per 1,000 people over 65 depending on availability of community resources.[42] Based on the available data, no CHO region is meeting the recommended number of dedicated acute mental health beds for older people. The provision of dedicated acute mental health beds for older people is only 50% of that recommended by *A Vision for Change*.[43]

Table 1 *Acute mental health beds for people over 65*

Community Healthcare Organisation (CHO)	Number of dedicated acute beds for people over 65 years	Recommended number of acute beds for people over 65 as per AVFC*
CHO 1	0	11
CHO 2	8	12
CHO 3**	10	10
CHO 4	8	18
CHO 5	0	13
CHO 6	6	12
CHO 7	9	18
CHO 8	8	16
CHO 9	14	17
Total	**63**	**127**

**A Vision for Change*
***CHO 3 also has 15 assessment beds*

International comparisons demonstrate the variations across culturally similar countries in provision of acute mental health beds for older people. Variations can occur due to the differences in community mental health provisions, including home treatment and day hospitals. Even in allowing for this, Ireland has an alarming under-provision of acute mental health beds for older people.

Table 2 *International comparisons of acute beds for older persons per 100,000 population*

	Acute beds for older persons per 100,000 population	Source
England	6	NHS 2018
Scotland	15	Scottish inpatient census 2018)
Wales	19.2	Statistics Wales 2018
Northern Ireland	9.7	Department of Health (2018)
Australia	4.2	Australian Institute of Health and Welfare 2018
Ireland	1.2	Mental Health Commission 2019

Continuing Care In-patient Mental Health Services for Older People

The number of purpose built residential units for older people with mental illness has increased rapidly over the past five years, with two units opening in 2020. These have been built as stand-alone units or as part of a community nursing units and replace out of date buildings that were poorly maintained and unsuitable. These new units have single en suite bedrooms, activity and recreational areas, and outside space with sensory features. However, there are still a small number of MHSOP residential units that require replacement.

[41] Access to Acute Mental Health Beds in Ireland A discussion paper analysing bed availability for adults, including international comparisons February 2020
[42] Model of Care for Specialist Geriatric Services Part 2 (2019) National Programme for Older People
[43] Access to Acute Mental Health Beds in Ireland A discussion paper analysing bed availability for adults, including international comparisons February 2020

Community Mental Health Services for Older People

Community Mental Health Teams (CMHTs) for older people are regarded as pivotal to the delivery of an integrated service. CMHTs provide continuity and coordination between other services within mental health (inpatient wards, hospital liaison, memory services) and beyond, such as geriatric medicine. The multi-disciplinary team membership can connect with local expertise, knowledge and skills, and enable the team to network with other relevant services that may need to be engaged in the individual care plan (e.g. housing and leisure). A single team approach to delivering services streamline referral sources and use shared assessment and care planning processes that will improve access and continuity.

There is serious under-resourcing of community mental health services for older people in Ireland. Older peoples' community mental health teams (CMHTs) are a vital component within a whole systems approach to providing high quality services to older people with mental health problems. Best practice recommends that care should be provided where possible in a community setting close to home. The service should be multi-disciplinary and operate in an integrated way that minimises the risk of multiple assessments and encourages a person-centred, holistic approach. *Sharing a Vision*, the current mental health policy, states that access to these teams can be difficult and that "older people who have mental health difficulties should have access to specialist expertise and joint care arrangements should be put in place where expertise to meet the 'whole' needs of an individual is located in both the general adult teams and the mental services for older people teams".[44]

There are 43 MHSOP teams in Ireland, which is only 66% of the number of teams recommended by A Vision for Change. All of these teams are under-resourced in multi-disciplinary staff, as can be seen in Table 3. Overall, MHSOP teams are only staffed to 54% of what is recommended by a Vision for Change.

Table 3 *Staffing of MHSOP Teams*

Community Healthcare Organisation	Percentage of recommended staffing of MHSOP teams
CHO 1	75%
CHO 2	73%
CHO 3	37%
CHO 4	31%
CHO 5	61%
CHO 6	51%
CHO 7	63%
CHO 8	52%
CHO 9	57%
Total	**54%**

The lack of staff resources means difficulty in providing a community based service in outpatients, day hospitals, and home assessments and treatment with lack of access to essential multi-disciplinary services. Older people do not receive a comprehensive service, staff are stretched and frustrated, and there are long waiting lists. This results in difficulty in recruiting and retaining staff where there are vacant approved posts, which further adds to the difficulties in providing a service.

International evidence suggests that there should be a day hospital providing 10-15 places per day for 10,000 people aged over 65.[45] In Ireland, we have approximately 0.26 places per 10,000. CHO2 and CHO5 have no MHSOP day hospital places and not all existing day hospitals operate a 5-day week.

[44] Sharing the Vision A Mental Health Policy for Everyone Department of Health

[45] Model of Care for Specialist Geriatric Services Part 2. National Clinical Programme for Older People.

Memory Services

Memory assessment services specialise in the diagnosis and initial management of dementia and are often the single point of referral for people with a possible diagnosis of dementia. Ideally, these services should be multi-disciplinary and include pre-diagnostic counselling and post-diagnostic support for the person with dementia and their family, including psychosocial interventions as well as monitored medication, if required.

A review of memory clinics conducted by the National Dementia Office (NDO) in 2017 found that memory clinics vary widely in their composition and type of service they provide. It also highlighted inequitable geographic spread of these clinics: over 50% of counties have no memory clinic in place. These findings highlight the lack of national development of dementia diagnostic services, and that services have developed in isolation. In order to address this, the Dementia Diagnostic Project was established in 2017.

According to *A Guide to Memory Clinics in Ireland*, there are 25 memory clinics in Ireland. The clinics are not positioned according to geography or by population. A recent survey found that there are memory clinics in 13 counties, but none in Donegal, Sligo, Leitrim, Cavan, Monaghan, Galway, Mayo, Clare, Louth, Longford, Kerry, Waterford, and Wicklow. A third of all memory clinics are based in Dublin, while there are none at all in the Northwest which has the highest prevalence rates of people living with dementia in Ireland.[46] [47]

[46] Fagan, M. (2017) Do Patients in the Republic of Ireland Face a Postcode Lottery for Dementia Tests, http://www.thedetail.tv/articles/patients-in-republic-facepatchy-memory-services-and-lengthy-waits accessed 09/09/2020

[47] A Guide to Memory Clinics in Ireland 4th edition Updated by Matthew Gibb, Dementia Services Information and Development Centre and Dr Emer Begley, National Dementia Office 2017

Liaison Mental Health Services for Older People

The presence of psychiatric co-morbidity in elderly general hospital admissions is common and is an independent predictor of poor outcome for patients and the general hospital. The provision of liaison psychiatry provides the general hospital with a dedicated specialist service to deal more intensively with patient management and the ability to provide training and facilitate more effective management of mental disorders by general ward staff.

Mental disorder affecting older people is three to four times more common in general hospitals than in the community, with 80% of the psychiatric morbidity being delirium, dementia, and depression. A systematic review of the literature shows the mean prevalence for depression to be 29%, delirium 20%, and dementia 31%.[48]

- Liaison psychiatry services in acute hospitals addresses the mental health needs of people being treated primarily for physical health problems and symptoms.
- Such services improve quality of care, dignity and quality of life for patients, improve mental health skills in non-mental health professionals and reduce adverse events and other risks to the acute hospital.
- Financial benefits come from reduced avoidable costs and ineffective or inappropriately located management of mental health problems by reduced length of stay, readmissions and investigations, and improved care of medically unexplained symptoms, dementia and long-term conditions.[49]

A multi-disciplinary liaison psychiatry service dedicated to the hospital, covering all wards and the emergency department, is a core service for every acute hospital.[50] The Royal College of Psychiatrists recommend the following MHSOP liaison team staffing for a 650-bed general hospital and emergency department: 1 consultant psychiatrist, 1 NCHD, 7.5 nurses (including one trained in intellectual disability); 0.2 psychologist, 0.5 social worker and 0.5 occupational therapist.[51]

There is a dearth of MHSOP liaison teams in Ireland. In CHO9, for example, there is one liaison team covering 1,827 medical beds across three hospitals. The staffing of this team consists of 1.2 consultant psychiatrists and 1 NCHD. In CHO 7, there is 1.5 consultant psychiatrists and 2 advanced nurse practitioners providing a service to three hospitals with a total of 1,800 beds. The remainder of the country's liaison services are provided for out of existing, limited resources on the MHSOP community teams.

[48] Anderson A, Holmes J. Age and Ageing 2005; 34: 205–207

[49] Royal College of Psychiatrists. Liaison psychiatry for every acute hospital Integrated mental and physical healthcare College Report CR183 December 2013

[50] Parsonage M, Fossey M Liaison psychiatry in the modern NHS January 2012 Publisher: Centre for Mental Health

[51] Liaison psychiatry for every acute hospital Integrated mental and physical healthcare December 2013 College Report CR2183 Royal College of Psychiatrists

Integrated care

The presentation of psychiatric illness in older people can be very different to working age adults, and the management of these conditions needs to take into account other co-morbidities. In addition, those with physical health problems are more at risk of developing a mental disorder. It is therefore important that services become more integrated and that the specific needs of the older population are recognised. Geriatricians and old age psychiatrists are both experts in the needs of this patient group.[52] The Integrated Care Programme for Older People (ICPOP) and the National Clinical Programme for Older People (NCPOP) are developing cohesive primary and secondary care services for older people, especially those with more complex needs. The focus is on the development of pioneer sites nationally, which builds on work and initiatives currently being developed locally in Ireland, and on the work to date on Acute and Mental Health pathways developed by the NCPOP. These sites are working to a 10-Step Framework that fundamentally adopts a population-based approach with new ways of working, at the core of which is a case management approach to integrated care. The ICPOP proposes to implement, test, and monitor integrated service developments for older people in pioneer sites and to evaluate this implementation so that lessons learned may be extended nationally. The Model of Care for Specialist Geriatric Services Part 2 (HSE 2019) recommends good interfacing with other services, such as geriatric medicine and primary care networks, including GPs, public health nurses, social workers, and occupational therapists. The Slaintecare Report recommended an integrated system of care with healthcare professionals working closely together, bringing together physical and mental health services o simultaneously improve the physical health of people with mental health difficulties and vice versa.[53]

However, there is evidence of a significant lack of integrated care across a number of CHOs. For example, it is common in some CHOs for GPs to send the same referral of an older person separately to the MHSOP and to the geriatrician, resulting in duplication, lack of communication, distress and confusion for the older person and their carers, as well as a lack of efficiency. Some teams reported difficulty in accessing home care packages and respite care. Access to physiotherapy, dietetics, speech and language therapy, and assessment of seating is ad hoc and sometimes not available in in-patient units resulting in the buying-in of private services where available. It is interesting to note that success in implementing effective integrated care has been found to depend heavily on interpersonal relationships. Therefore, as much attention should be paid to the way organisations and individuals collaborate as to the service design or strategy.[54]

[52] Caring for the whole person. Physical healthcare of older adults with mental illness: integration of care, College Report CR222 (2019) Royal College of Psychiatrists.

[53] Houses of the Oireachtas Committee on the future of healthcare, Houses of the Oireachtas Committee on the Future of Healthcare Sláintecare Report, May 2017

[54] Faculty of Old Age Psychiatry (2016) Integration of Care and its Impact on Older People's Mental Health (Faculty report FR/OA/05). Royal College of Psychiatrists.

Carers of Older People

Older people with mental health problems may have an increased requirement for care. This is often provided by family carers, the majority of whom are old themselves. Thirty percent of carers will suffer from depression at some stage, and carer breakdown has been found to be a major trigger for long term care.[55] Despite the increasing number of older carers, there is still limited insight about the experiences of this group. Caring responsibilities can be associated with physical, mental, and social challenges that can complicate existing difficulties related to chronic conditions, highlighting the need to further understand the support required by this population.

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

- information
- respite
- emotional support
- support to care and maintain their own health
- a voice.[56]

All MHSOP teams in Ireland provide support either individually or in groups to those caring for older people with mental illness. There were a number of excellent initiatives to engage carers and family members in all CHO areas.

Private Mental Health Services for Older People

Four private independent hospitals provide in-patient care for older people: St John of God Hospital, St Patrick's Hospital, Highfield Healthcare, and Bloomfield Hospital. In total, they provide 188 beds for older people with mental illness. Each service has a well-staffed MHSOP team and there are day services on each of the hospital campuses. While all four MHSOP are based in Dublin, the services accept referrals from all parts of Ireland. There are memory clinics in three of the services.

[55] Levin E, Moriarty J, Gorbach P (1994). Better for the Break. London: HMSO

[56] Colerick EJ and George LK(1986). Depression among Alzheimer's caregivers: identifying risk factors.Journal of the American Geriatrics Society,34,493-498.

CONCLUSION

As our population ages, the potential public health burden of late-life mental health disorders will increase. Resources need to be redistributed to address the increasing demands of an ageing population and older people's mental health needs should be central to expenditure planning. There are difficulties in recruiting and retaining staff but there is also under-investment throughout an older person's care pathway, from primary care and community care to specialist mental health services.

In Ireland, there are not enough MHSOP teams to meet demand at the present. We have 43 MHSOP teams, which is only 66% of the number of teams recommended by *A Vision for Change*. Overall, these teams have just 54% of recommended clinical staffing. This is insufficient to provide a nationwide comprehensive mental health service for older people. The variability across the country in providing mental health services for older people is evident and access to dedicated inpatient beds, day hospital places, assessment units, memory clinics, mental health residential places, psychology, occupational therapy, and social work depends on where the older person lives. As the population continues to age, serious thought must be given to future planning for these services and resources must be found to provide them.

It was evident that we have well trained MHSOP teams that continue to provide mental health services of a high standard. Numerous quality initiatives have been developed and implemented. However, these teams would welcome further integration with other services for older people and access to supports such as respite and home care packages in order to provide mental health services in the community. They recognise the risks of not having dedicated acute beds in mental health units and the lack of access to essential medical services.

Of prime importance is the requirement to train and support the other health and social care staff in primary care, general hospitals, care homes, and social care to identify mental health issues in older people at an early stage. Early detection of mental illness in older people is vital in securing their well-being. Providing support for friends, family and other unpaid carers is crucial given the major role they play in caring for older people with mental health problems. Unpaid carers themselves are often older and also at risk of developing mental health problems.

Older people's mental health services particularly benefit from an integrated approach with social care services and close working relationships with primary care and community services. These services need to provide care in a seamless way. Attempts to develop any form of integrated care can run into barriers created by institutional fault lines in the health and social care system, such as non-integrated information systems, difficulties pooling budgets across sectors and silos of care provision. There needs to be clear pathways to avoid people falling between service criteria boundaries across specialist community teams, physical health teams for older people, memory services, crisis intervention services, and acute hospitals. Integration is easier to establish where all the organisations involved share the primary goal of serving the needs of older people. Lack of such integration is evident in Ireland, although this is variable. The Model of Care for Specialist Geriatric Services Part 2 has, as one of its core principles, the integration of service provision. However, much needs to be done to achieve this. The lack of respite care, access to home care packages, and access to speech and language therapy, physiotherapy, as well as dietetics, shows a significant level of short-sightedness in providing integrated services for older people, potentially causing an increased demand for costly in-patient care.

In the past 6 months, the COVID-19 pandemic has had severe repercussions both physically and mentally for everyone, but in particular for our older population. Among adults, the risk for severe illness from COVID-19 increases with age, with older adults at highest risk. The elderly, however, face special challenges, and it is important that healthcare professionals identify and highlight their special needs so that they can be adequately protected and supported. The rapid transmission of COVID-19 pandemic outbreak, higher mortality rate, self-isolation, social-distancing, and quarantine can exacerbate the risk of mental health problems. This requires us to be sensitive at all levels for early detection of mental health care needs and plan appropriate interventions. This means more single en suite accommodation in residential and acute mental health care, adequately staffed community teams and supports to enable the older person to stay at home as long as possible and good online technology to allow virtual assessments and contacts.

Older people's mental health is an increasingly important area of public policy that does not get the attention it deserves. The levels of unmet mental health needs amongst older people are extremely high and improving current services is necessary. More work is needed to develop a shared vision and the scope of partnership working needs to be extended. This work is essential if we are to meet the mental health needs of an aging population into the future.

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