Joint meeting of the Cross Party Group on Older People, Age and Ageing and the Cross Party Group on Mental Health held on 26th April 2017, 5.30pm, CR6

1. PRESENT

CPG Older People, Age and Ageing

MSPs: Sandra White MSP; Bill Bowman MSP – membership tbc, Annie Wells MSP.

Non-MSP Members:

Organisation	Name
Age Scotland	Richard Baker
HIV Scotland	Liam Beattie
Pagoda PR	Callum Chomczuk; Paul Surgenor
Scottish Older People's Assembly	Diana Findlay; Eileen Wallace; Glenda Watt (Minutes); Avril Crossley (Minutes)

CPG Mental Health

MSPs: Clare Haughey MSP; Maree Todd MSP

Non-MSP Members:

Organisation	Name
Autism Rights	Tom Wightman
British Association for Counselling and Psychotherapy	Martin Bell Steve Mulligan
Care Inspectorate	Arvind Salwan; Paul Edie
Scottish Council on Deafness	Willie Macfadyen
Mental Welfare Commission	Kate Fearnley
Open Secret	Ulia Mather
Psychiatric Rights Scotland	Andrew Muir
Royal College of General Practitioners	Miles Mack
Royal College of Psychiatrists in Scotland	Elena Slodecki (Minutes)
Rowan Alba	Ewan Law
Support in Mind	Eric Walker
Voices of Experience Scotland	Pauline Bradley
Individual	Barry Gale

Non-members in attendance: Angela Dias (Speaker); Rosemary Carter (Speaker); Dianna Manson (Speaker); Dr David Christmas (Speaker); Dr John Mitchell (Speaker); Sarah Bax; Iona Beange; Anne Connor; Cathy Crawford; Margaret Follon; Dr Peter J Gordon; Chris Lord; Rob Murray; Hunter Watson; and Margaret Whitelaw.

2. WELCOME

Sandra White MSP welcomed attendees to the meeting.

3. APOLOGIES

Apologies for absences were received from: Beverly Bergman; Avril Hepner, Robert McGeachy; Carolyn Lochhead; Cath Logan; Alison Clyde; Hilary Robertson; Housing Options Scotland; Julie Robertson; Anna Buchanan; Alan Spinks; Nigel Henderson; Tom Berney; Bill Johnston; Sandra Martin; Sheila Duffy; Stacey Webster; Valerie Smith; Rohini Sharma Joshi.

4. MINUTES

a. Minutes of the CPG on Older People, Age and Ageing meeting held on 27 January 2017.

Minutes of the previous meeting held on 25 January 2017 were accepted as accurate. Glenda Watt, Secretariat of the CPG on Older People, Age and Ageing, provided an update on funeral poverty. It was also noted Fraser Johnson of Cycling Without Age has offered to give a presentation at a future meeting of this group. Sandra White MSP noted she was tasked to write a letter on behalf of the CPG regarding concessional fares and Integrated Joint Boards. The letters had been sent.

b. Minutes of the CPG on Mental Health meeting held on 24 January 2017.

Minutes of the previous meeting held on 24 January 2017 were accepted as accurate. In relation to the theme of the previous meeting, Veterans' Mental Health, Glenda Watt brought attendees attention to Poppy Scotland and its consortium of organisations linked to older people who are now in receipt of £4M funding to provide services for older veterans.

5. OLDER PEOPLES' MENTAL HEALTH

The group heard short presentations from invited guest speakers which was followed by a question and answer session.

'The Mental Health Strategy 2017-2027 – its application to older people'

Dr John Mitchell, Principal Medical Officer and Psychiatric Adviser, Scottish Government

Dr Mitchell thanked the group for inviting him to speak and for allowing him to be the first speaker on the agenda. Dr Mitchell's presentation covered the Mental Health Strategy: 2017-2027. He had proposed reflective questions. In 10 years' time Scotland will be quite different, and priorities will shift and change, which means the Strategy needs the ability to change as time goes by. This Strategy connects to other Scottish Government health strategies including: autism, dementia, road to recovery, alcohol framework, keys to life, suicide prevention, and palliative care. The Scottish Government will host a biannual forum, as a big event is needed to allow a broad range of stakeholders to get around the table to shift, change, and reassess priorities as time goes by. Dr Mitchell posed the question how can we deliver improved services for older people, as well as everyone else?

Dr Mitchell explained the vision is the heart and soul of the Strategy. There are fundamental ideas in the Strategy. There needs to be parity between physical and

mental health and all health needs thought of together. Access to treatment is important and early intervention. Dr Mitchell highlighted the issue of premature mortality: in Scotland you die 15-20 years younger than someone of the same social class if you have a mental illness. Finally, Dr Mitchell referenced the Strategy's rights-based approach and its aim to optimise peoples' involvement in their own care. Dr Mitchell backed a need to show, in mental health, that what we're doing matters and we need data to do this.

In the discussion that followed, these points were raised:

Dr Peter Gordon, Psychiatrist for Older Adults, West Lothian noted within the 10-year vision he could see only two references to older people. Dr Gordon also commented there's no mention of 'realistic medicine' in the Strategy.

Tom Wightman, Autism Rights, commented that you need a diagnosis of autism before you can get access to services. The criteria for getting a diagnosis is limited to people who have a mental health problem or who have learning disabilities. How is this going to help people who have autism but not either of those problems and still need help?

Bill Bowman MSP asked Dr Mitchell to expand on the comment that people with a mental illness are dying 15-20 years before their peers, and asked from which point this applies, i.e., from first diagnosis?

Dr Mitchell advised that 'realistic medicine' is a government policy, so there is an implicit assumption government policies connect to each other without necessarily referencing each other in text. The Strategy tries not to be diagnostically specific to anything. It is about mental health and wellbeing at a population level. The issue about premature mortality is as bold as, when you take two people in Scotland who have identical characteristics, the person with mental health issues is going to die 17 years earlier than you would expect. It's a universal finding across a population level. It's big data that has shown this.

Margaret Whitelaw from Lenzie Co Housing Group noted there is one reference to housing in prevention and early intervention and wondered if the strategy goes wider and includes the importance of a sense of place.

Hunter Watson advised he is concerned at the level of prescription of antipsychotic drugs. If these antipsychotic drugs do cause people to die prematurely it would seem to be a contravention of the Human Rights Act. Hunter asked Dr Mitchell whether he agrees legislation is required to tackle this problem.

Liam Beattie, HIV Scotland, asked for more information about how the Scottish Government plans to take forward antidiscrimination stigma and how it will be measured.

Dr Mitchell noted the Government has reached out to colleagues in housing policy. On the antipsychotics issue, Dr Mitchell noted learning disabilities and autism

colleagues have also expressed similar concerns. One action in the strategy is to develop a quality indicator and one of the measures proposes to look at use of antipsychotics for treating disorders other than psychosis. Dr Mitchell noted legislation is for politicians. Dr Mitchell referenced the 'See Me' campaign which has been working very hard on stigma and discrimination.

Andrew Muir, Psychiatric Rights Scotland, referenced the Duke of Hamilton, diagnosed with vascular dementia, who was forcibly put in hospital.

Dianna Manson, Age in Mind, referenced her concern on issues with out-of-hours services for people with a mental health condition, particularly long-term enduring conditions.

Miles Mack, Royal College of GPs, noted Action 15 of the Strategy provides for access to dedicated mental health professionals, particularly in GP clinics, and questioned what these primary care mental health workers would be and how they would fit in with the wider organisation.

Julia Mather, Open Secret, asked whether there are going to be any criteria for prescribing people antidepressants before sending them to a psychological therapist.

Dr Mitchell advised the Mental Welfare Commission is here to protect peoples' rights and investigate concerns. In reference to out-of-hours services and long-term conditions, Dr Mitchell noted a review is currently underway of services during public holidays and mental health is being considered as part of this work. In relation to the primary care model, a number of pilot projects are being tested in different places. In relation to antidepressant prescribing, NHS Education Scotland give advice about what psychological therapy is appropriate for which conditions.

Angela Dias, Change Network Officer, Action in Mind with Rosemary Carter and Dianna Manson

Angela thanked the group for the opportunity to speak. Angela advised she is part of the project called Age in Mind which looks at how people grow older with mental health conditions and what the issues are in terms of discrimination and stigma across Scotland. Angela explained people go to psychiatric services until they're 65, then they are transitioned to older peoples' services. A lot of people have said this structure constitutes institutional discrimination. When people go into older peoples' services with a long-term condition, they expect a certain level of treatment. Angela suggested that service is dramatically reduced when they go into older peoples' services. In addition to that there is a huge focus on dementia. Angela noted she is not aware of anyone being given a sensible, self-directed support budget with a level of control. It's not just about money, it's about attitude and low-expectations for older people.

Rosemary Carter greeted the group, noting she is there to talk about the conditions that prevail for Services for Old Age Psychiatry in Lothian. Rosemary

advised the group she is 70, paranoid schizophrenic and in the care of a community psychiatric nurse and consultant psychiatrist. Rosemary noted that the care she receives from Services for Old Age Psychiatry is greatly diminished from the care that she received from the Adult Psychiatric Services. Rosemary advised that she has been told to take concerns out of hours or at the weekend to NHS 24, Breathing Space, or to the Samaritans if there is a psychiatric emergency but none of these organisations are staffed by professionals who are psychiatrically trained. On a positive note, Rosemary told the group that four months ago a rapid response team for Old Age Psychiatry was put together which is accessible through a GP. Rosemary suggested more funding and more services are needed to contribute to Services for Old Age Psychiatry and that unless this happens there will be a tidal wave of elderly mental patients who are the first generation of elderly mental patients to be out in the Community and mentally ill.

Dianna Manson noted she was given a diagnosis of paranoid schizophrenia while a medical student. Dianna told the group she has moved from lifetime of care in an asylum to working and living within the community and back again. Dianna questioned why she has come full circle through no choice of her own, to be returned to the institutional life of a long-term continuing care in hospital for complex mental health conditions. Dianna suggested NHS hospital provision is more expensive than care in the community and also suggested by capping services at 65 and over, personal needs are bypassed.

In the discussion that followed, these points were raised:

Sandra White MSP noted the she will take the issue of over-65s being treated differently to the Scottish Government and asked whether the doctors seen in an Old Age setting are different doctors. Dianna answered they are the same doctors.

Hunter Watson said he thought the presentations from the speakers were brilliant. Hunter asked whether speakers are aware of the convention on the rights of persons with disabilities and, if so, are of the opinion Scottish legislation should be revised to take account of it. Dianna noted she is aware and sits on one of the committees.

Margaret Whitelaw, Lenzie Co Housing Group, commented that transitions, in general, are a very big problem in healthcare.

Ewan Law, Rowan Alba, asked whether Angela had come across or represented individuals or older veterans who have had trouble getting re-diagnosis or diagnosis on the autistic spectrum. Angela noted she has spoken to a couple of people who expressed this.

Tom Wightman expressed concern that there is no provision in care homes for autistic people with dementia. Dianna referenced a MWC report of someone with autism who was wrongly put into the type of care and that lady committed suicide. Kate Fearnley, Mental Welfare Commission, commented on the point about

autism, stating next year the commission will be developing a vision for services on adults and collecting experiences of services.

Eileen Wallace, member Scottish Older Peoples' Assembly, noted transitions from CAMHS [Child and Adolescent Mental Health Services] to General Adult services are mentioned but transitions to older age services are not.

'Depression in older age: do we know enough?'
Dr David Christmas, Consultant Psychiatrist, Advanced Interventions Service, Dundee

Dr Christmas explained he works in a NHS nationally funded specialist service, seeing people with depression and OCD who don't respond to usual treatments. About one-in-eight referrals for assessment is for people over 65. Dr Christmas spoke about context, uncertainties about treatment, and future challenges. One challenge is there is very little evidence to guide treatment decisions in older people with depression. Applying 12-month prevalence rates, around 1 in 5 cases of depression are in over 65s. The problem with this is that prevalence rates are almost always an underestimation. Significant amounts of depression are occurring in older age. Dr Christmas agreed that like people are saying, this often gets missed and is rarely a focus of treatment. Most of what we know about the effectiveness of drug treatments, come from trials of people between 18-65, probably from America, probably volunteers, and who don't look like anything seen in clinical practice. Dr Christmas noted that little is known about the preferred treatment strategies for people with dementia or about the effectiveness of maintenance treatments for depression in older people beyond 12 months.

Data from Improving Access to Psychological Therapies shows over 90% of all referrals from this programme come from people aged between 18-64, just over 6% referrals were for older adults. Dr Christmas noted only three-quarters of NICE studies report age of patients. Dr Christmas suggested there is a huge gap in research and treatment opportunities and what we know about treating this group. Dr Christmas stated there is a lack of evidence to tell us whether psychological therapies are effective in older people and in more severe or chronic depression. Dr Christmas referenced 365 studies, out of which only 1% had evidence on moderate depression in older age. Finally, Dr Christmas noted it is not known what the risk versus benefits are for maintenance treatments and psychological therapy for moderate depression.

In the discussion that followed, these points were raised:

Hunter Watson, stated current mental health legislation permits someone suffering from severe depression to be detained in hospital and given ECT and asked what Dr Christmas' attitude is to that.

Dr Peter Gordon suggested studies look at younger adults and not older adults due to being driven by the pharmaceutical industry and questioned the risks and benefits of long-term treatments.

Kathy Crawford, Lothian HIV Patient Forum, asked whether any of the studies included people in older age group who are also HIV positive and what are the results out of that.

Dr Christmas noted ECT treatment in Scotland is monitored very closely and whilst ECT is not without potential side-effects, in terms of effectiveness, 80% of people who receive ECT will get 50% better. Dr Christmas commented studies on the long-term benefits/risks of treatment with antidepressants are convincing in adults between 18-65 but less is known in older people. In response to the query regarding outcomes in older people who are HIV positive, Dr Christmas noted he isn't aware of any studies but is happy to look at whether those two groups coincide in any research.

[Following the meeting Dr David Christmas has submitted further information in relation to treatment of depression in HIV-infected persons. Please see Appendix A]

Margaret Whitelaw, Lenzie Co Housing Group, stated pharmacological companies do not take dosing across a lifespan into account when conducting trials, particularly as there are biological changes across as people age.

Dianna Manson questioned why more money isn't spent researching the genetic factors of response to medications. Dianna also commented that a lot of people who have ECT are very seriously unwell and they turn around very quickly after having ECT. It is not known why but it's well monitored. Medications are not well monitored and require more research.

Maree Todd, MSP, declared that prior to becoming an MSP she was a specialist mental health pharmacist. Maree asked whether Dr Christmas could share further information on the types of medical trials that are conducted.

Dr Christmas agreed there are changes in people across their lifespan and would like to think this is considered. In response to the question on genetics, for the last 30 years people have been predicting genetics will revolutionise treatment of mental health in the next 5 years. There are over 100 different genes that seem to confer some risk for schizophrenia and most seem to overlap with bipolar disorder, none have been shown to give reliable predictors of response or tolerability of medication. Dr Christmas noted there needs to be reliance on clinical practice, seeing people regularly and adjusting or trying different options. Dr Christmas noted drug trials are set up to show giving a drug is a little bit better than not giving a drug or a placebo. Those with comorbidities or psychiatric illness are excluded from drug trials. Dr Christmas referenced STAR-D, a very large real-world study of stepped care for depression (3,900 people). A key finding for most psychiatrists is that likelihood of response after the first two antidepressant treatments trials falls off.

Dr Miles Mack, Royal College of General Practitioners, noted he has a special interest in mental health and has worked together with Maree Todd in NHS Highlands. Dr Mack made a plea for generalism and patient care to be delivered by people who are able to see them in their entirety.

Margaret Whitelaw, Lenzie Co Housing Group, suggested there should be a no detriment cause, and people should take their level of service with them across their life course.

Hunter Watson intimated the problem with ECT is that politicians listen to experts and information from experts is not always the full information. Hunter suggested the most recent SEAN report does not make obvious the risks of giving ECT, which he states includes long-term and permanent memory loss.

Dr Christmas suggested when people talk about generalism there are lots of different components and it is continuity which people value the most. Dr Christmas agreed that transitions are really important and is a topic which has been talked about by the Royal College of Psychiatrists for years. Dr Christmas commented there may be cases where people do not get good advice about ECT and stated he was not placed to talk about that. All information from SEAN and the Royal College of Psychiatrists, clearly highlights around 2/3 people will experience short-term memory problems from ECT. Dr Christmas did not believe that there was good evidence that ECT causes brain damage and suggested it is important to note depression, and specifically chronic depression, has a significant impact on memory.

6. DATE AND TIME OF NEXT MEETING

Sandra White MSP noted that, due to the meeting already running over time, dates and times for the next meeting will be circulated to the respective groups by their Secretariat.

ADDENDUM

The date and time for the next meeting of the CPG on Older People, Age and Ageing is Wednesday, 6 September from 13.00-14.30pm.

The date and time for the next meeting of the CPG on Mental Health is Tuesday, 5 September from 18.00-19.30 in CR4.

APPENDIX – A

References relating to treatment of depression in HIV-infected persons

Kelly, J. A., Murphy, D. A., Bahr, G. R.*, et al* (1993) Outcome of Cognitive-Behavioral and Support Group Brief Therapies for Depressed, HIV-Infected Persons. *American Journal of Psychiatry*, **150**, 1679-1686. http://www.ncbi.nlm.nih.gov/pubmed/8214177

Markowitz, J. C., Kocsis, J. H., Fishman, B.*, et al* (1998) Treatment of Depressive Symptoms in Human Immunodeficiency Virus-Positive Patients. *Archives of General Psychiatry*, **55**, 452-457. http://dx.doi.org/10.1001/archpsyc.55.5.452

Nyaga, I. M. (2016) The Efficacy of Interpersonal Therapy on Depression Among People Living With HIV/AIDS Attending City Council Health Facilities in Dagoretti District - Nairobi. Doctor of Philosophy Thesis. Department of Psychiatry, School of Medicine, University of Nairobi, Nairobi. http://hdl.handle.net/11295/97913

Ransom, D., Heckman, T. G., Anderson, T.*, et al* (2008) Telephone-Delivered, Interpersonal Psychotherapy for HIV-Infected Rural Persons With Depression: A Pilot Trial *Psychiatric Services*, **59**, 871-877. http://dx.doi.org/10.1176/appi.ps.59.8.871

Riley, K. E., Lee, J. S. & Safren, S. A. (2017) The Relationship Between Automatic Thoughts and Depression in a Cognitive-Behavioral Treatment for People Living with HIV/AIDS: Exploring Temporality and Causality [In Press]. *Cognitive Therapy and Research*. http://dx.doi.org/10.1007/s10608-017-9839-8

Safren, S. A., Bedoya, C. A., O'Cleirigh, C.*, et al* (2016) Cognitive behavioural therapy for adherence and depression in patients with HIV: a three-arm randomised controlled trial. *Lancet HIV*, **3**, e529-e538. http://dx.doi.org/10.1016/S2352-3018(16)30053-4

Safren, S. A., O'Cleirigh, C., Tan, J. Y.*, et al* (2009) A Randomized Controlled Trial of Cognitive Behavioral Therapy for Adherence and Depression (CBT-AD) in HIV-Infected Individuals. *Health Psychology*, **28**, 1-10. http://dx.doi.org/10.1037/a0012715