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Background document and key messages for the EU thematic conference:

“Mental Health and Well-being in Older People - Making it Happen”

EU Thematic conference on mental health of older people

19th- 20th April 2010, Madrid

Organised by the European Commission Directorate-General for Health and Consumers and the Spanish Ministry of Health and Social Affairs with support of the Spanish Presidency of the European Union

2010
European Year
for Combating
Poverty and
Social Exclusion



GOBIERNO
DE ESPAÑA

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**Background document and key messages for the EU
thematic conference:**

**“Mental Health and Well-being in Older
People - Making it Happen”**

**Background document for
The Thematic Conference on mental health and well-being among older people
“MENTAL HEALTH AND WELL-BEING IN OLDER PEOPLE – MAKING IT HAPPEN”
Madrid, 19-20 April, 2010**

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This document has been prepared under a tender contract with the European Commission (contract No SANCO/C4/2009/01 – Lot 3: Mental Health), lead by the Department of Health of the Government of Catalonia (Gencat).

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http://ec.europa.eu/health/mental_health/policy/index_en.htm

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This document should be quoted:

Lang, G., Resch, K., Hofer, K., Braddick, F. & Gabilondo, A. (2010). Background document for the Thematic Conference on Mental Health and Well-being among Older People. Luxembourg: European Communities. © European Communities, 2010

BACKGROUND PAPER TO THE CONFERENCE

“MENTAL HEALTH AND WELL-BEING IN OLDER PEOPLE – MAKING IT HAPPEN”

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• KEY MESSAGES

- I. **Policy:** A wide variety of Member States' policies, not restricted to those specifically addressed at mental health, have an impact on the well-being of older people. As such, policies in multiple sectors should be formulated with consideration to factors which have an impact on the healthy ageing, well-being, autonomy and capacity of older adults. Providing a choice of services across sectors and involving older people in the design of policies are important tools to promote their empowerment.
- II. **Mental Health Promotion:** A healthy lifestyle, safe living environment and meaningful, active participation in society and the community are important protective factors for mental well-being in older age. Above all, however, support from families, peers and carers play a key role in promoting the mental health of older people. Prevention of loneliness and isolation is one of the most powerful strategies to promote mental health and well-being in old age. Mental health promotion measures are also important for improving physical health and successful ageing.
- III. **Mental Disorder Prevention:** Prevention of the most common mental disorders involves addressing the risk factors for mental health problems in old age, such as chronic diseases, physical impairment, and improving help seeking (for example, through combating stigma), early detection and intervention, before mental health problems emerge.
- IV. **Older People in Vulnerable Situations:** Older people from certain groups face a higher risk for mental health problems. This includes older women, those living in or at risk of poverty, experiencing chronic illness, suffering abuse and belonging to cultural or ethnic minorities. Measures to build resilience or to reduce their specific vulnerability (for example, through services) can improve living conditions and decrease mental health problems in these groups. These measures can also increase social inclusion and cohesion.
- V. **Systems for Care and Treatment:** Health and care systems, supported by research in the fields of old age psychiatry and geriatric medicine, have a key role to play in the early detection and tackling of mental disorders in older people. Care systems need to be community oriented and include multidisciplinary teams, as well as mechanisms for coordination between social and mental health care. Primary health care and general social services are primary access points for many older adults and should be used to proactively pursue the goal of good mental health. The management and coordination of palliative and end-of-life care requires good leadership and commitment in primary care teams with integration of both informal carers and other specialists.
- VI. **Informal Carers:** Informal carers carry the largest share of care provision, and the increasingly large proportion of this care is provided by older women. Supporting their role, training them, and protecting their well-being have positive outcomes for the mental health of carers and the people they care for.
- VII. **Research:** There are gaps in the existing knowledge base regarding older people's mental health, in terms of determinants of mental health at the policy level, effective implementation of promotion and prevention action and diffusion research to determine how results can be transferred into practice and policy.

- **KEY ACTIONS**

I. POLICY

1. Include specific actions, with budgetary provision, for the mental health of older people with measurable indicators and targets in the national mental health and active ageing plans or strategies;
2. Promote anti-discrimination legislation to counter ageist behaviour, stereotypes and stigmatizing practices and to encourage intergenerational activities.
3. Raise awareness of the importance and the potential of mental health and well-being in older age e.g. through awareness programmes and advocacy action across relevant stakeholders.

II. MENTAL HEALTH PROMOTION IN OLD AGE: HEALTHY AGEING AND WELLBEING

1. Adopt appropriate measures to improve and maintain a high quality of life for older people through promoting healthy lifestyles, active ageing and participation in community life:
 - create opportunities for meaningful roles in society, the workplace, community and neighbourhoods, such as volunteering, intergenerational support, training and life-long learning
 - introduce flexible retirement schemes, which enable and encourage people to continue their professional activities in ways adapted to their capacity and needs;
 - promote healthy nutrition and sexuality, as well as physical activity of older people through sports and other activities offered by regional stakeholders and municipalities
2. Provide living spaces, local environments and neighbourhoods that are safe, convenient and accessible, as defined by older people themselves, and that facilitate older people's participation, mobility, and autonomy, such as:
 - Clean, safe and barrier-free community infrastructures such as meeting places, spaces for relaxation and recreation, footpaths as well as public transportation systems.
 - Access to a range of home help and support systems, such as cooking, shopping, transport or health support.
 - Technical support for independent living through new technologies (monitoring options, e-health, technology assisted living)
3. Provide measures to promote mental health and well-being among older people receiving care (medical and/or social) in both community and institutionalised settings
 - respect identity and personal style of living of old people in care
 - promote their autonomy and independent living
 - increase their involvement in decisions regarding the care services they receive
 - address physical health problems including pain, visual or hearing impairments
 - address loneliness and isolation
4. Address negative stereotypes about old age, which erode (self-) confidence in the social and mental capital of older people, through media guidelines for non-disparaging reporting, policies and supporting campaigns to combat ageism

III. PREVENTION OF MENTAL DISORDERS AND ADDICTION

1. Develop setting specific protocols to identify early those at risk for mental disorder, based on the principles of comprehensive geriatric assessment, and implement them across all health settings, including:
 - Hospital wards (in particular geriatric, internal medicine and surgery wards);
 - Primary care services;
 - Nursing and home care services;
 - Long-term-care facilities.
2. Incorporate specific actions to tackle mental health risks in those with chronic physical disorders, with particular attention to reducing the impact of chronic conditions on mobility and autonomy, including:
 - Awareness-raising actions for health professionals;
 - Stepped care approaches based on evidence-based protocols
 - Patient education programmes aimed at improving self-management of chronic illness.
3. Adopt preventive psychological interventions targeted at groups at high risk of mental disorders, and make them available in a number of settings, such as primary care, community centres, homes, or long-term care facilities.
4. Address problems with addiction in older populations and adopt preventive measures, such as:
 - Guidelines for regular review of long-term prescriptions for older people, especially repeat prescriptions;
 - Increased taxation on alcoholic beverages and brief interventions for early stage alcohol problems.
5. Develop and investigate effective suicide prevention in older people, particularly older European men, and implement widely. Key principles include:
 - Multi-level and multi-component suicide prevention programmes
 - Measures that address the most prominent risk factors of social isolation and untreated mood disorders

IV. OLDER PEOPLE IN VULNERABLE SITUATIONS

1. Allocate specific resources for older people at risk of social exclusion, such as those who live in poverty, for example,
 - Community development programmes in deprived neighbourhoods, supportive networks and social inclusion initiatives, especially geared towards older women.
 - Own language and culturally appropriate prevention interventions and social inclusion initiatives for older people e.g. from ethnic minorities and migrant groups
2. Improve recognition and support for older people living in abusive relationships, for example, through:
 - Confidential telephone help and advice lines for those suffering from or witnessing abuse and for those abusing.
 - Ensure quality control and sufficient funding for health and social care services as well as support and guidance for informal carers.

- Raise awareness about elder abuse, how to detect and prevent it, among social workers, primary care professionals, police staff and the general public (including families). Provide settings where abuse can be reported and fully redressed.
3. Coordinate health and social welfare sectors to improve access for vulnerable populations.
 4. Highlight issues of ageing for non-governmental agencies representing groups at higher risk of social exclusion (e.g. organisations or interest groups representing older women, homeless people, migrants, ethnic minorities, lesbian, gay, bisexual and transgendered individuals)

V. HEALTH SYSTEMS FOR CARE AND TREATMENT

1. Create health care systems, based on the principles of geriatric medicine, that are community and outpatient oriented, that include proactive collaboration between the treatment systems for mental and physical disorders as well as between the health and the social sector.
2. Ensure the availability and access to skilled and multidisciplinary teams, which include general practitioners, gerontologists, mental health specialists (especially old age psychiatrists), social workers, educators and nurses, trained to detect and treat mental disorders in older people.
3. Ensure that nursing homes provide high quality care through a highly skilled and large work force, and working conditions that prevent high staff turn over. Encourage collaboration with mental and other health professionals and by implementing independent quality control measures.
4. Incorporate new technologies (including information and communicative technologies, e.g. ICTs and eHealth) and technical aids into programmes for mental health promotion, disorder prevention, treatment and care of older people.
5. Support professional carers and develop guidelines for nursing and long-term care aimed at preventing maltreatment of older people and to allowing them to live with dignity in an appropriate environment.

VI. INFORMAL CARERS

1. Provide official recognition, financial support and social security benefits to informal carers (including spouses and older carers). Include concrete support to those unable to work because of their caring commitment, including income compensations and pension rights. Consideration should especially be given to older women as caregivers.
2. Provide mental health protection measures for informal carers such as
 - possibilities for respite, flexible and part-time work
 - psychosocial support (social networking, peer support, self-help literature and support lines, and helpdesks)
3. Provide training with flexible scheduling, monitoring and professional help to informal carers, including:
 - Tools to evaluate carers' own physical and mental health needs.
 - Curricula focusing on how mental health in old age can be promoted and how (mental) disorders can be prevented.
 - Professional home visits and regular communication between professionals and informal carers, including assessment of the health and safety conditions and technical aids.
 - Use the valuable experience which informal carers have of the cared-for individual in training and supporting professional carers to continue or support their role.

VII. RESEARCH

1. Provide incentives, such as calls and funding programmes, to direct research towards gaps in the field:
 - Identify contributions of older people to social, cultural, spiritual and economic capital;
 - Identify the economic value of informal care;
 - Develop cross-culturally validated research instruments to investigate well-being and determinants of mental health in this age group;
 - The impact of policies on mental health;
 - Prevention of depression, anxiety, alcohol and drug addiction, suicide and elder abuse.

1 INTRODUCTION

Rationale for the EC Thematic Conference: The value of mental health in old age

Mental health and wellbeing in later lifeⁱ affect us all as we all move towards our own older age. There are humanitarian, social and economic reasons why we should pay more attention to these issues. Good mental health and wellbeing in later life benefits each one of us by ensuring that we are able to lead long healthy lives that are enjoyable and fulfilling. Promoting good mental health in older people is one way to maximise the valuable contributions that older people can make to society and to the economy, while minimising the costs of care related to poor mental health.¹

Ageing in good physical and mental health is a right of all Europeans. Such rights extend to a reduction in the stress of carers, active social lives for all and ensuring equitable access to health care systems and employment opportunities, both in the paid and voluntary sectors. More Healthy Life Years means a healthier workforce, and less retirement on the grounds of ill health.

The determinants (causes and consequences) of mental health and well-being in old age can be found on different levels: the individual level (self-esteem, coping skills, physical health, life-styles and life-experiences); the interpersonal level (interactions and relationships with friends and family, daily functioning in the community); the societal level (societal policies, structures and resources), and; the cultural level (equity, value, tolerance of difference).

Challenges faced by Europe: Social and demographic change

The demographic change the European Union is facing, resulting from low birth rates and increasing longevity, means that in the coming decades there will be fewer young people and young adults, and a greater number of older workers, pensioners and very old people. The proportion of the population above 65 years of age in 2050 will be around 30%, and 11% will be over 80 years old in EU25 countries². This aging shift will necessitate increased support and services in Member States and will have knock-on consequences for the workforce, healthcare systems, informal and formal carer capacity and society.

Demographic change happens at a different pace in each European country, with the highest acceleration in the ageing process takes place in Poland and Romania. Whereas the current proportion in both countries is around five people between 15-65 years to one over 65, by 2050 the ratio will reduce to two of “working age” per older person.³ It is clear that measures to reduce early retirement, increase flexibility of retirement schemes and allow those who want to, to remain in employment for longer will be needed to sustain European economic security and quality of life.

Changes are also occurring in European family structures, partnerships and gender roles which have significant effects on the living situations of older people⁴, and in turn on risk and protective factors for mental health and wellbeing. For example, increasing divorce rates and migration of younger generations for work have resulted in an increase in older single-person households in Western Europe, predominantly for women.⁴ Living alone, if not adequately supported, can produce feelings of instability in social relations, isolation and loneliness, increasing the risk of depression and anxiety.

ⁱ For the purposes of this document, the key messages document and the EC Thematic conference, and based on several Commission documents, the terms “later life”, “old age” and “older people” have been used and refer to those people 65+ years of age or over the legal age of retirement in European member states, unless otherwise stated. Those of 80+ are referred as the very old. It is noted however that such cut off points are arbitrary.

Much diversity is found across the EU in relation to household composition and family structures, both between countries and within countries, due to variation between norms in urban and rural communities. In some countries, particularly in Southern Europe, it is still common for older people to cohabit with their children who often later take on the role of informal carers. In others, older people typically live alone, relying on formal care services where needed, and a large proportion of the very old live in institutions.

Although many older people prefer not to be admitted to long-term care facilities, there is sometimes no other choice. However, considering older people's own preferences as well as the high costs associated with long-term care and the probable negative impacts of institutionalisation, efforts to prevent or delay placement in long-term care and to replace care institutions by community-based nursing homes are very much needed⁵. Thus, investments in home care initiatives and improving care facilities are important issues in the care of old people.⁶

Mental health and well-being in older people

For some, old age is a positive experience, bringing a freedom from the burden of working and more free time at an age when most are in fairly good condition to enjoy it. Becoming a grandparent is a unique experience and an important role for many older people, providing a feeling of continuity in life and an opportunity of give without conditions.⁷

However, there are also critical issues during this phase of life. Retirement can have a major impact on the mental health of older persons. It is often associated with a loss of status and structure in daily activities, which work entails, as well as a perceived reduced role in life and fewer social relationships. Other factors that may impact on the mental health of this age group include a gradual deterioration in health and physical capability, loss of financial stability, changing environment (moving home) and a loss of the sense of belonging.^{8,9} Older people often increasingly face the loss of close friends, family and partners, deteriorating functional ability, sense of purpose and poverty.¹⁰ The fear of losing independence is also common in this age group.⁸

In general, European older people feel less happy with their life than younger people, particularly in new Member States where there are larger differences in life satisfaction and happiness between age groups.¹¹ Depression or anxiety, the most common mental disorders, have been found to be high in later life, with depression affecting 10-15% of persons over 65¹².

There is also considerable between-country heterogeneity in both later-life depression and well-being across Europe. For Europeans aged over 50 years, the Scandinavian countries, Austria, and the Netherlands seem to do best in terms of mental health (high well-being and low depression), followed by France and Germany (medium or low depression, medium or high well-being), whereas older people in Italy, Greece, and Spain have the worst mental health (high depression, low well-being).¹⁰

In addition, beyond the profound immediate impact on quality of life, depression in older adults is a risk factor for functional disability^{13,14} and may predict premature mortality. Older people with depression are 2-3 times more likely to have two or more chronic illnesses and 2-6 times more likely to have at least one limitation on their daily life activities¹⁵ compared to younger groups. Co-morbid depression in older people also increases the frequency and cost of professional help and the risk of premature placement into nursing homes.

Some 6 million people in the EU have dementia (between 1.1-1.3% of the population), defined as 'the loss of intellectual functions of sufficient severity to interfere with a person's daily functioning'¹⁶. Alzheimer's disease, a slow neurodegenerative process which, to date, cannot be halted nor totally prevented, is the most common form (60%) of all dementia cases. Furthermore, there is little awareness of the common early symptoms of the disease among the general public or affected families, and up to 70% of primary care physicians have expressed difficulties to detect early signs of the disease¹⁷. Stigma and denial are also important factors contributing to late or insufficient diagnosis

of dementia, with particular cultural contexts playing a role¹⁸. Neurodegenerative disorders are often comorbid with depression and other mental health problems.

Mental health of caregivers

Demographic ageing can be expected to have important implications for family arrangements. The share of the very old (+80) in the total population is expected to double over the period 2000–2030 and many of them will need daily care. They will have fewer children to look after them and these may not be able to do so for professional reasons or due to geographic separation. Thus a strong development of professional care services is likely to be necessary, particularly in those countries or rural areas where most of the care for the elderly is still being provided within families.¹⁹

According to a 2007 Eurobarometer survey, 47% of people over 65 years reported that they had personally been in need of some regular help and long-term care over the last ten years.²⁰ A significant proportion will receive this help from another older person: in 2002, 13-16% of Europeans over 65 reported caring for ill, disabled or elderly in the home.¹¹

Care in the family home brings with it particular physical, psychological, social, and financial strains, and family members (usually women) often have to sacrifice a great deal to look after relatives. The problem is exacerbated by a lack of proper preparation and insufficient financial, social and emotional support for carers. Consequently, caregivers show an increased risk for physical and psychological ill-health that suggest a need for more effective support to help them avoid becoming ill themselves. In fact, almost 25% of family caregivers present clinically significant levels of anxiety.²¹ General health problems and physical injuries such as strained backs associated with lifting are also frequent. Furthermore, informal carers of people with dementia are likely to have higher levels of stress and burden, and to report higher levels of depression or fatigue.²²

The negative impact of care-giving can span across the lifetime. For example, as they themselves get older, informal carers of people with dementia, who have interrupted their working lives to look after a relative, are at increased risk of poverty linked to a reduced remunerated active life and shortened pension contributions.

Cross-cutting issues

Several issues cut across the sub-themes of this priority area and are important for the successful implementation among older people of the European Pact for Mental Health and Well-being:

1. Empowerment:

Empowerment of older people in society increases their potential for autonomous and satisfying living and is a key element of success in mental health promotion initiatives;

2. Diversity in older age groups:

There are no agreed definitions of when “old age” begins and the common understanding of belonging to older age groups has different connotations and meanings across cultures, societies and peoples. These older populations represent a heterogeneous group of individuals with widely differing life-styles, capacities, needs and attitudes. Important diversifying characteristics of older people include biological and functional age, state of health, gender, sexuality and culture.

3. Earlier intervention:

Ageing starts at birth and that the state of health in older age is largely determined by earlier life, so mental health promotion needs to start before older age to have maximum effect;

4. Social inclusion and social capital:

Social and family bonds are key protective factors for mental health among older people and provide resilience during later life transitions;

5. Inequalities and Poverty:

Inequalities in education, employment and health care, based on race, ethnicity or gender, which start early in life are exacerbated by old age. Poverty adds to other causes of social exclusion, further reducing help-seeking capacity, mobility and social capital in those who have experienced earlier inequalities;

6. Gender issues:

Attention to gender issues is another key element of successful implementation of health improving actions among older populations. Both men and women face different risk factors, are at risk of different mental health problems and encounter different barriers to receiving adequate care or support;

7. Inter-sectoral collaboration:

For the successful implementation of preventive and promotion action, efforts need to be integrated into the work of health and social sectors and broad inter-sectoral cooperation is required. The latter is especially true for the provision of effective services and care to the older people across countries of Europe. It is therefore important to establish effective referral protocols as well as providing training in the early detection of mental health problems in multiple relevant disciplines.

8. Research and knowledge base:

Involving older people in research (including the definition of research questions and intervention aims) and developing robust methodological frameworks in this area is essential for the development and implementation of effective action.

2 AN IMPLEMENTATION FRAMEWORK FOR MENTAL HEALTH IN OLDER PEOPLE

2.1 HEALTHY AGEING AND WELLBEING: MENTAL HEALTH PROMOTION IN OLD AGE

Message

A healthy lifestyle, safe living environment and meaningful, active participation in society and the community are important protective factors for mental well-being in older age. Above all, however, support from families peers and carers play a key role in promoting the mental health of older people. Prevention of loneliness and isolation is one of the most powerful strategies to promote mental health and well-being in old age. Mental health promotion measures are also important for improving physical health and successful ageing.

Mental health promotion in older age is a complex issue and will be described in several subchapters: 1) Social participation and inclusion; 2) personal factors and life-style issues; 3) older people's environment, living spaces and neighbourhoods; 4) occupational issues and retirement policies.

2.1.1 Social Participation and Inclusion

The Problem

Many older people may suffer from **social exclusion and isolation**. A large proportion of older people report feelings of loneliness (35% in one Swedish study, with 45% showing reduced subjective health) and women report more loneliness than men²³. In particular, frail older people may suffer from social isolation and loneliness, often associated with living alone and being impaired in mobility. A decline in health and changes in living situations (e.g. institutionalisation) may lead to a limited social life²⁴.

Social exclusion and loneliness impact on health negatively. A major predictor of loneliness in older age is poor mental health and depression²⁵, psychiatric morbidity, increased physical impairment, small social networks, low life satisfaction and reduced quality of life²⁶. In addition, major life events in old age such as separation or bereavement are associated with negative health effects²⁷.

Social networks have a positive and protective effect. Socially embedded older people in frequent contact with family, close friends, and neighbours tend to have better physical and mental health than those who are less involved²⁸. Furthermore, a better sense of neighbourhood and community involvement is associated with better social support, greater physical activity and lower levels of stress²⁹.

“Productivity” in older age groups takes many forms, including employment, (child) care and volunteering (see chapter 2.1.4). Volunteering can give social recognition, meaning and structure to older people and creates a sense of security and acceptance, increasing self-esteem, well-being and positive mental health³⁰. In turn, volunteering or other forms of unpaid labour such as intergenerational mentoring or child care, may benefit the recipients and society as a whole.³¹ It should be noted that most evidence for volunteering schemes comes from the USA and is not particularly strong. Given the substantial cultural differences between European countries and the US with regards to volunteering, including incentives used in the US, further European research is needed on the benefits of volunteer initiatives for older people.

Participation in education provides a stimulus to behavioural change, whether in employment or in other spheres of everyday life. The relationship between participation in learning and engagement in social

and civic activity is largely beneficial. Social networks (the units of social capital) are a basis for social cohesion and reciprocity, which work as protective factors during major life transitions.³² Hence continuing education or **lifelong learning** provides the opportunity for new knowledge, skills and competences, especially for people at risk of social exclusion. (Older) adults with low socioeconomic status (with reduced educational and occupational qualifications) and other often marginal groups (such as migrants, women and people with disabilities) should be especially targeted for integration to lifelong learning. Many older people want to participate in learning in order to keep an active mind and for the social element of attending classes and reciprocal exchange in learning. However, access and uptake of learning is highly determined by external influences and personal circumstances, such as retirement or ill-health. Barriers include cost, distance, lack of transport, timing, enforced target setting and assessment and bureaucracy. Participation in lifelong learning programmes is low among older age groups and needs to be improved³³.

Assets of learning are training in cognitive skills, increased knowledge, practical applicable skills and sociability and older people participate in formal learning for many of these reasons. The majority of older people learn informally, for example through the family (including children and grandchildren) and friends. However, social networks are decreasing in older age, with consequent negative impacts on the levels of activity, network and learning.³⁴

Principles of what works

Principles of effectiveness include:

- Empowerment and community engagement of individuals in order to (re)gain control of their own health
- Provide meaningful social and group activities such as volunteering, lifelong learning, joining of associations and possibilities
- Preventive and activating home visits
- Enable continued professional experience in older age

Empowerment and community engagement

The empowerment of older people promotes the individual ability for decision making and taking control of their health and well-being. Empowerment describes a process in which individuals (or individuals in communities) are able to express their health needs, to present their concerns and to devise strategies for involvement in decision-making³⁵.

To promote the empowerment of older people, the social participation in groups for information, exchange of experiences and learning are necessary. Self-worth must also be strengthened, in order for older people to use their personal skills and competences. Another important aspect is to promote independence and autonomy of individuals through enhancement of practical skills, access of new technologies (e.g. through training) and respect older peoples' ability to provide assistance and for autodidactic learning.³⁵

Meaningful social and group activities

Group activities with educational or practical outcomes are effective in promoting social inclusion among older people (e.g. educational inputs, skills courses). Social activation programmes, bereavement support for widowed older people, therapy-type discussion groups and peer- and professionally-led counselling/discussion groups have been shown to be effective in reducing loneliness

or social isolation in specific groups including women, caregivers, widows, physically inactive older people and older people with mental health problems.³⁶

Effective examples include: tenants in senior citizens' apartment buildings being encouraged to organise social activities and to take responsibility for domestic work increased social participation and responsibility; Self-help groups for widows with professional or peer-facilitators decreased depression and loneliness; Focus groups with discussions were effective in reducing loneliness and increases social activity, although social isolation remained high in older people with mental health problems.³⁶

Lifelong learning

Lifelong learning initiatives are effective means to increase activity, responsibility and to reduce dependency. It is the responsibility of communities, through local and national policies, to create institutional framework conditions and learning environments in which older individuals feel welcome and motivated to develop their own knowledge and skills.

Important factors which shape relationship between individual and learning organisations include:

- Learning possibilities need to have a meaningful character,
- Actively involve participants in the process of learning,
- Initiatives to increase participation of excluded older people (information shortfalls of groups which normally do not participate, such as groups with low educational background)
- Establishment of opportunities to take part in social groups (e.g. through technologies).³⁴

Furthermore, learning consultation and other forms self-directed learning show promising results (e.g. learning festivals or internet cafes, educational breakfasts). Effective approaches for learning in later life consider the know-how of older people, learning in groups/networks and learning through electronic Platforms.³⁴ In addition, projects and programmes show the best results when older people are involved in the project design and implementation, contribute to the project as networkers and trainers and when the action responds to older people's feedback.³⁵

Volunteering

Volunteering or other forms of professional activity show positive effects on older people. It is sometimes possible to retain some of the benefits from paid work after retirement through volunteering by maintaining social networks and roles. Hence, policy and organisations in the social and health sector should provide adequate volunteering possibilities for older people. Hybrid and age-based arrangements between employment and voluntary engagement are needed to allow older people to find individual solutions for their specific situations. For instance agencies for volunteer work are helpful and can connect demand and supply.³⁷ (see chapter 2.4)

Activating home visits

Home visiting programmes for older people can effectively reduce mortality and admissions to institutional care^{38,39,40,41} (see also chapter 3.3) but little is known about how they can improve mental health and well-being among older people. For instance, preventive home visit interventions (by nurses) demonstrated a reduction in social isolation and loneliness through the combination of health assessments, advice, health information and promotion and through referrals to further services if required.^{42,43,44,45}

Policies and programmes for action

Empowerment strategies

Strategies include training and voluntary placements to increase skills base and peer and project networking.

Box 1: SenEmpower

(<http://www.senempower.eu/project/>)

The aim of the SenEmpower project is to combine two aspects of civil society and the roles that seniors can play in it: Firstly, the most important risk factor for social exclusion of older people is a low level of formal education. Therefore, ways have to be found and developed to utilise informal skills to enable them to participate in community life. Secondly the contribution to social welfare of older people through self-help groups and other initiatives is tremendous but needs to be acknowledged and supported by educational offers and cooperation at community level. Given this background, SenEmpower offers training courses to members of older people's self-help groups and voluntary work initiatives to improve their skills. The idea is to encourage older people with weak family and social networks to take a greater role in society.

Box 2: Health promotion for older people in the urban setting (Plan60)

(<http://www.fgoe.org/projektfoerderung/modellprojekte/aeltere-menschen-in-der-stadt>)

Plan60 aims to improve the life quality of older people in Vienna through empowerment, activation and strengthening of their own resources. To this end, a network point and training courses were developed and offered to older people to assist individuals in the creation of their own projects for peers. In the course of the project several initiatives were installed such as a travel group for older people, library support for older people, translation of old-style German writings (Kurrent-script) etc.⁴⁶

Home visits programme

Box 3: Healthy and Active Ageing in Radevormwald – WHO demonstration project

(<http://www.aktiv55plus.de/>)

The WHO demonstration project "active55plus" aims at improving an active and independent way of living among older people in the community. The project intends to maintain and improve the quality of life in older age through increasing the degree of activity, independence and self-esteem which is positively associated with health. To realise these aims the project refers to existing resources in the community. The project is based on a twofold strategy: a multi-sectoral approach at the local level is combined with a client centred approach (individual case management by home visits). Two levels are taken into account: on the one hand the project refers to the clients' individual needs; on the other hand systemic barriers and aims to overcome them by innovative strategies are focused on at the community and regional level.⁴⁵

Group activities

Factors influencing beneficial outcomes include addressing barriers to access presented by mobility problems, peer-led activity and multi-level involvement across the political, expert and public spheres.

Box 4: Silver Song Club – Sing for your Life

(http://www.singforyourlife.org.uk/silver_song_clubs.htm)

The programme designs and delivers programmes of social music making for older people who may be socially isolated or suffering from the effects of age-related health problems. The programmes are delivered through The Silver Song Club network which operates over 30 clubs across the South East region of the UK. Clubs meet on a regular basis and sessions are led by trained facilitators supported by volunteers drawn from local amateur music groups. The sessions are open to all and are free of charge. Help with transport is available for those in need and refreshments are provided at most clubs. Silver Song Clubs operate in a variety of venues and are targeted to meet a wide range of different needs. These include sessions specifically designed for participants with late stage Alzheimer's or other degenerative mental health conditions. Sessions are also provided in secure units. The organisation is also in the process of developing Silver Song Clubs for minority groups to reflect their musical and cultural traditions.

Box 5: From Isolation to Inclusion (i2i) – (Re-)integration of isolated seniors into community life

(<http://www.i2i-project.net/>)

The i2i project identified measures which enable older people to fully participate in community life, in particular those older people with high risk of social exclusion (single, ethnic minority groups, disabled older persons, chronically ill, older women etc.). Initiatives that strengthened older people by older people were the focus. Through the combination of political impetus, expert know-how and direct links into practice, the i2i-project increased the chances for a successful implementation of socio-political measures in favour of isolated older persons.

Learning and volunteering

Successful actions include small group workshops to target and improve the uptake of learning opportunities, networks to exchange information on volunteering initiatives.

Box 6: Sustainable Learning in the Community (SLIC)

(www.slic-project.eu)

SLIC addresses the issue of increasingly ageing societies and the promotion of active ageing. The aims were to develop new, practical ways to help older adults review their past experience and personal skills and to explore new and potential opportunities for learning and community engagement. This was achieved through developing an innovative workshop model which is set out in the handbook. The main parts of the two-day workshops are to create an individual skills profile from past experience and learning and to create a personal action plan based on identifying and prioritising areas of new interest. The workshop format offers a high degree of interactivity in a secure and confidential environment with small group work identified as an ideal way of addressing diverse needs. The workshops worked well with groups of volunteers coming from established programmes and with other groups of participants. Older people not previously engaged in learning or volunteering but who were looking for new activities and older people from local ethnic minority communities all successfully took part in the workshops.

Box 7: Experience corps

(<http://www.experiencecorps.org>)

The aim of Experience corps is creating opportunities for older adults to engage in the education of children and support societal challenges through strengthening their academic skills. Tutoring, mentoring and in-class support are provided by older people, who receive a small reimbursement e.g. for transport or lunch. In an interview study of Experience corps volunteers, three main points for volunteering were reported: Besides a deep belief in the importance of helping others, the good fit with availabilities and interests of the older people and the chance to improve their own quality of live are positive aspects of the initiative for older people.⁴⁷

Box 8: Senior European Volunteers Exchange Network (SEVEN)

(<http://www.seven-network.eu/site/>)

SEVEN is an international network of 29 organisations that promote voluntary service in Europe as an educational and lifelong learning tool for senior citizens. The network includes NGOs, local governments, universities and research centres working with NGOs with at least 5 years' experience in the coordination and management of older people's volunteer programmes. The aim of the SEVEN network is to create a "European Wide Space" where all organisations involved can easily exchange information on the implementation of their mobility and exchange projects, and take part in common project proposals. Another aim is to give advice on senior volunteering to national and international institutions dealing with active ageing, educational tools, active citizenship and social cohesion.

2.1.2 Personal Factors and Life-style

The Problem

In 2002, the World Health Organization⁴⁸ identified behavioural determinants at the individual level as partly responsible for active ageing. Mental health, as well as physical health, is influenced by people's life-styles. Physical activity, a balanced diet, not smoking, moderate alcohol consumption and an appropriate use of medication, in short, adopting a healthy lifestyle, is essential to maintaining good mental health in the later years and, ideally, should be fostered by policy^{49,50}.

Impairments in physical health or a poor physical condition have a negative impact on mental health and, conversely, a good physical condition supports mental wellbeing⁵¹. There is a relationship between psychological and cognitive health and lifestyle⁵². Moreover, the subjective evaluation of personal health plays an important role in determining the individual's risk of developing a mental disorder or illness⁵³.

Principles of what works

Promote a healthy lifestyle of older people by:

- Maintaining physically activity;
- Supporting healthy eating behaviour and avoiding malnutrition;
- No smoking and no or moderate alcohol consumption.

In general, one of the keys to staying mentally healthy throughout older age is building up cognitive reserves, physical resources and remaining socially active, e.g. through reading and doing crosswords⁵⁴ and light leisure activities⁵⁵, which contribute to a level of mental activity. Socially active and integrated older people with stable social networks enjoy enhanced psychological health. Especially for many older people, religious affiliation and church attendance plays another important role.⁵⁶ (see also chapter 3.1.2)

Physical activity

Within the behavioural determinants for mental health, physical activity (e.g. aerobic, moderate intensive exercise) shows the most evidence for mental health promotion. Regular exercise has favourable direct and indirect effects on wellbeing, mood, memory and cognitive function^{57,58,59}. In addition physical exercise can improve sleep quality and is associated with a decreased risk of clinical depression. People, who are more active have a higher self-esteem and judge their mental well-being as far better⁶⁰.

Balanced nutrition and group mealtimes

Nutrition and a healthy diet also contribute to a better quality of life, better physical performance and a healthy body weight^{49,61}. Of additional importance is the relationship between malnutrition or a poor and unbalanced diet and social isolation, lack of motivation, loneliness, and depression⁵⁷. Eating is perhaps quintessential bio-psycho-social behaviour, and while evidence is emerging for the neuro-protective role of a number of nutrients and balanced diets⁶², social aspects of family or group mealtimes is also an important factor for mental health promotion.

Smoking

Furthermore, not smoking is associated with healthy mental ageing⁶³, whilst smoking is strongly linked with poor mental health⁵³.

Moderate alcohol consumption

While moderate alcohol consumption appears to be related to some protective factors for mental health, high alcohol consumption is associated with symptoms of depression. Problematic alcohol use can be a contributing factor and a consequence of mental health problems such as stress, depression, anxiety and as a consequence is a risk factor for suicide^{64,65,66}. (See also chapter 3.2)

In general, large-scale and sustained national or regional mental health promotion initiatives are needed in Europe⁵² and behavioural change on individual level must necessarily be accompanied by a transformation of the environment. Therefore living spaces, services, communities and, as a consequence, policies have to be modified⁶⁷ and institutional relationships and networking should be encouraged⁶⁸. The positive impact of policies and programmes will be improved if older people themselves are included in the planning phase of policies and programmes affecting them.⁵²

Above all, only an interdisciplinary approach, including relevant local authorities and political departments with actors in fields of social, employment, discrimination, research and education, can guarantee long-term solutions⁶⁹. It must be ensured that policy makers take an integrated perspective (see chapter 3.3). Furthermore, health care professionals need to be empowered as well as families and service users to tackle mental health challenges.⁵¹

Policies and programmes for action

The following actions are recommended to promote **physical activity** for older people:

- Provide appropriate and accessible information on physical activities for older people
- Offer, and make accessible, informal and low-demand exercise opportunities such as walking, dancing, hiking, bowling or swimming
- Organise and offer sporting activities with the older population by well known and accessible local services, such as sport clubs and senior organisations.

Box 9: Thematic Network for Adapted Physical Activity (THENAPA)

(<http://www.kuleuven.be/thenapa/> & <http://www.thenapa2.org/>)

The European Thematic Network "Educational and Social Integration of Persons with a Handicap through Adapted Physical Activity" tries to improve the integration of persons with a handicap by means of adapted physical activity and sports in all European countries. Another objective is the improvement of the formation of experts and between initiatives in this field. The aim of THENAPA II is to collect and bring together information concerning physical activity and sport for older adults and to make the identification and the fulfilment of relevant educational programmes possible. THENAPA II products are Active Ageing Activity Cards, motivational DVD "Never Too Old To Be Active, The Joy of Movement", a brochure with THENAPA II Recommendations and a European Master in Adapted Physical Activity for the Elderly (interactive curriculum).

Box 10: Walking the way to health initiative project

(<http://www.whi.org.uk/>)

This five year, nationwide project in the United Kingdom, which started in 2000, was initiated by the British Heart Foundation. The main aim was to motivate older people to become more active and to walk more within their own communities. 200 separate local schemes have been developed. The project has been evaluated through a prospective survey and people who participated in the project named the following aspects as positive to their mental health: social contacts, increased sense of well-being, improved joint problems and mobility, incentives to get out, and sleeping better.

Box 11: Life Quality in old Age (LIMA)

(www.bildungswerk.at/lima/0)

LIMA (Lebensqualität im Alter) is run by the Catholic Education Institute in Austria (Katholisches Bildungswerk Österreich). It aims to promote physical activity and mobility through group based behavioural training of body, mind and soul and to contribute to the autonomy of older people. The project has developed holistic training courses on a theoretical basis (SIMA handbooks) and older volunteers were trained to offer these to the peer groups of older people. The courses are offered in catholic services with different course modules such as:

- memory training (concentration, memo-techniques, attentiveness),
- fitness training (bodily fitness, breathing exercises, dancing, games and fun, perseverance and stamina),
- training of everyday competences (living situation, healthy nutrition, social contacts, information on support networks), and
- questions of meaning and beliefs (anxieties and doubts, hopes and wishes, meaningful structuring of life, partnership, sickness and death, loneliness).

Box 11: Big!Move

(www.bigmove.nu)

The Venserpolder health centre in Amsterdam has developed a vision of primary care focused on health promotion, alongside its usual medical care and disease treatment. A separate health promotion department has been set up and has developed a new method called Big!Move. The project forms a bridge between health care and individual participation in local activities in the neighbourhood, focusing on healthy behaviour and “people power”. During the course, participants are encouraged to participate in local activities and to organise activities themselves. People can participate in dance activities at local community centres or in swimming, walking or cycling groups. There are also special groups for very old people, which convene in residential homes.

Promote a healthy diet and eating habits

- through improving access to fresh and affordable foods (e.g. meal or shopping services)
- family style mealtimes

Box 12: Healthy nutrition in old age

(<http://www.healthproelderly.com/database/plists/singleview/218>)

The main aim of this Slovenian project was improve the education of older people on healthy nutrition and also to facilitate their cooking healthy meals. Participants learned about the associations between nutrition and healthy ageing. Different meals and menus were prepared together with experts. Evaluation by family doctors showed fewer health problems for people who attended the nutrition courses.

Box 13: Delicious Life

(<http://www.healthproelderly.com/database/plists/singleview/39>)

The goal of this project, from the Czech Republic, was to improve the knowledge and cooking skills of older people to encourage a healthier diet, to enhance their physical activity and increase their motivation to maintain a healthy lifestyle. The project was based on the findings that dietary habits of older people are often inappropriate and their improvement requires not only a nutritional but also a social impact. “Delicious Wednesdays” were held, comprising a short physical warm-up, educational lectures on healthy diets from cuisines around the world (Greek, Italian, Asian etc.) and practical lessons on their preparation with tasting sessions. The lectures were given by dietary experts, or by older people themselves. Participating centres organised “Delicious Wednesday” sessions using a common methodical approach, but always with variation in certain specific elements. The interactive participation of seniors led to their increased activity. Participants selected recipes, prepared food and ate together. Participants in “Delicious Wednesdays” were involved in the development of a desk calendar, which contained the most successful recipes, advice and other health promotion ideas.

2.1.3 Living Spaces, Environment and Neighbourhood

The problem

Adequate housing is a basic factor for mental health and well-being. Living spaces and their design are integral to the life satisfaction of older people. Even small inconveniences in people's own rooms can contribute to stress levels, feelings of discomfort and poor mental health, and, if they accumulate, to mental disorders.^{65,70}

A high number of older people wish to stay in a familiar environment for as long as possible in later life, to preserve their orientating landmarks, neighbours and community. Across the different European health care systems older people in social security systems live at home to a large extent (e.g. 90 % in Germany and 75 % in Austria).^{70,71,72} In general, only a small percentage of older people are accommodated in alternative or institutional housing, although it is probable that the need for alternative housing will increase in the future with the ageing of the European population and an increase in numbers of very old⁷¹. Considering the growing number of people with mental and cognitive disorders, ethical questions have to be kept in mind too. Interacting factors which are beneficial to individuals, for example, independence on the one hand and security on the other hand, have to be weighed up and decisions for optimal personal living and housing have to be made.⁷³ (see chapter 3.1.2)

Enabling those with mental disorders to carry on living in their homes for as long as possible has health promoting potential⁷⁴. Despite this being the option being favoured by most old people, it still does not receive the policy attention it deserves.⁷⁵ On the other hand, living in an institutional housing facility or home with on-site professional assistance usually provides shelter and the feeling of security. This is very important for the mental health of older people, particularly for some older women, who may feel insecure and vulnerable on their own⁷¹.

Physical environments, in urban and rural settings need to be safe and appealing to older people to enhance their mental health and well-being. Spending time in natural surroundings can have positive effects on people's moods, and also seem to have benefits for those suffering from mental health problems such as stress or psychological fatigue.^{76,77} Consequently, the physical design of rural and urban living spaces has to meet people's needs in order to influence the mental health of older people in a positive way⁷¹. Green places, especially in cities, gardens with water installations and a variety of foliage, appear to have a mental health promoting effect⁷⁸. Moreover, such environments offer pleasant visual experiences, reduce environmental noise and improve air quality.⁷⁴

Principles of what works

- Provide adequate housing options
- Create socially attractive neighbourhoods
- Offer healthy physical and natural environment

Adequate and ample housing options

Structural (location, rural/urban, barrier-free), social (neighbourhood, community), financial (costs) and subjective (autonomy, mobility, security, integration) factors play an essential role in housing choices. In addition, aspects such as the possibility of receiving assistance in the household or to engage care have to be considered.⁷⁰

For instance, retirement/sheltered houses (20 to 40 flats or bungalows located next to each other, e.g. for people with dementia) with communication centres where people can meet and spend time together (e.g. in social events) can lead to higher self-determination, autonomy, security and advanced quality of

life⁷⁹. Extra care sheltered housing is organised in self-contained flats in which people can receive support and independence, and where caring staff is available. Other housing options are Park (mobile) homes, buying retirement housing or renting from the local authority, from a housing association or from a private landlord. Moreover, there is a possibility for some older people to move in and live together with relatives in one house.^{71,79,80}

In addition assisted living approaches (services for care, housekeeping or transport, new technologies) have shown good results as an intermediate option between independent living in the community and nursing care.^{71,81} In addition, new technologies can enable older people to feel that they live in a safe and secure environment at home (e.g. through monitoring options, e-health or e-care programmes): For instance, electronic sensors have been developed that inform care providers or family members whether or not an older person has left their bed, has fallen/been injured or exposed to another health risk. Verbal messaging units can remind people with memory impairment. Although IT literacy is still not as often used in higher age than in younger age groups, the internet represents a new medium which can help older people to maintain social contacts or to find useful information, once IT literacy deficits can be eliminated.⁶⁹

Socially attractive neighbourhoods

Concerning the direct social environment, the sense of community, friendly people and access to health services and safe places are of utmost important for older citizens. Adequate footpaths, accessible transport, crime-free environments and facilities and spaces for people to exercise, meet and interact , such as 'walking friendly parks', offer greater opportunities to stay in shape, enjoy acquaintances and regenerate⁸² if requirements such as relaxation, recreation, calmness, security and mobility are met^{78,83}. Therefore, individual needs and satisfaction with the community need to be guaranteed.^{29,77,83,84}

Healthy environments

An optimal natural environment to improve mental health turns out to be clean, free of waste and pollutants. Public places have to be safe, lighted, accessible (e.g. well-connected with public transportation) and clearly arranged.^{78,83,74,85,86}

In general, political actors, local authorities, health bodies, housing associations and voluntary agencies have to work as strategic partners in developing and providing healthy environments, also in public health services⁷⁵ (see chapter 3.4). It is essential to involve diverse community voices, including older people, in planning and the design of internal and external living spaces, and to implement strategies, which are favoured by the community⁸⁷.

Policies and programmes for action

Housing options and living conditions

The following recommendations are made to enable older people remaining in their own homes:

- Establish and communicate different housing options to older individuals and couples and provide customer friendly financing systems
- Adopt new technologies in peoples homes
- Ensure equity in standards of living (comfort, mobility, heating)
- Provide supporting systems such as home help services, meal, shopping or other transport services

Box 14: eIDeRly-friEndly Alarm handling MonitorING (DREAMING)

(http://www.dreaming-project.org/pilot_sites.html)

The aim of this project is to keep people in their own homes as long as is possible. Besides the use of new technologies, older people are supported through social health services, such as visits by community nurses and social workers, psychological support, delivery of hot meals and shopping, special transportations for people with limited mobility and house cleaning. Technologies used include an environmental monitoring system, which detect movements in the flat and report sudden changes to normal pattern to the Contact Centre. In addition, a mobile alarm and localisation system with integrated fall detectors are measures adopted. The project is being piloted in Denmark, Estonia, Germany, Italy, Spain and Sweden, with the outcomes of the set interventions measured through a randomised controlled trial.

Box 15: The Ambient Assisted Living (AAL) Joint programme

(<http://www.aal-europe.eu/about-aal>)

The objective of AAL is to enhance the quality of life of older people through the use of information and communication technologies (ICT). ICT-based products are helpful in assisting older people in carrying out daily activities. Moreover, they allow older people to live in their own homes for longer. Twenty European Countries are involved in this project which helps to reduce the costs of health and social care in their areas.

Social neighbourhoods

- promote social contacts and self-help activities in the neighbourhood (e.g. two-way visiting plans or telephone chains)
- establish community meeting points (e.g. activity centres) for older people and give them ample chances to participate in the community

Box 16: European Neighbours Day

(<http://www.european-neighbours-day.com/>)

The European Neighbours Day aims to strengthen community cohesion and create exchange networks for community practices in Europe. It takes place on the last Sunday in May and offers the chance for increased neighbourhood solidarity. Towns, cities and social housing organisations encourage people to organise neighbourhood parties, where residents come and spent time together. This event is organised with the support of Cecodhas, EuroCities and the Committee of the Regions, and endorsed by the European Commission.

Box 17: Growing old in a good and self-determined way in an urban setting (sALTo)

(<http://www.wien.gv.at/stadtentwicklung/grundlagen/stadtforschung/sozialraum/salto.html>)

The project was put into practice between 2006 and 2008 in two districts of Vienna. Measures were developed to encourage active and self-determined ageing, in cooperation and consultation with many stakeholders in the city. In the end, the ideas were implemented together with the target group (the focus was on mobile older people and migrants). To guarantee sustainability, district ownership and participation was fostered and the implementation was based on the available resources in the districts. Despite health issues like diet, depression etc. older people were empowered to engage themselves. For instance older citizens created an intergeneration park bench where people can meet on a regular basis, an intergenerational sports festival, pictures for local institutions. They also created green living spaces by planting plants.

Environment

- Establish green spaces and parks with different plants and water installations that are accessible for older people
- Reduce noise and pollutants
- Increase safety through well-lit, barrier-free and clearly arranged public places
- Support transport schemes for older people

Box 18: Thematic town twinning project on older people's needs

(http://eacea.ec.europa.eu/citizenship/index_en.php)

The Europe for Citizens town twinning programme funds a thematic exchange project which brings together local authorities and older citizens groups from Grosseto (Italy), Woluwé St. Lambert (Belgium) and Wexford (Ireland). The town twinning project focuses on the daily life experience of older people in these cities and their active participation in the development of local policies. The project aims at facilitating an exchange of views on the policies implemented by local authorities to help older people live independently, exchange good practice in areas such as older volunteering, lifelong learning, intergenerational activities, heritage, care and informal carers, new technologies, relations between generations within the family and in the community, sustainable partnerships for home care, long-term care, dependency insurance, gender equality, age friendly cities, innovative services, etc.

Box 19: Potentials for a Spatial Development under the Aspects of Decline (HINTERLAND)

(<http://www.hinterland-info.net/index.php?css=normal>)

This project aims at the development of rural Baltic Sea Regions. The population there is over-aged and less active. Houses and infrastructures as well as the economic and social activities are very bad. Strategies through future settlement structures according to landscape, agriculture aspects, rural-urban business relations, infrastructures and transport schemes are developed and applied in pilot activities.

Box 20: EUROCITIES Demographic Change, Urban mobility and Public Space project

(<http://www.eurocities.eu/main.php>)

Eurocities is a platform or a network where European cities come together and develop innovative solutions through a wide range of policy areas. This project represents a comparative Study due to Demographic Change, Urban mobility and Public Space from five European cities (Berlin, Copenhagen, London, Vienna and Zurich). A set of key areas for action have been identified. It is committed to promote more sustainable and integrated urban transport systems, to provide citizens with convenient and accessible public transport, and to protect the safety of pedestrians and cyclists.

Box 21: QeC-ERAN Network

(<http://www.qec-eran.org/>)

Qec-ERAN is a network of towns with the aim to promote the revitalisation of disadvantaged areas through an integrated approach. Politicians, technicians and local residents are involved in that process. Qec-ERAN plays a key role in the URBACT programmes and remains committed to be a leading edge according to the changing realities in regeneration areas. It is one of the key players in the URBACT programmes.

2.1.4 Occupational issues and retirement policies

The problem

Beside the influence of genetic, environmental or lifestyle factors, life events also have an effect on mental health. For older people, the transition from employment to retirement has to be highlighted as such a life event, with an impact, for better or worse, on mental health⁸⁸. Employment often gives people a sense of accomplishment and of being a useful member of society. Moreover, through employment people may be integrated into a larger social environment and with positive outcomes self-identity⁷⁷, and retirement can lead to isolation and loneliness because the number of social contacts and relationships are reduced⁵⁷. On the other hand, the level of activity and input of time required by employment may reduce individuals' time for family and social interaction and make a job physically or mentally demanding, and, especially in rural communities, retirement offers an opportunity to many people to relax and reap the long-awaited rewards from a lifetime of working.

Retirement is usually accompanied by a lower level of income. In numerous European countries retirement is a risk factor for poverty⁸⁹. In addition, some countries in Europe have recently contributed to this by promoting early retirement in order to reduce unemployment⁹⁰. As a result, people have to minimize living standards or continue working illicitly, in order to manage their lives with such low incomes⁸⁸. Economic and social disadvantages are still higher for forced retirees. There is a statistically significant relationship between being forced to retire and poorer mental health outcomes.⁹¹ There is a widespread view that productivity decreases during the process of aging⁹², and retired people are often marginalized from productive work, while having more available time than ever before.⁹³

One of the main problems reported in this transition period is the lack of institutionalized responsibility. Retiring people are left to orient themselves in their new position, instead of getting organizational support e.g. from social welfare institutions. This orientation often takes a long time and older people look for possible ways of contributing to society for many months⁹⁴.

Principles of what works

- Provide other forms of productivity such as:
 - Volunteering, lifelong learning and intergenerational opportunities after working life
 - Assist older people in retirement planning, in a timely manner and on a local level
 - Provide flexibility in the plans for older people to retire or continue working

Volunteering, lifelong learning and intergenerational opportunities

Evidence from the USA suggests that for many older people, volunteering may be a meaningful option to promote mental health and well-being; Women who participated in a voluntary organization had a greater longevity than those who did not.⁹³ Moreover, higher levels of well-being and an increase in life satisfaction can be identified, in those who volunteer⁹⁵. Reasons for such positive effects could be a sense of social status, productivity and social integration⁹⁶, increased self-esteem as well as social and intellectual stimulation⁷⁷. As previously noted, these results have yet to be replicated in European research, given that significant cultural differences exist between volunteering in the USA and Europe.

Experts highlight lifelong learning and acquisition of new skills as key means to remain active and productive³⁴. Lifelong learning, with courses, classes and assignments, can lend structure to older people's lives, as well as giving them skills which enable them to retain autonomy, independence motivation and interest in life. In addition, projects which support autobiographical work can be effective in promoting satisfaction in later life.⁹⁷

Intergenerational work among the older population is a chance for them to take a meaningful role in society as well as making the most of valuable life experience they have. For instance, supporting the well-being and educational outcome of pupils in schools through tutoring, small-group reading or organising quizzes enriches life of both parties enormously. In addition, teachers, other educational staff and parents are assisted⁹³ and knowledge, experience and social competences of the older and young people and society are increased.⁹⁷

Assistance for retirement after full working life

First of all, it is important to provide adequate working options for older workers to maintain their productivity and to delay the process of retirement. Moving posts within the workplace or working between two parts can be means by which to accomplish this.⁹⁸ Moreover, an increased control over work and a balance between efforts spent and rewards received are important for the mental health of all workers⁹⁹, and need to be safeguarded in older workers too. For the individual deciding to retire after a full working life (i.e. at the national age of retirement), organisational support ranging from assistance with social welfare institutions throughout the whole process of retiring, with the chance to ask specialists (e.g. employment agencies, peer volunteers) for further advice is empowering.⁹⁸

Flexible retirement or working schemes

There are several flexible working schemes which employers can offer to their employees, such as part time working, job sharing, downshifting, sabbaticals or secondments. Downshifting means reducing workplace responsibilities and changing the job/position within the organisation. In a sabbatical employees are given time off to travel or for further education.

Policies and programmes for action

The following measures may be taken to promote mental health through the occupational sphere and employment/retirement schemes:

- Establish institutional support for the transition from employment to retirement.
 - Promote social inclusion of older people and create opportunities for their social participation, such as the establishment older people's councils and community boards or just by the promotion of social networks, including internet based ones
- Promoting meaningful activities of older people, such as:
 - Introduce flexible retirement schemes, which enable and encourage people to continue their professional activities in ways adapted to their possibilities and needs;
 - Promote and create incentives for older people to provide intergenerational support to younger generations, for instance by involving in childcare in collaboration with schools and day care centres.
 - Promote opportunities for volunteering, training and life-long learning; (see also chapter 3.1)
 - Enable old people to maintain professional activities

Promote employment of older workers and active ageing

Box 22: Intergenerational camps

[\(http://www.skupine.si/en/programi/tabor/\)](http://www.skupine.si/en/programi/tabor/)

In this Slovenian project, older volunteers spend some time in holiday camps made up of trios (not relatives) from 3 generations with the aim of normalising older age and promoting intergenerational bonding as well as their quality of life. The dynamic of young people on the one side, and the experiences and wisdom of older people on the other side provide optimal conditions to transfer conditional values and vitality.

Box 23: Learning with older people

Learning with older people is a Spanish project targeting in promoting knowledge and understanding across generations. Several collaborative activities in care homes and schools are provided to allow interactive and intergenerational growth. For instance, children visit older people in care homes.

Box 24: NHS retirement schemes, UK

In the United Kingdom the National Health Service (NHS) provides the following five flexible retirement options for their employees over the age of 50:

- “Winding down” describes a decrease in working hours and days. People work part time and accrue special benefits for later retirement.
- “Stepping down” can be especially interesting for employees in higher positions. They get the chance to give up the pressure and responsibilities of their current position and can opt to step to a less demanding, lower graded and lower paid post, which also fits to their skills.
- “Retire and come back” is the possibility to retire, take the pension and then leave the pension scheme in order to work again.
- “Draw down” is only a possible option for the members of the 2008 pension scheme of the NHS. People continue working as an NHS employee but also take parts of their pension.
- “Late retirement enhancement in 2008 Section of Scheme” means that people get an increased pension benefit if they choose to retire after their 65th birthday.

In general, UK NHS gives retired older people the chance to work in their organizations how much and as long as they want in order alleviate them the crossover period.^{100,101}

Box 25: MATURE@eu

[\(http://www.mature-project.eu/\)](http://www.mature-project.eu/)

The aim of mature@eu-Supporting employers is to establish an evidence base for redirecting recruitment policies and the selection process of candidates, for the benefit of marginalized older workers in the labour market. Local actors from Austria, Bulgaria, Germany, Greece, Hungary, the Netherlands, Slovenia, Switzerland and the United Kingdom are involved. Moreover, age diverse employers are presented to stakeholders.

Box 26: PATRON

<http://www.patronproject.org>

PATRON targets intergenerational learning and the transfer of skills and knowledge from senior managers to young entrepreneurs and managers. The project will identify and test ways of transfer of the skills that senior managers and entrepreneurs have developed in their working life, and had helped them to develop their creativity, competitiveness and management and entrepreneurial skills. Young entrepreneurs and managers will receive the transfer of these skills in the technical participant countries and regions and the methods and results will be disseminated as to be employable in other participant regions. The project has partnerships in Czech Republic, Italy, Latvia, Lithuania, Poland, Slovakia and Spain.

2.2 PREVENTION OF MENTAL DISORDERS AND ADDICTIONS

Message

Prevention of the most common mental disorders involves addressing the risk factors for mental health problems in old age, such as chronic diseases, physical impairment, and improving help seeking (for example, through combating stigma), early detection and intervention, before mental health problems emerge.

The Problem

Common mental disorders in old age

Mental disorders, and especially depression and anxiety, are a common cause of reduced quality of life and excess mortality in old age^{102,103,104}. They are characterized by high prevalence (up to 15 % of the general elderly population have clinically significant depressive symptoms^{105,106} and up to 15% have an anxiety disorder^{107,108}), poor prognosis^{109,110} (only one third recover completely from depression after 2 years¹⁰³), intense impact on functioning (comparable to or worse than many chronic medical conditions such as heart disease, arthritis or diabetes^{111,112}), increased use of medical services^{102,113}, and are associated with cognitive decline^{114,115}.

Findings from different prospective and cross-sectional studies show that depression and/or anxiety in old people living in the community is associated with a number of (risk) factors, such as^{116,117,118,119}:

- living with functional impairment,
- being bereaved or unmarried,
- having a number of chronic illnesses,
- antecedents of prior mental disorders or
- being a woman.

It is well known that physical health, in particular, has a strong impact on the mental health of older people^{120,121} and that chronic disorders can exceed the impact of other risk factors^{122,123}, being also predictors of both the onset and persistence of depression^{122,124}. When suffering from physical health problems in old age, the availability of accessible and coordinated health and social services is of high importance to reduce a potential negative impact on mental health, as it is also the ability of the older person to self-care for the disorder or to follow medical recommendations. This capacity is strongly affected by factors such as health literacy^{125,126,127}, a strong predictor of mental and physical health among community-dwelling older adults¹²⁸ and which is not widely present in this age group.

Older people living in long term care facilities are also a group of special risk of developing depressive disorders, a fact that has been linked to more frequently occurring chronic physical illness, social-environmental or care-related factors^{129,130}. Among nursing home patients, prevalence rates range up to 26% for major depression, and up to 50% for minor depression, as measured by symptom rating scales¹³¹. The risk of depression in these groups has specific patterns that should be monitored and targeted, including:¹³²

- health related factors like pain, visual impairment, stroke and functional limitations,
- lack of social support and loneliness
- perceived inadequacy of care

- recent negative life events
- sub- threshold depression
- age below 80 years.

Another finding of special concern is that common mental disorders often remain misdiagnosed, ignored or inadequately treated¹³³. Less than 20% of depressed old people in the community are detected or treated^{103,105,120} and fewer than 50% those with clinically significant mood disorders are properly diagnosed in primary care¹³⁴. Symptoms are too often confused with somatic complaints and also perceived by older people, their families, or even by professionals, as an inevitable aspect of the ageing process, rather than as health problems which can be addressed and treated.^{135,136}

A growing number of arguments demonstrate that prevention of common mental disorders in old age should be given stronger priority in national/regional health plans and budgets. Some of them are listed below:

- A large number of cases of old age depression (up to 1 out of 5 each year) are new or recurrent, rather than chronic cases, which are susceptible to prevention interventions^{119,137}
- Prevention has the potential to impact considerably on the burden of disease caused by depression. Even the most optimal treatment conditions will not reduce the total burden of depression by more than 50 %¹³⁸.
- The evidence for the effectiveness of preventive interventions in depression is growing. Well designed interventions have been shown to reduce the onset of new cases of depressive disorder by up to 30%¹³⁹.

Medication misuse, alcohol problems and addiction

Alcohol problems and misuse of medication can cause or aggravate mental health problems in older adults¹⁴⁰, and, conversely, psychological, social and health problems experienced in old age can serve as risk factors for alcohol, substance and medication misuse.^{141,142}

Older adults are frequent users of alcohol and frequent recipients of prescribed and over-the-counter medications¹⁴³. Older people frequently hold repeat prescriptions for medications to treat chronic of painful conditions. These medications can also be dependency forming. The 2007 Eurobarometer survey estimates that 27% of European people aged over 55 years had drunk alcohol daily in the previous month, compared to a European average of 13% and 16% had several episodes per week of binge drinking (5+ drinks of 50g alcohol on a single occasion) during the previous year (compared to a European average of 13%)¹⁴⁴. There are also reports of increasing illicit drug use in older populations¹⁴⁵. The combined use of alcohol and other drugs leads to an increased risk of social, psychological and physical health problems, and may adversely affect the neuro-cognitive developments associated with ageing, even where alcohol intake is light or moderate¹⁴³. This is further complicated by the fact that older people metabolise drugs more slowly and appear to be more sensitive to drug effects and side effects¹⁴⁶. Conversely, moderate alcohol consumption is associated with important benefits for the elderly, which should not be overlooked, such as association between moderate drinking and social contact and support, as well as a reduced risk of developing Alzheimer's disease and vascular dementia^{147,148}.

Alcohol and substance use problems in the elderly may be under-detected because of pre-conceptions (alcohol use perceived as a normal response to poor health and life circumstances), a lower degree of suspicion when assessing older people and atypical or masked symptoms (confusion, falls, injuries, etc).

While the number of older people with substance use problems or requiring treatment for a substance use disorder is projected to more than double between 2001 and 2020¹⁴⁵, services for treatment of alcohol and substance use problems are currently set up to deal with younger users who appear to have distinct needs and priorities.

Suicide

Although changes in late life suicide rates are variable across Europe, there is a general trend in industrialised countries towards increasing suicide rates with increasing age¹⁴⁹, with the highest rate occurring in men aged 75 and older. In addition, a far higher proportion of suicidal acts are fatal among older adults¹²⁰.

Risk factors for late life suicide are:

- affective disorders
- physical illnesses, especially those which are associated with chronic pain and decreased mobility
- social stressors (family discord, relationship problems and financial strain)
- alcohol problems¹⁵⁰

Protective factors are:

- robust social supports (lack of social support represents 27% of the population attributable risk¹⁵¹)
- having a confidant

The assisted living community, whilst fostering independence and self-determination, which can promote well-being, can, simultaneously, be an environment in which older people experience loneliness and social isolation and the warning signs for suicide can be missed¹⁵², representing a strong argument for attention to the quality of community care.

Principles of what works

Screening and early detection of mental disorders and associated risk in relevant settings

The development of **setting specific protocols** for early detection of common mental disorders, as well as **training** and **ongoing support of key actors** increases the commitment and subsequently the probability of success in prevention and treatment.

- The screening of patients in primary care for depression has been shown to be feasible and effective, when included within disease management programmes^{153,154} or staff-assisted depression care supports¹⁵⁵.
- Early identification of alcohol and substance use disorders in primary care is also recommended and can be facilitated by the use of specific instruments such as CAGE and MAST-G.
- A number of instruments, such as the *Centre for Epidemiologic Studies Depression Scale*¹⁵⁶ or the 15 item version of the *Geriatric Depression Scale (GDS)*¹⁵⁷ have also been validated for case finding and can be used by different community professionals, such as those responsible for home care or day centres.
- Specific training programmes which cover the distinct features of mental disorders in old age should be available for primary care professionals

Indicated/selective psychological interventions with multiple access points

Selective and indicated preventive interventions for depression appear feasible, more cost-effective, and have shown good results with reductions in the incidence of depression of up to 22%^{124,158}. It is important that interventions should be **targeted at proven high-risk groups**.

Some **low-threshold brief psychological interventions**, in particular, those involving **cognitive behavioural techniques**, are effective in preventing depressive disorders in older people at risk¹⁵⁹ across a **broad range of populations and settings**^{160,161} such as community centres, primary care, homes, or long-term care facilities.

Examples include:

- individual therapy for those bereaved^{36,162},
- educational interventions for subjects with chronic illness^{163,164},
- cognitive behaviour interventions to reduce negative thinking^{165,166}
- life review^{137,167} (where there is no evidence of past suicide attempts)
- Bibliotherapy has also shown good results for those suffering mild symptoms of depression in the community¹⁶⁸.

Interventions to improve the management of chronic illness and to reduce its effects on mental health

Specific models of care, such as the *chronic care model approach* have been shown to be effective in tackling depression among older people with long term physical conditions¹⁶⁹. They include:

- Stepped care approaches based on evidence based protocols, screening of high risk groups, integration of specialists into the primary care team, or specific clinical case management for patients with complex needs^{170,171}.

Several **health promotion measures** aimed at **improving self-management of the chronic illness** have been found useful in improving the mental health and reducing the risk of subsequent mental disorders. They include:

- They include generic and disease specific education sessions or “health literacy” programmes¹²⁸
- Raising awareness of mental disorder prevention opportunities in medical practice (for example, considerations for the mental health of those with chronic physical conditions)

Nursing Homes: Evidence based interventions

Adequate **alleviation of pain, physical impairments, such as sight or hearing loss**¹⁷² as well as interventions to combat **loneliness** should be given special attention and be a major goal in developing a care programme also for patients a nursing home setting.

There is evidence that some forms of psychological interventions can alleviate depressive symptoms and prevent depression in nursing homes residents. These include interventions based on cognitive behavioural techniques, life review sessions, as well as support groups and educational activities for residents.

Additional Specific factors which can improve the mental health and prevent mental disorders in older people's residences include: ¹⁷³

Helping residents to keep their **identity**:

- have their own possessions
- attend local faith communities
- wide range of cultural, dietary and spiritual options
- encourage the maintenance of interests and skills

Encourage **networking**:

- Visiting hours
- Visitor schemes
- Activity programmes

Workforce development to ensure the adequate capacity and skills of personnel:

- Training (especially communicative skills training for those working with people with dementia and acute hearing and/or sight loss)
- Support
- Measures to reduce staff turnover

Homes should develop good **links with local specialist services**:

- Community mental health teams for older people
- Access to GPs

Prevention of alcohol and substance use problems

Managing **prescriptions** and medications:

- Monitoring of repeat prescriptions and multiple medications. – annual or 6 monthly (for multiple prescriptions) **medication reviews** (e.g. National Service Framework for Older People – UK March 2001: “All people over 75 years should normally have their medicines reviewed at least annually and those taking four or more medicines should have a review 6 monthly”¹⁷⁴)

Providing **older-age-appropriate addiction treatment/harm reduction** services:

- Raise **awareness** of older age addiction in primary care and A&E
- Attention in addiction services to **comorbid problems with substance use** (e.g. chronic physical illnesses): basic medical attention or referral to a medical specialist.
- Age-specific dose regimens for detoxification
- **Same-age settings** for alcohol addiction treatment attain better results¹⁷⁵

Prevention:

- Prevention aimed at specific vulnerable situations or moments (transition to retirement, changing roles, illness, losing relatives, etc) where intensive interventions can be applied.
- Supporting policies and programmes that intervene in middle age, at the work place, community and primary health care settings as alcohol problems in later life are consequent on earlier consumption.
- A combination of **price increases and brief interventions** for hazardous and harmful consumption are the best approaches.

Prevention of Suicide

Strategies aimed at preventing suicide in the general population, including the **adequate follow-up of attempted suicides**, are also applicable to the older populations in Europe. For a detailed discussion of such approaches, please see the background paper for the EC Thematic conference on the Prevention of Depression and Suicide.¹⁷⁶

Beyond the measures aimed at the general population, several specific approaches are geared towards the prevention of suicide among older age groups:

- Universal prevention through education programmes to **reduce stigma** associated with seeking help for emotional distress and loneliness, **remove access to immediately lethal means** and **improve access to quality health care**.¹²⁰
- **Improve the detection and treatment of later-life depression** – especially in primary care settings – for example through training modules, on-hand information, quick screening tools and decision support for general physicians and nurses. Certain therapeutic methods, such as those which broaden the individual's options in decision making, concurrent family and individual psychotherapy and stepped care models have also been found to be more effective in reducing depression and suicidal ideation in older age groups¹⁷⁷.
- **Selective preventive interventions**, targeting specific groups of older adults at risk for suicide because of their social isolation, recent losses, pain, or functional impairment appear to be effective for older women. In addition, there is some evidence that community-based suicide prevention, involving group activities, is effective in reducing suicidal risk in older women, but not men.¹⁷⁸

There is a need for **further European research** in this area. The scientific knowledge base is geared towards American and Japanese populations, which have distinct characteristics in suicide trends and the availability of means. The European Alliance Against Depression, whilst presenting promising results in the general population, requires investigation with regards to effects in the group at highest risk of suicide: older men.

Policies and Programmes for Action

Make available low threshold psychological interventions to prevent depression and/or anxiety in high risk populations

Implement evidence based brief psychological interventions to prevent depression and anxiety in high risk populations, specially those with sub-threshold symptoms, but also additional risk groups such as the bereaved, or those with functional impairments.

Make these interventions available from a number of accessible settings, including primary care, community centres, day hospitals, long term care facilities or homes.

Provide resources for the adequate formal clinical supervision and continuing professional development of professionals involved.

Box 27: Stepped-care prevention programme

An indicated stepped-care prevention programme for depression and anxiety disorders in the elderly, in which participants sequentially received a watchful waiting approach, cognitive behaviour therapy-based biblio-therapy, cognitive behavioural therapy-based problem-solving treatment, and referral to primary care for medication, if required, showed effectiveness in reducing up to 50% the risk of anxiety and depressive disorders.¹⁷⁹

Box 28: Pearls

The PEARLS (USA) is a home-based programme for managing minor depression in medically ill, housebound older adults. Trained therapists administer a reduced number of a problem-solving therapy focusing on the development of social and physical activity. The therapists receive case-by-case supervision and the primary care physician is asked to visit the patient if no improvements are found after one month of therapy. Patients are followed up with brief telephone contacts, in which the therapist monitors the patients' progress and reinforces the use of problem-solving strategies. A randomized controlled trial of PEARLS vs treatment as usual was conducted and found that the programme produced significant reductions in depressive symptoms, as well as improvements in functional and emotional wellbeing.¹⁶⁹

Box 29: Ageing Well

Ageing Well is a health promotion initiative developed across England and Wales that enables old people to take control of their own health and promote healthy lifestyles to their peers. The programme recruits and trains volunteers who are 50 years or over to become Senior Health Mentors. Volunteers then make contact with isolated people and community groups, providing vital links to health services and opportunities in local communities. Volunteers act as positive role models of 'normal everyday people' reducing the common perception that health is linked only to medical services. The programme focuses on providing advice on a range of issues, including diet/nutrition, physical activity and preventing falls, and offers services within the context of positive and holistic health. Projects work in partnership with local health providers, addressing local health improvement programmes, the National Service Framework and other targets. Findings indicate that clients, and to a lesser extent volunteers and coordinators, gain health benefits and that clients had benefited physically, socially and emotionally from participating in *Ageing Well* activities.

Provide models of care for chronic illness which take account of mental health, including concrete interventions to improve self-care for disorders

Box 30: Educational programme for older adults with arthritis (USA)

An educational intervention was developed for community-dwelling older adults with chronic arthritis, one of the most common chronic, debilitating physical conditions among this population. The programme included 1,5 hours/week classes providing education about their illnesses, pain management strategies and motivation to manage the symptoms so that they will be less susceptible to the depressive symptoms associated with arthritis. The intervention group was compared to a program providing the same amount of stimulation and social contact. The symptoms of depression among the two groups were compared one year after the intervention and again one year later. The results indicated that the elders who were educated about their illnesses had significantly fewer symptoms of depression than those who received no education, and that they also reported more medical social support.¹⁶⁴

Develop and apply setting-specific protocols to identify those with or at risk of mental disorders, alcohol or substance abuse problems

- Develop setting specific and evidence-based screening and assessment protocols. Involve relevant stakeholders in the process.
- Raise awareness of the problem and train key professionals, including: Community nurses, those in long term care facilities or community gatekeepers, such as social workers or priests.

Box 31: Screening and treatment

Screening and assessment for alcohol and substance use problems in primary care (CAGE and AUDIT) followed by brief intervention.

The Alcohol Use Disorders Identification Test (AUDIT) is a useful screen for detecting harmful and hazardous drinking in the elderly while the CAGE is valuable when screening for dependence. In the future, the Alcohol-Related Problems Survey, a computer-based screen, may prove to be superior if practical implementation problems can be overcome.¹⁸⁰

Suicide prevention through depression care management in primary care

Adopt effective care management systems and protocols, including interdisciplinary teams and trained case managers to reduce suicidality due to untreated mood disorders.

Box 32: Prospect study - USA¹⁸¹

The Prevention of Suicide In Primary Care Elderly: Collaborative Trial (PROSPECT study) compared usual care by the primary care providers with algorithm-driven antidepressant treatment; interpersonal psychotherapy when indicated; physician, patient, and family education about the illness; and care management by a depression specialist (social worker, nurse, or psychologist). In a sample of 598 subjects older than 60 years who had depression, rates of suicidal ideation were found to decline significantly faster in the intervention than comparison condition.

Box 33: IMPACT - USA

The IMPACT intervention included a depression care manager collaborating with a psychiatrist and primary care provider to offer patient and family education, facilitation of antidepressant treatment, and the option of brief problem-solving psychotherapy. In addition to significantly greater improvements in depressive symptoms, intervention subjects had significantly lower rates of suicidal ideation than controls for up to 24 months.

(See also the prevention of depression and suicide background document p. 18 - BOX 15. The Netherland's Depression Initiative: integrated care¹⁷⁶)

Outreach programmes

Telephone outreach represents cost-effective approach to reduce social isolation and risk of suicide.

Box 34: Telehelp-telecheck – Italy¹⁸²

The Telehelp/Telecheck represents a selective late-life suicide preventive intervention targeted at older adults who are socially isolated and functionally impaired. Telehelp/Telecheck, based in Padua, Italy, provided telephone-based emergency alarm service and outreach, evaluation, and support services to more than 18,600 seniors with a mean age of 80 years; 84% were women. Over 11 years of service delivery, significantly fewer suicides occurred among clients than would have been expected in the elder population of that region. In subsequent analyses, however, no specific effect of the intervention on suicide in men could be shown; the intervention seemed to be effective in reducing suicide only in elderly women.

Equity in financial assistance for mental health problems

Health insurance cover needs to be equal for mental health treatment as that for physical health services, otherwise it represents a financial barrier to seeking help for mental health problems.

Restriction of lethal means

As described in the prevention of depression and suicide background document.¹⁷⁶

Share good practice across Europe for prevention of alcohol-related harm among older people

Box 35: VINTAGE project (EU)¹⁸³

VINTAGE is a new project focusing on prevention of harmful alcohol use among older people in Europe. The general objective of VINTAGE is to build capacity at the European, national and local levels by providing the evidence base for best practices to prevent the harmful use of alcohol among older people, including the transition from work to retirement.

Specific objectives include:

- Systematic reviews on the impact of alcohol on the health and well-being of older people and prevention of harmful alcohol use by older people;
- To collect examples of best practices for preventing harmful alcohol use by older people from all European countries at different levels;
- To disseminate the project key findings, and their implications for policy and programme development, to those responsible for alcohol policy and programme development.

2.3 OLDER PEOPLE IN VULNERABLE SITUATIONS

Message

Older people from certain groups face a higher risk for mental health problems. This includes older women, those living in or at risk of poverty, experiencing chronic illness, suffering abuse and belonging to cultural or ethnic minorities. Measures to build resilience or to reduce their specific vulnerability (for example, through services) can improve living conditions and decrease mental health problems in these groups. These measures can also increase social inclusion and cohesion.

The problem

Vulnerable populations are at higher risk of poor physical, psychological and social health. Poor physical health (e.g. chronic illness) may make an individual more vulnerable to mental health problems (e.g. depression) and/or social deprivation (e.g. few social contacts). Vulnerability can be the result of social trajectories (i.e. an individual's course through life), interactions and social contexts or environments¹⁸⁴. Moreover, these factors are central in determining the development of mental health problems. For example, people living in an adverse social environment, experiencing severe life events, lacking supportive relationships and appropriate services are at increased risk of mental health problems^{185,186}.

Specific vulnerable states which represent risk factors include: poor physical state (dependency or disability), low socioeconomic status (poverty), low social capital (isolation) and scarce human capital resources (education).

Groups that are of specific vulnerability in old age include:

- older people living in poverty or at a higher risk of poverty, such as older women
- those living in isolation and those with severe physical restrictions and need of assistance (e.g. at a higher risk for elder abuse)
- those facing or coping with (critical) life-events and transitions (separation, bereavement and loss (of spouse or of children) and abuse)
- ethnic minority/migrant groups
- homeless older people and prisoners (often experiencing traumatic situations)
- those who are lesbian, gay, bisexual or transgender
- those who are ageing with pre-existing mental health problems or disorders

Poverty

In 2008, 17% of all Europeans (EU-27) were at risk of poverty, but older people face a higher risk of poverty (19%, or 13 million older people) than the general population^{187,188}. Poverty is a multidimensional social phenomenon and can be characterised by low socio-economic status, unemployment/low pensions, and low level of education. Women face a higher risk of poverty than men, particularly in later life, because of the tendency for women to have fewer and lower financial resources from pensions or savings, even when they have been working. Rather than actual income, several education-related factors may work as mediators for the risk of mental disorders (e.g. insecurity, hopelessness, poor physical health, limited response to rapid social change, limited opportunities)¹⁸⁹.

People living in poverty have more limited access to appropriate health care. Thus poverty and mental illness interact and exacerbate one another in a vicious cycle¹⁸⁹.

Elder abuse

Elder abuse has already been recognised as a major problem and challenge by some European countries, but actions aimed at preventing elder abuse vary¹⁹⁰. Elder abuse is “a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person. Abusive behaviour can take various forms: physical, psychological/emotional, sexual, financial or simply reflect intentional or unintentional neglect”¹⁹¹. Elder abuse happens more often in the domestic context than in the institutional context. Domestic elder abuse is estimated between 6 and 12 percent, whilst abuse rates in care and institutional settings are higher (e.g. due to dementia, higher care efforts and problematic relationships).^{192,193} In addition, psychological and emotional abuse occurs more often than other forms of elder abuse and women more often experience elder abuse^{194,195,196}.

Elder abuse is often connected with limitations due to poor health and mobility or care situations. There are several important pre-disposing factors in a multi-factorial context, such as a (long) history of problematic relationship/s, substance misuse or psychiatric illness (of the carer or older individual). Typically the perpetrator is likely to be known by the abused person.

Moreover, elder abuse has a devastating effect on the mental health of individuals.¹⁹⁷ Abused older people often report that they couldn't forget the event, they report of fear, feelings of disrespect and humiliation. In addition, financial damage and in many cases physical injuries can be the result of abusive behaviour.¹⁹⁵ Sometimes abused older people feel cut off from family and friends¹⁹⁶ and experience a loss of confidence, depression, sleep disturbances and increased isolation^{198,199}.

Homelessness

Contrary to poverty and elder abuse, homelessness strikes mostly unemployed men, who have low levels of formal education, live alone with very limited (social) network availability, social isolation and absence of adequate housing.^{200,201} Estimations of the prevalence of homelessness are difficult, but vary between 1.8 and 2.7 million homeless people in Europe.²⁰² Out of all homeless people about 4% are older persons with a mean age of 72 years.²⁰³ The share of older homeless persons in Western countries is small, but the numbers are growing.^{201,203}

Older homeless people can be characterised as fragile, extremely vulnerable and many suffer from physical, mental problems and increased mortality (higher than in the general population).²⁰³ About one-third of single homeless adult have a serious mental disorder and the prevalence is higher in women.²⁰¹ Furthermore, about 50 percent of homeless older people have intoxicant dependencies with approximately 30 percent of these suffering from alcohol problems. Nevertheless no overall consensus exists as to the causal factors of homelessness. Often a history of alcohol, substance abuse, and problems with family, finances and housing exist before homelessness.²⁰⁰ Once people become homeless, it is extremely difficult for them to return to their previous life.

Ethnic minority groups

Migration plays an important role in population dynamics in European countries. More than half (56%) of the non-nationals living on the territory of the EU-27 Member States have European citizenship and around 40% of foreigners in member states come from countries outside Europe.²⁰⁴ Migratory groups are – under certain circumstances – at a higher risk for poor health (stress, trauma) due to unique combination of migration biography and post-migration experiences. Ethnic minorities face particular social disadvantages such as lack of family in proximity, language difficulties, racial and religious

discrimination, etc.²⁰⁵ There is wide variation in standardized mortality ratios for older suicides among different migrant groups. Migrant suicide is related to their country of origin, circumstances and process of migration and the host country. Risk of depression is also higher due to poor family support, loneliness, inadequate access to community services and inability to return home. Family support is the main buffer against depression, but others like religious practices and reliance on peers also seem to afford some “protection”.²⁰⁶

Lesbians, gays, bisexual and transgender individuals

Lesbians, gays, bisexuals and transgender individuals suffer from intolerance of their sexuality or gender, discrimination and victimisation. Gay men and lesbians report more psychological distress and higher levels of substance use than heterosexuals do. In the scientific literature there is indication that they have higher rates of anxiety, depression and suicidal behaviour and more experiences with mental health services (consultation of a mental health professional). They report levels of discrimination in the workplace and social settings, especially transgender individuals, and as a result are at higher risk of poverty, unemployment and social isolation. These problems, whilst sadly experienced by individuals of all ages, are particularly acute among older people. This is in part due to the growing acceptance of minority sexualities and genders, starting in younger ages, which is not a part of European cultures of older adults. Another element is that discrimination has often forced these individuals towards underground working arrangements, resulting in a lack of financial security in older age²⁰⁷. In addition, the same discrimination can appear in mental health services. In one study around 30% reported negative or mixed reactions from mental health professionals when being open about their sexuality.²⁰⁸

Those ageing with pre-existing severe mental disorders

One often unacknowledged group within the aging population are older people with a pre-existing mental disorders. Longer life spans are expected due to recent treatment advances and will bring, together with the demographic transition, a notable increase in the size of this older population. Combined with European movements towards a greater number receiving care in the community, the ageing of these deinstitutionalized psychiatric patients will have major implications for health care policy and will also require specific efforts from family and social networks, as well as from resources in the community.

Certain symptoms of serious mental disorders (the “positive” symptoms, in psychiatric terms) often reduced with age, whilst other problems persist or appear in later life, which increase the need of help and support for this population. Changes include persisting social or problem solving skills which are frequent in those with severe mental disorders, but which also present as new challenges related to age, such as:

- extreme social isolation after normal losses and transitions related to age
- reduced autonomy due to normal cognitive and physical decline
- financial restrictions and risk of poverty due to the small pensions in those (most of them) who have not been able to work as a result of their mental illness.

The aging and deaths of family carers themselves (often parents) pose additional barriers to those with severe mental disorders staying in their own home environment, and often leads to their admission to institutional settings. General long-term geriatric services are centered on physical or cognitive impairments associated with the ageing of those in the general population, and there is often a lack of experience and resources to attend those with severe mental disorders.

In addition, those with long term mental health problems often encounter nihilistic attitudes, as they reach old age, among professionals, who feel that they don't have the knowledge and skills needed to provide effective help to this population.

Overall, it is important to note that experience of some types of vulnerability increase the risk of poverty, homelessness or other vulnerable situations. Interventions must be planned and implemented with regard to the specific living situations of those in vulnerable situations.¹⁸⁶ An important component of cost-effective promotion and preventive measures is the identification of groups of people who are at high/higher risk of mental health problems. Specific interventions, such as those aiming to promote coping skills, can help older people in vulnerable situations to adjust to adverse life events such as job loss, bereavement, and divorce/separation.²⁰⁹

Principles that work

Various interventions for vulnerable groups have been shown to be effective for preventing and promoting mental health, at the individual, organisational/municipal and societal level:

185,189,197,200,201,203,205,208,210,211

Individual level:

- Social support and empowerment programmes such as help lines, skill training, the reduction of hopelessness
- Provision of greater economic security through education or microcredit schemes.
- Strengthen intimate relationships and reduce the burden on informal carers by parenting training, mentoring and marriage counselling.

Organisational, service and expert level:

- Implementation of psychosocial and educational programmes (sensitization, awareness, knowledge, understanding, how to recognise, risk factors, local policies for safeguarding) for practitioners and specialists working with older people in order to be able to identify groups in vulnerable situations which are in high risk of mental ill-health
- Direct involvement of vulnerable groups in the identification and exchange of best practices with a focus on empowerment.
- Offer barrier-free and proactive access to high quality mental health services (e.g. centres and shelters for vulnerable groups offered by social workers, geriatricians etc.) by taking into account the vulnerable groups' specific factors such as (sub-)cultural differences, language, fear of unnecessary prescriptions)
- Cross-sector co-ordination and high quality promotion (e.g. outreach programs) and (early) prevention interventions (e.g. coping skills, social support programmes for the reduction of strain) led by pro-active and specialist agencies in primary health care and specialist services

Community and society level

- Improve the public recognition and awareness of vulnerability and about its causes, including guidelines and recommendations on how to react.
- Social policies for adequate pension incomes and social security to reach gender equality, income equity and stable housing.
- Community development programmes with sector reforms, e.g. by decentralisation, participation of local community leaders, empowerment of the marginalised.
- Provide measures including those to improve financial security, adequate community housing with support measures for daily living (see box 45) for those growing old with pre-existing mental disorders.

Policies and Programmes for Action

Key actions in this regard include:

- Interventions which **promote psycho-social skills and coping mechanisms** at individual level (e.g. older people in major life transitions, including retirement, divorced and bereaved groups)
 - Focus on the **resources of older people** who live in poverty or high risk areas by community development programmes in or in deprived neighbourhoods and by the provision of an own language and culturally appropriate prevention interventions and social inclusion initiatives for older people (e.g. ethnic minorities and migrant groups).
- **Coordinate health and social welfare sectors** to improve access for vulnerable populations, e.g. by the recognition and support for older people living in abusive relationships, treatment for substance/alcohol misuse, correct detection and treatment for those growing older with severe mental disorders.
- Highlight issues of ageing for **non-governmental agencies representing marginalized groups** (e.g. organisations or interest groups representing lesbian, gay, bisexual and transgender representatives, homeless people)
- **promote supportive networks and social inclusion measures** at interpersonal and social levels (e.g. inclusion interventions for dependents, people at risk of elder abuse, migrants and refugees)
- **Anti-discrimination policy and legislation** to reduce the marginalization and exclusion of minority groups in vulnerable situations, with reference to older ages.

Lesbians, gays, bisexual and transgender individuals

Box 36: Buddy care for Homosexual Elderly People – Pink Buddies

(<http://www.schorer.nl/106/25-jaar-buddyzorg/>)

The programme in the Netherlands, led by the Schorer institute for homosexuality, health and well-being, aims to reduce loneliness in older homosexuals and improve their mental health. Because this group can be difficult to reach, Buddy Care uses different media and means, e.g. by networking with specialist services. About 200 Punk Buddies (volunteers) were trained on how to work with the older target group and they visited gay, lesbian and transgender people aged 55 or over in their homes, providing emotional, social and practical support. The results of the evaluation showed that the programme is able to reduce loneliness, which is a major cause for depression.

Box 37: Self-help Group for Homosexual Men 50+

(<http://www.subonline.org/>)

The project aims at preventing isolation and depression in homosexual older men and supplying information about homosexuality and aging for all local facilities of social welfare. This self-help group for gay older people meets every Monday evening to share leisure activities. The group organises events and activities such as walking-tours, sightseeing and cultural events. In case of ill health, the group members keep up social contacts and provide support and assistance (e.g. home visits). Furthermore, local facilities and authorities (especially the department of seniors) become sensitised to the target group and their problems (e.g. in 2004 a local survey on "Aging and Homosexuality" was carried out by the city of Munich, initiated by the self-help group).

Ethnic groups and migrants

Box 38: Active Ageing! Investment in the health of older people²¹²

(http://www.soz.univie.ac.at/fileadmin/user_upload/inst_soziologie/Reinprecht5.pdf)

The initiative is dedicated to research on the quality of life of older people in the course of a WHO demonstration project in Vienna. It is concerned with health promotion and the social motivation of isolated population groups among older people with special focus on socio-economically deprived districts, older migrants and older people with a recent critical life-event (retirement, widowhood, bereavement). In the course of the project older people were visited in the

residential area for counselling and regular contact was held over a longer time period. "Health Markers" were developed as brochures for older migrants with information on health services and they were also translated into Turkish and Serbo-Croatian.

Box 39: Active Ageing of Migrant Elders across Europe (AAMEE)

Good-Practice Exchange Programme for Voluntary Organisations (www.aamee.eu/)

Within the framework of the Active Ageing of Migrant Elders across Europe (AAMEE) project Good-Practice for voluntary organisations are exchanged. Objectives of the AAMEE Good-Practice Exchange are to initiate and promote the work of voluntary organisations in the field of migrant elders, sensitise the political and societal surroundings for voluntary work with and for migrant elders, set up a good practice platform/ network for the exchange of experience between voluntary organisations, compile and publish a check list for voluntary work with and for migrant elders as well as a good practice booklet with examples from all over Europe, develop principles and recommendations for the EU aiming at and promoting voluntary work with and for migrant elders in Europe.

Box 40: Immigration as a social resource, rather than a source of fear

(www.auser.it)

The AUSER (Service and Solidarity Self-management Association) project intends to link older people with immigrants. Intercultural meetings, regional seminars and teaching materials are set up. Meetings between the older people and their families and the families of immigrants were organised with the aim of overcoming stereotypes and building cultural awareness and exchange. The main results were increased self-esteem and awareness of people taking part, attenuation of anxiety based on fears linked to racial stereotypes, better understanding and perception of cultural tools in dealing with situations, better links built across ethnic groups within the community, openness and readiness to talk about "diversity" in society.

Elder abuse

Box 41: Breaking the taboo - Empowering health and social service professionals to combat violence against older women within families

(http://www.roteskreuz.at/fileadmin/user_upload/PDF/GSD/Brochure-English.pdf)

The aim of the project is to raise awareness concerning violence against older women in families, to empower health and social service professionals to recognize abusive situations and to help combat them, to develop awareness-raising activities and materials and to develop tools and strategies to improve early recognition of violence against older women in the family and to support professionals to react accordingly. Therefore the main output of the project is a brochure containing tools to recognise violence, strategies how to deal with violence and abuse and country specific information on the legal framework, as well as organisations to provide awareness raising workshops for professionals in the field, an expert conference in Austria, Finland, Italy and Poland and a short summary of the experiences of the project for policy makers.

Training to support those with pre-existing mental disorders

Box 42 PROSPECT training programmes

Prospect is a result of a European Partnership Project developed by the European Federation of Associations of Families of People with Mental Illness (EUFAMI) and brought together the concern and input from sixteen partner organisations and representatives of people with mental illness, family carers, health and social care professionals from twelve European countries. The Training Programmes are now available in twelve European languages:

- The **Prospect Family and Friends training programme** addresses the needs of family members and friends in their own right, enables them to gain confidence, improves their coping skills, supports regaining control and improves their quality of life.
- The **Prospect People with Self-Experience training programme** promotes recovery, enables greater community integration, and improves skills and work opportunities for people with self-experience of mental illness.
- The **Prospect Health and Social Care Professionals training programme** puts the person with self-experience in a social context, which includes carers and also includes carers as potential citizens
- The Prospect Common Ground Module addresses the theme of "Three Way Communication" amongst the three groups identified in the Prospect Project (people with self experience, friends and family, and health and social care professionals).

2.4 CARE AND TREATMENT SYSTEMS

Message

Health and care systems, supported by research in the fields of old age psychiatry and geriatric medicine, have a key role to play in the early detection and tackling of mental disorders in older people. Care systems need to be community oriented and include multidisciplinary teams, as well as mechanisms for coordination between social and mental health care. Primary health care and general social services are primary access points for many older adults and should be used to proactively pursue the goal of good mental health. The management and coordination of palliative and end-of-life care requires good leadership and commitment in primary care teams with integration of both informal carers and other specialists.

The problem

There is a lack of integrated mental health care in Europe and this represents one of the main problems in the provision of mental health services.

Frequent deficiencies include the lack of coordination between out-patient and in-patient mental health services (including discharge management), and of links between general medicine and mental health. On the one hand, the planning, implementation and evaluation of mental health and social care services (such as housing or social welfare) is often not well coordinated^{213,214,215 216,217}. This leads to repeated assessments, confusion among older people about services and unclear division of responsibilities among service providers and their staff²¹⁴. Reasons for this lack of coordination include different terms of employment in the various institutions involved and different working cultures across sectors. Stronger leadership in the management of mental health care at the local level is also needed in many Member States^{213,216}.

Most EU Member States face similar challenges when aiming to improve the quality of services, which include:

- At the **policy level**, incorporating mental health in old age into national health service and social care priorities;
- At the **service providers level**, having a well trained, multidisciplinary and ample workforce; successful negotiation between highly competing agendas/priorities, and; effective coordination of all stakeholders involved in the caring process, to define a clear distribution of responsibilities (to avoid older people getting "lost" in the system and receiving inadequate care as a result);
- At the **families / carers level**, having their "caregiver burden" and decreased quality of life considered and valued, receiving up-to date information and training on available treatment and support;
- For the **older person**, overcoming barriers to adequate treatment and care (e.g. stigma, insufficient involvement in decision making).

Principles of what works

- **Integrated treatment and care services** for older people with mental health problems, assuring coordination across health and social services, physical and mental health services, and in-patient and out-patient care. Concrete examples with proven effectiveness include:
 - Multidisciplinary individualised community services,
 - Primary/specialist care collaborations for the treatment of later life depression,

- Outreach services to residential care,
- Integration of acute hospital and community mental health services,
- Single entry-point systems,
- Models involving case management in the community,
- **User- oriented services** (vs. provider-oriented), with access based on needs (and not on age) and active involvement of users and carers in decision making.
- **Ongoing training** of professionals across the spectrum of care, enabling them to recognise and deal with the complexities and particularities of mental health problems in old age.
- Provision of **setting appropriate guidelines** for the detection and management of mental disorders in old age, and also elder abuse.
- **Partnership** with non-governmental organisations, regional authorities and additional stakeholders.
- **Clear and strong leadership** across health and social sectors and local authorities, aimed at communicating the vision for older people's health and at supporting professionals.

Integrated mental health services for older people – also known as combined care, a whole systems approach²¹⁶, or integrated care^{215,218} – have proven effectiveness in dealing with mental disorders in old age. Diagnosing and treating mental illness in old age is complex, and integrated psychiatric/general medical services have shown positive outcomes²¹⁹. Countries which have well expanded geronto-psychiatric services show positive effects on reducing later life depression²²⁰. More detailed integrated care planning means joint budgets of service providers, integrated information systems, improved case/care management, a greater number of multi-disciplinary teams and effective discharge management²²¹. A single point of entry into mental health services has also been proposed as one possible way of facilitating access to those in need²¹⁶.

Another major component of effectively and holistically treating ill health in older people is ongoing training of workforce in all levels of care, which would enable them to detect and manage the complexities of mental disorders at this age²¹⁵. The provision and wide dissemination of setting appropriate, updated and user-friendly guidelines, can also help to improve the quality of care provided by professionals.

Preventive home visits could also alleviate mental health problems in older people^{52,222}. A systematic comparison suggest that visits have a preventive effect on older people in terms of reduced hospitalisation, reduced nursing home admissions, mortality rates and costs²²³. For mental health outcomes, results in Denmark show that home visits have the potential to increase psychosocial functioning and to decrease anxiety on older people^{52,224}. Effectiveness of these interventions relies on multi-dimensional features, including geriatric assessments, as well as follow-up visits²²².

For the implementation of effective services stronger leadership and management are needed in mental health promotion. Teams need to be set up and commissioners need to be enabled to develop, implement and evaluate services. One way of providing these services would be to assign mental health commissioners for older people in the community or to develop a community mental health team (CMHT) as done in the United Kingdom²²⁵. The development of leadership (skills) as part of capacity building is underlined in the literature.

Policies and Programmes for Action

- Integrated care systems, that are community and outpatient oriented, that include proactive collaboration between the mental and physical health services, and between the health and the social sector.
- Multidisciplinary community teams, which are available and accessible, and which include skilled general practitioners, gerontologists, mental health specialists (especially old age psychiatrists), social workers, educators and nurses, trained to detect and treat mental disorders in older people.
- Palliative and end-of-life care which provides high quality of life until the end for older patients, combined with support for the informal (family) carers, based on accepted principles and guidelines, including bereavement counselling where indicated. This requires good leadership and a high level of commitment from primary care teams, including informal carers and specialists when needed.
- Nursing homes which provide high quality care through a highly skilled and ample work force, and working conditions that prevent high staff turn over. This can be facilitated by independent quality control measures and active collaboration between mental and other health professionals.
- Guidelines for nursing and long-term care for the promotion of mental health of older people (allowing them to live with dignity in an appropriate environment) and the prevention of mental disorders and maltreatment.
- Mental health commissioners at the community/regional/national level.
- New technologies as part of the programmes for mental health promotion, disorder prevention, treatment and care of older people (including information and communicative technologies, e.g. ICTs and eHealth and technical aids to reduce impairment).

Box 43: Partnerships for older people (POPP)

(www.changeagentteam.org.uk/popp)

The POPP program is one good practice example for a joint program between health and social care in the United Kingdom, which has been facilitated since 2006 in 29 different parts of the UK²²⁶. Special evidence can be gained from the program in Leeds and Bradford, which has a special focus on delivering integrated care for older people with mental health problems.

The 6-12 week program employs different staff trained in social care or health care. The staff visit older people with mental health problems who have recently been released from hospital. The objectives of these home visits are to reduce the rate of those in potential need of long-term care, to enable them to stay at home, to deliver integrated (social and general health) packages of care, to promote health (through education, enhancement of skills, etc.), to promote independence and self-care, and reduce hospital emergency bed admissions. On the basis of weekly reports of assessments by the care staff, older people's skills and abilities appear to be improved. Results show reductions in overnight hospital stays by 47%, and a number of additional benefits.²²⁷

In Leeds and Bradford, special dementia cafes have been developed where older people with dementia or functional mental health needs, can talk about their mental health problems. The programme in Leeds was evaluated by the University of Leeds and showed a clear benefit after the 6-week-intervention.

A partnership between health care, social care, and voluntary services was also established in Leeds. Intermediate care team links are provided between inpatient care and community mental health care, which prevent admissions to hospitals and facilitate early discharges.

Box 44: NSF from the UK

(www.dh.gov.uk/en/SocialCare/Deliveringadultsocialcare/Olderpeople/OlderpeoplesNSFstandards/DH_4002284)

The NHS has implemented the "Standard 7 of the National Service Framework (NSF) for Older People" which aims at developing and implementing integrated mental health care for older people with community mental health teams (CMHT). Each CMHT consists of a workforce with clearly defined roles from both the health care system (e.g. gerontopsychiatry, community psychiatric nurse and dietician) and the social welfare system (e.g. social worker, speech therapist). The CMHT have joint documentation and formal joint meetings to prevent communication failures due to different backgrounds, skills and working styles. CMHTs need to be well managed by a qualified team manager²²⁵.

Box 45: Sunny Dale

In Slovenia, one good practice example of an older people's home is "Sunny Dale" (translated title), a home for 160 private and state-funded older people, where they receive health and social support depending on their state of health and wellbeing. Two of the seven floors are inhabited by older people with mental health problems (especially those suffering from dementia and cognitive impairments). These are staffed 24 hours a day and 7 days a week. On the ground floor, 15 carers, 1 social worker and 3 medical doctors provide all necessary mental health care for these older people, including prevention and health promotion (e.g. a singing group). The advantage of this way of living (integrated care in one home) is that older people can be attended by services in one location, where they reside, and do not need to change from informal support to formal support or vice versa, with any fluctuations in health conditions. In this example the older person does not change his/her position in the health care system and does not have to work his/her way through the whole system, but the health and social care system works its way towards the person to ensure optimal care²²⁸.

2.5 INFORMAL CARERS

Message

Informal carers carry the largest share of care provision, and the increasingly large proportion of this care is provided by older women. Supporting their role, training them, and protecting their well-being have positive outcomes for the mental health of carers and the people they care for.

The problem

Care can be organised through out-patient and in-patient facilities, as well as day care, and is provided by formal and informal caregivers. Most older people being cared for, e.g. people with mental and physical health problems, live in their private homes rather than an in-patient institution²²⁹. The majority of this care is delivered by informal carers at home by family members (mostly daughters and daughters-in-law, but also from siblings and spouses)²³⁰.

Beyond doubt most of the caregiver burden lies with informal carers. The magnitude of the caregiver burden is mostly dependent on the recipients' mental and functional health status²³¹. The time spent on caring for people with dementia by families is huge. Time spent by informal carers is about 8.5 times greater than care provided by formal services (299 hours versus 35 hours spent per month). Half of the time is spent for surveillance during the day and night (24 hours care responsibility)²³².

Many carers are worried about aspects of their role as carers (for example, they may be concerned about their own health, about the health or the behaviour of the person they care for, about who will look after the person in the future) and are concerned about their ageing status, their deteriorating health and their ability to continue to care for their dependents²³³.

In fact informal carers have poorer psychological health than the average population²³⁴ and a range of problems can emerge in relation to their well-being such as sleeping problems, eating disorders, risk of self-harm, and thoughts of suicide²³⁵.

In addition many caregivers lose (parts of) their social life and replace a formal professional occupation with caring (change to part-time occupation with respective lower wage), and reduce the frequency of seeing friends and taking recreational time whilst caring for an older person in their family. Carers are often not able to participate in social activities since they are unable to leave the cared for individual on his/her own²³³ which may lead to loneliness and social exclusion. This again results in guilt from the carer's perspective. In the long run informal caregivers are at risk of being physically and emotionally exhausted which means a high risk for becoming physically and mentally ill²³⁶.

The caregiver burden is higher in carers with lower educational background, in carers of younger patients and in carers of patients with more hospitalisations in the previous three years²³⁷. It is essential to note that female carers are more often at a higher risk of developing a mental illness, such as depression²³⁶. Depression is also more common in carers of people with a neurodegenerative disorder (e.g. dementia) and in those living alone²³⁸. The higher the caregiver burden, the higher is the risk of developing depressive symptoms²³¹. In summary, caring for an older person (e.g. with dementia) can be stressful and carers' needs must be recognised and dealt with in a timely manner²³⁹.

Principles of what works

- Implementing a national lobby for informal carers to represent their interests on a political level
- Supporting informal carers through community based resources and programmes (e.g. self-help groups for carers) and whole-family approaches
- Training for informal carers about the onset and management of mental illnesses

- Providing legal and financial support for carers, community services, and health promotion for their patients and themselves

In the near future health care systems which rely on informal carers should concentrate on principles of what works. Carers, especially informal carers, face a high risk of becoming ill due to the caregiver burden they have to carry. This raises costs for treating their symptoms arising from the caregiver role. Therefore health promotion and prevention for carers is urgently needed. There is an acute need for more support for relatives²³⁷.

The situation of carers has to be improved on more than one level. Implementing a lobby for carers has shown to work in some EU-countries representing carers' interests on a political level and raising awareness of their "working" conditions.

Support services (such as out-patient services, community based care and respite care) which are affordable to all families in all social strata work best, so that families can care for their relatives and have additional help from outside the family.

Caring for a relative could also be charged to one's retirement years (like raising children already can be). Informal carers are less strained if support services are adequately funded and if an integration of services – notably between health and social services – takes place²³⁹.

An investment in the training of informal carers has to take place in the future and elaborated on what already works. Studies show that educational interventions increase the knowledge level of carers²⁴⁰, but there is fewer evidence that they reduce the caregiver burden²⁴¹. The provision of clear, accessible and relevant information, through education or training programmes is recommended. Training should help carers to recognise mental disorders in their cared ones, as well as to manage them²³². Additionally informal carers should learn to improve their own physical, mental and social behaviour²³³, as well as their coping styles, the sense of control over the situation as well as self-control^{234,236,240}. Actions focusing on the needs of the caregivers and giving advice on coping styles show positive effects²³⁶.

Whole-family-interventions have been described as the best support to carers and the older people they care for, and they include family therapy and family counselling, which helps to improve patient behaviour, family relationships and to reduce the caregiver burden²²⁹.

The role of (mutual) support and self-help groups is also of interest as they bring information, advice, and participation in social activities. Positive aspects of group involvement includes shared experiences, emotional support, helping carers to cope with their current situation in the family and developing a more positive perspective on the future.²²⁹

Positive effects on health are also evident when short-term breaks for informal carers are made possible²²⁹. Additional measures of support include e-forums and telephone help-lines are seen as supportive and should be made available²²⁹. They show a positive relation to depressive symptoms, stress and burden, overall life satisfaction, and actual use of social support by carers.

Programmes and policies for action

- Provide official recognition, financial support and social security benefits to informal carers (including spouses, siblings and older carers). Include concrete support to those unable to work because of their caring commitment, including income compensations and pension rights. Consideration should especially be given to older women as caregivers.
- Provide mental health protection measures for informal carers such as
 - possibilities for respite care, flexible and part-time work
 - psychosocial support (social networking, peer support and self-help)

- Provide training with flexible scheduling, monitoring and professional help to informal carers, including:
 - Tools to evaluate carers' own mental health needs.
 - Curricula focusing on how mental health in old age can be promoted and how (mental) disorders can be prevented.
 - Professional home visits and regular communication between professionals and informal carers, including assessment of the health and safety conditions and technical aids.
 - Use the valuable experience of the cared-for individual in training and supporting professional carers.

Box 46: Health Promotion for Informal Carers

(<http://www.hauskrankenpflege.at>)

The project consists of 2 core phases. In the 1st phase consultants (not necessarily old aged) were trained in a new developed concept (interdisciplinary & in-service training, 160 hours). In total, 42 people were trained (39 completed positively). In the 2nd phase the consultants operated in 24 Austrian regions as health promotion consultants for informal carers. The offer was free of charge but restricted to maximal 4 consultations per person (incl. group consultations). Health Promotion for Informal Carers has an innovative concept that covers the needs of informal carers. The service was easy reachable for everyone. The 39 trained consultants from different professions installed the service in 24 districts of Austria and in 7 different settings (via telephone, public talks, self-help groups, individual and group consultations and also consultations at home were possible). The project was accepted highly in the whole Austrian Red Cross and was also strengthened by the high engagement of the consultants.

Box 47: Edinburgh Young Carers' Project (EYCP)

(<http://www.youngcarers.org.uk/index.php>)

Edinburgh Young Carers Project is a voluntary organisation working with and on behalf of young carers throughout the Edinburgh region. The project works with young people aged 5 to 25 years old who care for or are affected by someone else at home – usually a parent or sibling. The person they care for may suffer from mental health problems, disability, chronic ill-health, drug and alcohol misuse. The mission of the project is to improve the lives of young carers through support, information, training, working in partnership with other agencies and promoting social inclusion. The purpose is to provide services (e.g. support, information, opportunities), to promote development (raise awareness of their needs, provide training to agencies and professionals, develop partnerships to address the needs of young carers and to support research and provide data) and to inform policy and practice (promote rights and needs of young carers).

Box 48: Assisting Carers using Telematics Interventions to meet Older persons' Needs (ACTION)

(http://www.dinf.ne.jp/doc/english/Us_Eu/conf/tide98/57/magnusson_daly.html)

ACTION is a 36-month European project that aims at maintaining or enhancing the autonomy, independence and quality of life for frail older and disabled people and their family carers by giving better information, advice and support in the home. This will be made possible by combining familiar equipment with modern information and communication technology.

The main purpose of the project is the empowerment of family carers. Both family and professional carers are involved at all stages of the development and decision making process to insure that the project is user driven and user friendly. The project is attempting to explore in a cross-cultural manner, the invisible nature and associated problems of family care giving. The ACTION project is supported and substantially funded by the European Commission DGXIII, Telematics Applications Programme, Disabled and Elderly Sector. The intention of this paper is to give a brief overview of the entire project with emphasis on users needs and programmes related to coping skills, emergency interventions, financial information and economic support for family carers.

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