OLDER PEOPLE AND MENTAL HEALTH
King's Fund, London, July 2nd

Niall DICKSON
Director of King's Fund
Not a political campaign but a campaign to instill public debate

3 challenges
- funding
- research
- new care models

Dr Julien FORDER
PSRU, LSE
Author of the WANLESS report

Population health is improving but evidence suggest healthy life expectancy is growing more slowly then total life expectancy

Older people not requiring care 5.5 m	+44%
With low needs 1.4 m	+53%
With high needs 0.9 m	+54%

Service packages

- personal care	22%
- social participation	19%
control	12%
nutrition	9%
safety	6%

the economics
- services produce outcomes but have costs
- effectiveness of services in producing outcomes varies with ADL need and Cl of recipients
- total social care expenditure between 10 and 12 billion £ (growing as fast as the GNP)

How to pay for care?
- Front-runners to be tested against the present system
- partnership model
- free personal care
- limited liability

Public guaranteed element + public matched funding + private contribution

A break from the underlying poor law philosophy of the current system
Reconfiguration of service/system and development

An other advantage of the partnership model : the choice

Simplicity : not to be a private detective to find long term care for your mother or your father

The most important point : to avoid complexity

Neil HUNT
Alzheimer's Society

The prevalence and the cost of dementia in UK

A similar survey in Australia in the past

700,000 people now affected by dementia – 1 million by 2025
a possible lift because of vascular diseases, and mixed cases
36% in care homes, 64% in the community

	Community mild	Moderate	Severe	Residential
	17	26	37	31
Part of informal care				

17 billion £ per annun
25,000 € per person with dementia

recommendations
- make dementia a national priority
- increase dementia research
- improve dementia care skills (training for health and social staff)
- develop community support
- improve carer support
- an national debate on who pays for care
- comprehensive dementia care models (to bridge the gap between care at home and care in care home)

Rani SVANBERG
www.dementiacare.org.uk

To see oler people not as a burden but as as a contributor of resources

From disempowerment to empowerment (1988- 1991)
Lack of human resources – lack of choice
Form 3Ds to 3Cs (capability – Valuable contribution – Control)
Former hair dresser to the senior community

Partnership with carers (1991-2007)

Alternatives to residential care

Number of clients 500 per week
220 staff
4 000 weekly care hours
The Bradbury Centre
Meeting center – as a hub
Contributors - white paper (2006) our health – our acre – our say – setup the social enterprise unit
From passive recipients to active board members
To make money to develop new centers

Dementia has to be a local priority too
Let's include housing and technology vital to independent living (falls and wandering) not just health and social care

Be safe
B healthy
Achieve and enjoy
Well-being

Child matters

Michele LEE
Researcher for AGE CONCERN

Independent organization

The majority of older people have good mental health and well-being
But a significant and growing do not
For instance 25% of older people with depression

Bsolute umbers will increase
Direct costs
Indirect costs £250 billion per year for informal care
Human costs

Older people's views
1- discrimination (second class citizen)
2- participation
3- relationships with family and community
4- physical health
5- financial health

A possible solidarity – older people helping themselves and each other

Marine MELE
LUTON Project for Older People

A top down and bottom up approach with community involvement
Gaps in services
New services – it is necessary to be as flexible as possible

- day service – early morning service
- Alzheimer's Society – meet & greet services
- Preventative services (specially Age Concern's Mind Gym)

A two-years project
On looking at the sustainability, the question of the funding and specially the NHS funding

NHS Institute for innovation and improvement 2005
NHS sustainability model Maher, Gustafson, Evans 2003

Evaluation by the Luton University

Pr Sube BANERJEE
Professor of mental health and ageing The Institute of Psychiatry King's College London

50% of time for research – 50% for clinical work

Increase in workload, severity & dependency, expectation but very little change in investment

Dementia implicity or explicity excluded from

- intermediate care developments
- public policies for mental health
- local commissioning

everybody cares with dementia but none in a integrated system – no leader
only a third at most of people with dementia receive any specialist health care assessment or diagnosis
too late treatment – particularly bad for people from minority ethnic groups

A pivotal role for specialist OPMH services
- primary care
- secondary care
- social care
- community/institutions

the two standards in dementia care

- serious mental illness strand
- early identification strand

it's possible to prevent the harms of dementia

- institutionalization
- break in relationship

A memory clinc - the Croydon memory service
Assoiciation of geriatric, mental health specialists, Alzheimer's Society
Referrals from GPs
Home assessment in pairs (patient and care)
Multidisciplinary team
Continuity of care
Treatment
Review

To avoid : emergency treatment

Universal system - 18% minority ethnic groups 19% people under 64 years
Getting things done – to manage the system in the all

The first reason to go to nursing homes – cost per place £400 per week
Nursing homes £6.4 billion
Spend on specialist OPMH services £1.O billion

6% reduction in insitutionalisation   £194 million savings per annum
A break-even at 8% - a big savings at 12% - 22% rate is possible

GD