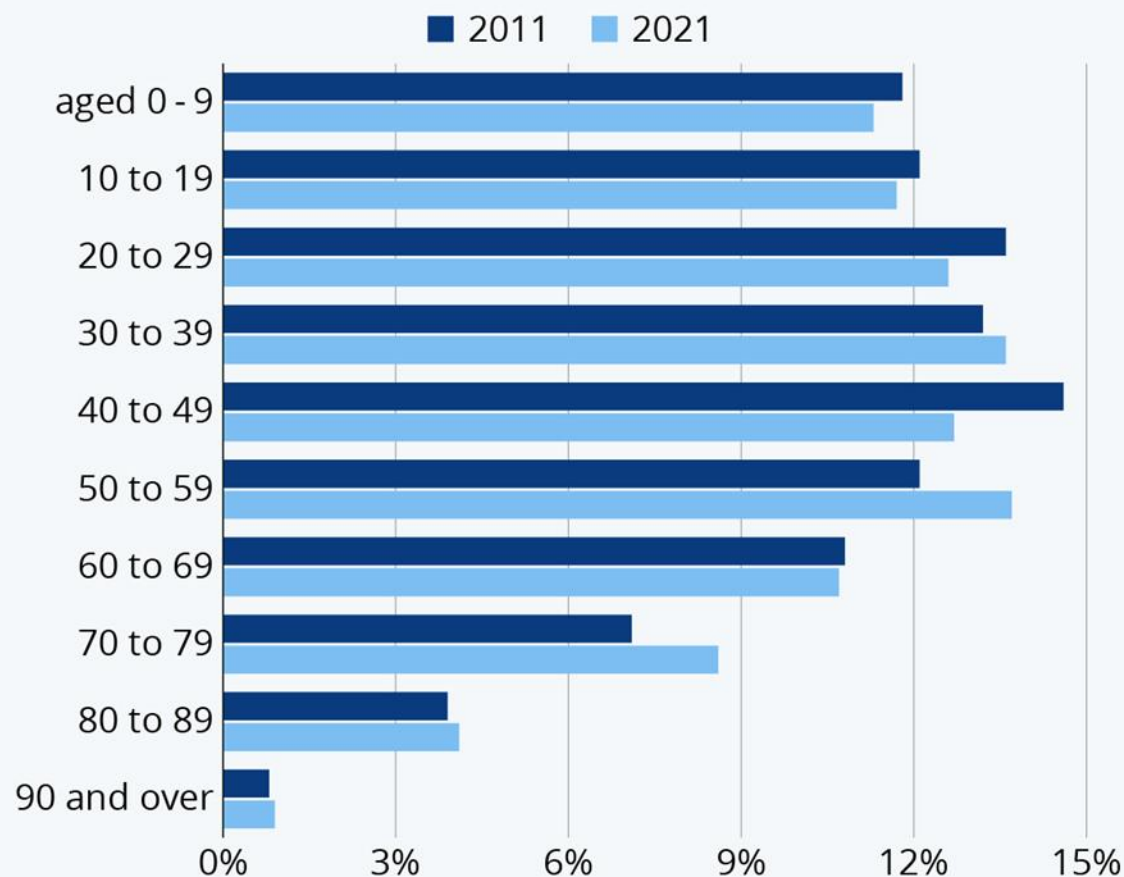


The Aging Population of England and Wales

Share of the population in England and Wales in 2011 and 2021 by age bracket



Source: Office for National Statistics



Mental Health and the Ageing Population

Assessment: 1

Assignment Title:	Component 1 – Coursework: Critical review Part 1: Critically review one theory that underpins our understanding of cognitive decline in old age. Part 2: Using empirical evidence critically discuss how an individual could slow down cognitive decline.	Word count (or equivalent):	2,500 words
Submission deadline:	9 th December 2023 (via Turnitin by 23.59pm)	Return date of provisional marks & written feedback:	11 th January 2024

TASK DESCRIPTION

Part 1: Critically review one theory that underpins our understanding of cognitive decline in old age.

Part 2: Using empirical evidence critically discuss how an individual could slow down cognitive decline.

Part 1: Approximately 1500 words

Briefly outline the theory before moving to a critical evaluation (strengths and weaknesses) of that theory. I would expect some empirical evidence to support your answer.

Part 2: Approximately 1000 words

Using empirical research outline how an individual could slow down cognitive decline. This will require you to read around the topic area and include empirical studies that demonstrate successful (or not) interventions that slow down cognitive decline (i.e., exercise, diet, processing speed tasks) in the elderly. At this level, I would expect you to provide a critical discussion on the studies you include.

Assessment: 2

Assignment Title:	Intervention proposal Dementia UK has asked you to create an intervention to help an elderly person/family with Dementia. This will be assessed in two parts (see below).	Word count (or equivalent):	2,500 words
Submission deadline:	16th December 2023 (Via Turnitin by 23.59pm)	Return date of provisional marks & written feedback:	11th January 2024

TASK DESCRIPTION

Part 1: approximately 1000 words

This part will include documents such as Government policies, initiatives and briefing reports that address Dementia care and provision for the elderly in the UK. Alongside these you must provide a narrative to explain what the documents are and how they support care and provision. This part will help you to demonstrate the prevalence of mental health issues in Wales and show understanding of what interventions/provisions exist for those with Dementia.

Part 2: approximately 1500 words

Using the proposal form provided, design an intervention to help an elderly person or their family deal with Dementia.

This is a “hypothetical” proposal, and you will not be required to complete this empirical research for this module. However, it is strongly advised that you write a proposal that would be realistic. Please also note that this is an academic task, and it is considered good practice in proposal forms to include in text citations and a reference list. Please make sure this adheres to APA formatting.



Mental Health and the Ageing Population

Depression

Mental Health Problems in Old Age

- Not a normal and inevitable part of the ageing process.
- Majority of older people enjoy good mental health and make valuable contributions to society.
- Promoting mental health and well-being in later life can
 - Improve the quality of life for older people, including social and economic contributions
 - Benefit the whole of society, minimising the costs of care and increasing the functioning of society.



Mental health in old age

In a 500-bed general hospital on an average day, estimates suggest that 330 beds will be occupied by older people.

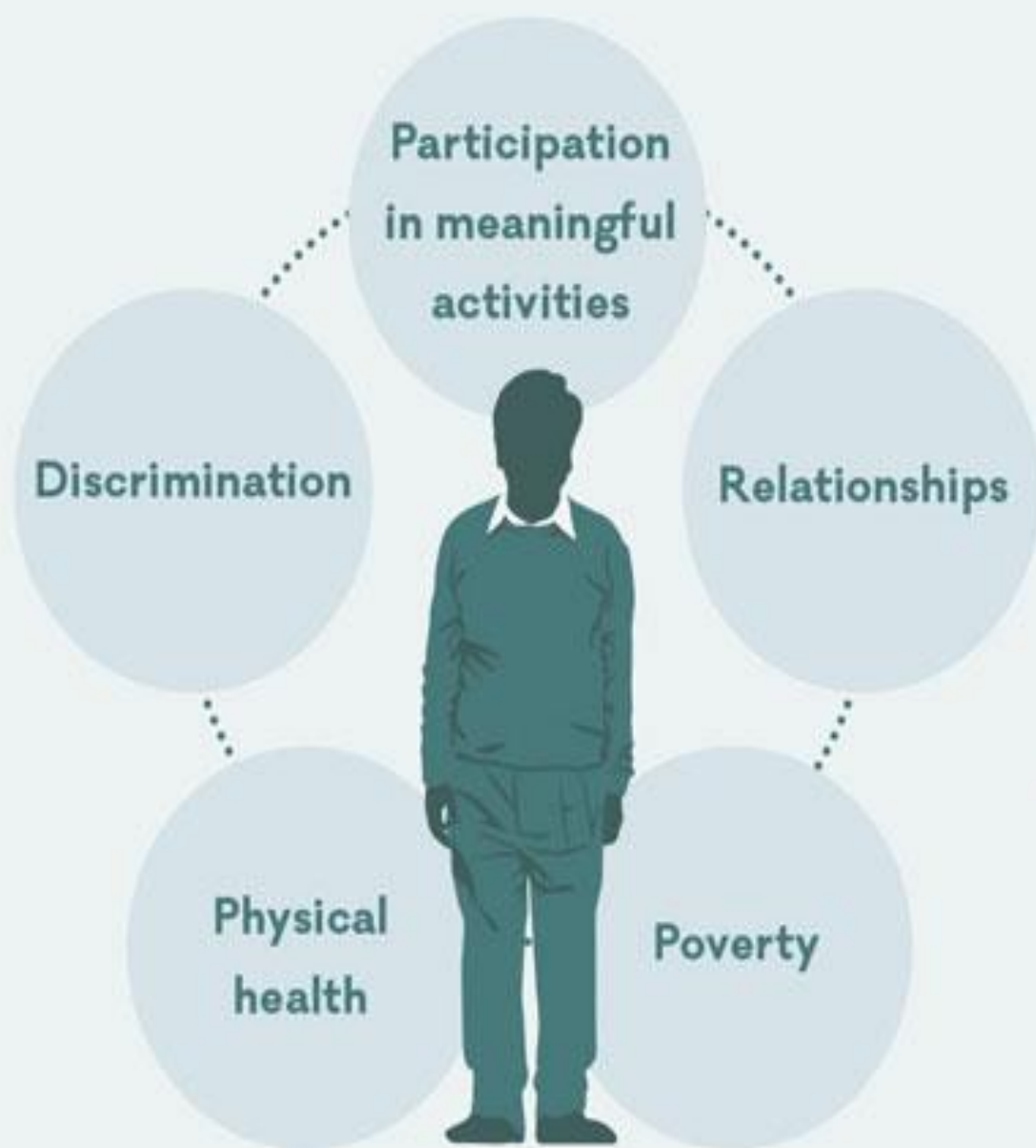
220 of whom will have a mental disorder, 100 will have dementia and depression, and 66 will have delirium
(Burns, 2015).



Depression affects 4 in 10 people living in care homes and in nursing homes



A third of people using specialist mental health services are older people, yet they currently only make up 18% of the general population.



The 5 key factors that affect the mental health and wellbeing of older people are: discrimination, participation in meaningful activities, relationships, physical health and poverty.

(Age Concern and the Mental Health Foundation, 2006)

Strong influences on mental health and well-being in later life

Discrimination on the basis of age is the most common type of prejudice experienced by people aged 55 and over = negative effect on their mental health.

The stigma attached to mental illness multiplies the difficulties for older people with mental health problems.

Participation in **meaningful activity**, staying active and having a sense of purpose are just as important for the mental health and well-being of older people as they are for younger people.

Yet older people face barriers to participation in many areas of public and private life.

Physical health and mental health are inextricably linked. Good physical health is associated with good mental health.

Poor physical health is associated with poor mental health.

Physical health is an important issue for many older people and improving it will improve mental health as well.

Activity Theory

Successful substitution of roles

—————→ High life satisfaction, high morale and feelings of well-being

Many elements of Activity Theory communicated to the elderly via media and health promotion programmes

Disengagement Theory:

Social and psychological withdrawal necessary in successful ageing

Voluntarily withdrawal of older adults

Societal withdrawal from older adults

Disengagement: Approval of society —————→ High level of life satisfaction

Checklist

Queensland Stay On Your Feet®



Will you stay active and independent?

If you are over 60 please take a couple of minutes to complete this checklist and then discuss your answers with a health care professional. Knowing and addressing your risk factors for falling is vital to reduce your risk of injury and loss of your independence.

Strong influences on mental health and well-being in later life

Secure and supportive relationships are important for good mental health and well-being. They may be with other people, such as family and friends, or with pets.

Social isolation is a strong risk factor for poor mental health and is experienced by one million older people in the UK. Strengthening positive relationships in later life will help to promote mental health and well-being for all of us.

Poverty is a risk factor for poor mental health. Nearly two million older people in the UK live in poverty.

It is not money *per se* but the things it can provide that are important to making people feel included in society in later life.

Older people want to have enough money to afford decent housing, heating, travel, social activities and occasional “treats” – for themselves and for others – that allow full participation in family and community life.



Depression in older age

Prevalence of depression in older people

Estimated that depression affects

22% of men

28% of women aged 65 or over.

40% of older people in care homes.



The Royal College of Psychiatrists (2018) has estimated that

85% of older people with depression receive no help at all from the NHS.



ONS 2013:

Highest UK suicide rate by broad age group was amongst men aged 45 - 59

Rate for 60 - 74 year old men had risen significantly from 2012 to 14.5 per 100,000

It is a matter of concern that older adults have a higher completion rate (ie fewer attempts in relation to completed suicides) than adults in younger age bands

Potential risk factors

Psychosocial factors

- Limited social support
- Bereavement
- Loss of social network
- Loneliness

Biological factors

- Female gender
- Family history of depression
- History of depression
- Negative life events

Clinical factors

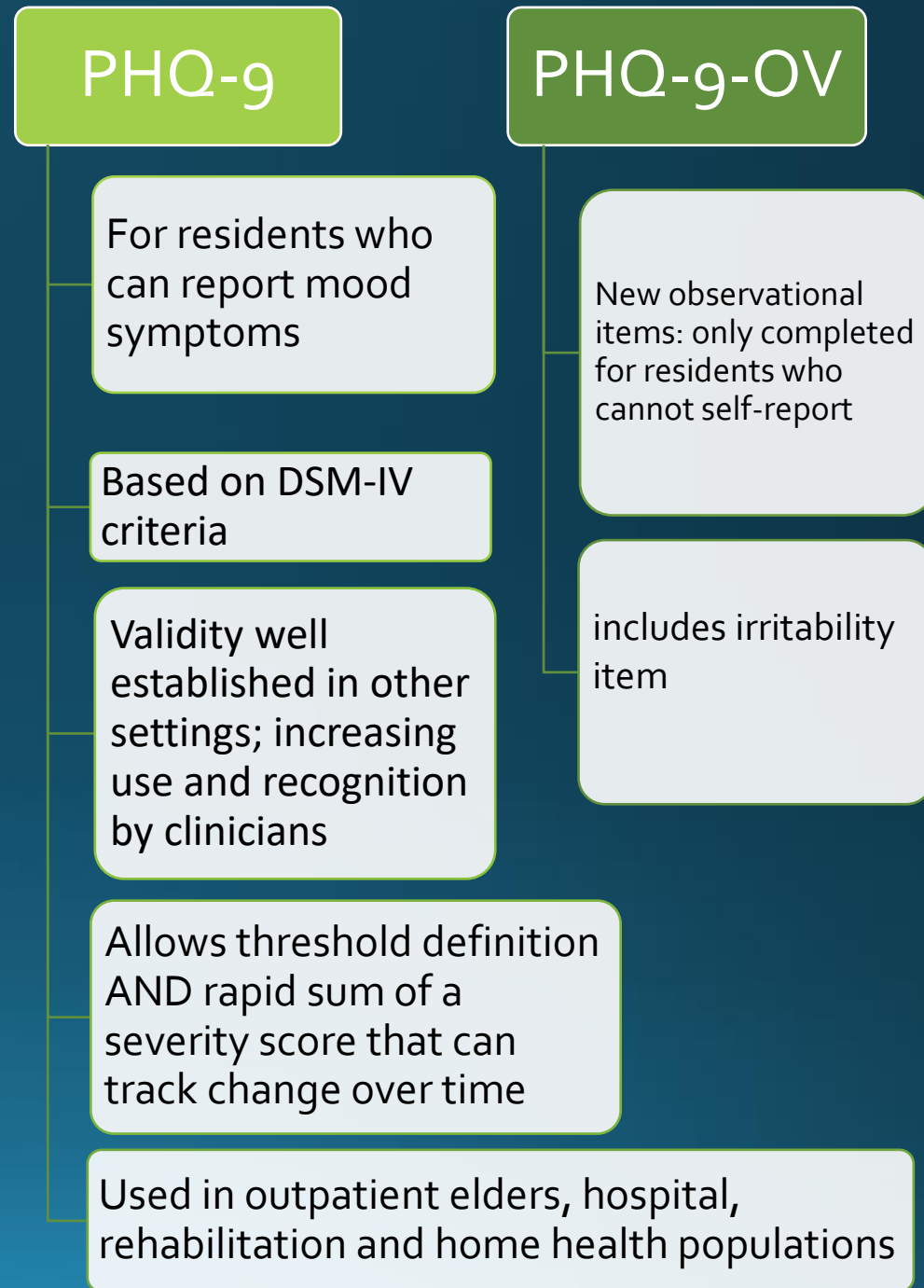
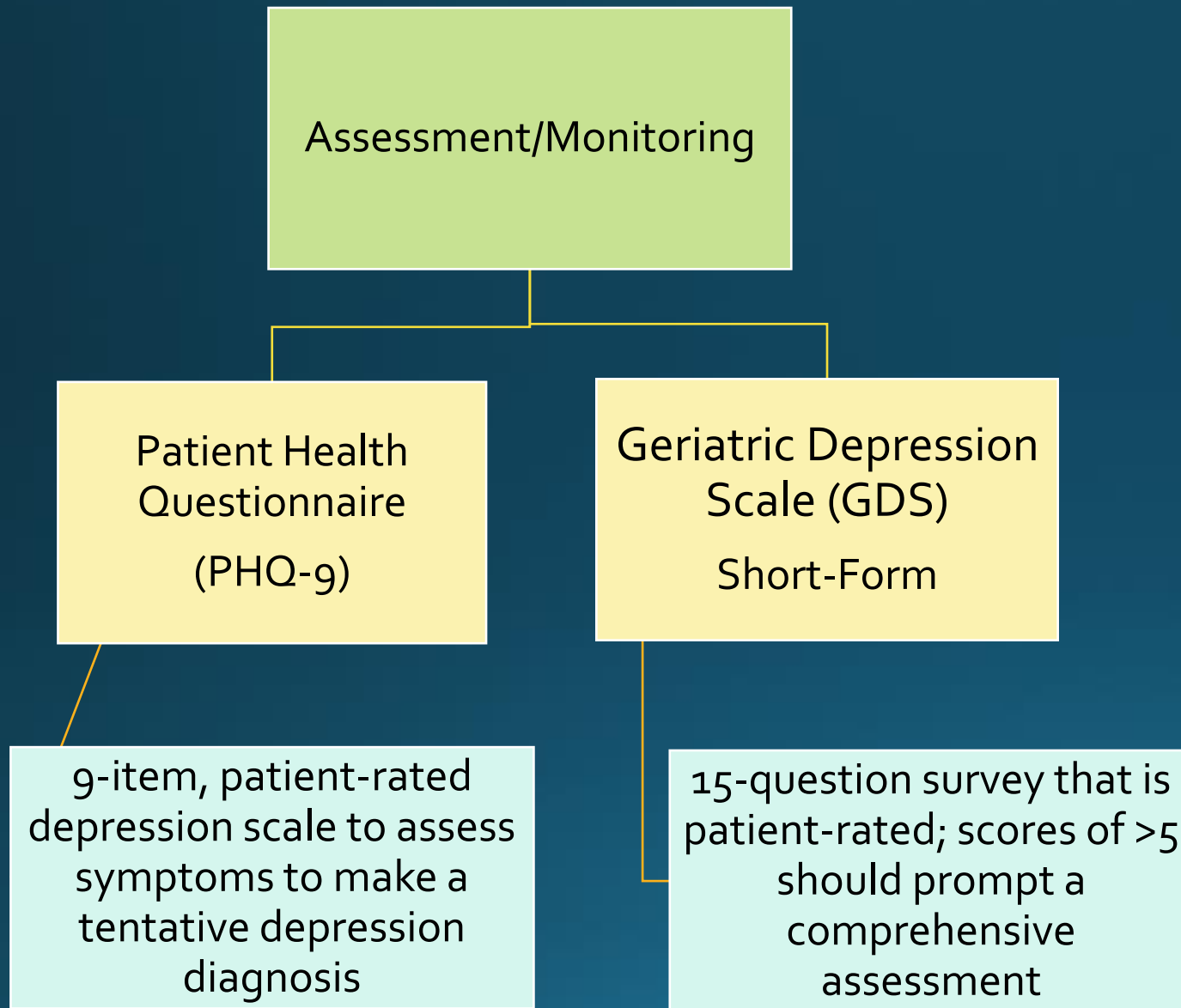
- Medical illness
- Physical disabilities
- Poor health
- Multiple medications

A major depressive episode may include :

- Persistent sad, anxious or "empty" mood
- Feelings of hopelessness, pessimism
- Feelings of guilt, worthlessness, helplessness
- Loss of interest or pleasure in hobbies and activities, including sex
- Decreased energy, fatigue, feeling "slowed down"
- Difficulty concentrating, remembering, making decisions
- Insomnia, early-morning awakening, or oversleeping
- Low appetite and weight loss or overeating and weight gain
- Thoughts of death or suicide, suicide attempts
- Restlessness, irritability
- Persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and pain for which no other cause can be diagnosed.

Five (or more) have been present during the same 2-week period and represent a change from previous

Assessment and Diagnosis



Scales

GDS (4 and 15 questions):

<https://patient.info/doctor/geriatric-depression-scale-gds>

PHQ-9:

<https://patient.info/doctor/patient-health-questionnaire-phq-9>

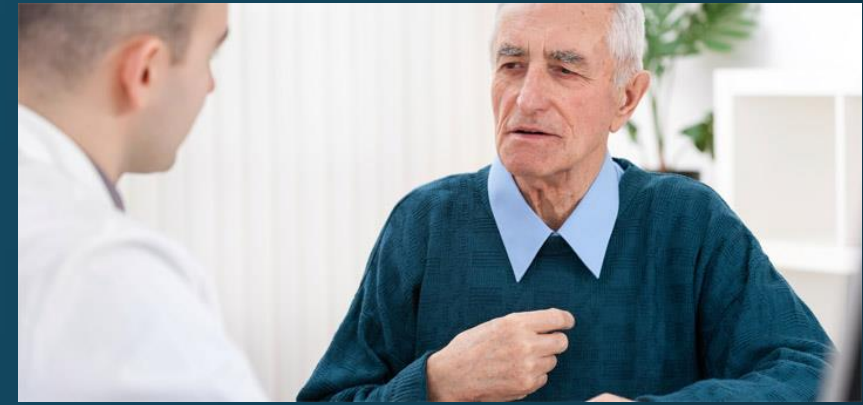
Point: PHQ uses the term 'depressed' in one of the questions to diagnose depression.

Is this appropriate?

Kroenke, K., & Spitzer, R. L. (2002).
The PHQ-9: a new depression
diagnostic and severity measure.
Psychiatric annals, 32(9), 509-515.

Nine Symptom Checklist				
Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?				
	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.....	0	1	2	3
2. Feeling down, depressed, or hopeless.....	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.....	0	1	2	3
4. Feeling tired or having little energy.....	0	1	2	3
5. Poor appetite or overeating.....	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down.....	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.....	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual.....	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way.....	0	1	2	3
(For office coding: Total Score ____ = ____ + ____ + ____)				
If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?				
Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult	
☐	☐	☐	☐	
From the Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission.				

Barriers to diagnosing depression



1. Patient factors

- **Non-specific symptoms** such as malaise, tiredness or insomnia rather than disclosing depressive symptoms.
- **Physical symptoms**, including pain, are common – depression related or not
- **Forgetfulness** may lead to concern that a patient has cognitive impairment or early dementia. (Rabins, 1996).
- **Beliefs that may prevent older people from seeking help** for depression
e.g.fear of stigma or that antidepressant medication is addictive.
- **Misattribute symptoms** of major depression to 'just old age', (Burroughs, Morley, Lovell et al, 2006) or ill-health or grief.

2. Practitioner factors

Primary care practitioners may **lack necessary consultation skills or confidence** to correctly diagnose later life depression or may see the symptoms as part of the ageing process.

They may be wary of opening a 'Pandora's box' in **time-limited consultations** (Burroughs, Morley, Lovell et al, 2006).

3. System factors

The barriers difficult for those from **lower socioeconomic and minority groups** who have higher risk of physical and mental ill health as well as disability (Rait, Burns, Chew, 1996)

Mental health services for older people in the UK tend to be separated from general medical services, - **difficulties in attending different sites for mental and physical disorders** (NHS Confederation, 2003).

Depression and other mental health conditions in older people often go underdiagnosed and undertreated.

However older people with mental health problems are likely to respond to treatments as well as or better than the younger population.

A greater proportion of older people (42%) complete treatment than their working age counterparts (37%) after being referred to Improving Access to Psychological Therapies (IAPT) services.



Medication: moderate to severe symptoms

NICE guidelines: first line treatment should be selective serotonin reuptake inhibitor (**SSRI**). SSRIs block the reabsorption (reuptake) of neurotransmitters serotonin into neurons.

This makes more serotonin available to improve transmission of messages between neurons. Serotonin (and noradrenaline) is linked to mood and emotion.

SSRIs are called selective because they mainly affect serotonin, not other neurotransmitters.

Antidepressant decisions should be guided by the **patient's previous experience** of an antidepressant, and by co-morbidities and side effects.

Not usually prescribed for mild depression.

Tricyclic antidepressants (TCAs) **should not be initiated in primary care**, but are occasionally suggested by secondary care for use in treatment-resistant depression.

Amitriptyline is frequently started in primary care for older people with chronic pain, but co-prescribing of both a TCA and an SSRI should be avoided.

Psychological and talking therapies: moderate to severe symptoms



Many older people express a **preference for a talking treatment** and there is good evidence for the effectiveness of a number of psycho-social interventions such as Cognitive Behavioural Therapy (CBT), Behavioural Activation and Problem Solving Treatments

(Woods, Roth, 2005; Givens, Datto, Ruckdeschel et al, 2006).

There is evidence, however, that GPs continue to refer younger rather than older people for talking treatments (Kendrick, Dowrick, McBride et al, 2009).

Therapies:

Psychotherapy interventions

- Cognitive behavioural therapy
- Behavioural therapy
- Problem-solving treatment
- Interpersonal psychotherapy
- Reminiscence therapy
- Cognitive bibliotherapy



- Multidisciplinary geriatric mental health outreach services
- Collaborative and integrated mental and physical health care

The Strategy for Older People in Wales

<https://www.gov.wales/sites/default/files/publications/2019-06/the-strategy-for-older-people-in-wales-2013-2023.pdf>

Older Peoples' Mental Health

<https://www.england.nhs.uk/mental-health/adults/older-people/>

Management of depression in older people in primary care

Physical activity

- Exercise is recommended as a treatment for mild to moderate depression (NICE, 2009).

Psycho-social interventions

- Befriending may also be useful in management of mild depression in older people (Mead, Lester, Chew-Graham et al, 2010).

Collaborative care

- A case manager co-ordinates care.
Delivers a specific psycho-social intervention with or without medication management.
Liaises with both the GP and the specialist mental health services. (Chew-Graham, Lovell, Roberts et al, 2007).

The impact of depression on the elderly

Relationship between mental and physical health.

Lead to significantly poorer health outcomes and reduced quality of life.

Costs to the health care system are also significant – by interacting with and exacerbating physical illness, co-morbid mental health problems raise total health care costs by at least 45 per cent for each person with a long-term condition and co-morbid mental health problem

Co-morbid mental health problems have a number of serious implications for people with long-term conditions, including **poorer clinical outcomes, lower quality of life and reduced ability to manage physical symptoms** effectively.

Poorer clinical outcomes and prognosis



Cardiovascular patients with depression experience 50 per cent more acute exacerbations per year (Whooley et al 2008) and have higher mortality rates (Katon 2003).

A meta-analysis suggested that depression leads to a two- to threefold increase in **negative outcomes** for people with acute **coronary syndromes** (Barth et al 2004).

Lesperance et al (2002) - **depression increases mortality** rates after heart attack by 3.5 times

Blumenthal et al (2003) – a twofold increase in **mortality after heart bypass surgery** over an average follow-up period of five years

Patients with chronic heart failure are **eight times** more likely to die within 30 months if they have depression (Junger et al 2005).

Adverse health behaviours and poorer self-care

Mental health problems are associated with

- Low attendance rates for medical appointments
- Non-compliance with medical regimens

For cardiac patients, depression has been shown to

- Increase adverse health behaviours (e.g. physical inactivity)
- Decrease adherence to self-care regimens incl. smoking cessation, dietary changes and cardiac rehabilitation programmes
(Benton et al 2007; Katon 2003).

Non-compliance with medication is higher among COPD patients with depression than those without.

A review found that patients with a range of medical conditions are **three times less likely to take medications as recommended if they also have depression** (DiMatteo et al 2000).

Depression is associated with an increase in re-hospitalisation rates in cardiovascular disease.

For patients with chronic heart failure the emergency admission rates are 2 – 3 times higher
(Himelhoch et al 2004; Fenton and Stover 2006)

Adverse health behaviours and poorer self-care

Mortality rates for individuals with co-morbid asthma and depression were twice the level among those with asthma alone

(Walters et al 2011).

COPD patients with co-morbid mental health problems have more than 50 per cent more acute exacerbations per year (Laurin et al 2009), experience higher rates of hospitalisation, and in one study spent twice as long in hospital as those without mental health problems

(Yellowlees et al 1987).

Co-morbid mental health problems

- Lead to greater difficulties with diabetes self-care

(Das-Munshi et al 2007)

- Associated with **poorer dietary control** and adherence to medication

(Vamos et al 2009).

The impact of depression

Memory functions are affected and impact

Thought organisation
Decision Making
Task initiation
Planning future actions



Disturbances in executive functioning (Lesser, et al, 1996, Butters, 2000), including

- Impaired planning
- Organizing
- Initiating
- Sequencing
- Shifting
- Information processing speed
- Working memory

'Depression-executive dysfunction syndrome'

Patients with the DED syndrome found to have

- Reduced fluency
- Impaired visual naming
- Paranoia
- Loss of interest in activities
- Psychomotor retardation

But showed a rather mild vegetative syndrome - caused by neurotransmitter imbalances (that enable individual brain cells to "talk" to each other and store new memories).

- Also **impaired - ability to create long-term memories** due to lack of attention and concentration creating a loss of coordination between working, short-term, and long-term memory.
- A depressed person may be too inattentive and unfocused to file passing events in short-term memory.
- In this case, it isn't so much that the depressed person has forgotten, but that the memory was never stored in the first place.

The impact of depression



Often exhibit cognitive deficits compared to healthy individuals in the same age group.

Memory and executive function - most consistently impaired (Kohler et al., 2010).

Association between impaired cognition and altered cortisol secretion in older patients with major depression

(Fiocco et al., 2006)

Depression in later life takes a significant toll on patients and families.

Family members of depressed older adults experience the moderate to high levels of general caregiver burden that dementia caregivers often report

(Sewitch, McCusker, Dendukuri, & Yaffe, 2004).



Summary

- Depression is prevalent amongst older people
- Older people with depression do not always receive appropriate help
- Several barriers to gaining help
- Issues with diagnosis
- Adverse outcomes: physical health and cognition
- Impact on caregivers

References

- Godfrey M et al (2005). Literature and policy review on prevention and services. UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern/Mental Health Foundation.
- Craig R, Mindell J (eds) (2007). Health survey for England 2005: the health of older people. London: Information Centre.
- Age Concern (2006). Promoting mental health and well-being in later life: a first report from the UK Inquiry into Mental Health and Well-Being in Later Life. London: Age Concern/Mental Health Foundation.
- Rait G, Burns A, Chew CA (1996). Old age, ethnicity and mental illness: a triple whammy. British Medical Journal 313: 1347–1348.
- Amore M, Tagariello P, Laterza C, Savoia EM (2007). Subtypes of depression in dementia. Archives of Gerontology and Geriatrics 44 (s1): 23–33.
- Egede LE (2007). Major depression in individuals with chronic medical disorders: prevalence, correlates and association with health resource utilization, lost productivity and functional disability. General Hospital Psychiatry 29(5): 409–416. 10
- NICE (2009). Depression in adults with a chronic physical health problem: treatment and management. London: NICE. <http://www.nice.org.uk/nicemedia/pdf/CG91FullGuideline.pdf> [accessed February 2016]
- Moussavi S, Chatterji S, Verdes E et al (2007). Depression, chronic disease and decrements in health. Results from the world Health Surveys. Lancet 370: 851–858.

References

- Dewey, Saz (2001). Dementia, cognitive impairment and mortality in persons aged 65 and over living in the community: a systematic review of the literature. *International Journal of Geriatric Psychiatry* 16(8): 751–761.
- Mykletun A, Bjerkeset O, Øverland S et al (2009). Levels of anxiety and depression as predictors of mortality: the HUNT study. *British Journal of Psychiatry* 195: 118–125.
- Hemingway M, Marmot M (1999). Psychosocial factors in the aetiology and prognosis of coronary heart disease: systematic review of prospective cohort studies. *British Medical Journal* 318: 1460.
- Nicholson A, Kuper H, Hemingway M (2006). Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6362 events among 146,538 participants in 54 observational studies. *European Heart Journal* 27(23): 2763–2774
- National Confidential Inquiry into Suicides and Homicides (2010). Annual report: England and Wales. Manchester: National Confidential Inquiry into Suicides and Homicides <http://www.medicine.manchester.ac.uk/psychiatry/research/suicide/prevention/nci/inquiryannualreports/AnnualReportJuly2010.pdf> [accessed February 2016]
- Alexopoulos A (2005). Depression in the elderly. *Lancet* 365:1961– 1970.
- Burroughs H, Morley M, Lovell K et al (2006). 'Justifiable depression': how health professionals and patients view late-life depression – a qualitative study. *Family Practice* 23: 369–377.
- Foresight Mental Capital and Wellbeing Project (2008). Final project report. London: Government Office for Science

References

- Department of Health (2011). Talking therapies: a four-year plan of action. London: Department of Health
- Givens J, Datto C, Ruckdeschel K et al (2006). Older patients' aversion to antidepressants: a qualitative study. *Journal of General Internal Medicine* 21:146–151.
- Woods R, Roth A (2005). Effectiveness of psychological interventions with older people. In: Roth A, Fonagy P (eds). *What works for whom? A critical review of psychotherapy research* (second edition). New York: Guilford Press 425–446.
- Kendrick T, Dowrick C, McBride A et al (2009). Management of depression in UK general practice in relation to scores on depression severity questionnaires: analysis of medical record data. *British Medical Journal* 338: b750.
- Mead N, Lester H, Chew-Graham C et al (2010). Effects of befriending on depressive symptoms and distress: systematic review and meta-analysis. *British Journal of Psychiatry* 196: 96–101.
- Chew-Graham CA, Lovell K, Roberts C et al (2007). A randomized controlled trial to test the feasibility of a collaborative care model for the management of depression in older people. *British Journal of General Practice* 57: 364–369.
- Netuveli G, Wiggins RD, Montgomery SM, Hildon Z (2008). Mental health and resilience at older ages: bouncing back after adversity in the British Household Panel Survey. *Journal of Epidemiology and Community Health* 62 (11): 987–991.
- White H, McConnell E, Clipp E (2002). A randomized controlled trial of the psychosocial impact of providing internet training and access to older adults. *Aging & Mental Health* 6(3): 213–221.
- Windle J, Hughes D, Lick P et al (2008). Public health interventions to promote mental well-being in people aged 65 and over: systematic review of effectiveness and cost-effectiveness. London: NICE. <http://www.nice.org.uk/nicemedia/live/11999/42401/42401.pdf> [accessed February 2016].