Older adults

Earlier chapters have highlighted the many factors that can either build or erode mental health and wellbeing at different stages of life. Life experiences, circumstances and behaviours accrued over the entire life course play out over many decades, however, their net effects can be seen as coming home to roost in later adult life, when people frequently face new types of challenges, such as declining physical health and confidence, financial insecurity, threats to independence, bereavement and facing life alone, perhaps for the first time. Establishing good reserves of mental health and wellbeing is critical to the ability of older adults to successfully navigate and adapt to these challenges, to contribute effectively to society, make relatively free choices and enjoy life to the full.[87] Mental and emotional resources for health in late life includes cognitive (thinking) ability, flexibility of attitudes and behaviours, continued learning and emotional intelligence (the ability to identify, understand and influence the emotions of self and others).

Building mental health and wellbeing in older adults begins decades earlier, using the types of approaches we will describe in this chapter. Although there is no fixed point at which people stop being ‘adults’ and suddenly become ‘older adults’, there is no doubt that the process of ageing does bring particular issues, which will be explored in this chapter.

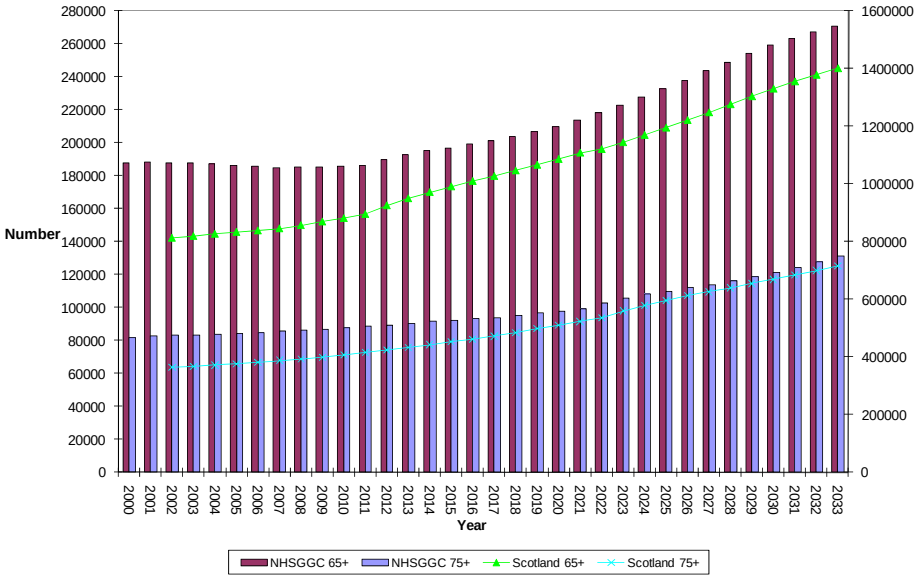
All this needs to take place in a rapidly changing, relatively turbulent context. Globalisation, the current fiscal and economic crisis, the pace of demographic change, the changing nature of work and new societal structures, all represent significant challenges to human wellbeing. If we are to prosper sustainably in this rapidly evolving environment, it is vital that we take preventive action now. Two actions are particularly crucial, firstly, we must establish protective lifestyles for those in middle age; and, secondly, we must decisively create a new mindset about older age to tackle the stigma and explicitly value the considerable mental resources of older people for the benefit of all members of society.

Section 1: Who are older adults?

1.1 As highlighted earlier in the report, we are an ageing society. The percentage of the UK population over 60 is expected to expand from its present level of 22%, to around 29% by 2033, and 31% by 2058.[88] People over 60 now outnumber the under-16s for the first time and the number of over-85s has increased five-fold since 1951. This rapidly shifting demographic is a highly topical issue, usually portrayed in negative terms, as a problem, challenge or burden. Yet this growing population subgroup, with an age span of four decades, represents an enormous diversity of individuals, each with unique perceptions of what it means to be an older person. The meaning of age is created by our cultures, relationships and personal values; a large 2010 survey on behalf of the UK Department of Work and Pensions asked 60-64 year old adults at what stage of life they considered themselves to be; 45% considered themselves to be in middle adulthood.[89]

1.2 In NHSGGC, 18% of our current population of 1,203,870 is of pensionable age, slightly less than the 20% proportion for Scotland as a whole. The number of NHSGGC residents over 65 has been stable for the last decade, but is expected to rise steeply in the near future, mainly because overall life expectancy is improving (Figure 6.1). This trend is predicted to affect some CH(C)Ps much more than others; for example, by 2033 people aged 65 and over will account for 32% and 31% of the total populations in East Dunbartonshire and Inverclyde respectively, contrasting with a projected estimate of only 19% for Glasgow City.

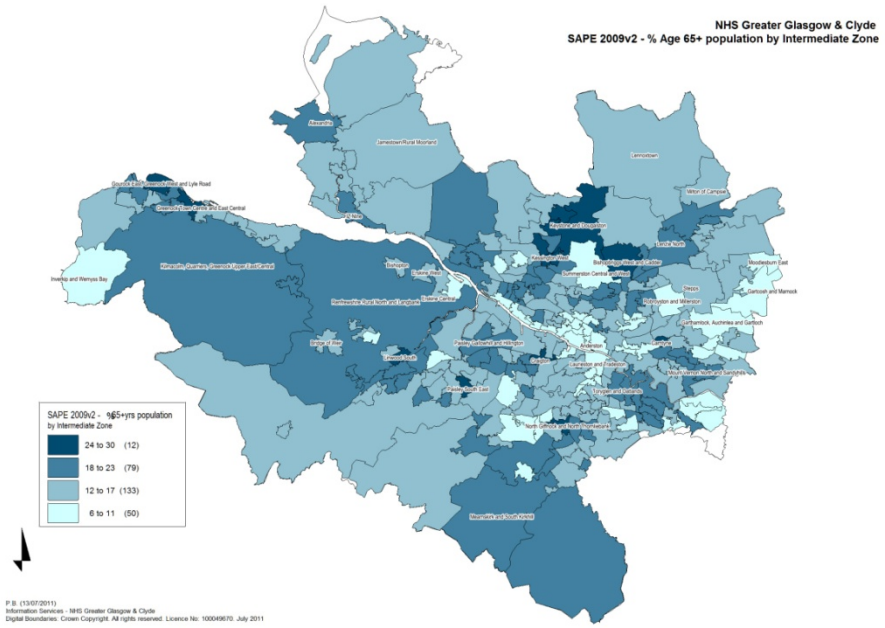
Figure 6.1: NHSGGC population estimates 65+ & 75+, 2000-2033
Source: National Records Scotland



1.3 The current age profile of our local neighbourhoods in NHSGGC varies immensely. Older people account for almost a third of all residents in some localities, but less than one in ten in others, as shown in the map (Figure 6.2). Reasons for these variations include historical patterns of housing, employment and population growth. Local economic and social circumstances also play a major role here because of their strong association with life expectancy in NHSGGC's most profoundly deprived communities, average life expectancy is up to 10 years shorter than in the most affluent areas. This is due to a disproportionately high numbers of premature deaths from preventable conditions.

1.4 Understanding current and future population age profiles is the crucial first step in ensuring that all of our public planning activities, both within the NHS and in our many partner organizations, jointly promote active ageing, maximise all opportunities for health, and foster community participation and security.

Figure 6.2: Proportion of individuals aged over 65, by area, 2009



Section 2: What is our vision of a mentally flourishing older population?

2.1 The key components of mentally healthy later life in Scotland are well articulated in public policy; they are broadly similar to the factors that underpin mental health across the entire life course.[35, 90] They include:

- Reduced discrimination
- Increased participation
- Secure and supportive relationships
- Promotion of physical health
- Supportive environments
- Reduced poverty

2.2 Although securing these assets is necessary for building the foundation of mental health and wellbeing in older adults, this is not sufficient in itself. Some of these factors, e.g. physical health, discrimination issues and opportunities for participation, assume much greater significance and/or change their nature in older adults. It is therefore important to understand and respond to the determinants of mental health and wellbeing among this sub-population through a distinctive older adult lens.

2.3 The World Health Organization's (WHO) 'Global Age-friendly Cities' movement has spawned many

innovative projects to translate this aspiration into practical action.[91] [92] It aims to optimise opportunities for health, participation and security and to enhance quality of life as people age, via the following actions:

- recognising the wide range of capacities and resources among older people
- anticipating and responding flexibly to ageing-related needs and preferences
- respecting older people's decisions and lifestyle choices
- protecting those who are most vulnerable
- promoting older people's inclusion in and contribution to all areas of community life

2.4 Promotion of healthy ageing is a key theme promoted by the WHO Healthy Cities Network, of which Glasgow City has been a member since 1988. Although a number of successful healthy ageing initiatives operate in the NHSGGC area, such as the 'Silver Deal Active' partnership that provides physical activity and social interaction opportunities across Glasgow City, in partnership with GHA, Glasgow City Council and NHSGGC, we would benefit from concerted action on several fronts. The 'Age-Friendly New York City Initiative' is an outstanding example of what the 'Global Age-friendly Cities' framework can achieve, at relatively low cost, if supported by visionary political leadership and high quality community engagement. New York City's mayor, Michael Bloomberg, has been an enthusiastic proponent of the initiative. The 'Age-Friendly New York City Initiative began in late 2007 with a comprehensive assessment of the age-friendliness of New York City, mainly through dialogue with older New Yorkers in a wide range of locations, culminating in development of a series of initiatives intending to reposition New York as an age friendly city, grouped into four main areas; community and civic participation; housing; public spaces and transportation; and health and social services. Access further information on Age-friendly NYC – Select Initiatives. It is currently piloting three 'Aging Improvement Districts' that translate all of this into a local neighbourhood context.

2.5 We could deliver a similar collective vision for NHSGGC. As a starting point, we should build on the following examples of good practice in local areas, moving towards a position where:

- Older people are active participants, valued for their experience and knowledge, with the whole community benefiting from their participation in volunteer or paid work. The Playbusters project in North East Glasgow is just one example of several in NHSGGC, in which older adults teach younger members of the community traditional crafts such as knitting and crocheting and, in return, learn more about modern information and communication technologies.

Playbusters: Connecting Generations

© Playbusters – Glasgow East End

- Older people are valued for their connections between our past, present and future. For example, the SPARR project in South Glasgow mapped the history and shipbuilding heritage of Govan in the 20th century. Young people took the lead as researchers, graphic designers, filmmakers and interviewers, engaging with older people in the community - former shipyard workers and the Gaelic-speaking families who emigrated from the Western Isles to find work in the yards.

2.6 Achieving these aspirations will need substantial and sustained efforts at all levels, from local communities to local and national government, supported by visionary political leadership. The Director of Public Health plays a key role in articulating this vision and advocating for the action we need to deliver, predominantly through partnerships fostered by CH(C)Ps with planning leads, local housing associations, social work teams, local private and voluntary sector organisations, education providers, employability services – but most importantly - with older adults themselves.

Section 3: What are the drivers of mental health and wellbeing in older adults?

3.1 Among the strongest drivers of the experience of ageing are society‘s attitudes to old age and later life. Unfortunately, current popular representations of older people as a group are often stereotypical and generally negative, underpinned by three common assumptions:

- older people are all the same
- old age brings inevitable decline
- older people are dependent/a burden on society

3.2 These negative stereotypes have serious consequences. Not only do they directly interfere with older people’s enjoyment of life, but they also reduce their confidence and expectations of themselves, impair their will to live and shorten survival. Such negative stereotypes also have a powerful effect on service providers, making them less likely to treat older people as individuals and more likely to discriminate actively against them. Conversely, holding positive views of ageing may have very powerful positive effects: a population-based study involving 660 individuals aged over 50 found that older individuals with more positive self-perceptions of ageing, measured up to 23 years earlier, lived 7.5 years longer than those with less positive perceptions. This advantage remained after controlling for age, gender, socioeconomic status, loneliness, and functional health.[8] The Scottish Government launched an initiative See the person, not the age to help tackle ageism and provide support for change.

3.3 Research on mental health in later life consistently identifies that: being physically fit, having a role in society, good social relationships with family, friends and neighbours, an adequate income and a supportive neighbourhood enhance mental health and wellbeing.[93] Having a positive outlook and maintaining control over one's life are also frequently cited by older people as key features of a good overall quality of life. In contrast, the issues that older people identify as undermining of mental health are: deteriorating health, loss of independence, loneliness, fear of death, living in poor housing, run-down neighbourhoods and decreased income.

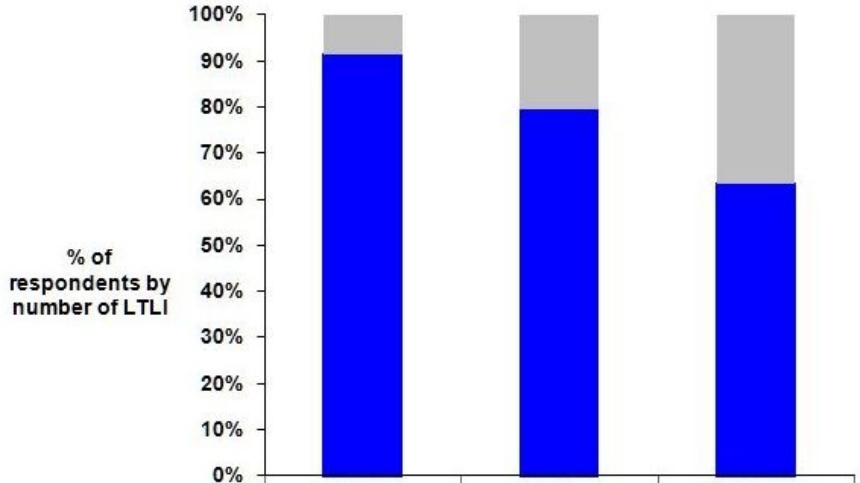
3.4 Many of these adverse factors are systematically more likely to affect older people. They especially include a higher prevalence of long-term conditions and more physical disability. However, they also involve having to negotiate major new types of life transition, including retirement, financial insecurity, moving from the family home into sheltered or residential accommodation, loss of partners and adaptation to life alone.

3.5 Older people are also much more likely to experience fuel poverty than the rest of the population. Fuel poverty is defined as having to spend 10% or more of a household's net income on heating the home to an adequate level. Fuel poverty in Scotland has been rising in more recent years, largely because current increases in fuel prices are only being partially offset by rising incomes and energy efficiency increases. In 2009, 33% of households were in fuel poverty, compared with 13% in 2002. Risk of fuel poverty generally increases with age. Within In those households where the oldest person is aged between 60 and 79, almost a quarter is living in fuel poverty, rising to over a third of the oldest households (80 plus).

3.6 Long-term conditions (LTCs) are an important cause of poor mental health in older adults and the co-existence of long-term physical illness with mental health problems generally worsens outcomes for both conditions. The likelihood of needing medical treatment for one or more conditions rises steeply with age; in our 2008 health and wellbeing survey in NHSGGC, the

prevalence of LTCs rose from 12% in those aged 16-24 to 72% in the over 75s.[94] Overall, around 30% of people with LTCs experience poor mental health, compared with only 9% of other adults; the likelihood of experiencing poor mental health increases in proportion to the number LTCs experienced (Figure 6.3).[95, 96] People with diabetes are three times more likely to experience depression and are also more likely to experience it in more severe and enduring forms; however, fewer than a third of affected individuals are diagnosed or treated. Depression worsens diabetic control and increases the risk of diabetic complications.[96] Similarly, up to a third of people experience a depressive episode following a heart attack; those affected have poorer cardiovascular recovery, with one study suggesting a 3.5-fold increase in mortality of depressed patients compared with non-depressed patients within six months of myocardial infarction.

Figure 6.3: GHQ-12 Grouped Score by Number of Long-term Limiting Illnesses Number and % of Respondents Aged 65+
Source: NHSGGC Health & Wellbeing Survey, 2008



	None	1-2	3 or more
GHQ12 Score 4+ (indicating poor mental health)	40	166	89
GHQ12 score <4	430	648	155

3.7 The key challenge to the mental health and wellbeing of older people is the need to adapt successfully to the physical, social, interpersonal and psychological transitions that accompany ageing. The ability to adapt to these challenges varies considerably from person to person - older people who are able to adapt well tend

to do better overall. However, the resources and opportunities available to them are shaped by the social context within which they live, which we can directly influence through public health actions.

Section 4: How do we promote and improve mental health in older adults?

4.1 We are increasingly clear about what a mentally healthy old age looks like - and the factors that either impede or support it. Nevertheless, what are the right kinds of practical actions and strategies that will move us most effectively and efficiently to this position? Coordinated action is needed at several levels.

4.2 Individual level: by increasing emotional resilience through interventions designed to promote self-esteem, strengthen coping skills and maintain meaningful relationships. One of the most basic but often neglected human needs is reciprocity—the ability to give something in return for receiving. There is strengthening evidence suggesting that reciprocity is a particularly important means of improving health and wellbeing in frail elderly people and may explain the differences between effective psychosocial interventions and those showing no beneficial effects. None of this requires new sets of interventions designed to achieve these outcomes, rather, it means using all contacts with older people to promote confidence, choice and control; fostering reciprocity by providing subtle support that does not diminish self esteem and allows the patient to give back; providing information about opportunities for promoting self-reliance and independence; and helping older people to link into networks and activities.

Regular physical activity is one of the most effective and cost-effective interventions available for enhancing physical, mental and social wellbeing. There is abundant evidence that most adults are not sufficiently active for optimal health.[95, 96] NHSGGC co-delivers a wide range of evidence based physical activity programmes, suitable for people with different physical abilities and medical conditions, such as Live Active, Vitality and Glasgow Health Walks. Silver Deal Active is a Glasgow City-led programme customised for older adults, providing coach-led exercise and 'Active Art' classes to Glasgow residents aged 60 years and over.

© Silver Deal Active – Glasgow Life / Glasgow Sport

4.3 Community level: by increasing social inclusion and intergenerational participation, improving neighbourhood environments, including community safety measures, strengthening support networks. In NHSGGC, an Ageing Population Planning Group was established to plan a system-wide response to the rapid demographic changes we are likely to see in the near future. The group should develop strategies for mainstreaming the types of approaches explored in this chapter that will deliver the types of outcomes we want to see at community level.

4.4 Reduction of structural barriers to mental health: this involves large-scale policy initiatives to tackle discrimination, promote educational and employment opportunities and ensure availability of appropriate housing, services and support for older adults. This can be achieved through changing employment practice to allow employers to benefit from the skills of older people, matching work and working environments to the needs and capabilities of older adults and improving the design of homes and towns to meet the

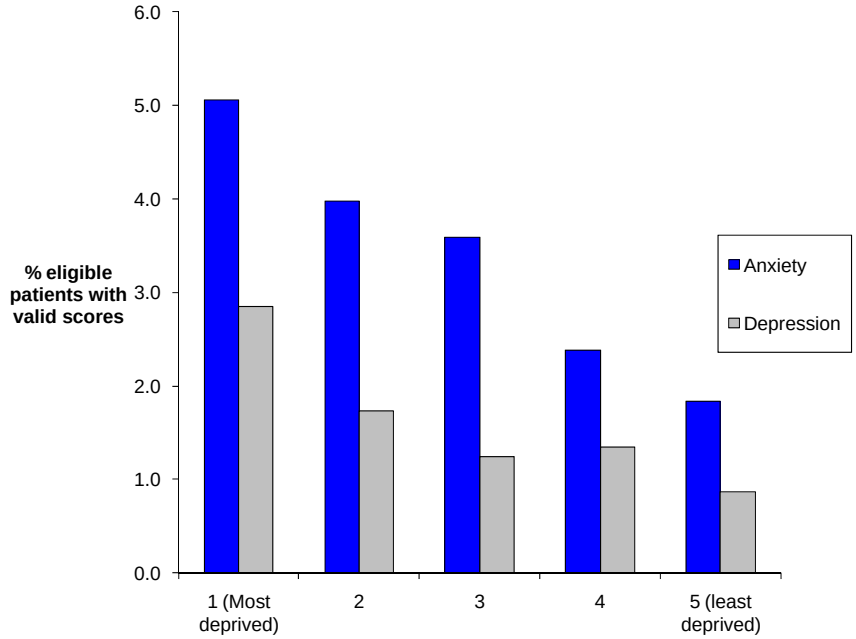
needs of older people, using older people as a key resource for advice. For example, from 6 April 2011, employers will no longer be allowed to issue forced retirement notices to their employees and the default retirement age will be phased out completely by October 2012.

4.5 In August 2012, the World Active Ageing Congress will be held in Glasgow. This offers an opportunity to explore and debate the scientific evidence on active ageing and ultimately to create the type of physical and social environments which promote active participation in society by older adults in NHSGGC.

Section 5: Identifying and responding to mental health issues in older adults?

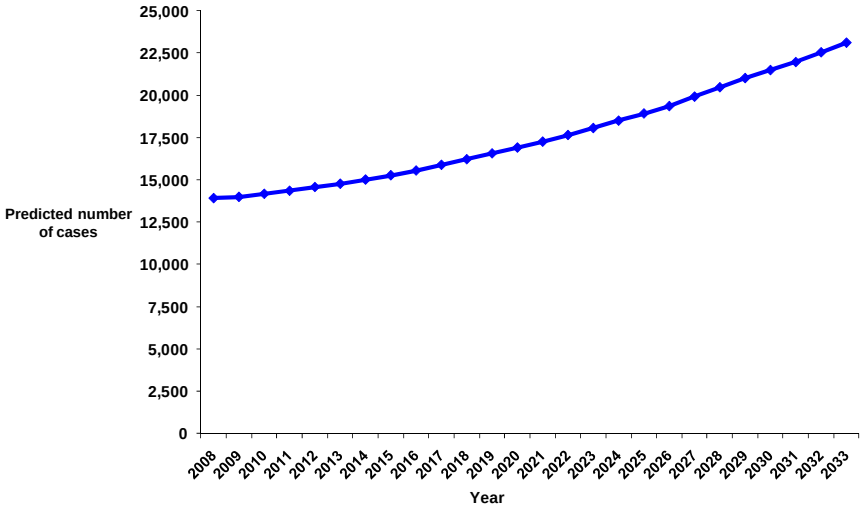
5.1 Whilst most people remain fit and well into old age, significant numbers will experience some form of mental ill-health. Depression is the commonest type of mental ill-health in older adults, affecting 10-15% of people over 65. Surveys suggest that the prevalence of depression amongst those in care settings is much higher, at around 40%. However, we need more systematic age-specific outcome data on the extent to which the needs of older people with depression are met fully in NHSGGC. Given the interaction between mental health and long-term conditions, it is essential that our clinical care systems for all types of illness systematically look for and respond to the psychological needs of patients and their carers. Data from our Local Enhanced Services programme show that approximately 4% of patients with coronary heart disease have significant anxiety and 2% have depression, with a marked social gradient (Figure 6.4).

Figure 6.4: NHSGGC Coronary Heart Disease Local Enhanced Service: Prevalence of depression and anxiety, by SIMD quintile



5.2 Ageing of our population means that many more individuals can expect to develop dementia, as age is a key risk factor. Among those aged 80 plus, the prevalence is around 20%; in nursing homes, the prevalence is up to 70%. Over the next 30 years, the number of people with dementia in the NHSGGC is expected to increase by around 64%, to 23,000 by 2033, exerting major impacts on patients, their families and carers; and the formal health and social care systems (Figure 6.5). In the North West Glasgow Keep Well area, a specific anticipatory care intervention is being piloted to identify and meet the preventive healthcare needs of carers, in order to optimise their own health and support their ability to fulfil a caring role.

Figure 6.5: NHSGGC Predicted Numbers of Dementia Cases (65+) 2008 to 2033 Source: EURODEM



5.3 There is much potential for prevention, which must start early in life, rather than addressing the issue of cognitive decline when it first occurs in older adulthood. Encouraging physical activity in young and middle-aged adults to promote a healthy cardiovascular system, continuing education and learning through the life course and promotion of safe levels of drinking are key to maintaining cognitive (thinking) reserve.

5.4 Early detection of dementia is an area of very active research at present. Although there is some (currently limited) evidence indicating that intensive, multi-component interventions to support carers may delay nursing home admission for people with dementia, most studies of screening have demonstrated few direct benefits for either patients or carers. Examples of positive action to support individuals with early dementia include use of Alzheimers Scotland Dementia Pack for Schools (currently implemented in some primary schools in Glasgow) and awareness raising materials such as ‘Changed Days’, which support the psychological needs of older patients with dementia and their carers.

5.5 Effective dementia care is critically dependent on effectively integrated services across the primary, secondary and social care systems, genuinely placing the older person at the centre of service planning. Improving the care of people with dementia in acute settings, reducing the use of antipsychotic medication for care home residents with dementia and ensuring

consistency of good quality care for patients with dementia are key priorities. NHSGGC held a dementia convention in March 2011,[97] which has now resulted in a set of wide-ranging practical recommendations to take forward the Scottish Government's National Dementia Strategy. These include implementation of agreed pathways and models, new learning and development programmes, and awareness raising among staff, carers and the wider population.

Section 6: Recommendations

6.1 NHSGGC should consider systematic development and mainstreaming of The World Health Organization's Global Age-friendly Cities' framework, to ensure the right physical and social environment for an ageing population, recognising the importance of digital inclusion.

6.2 Regular physical activity is the single most effective and cost-effective intervention available for enhancing physical, mental and social wellbeing in older adults. An action plan for increasing physical activity in older adults should be established across all NHSGGC localities.

6.3 The NHS must demonstrate leadership in encouraging the active participation of older adults in planning our services, treating all older adults as individuals and challenging negative stereotyping where it exists.

6.4 Given the projected increase in numbers of older people with dementia in NHSGGC, integrated planning should be supported and embedded consistently across all parts of the system, ensuring implementation of the Dementia Convention's[97] recommendations for universally high quality care. This should be supported by an integrated care pathway and clear models of best practice for dementia care, development of an exemplar site, clear actions to increase public awareness and intensified learning and development/training for all staff.