



AGE
Concern

Undiagnosed, untreated, at risk
The experiences of older people with depression



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Depression is an illness that blights the lives of many older people. It is not “one of those things”. It is not “what you can expect at your age”. It is not an inevitable part of ageing.

It is an illness that can be treated: if older people seek help, are diagnosed, and receive appropriate treatment.

The scandal is that for many older people this doesn't happen. Many do not seek help. For those who do, ageist attitudes among health professionals can prevent diagnosis. And for the lucky ones who are diagnosed, access to the full range of treatments may be denied because of their age.

Older people with depression deserve better.

Ignoring the problem is not an option: if not identified and treated, depression ruins people's quality of life, increases the risk of other illnesses, and can even lead to suicide.

In August 2007, the independent UK Inquiry into Mental Health and Well-Being in Later Life, supported by Age Concern, released its report on improving services and support for older people with mental health problems and their carers.

The Inquiry identified age discrimination as a significant obstacle to older people receiving treatment for depression. This finding echoed research carried out by Age Concern and other organisations and academics in previous years.

The Government has repeatedly stated its commitment to promoting age equality in mental health. However, at the same time, it set up pilots of psychological therapies for people with depression which were restricted to so-called “adults of working age”.

This ignored guidance from the National Institute for Health and Clinical Excellence (NICE) that a full range of treatments is effective and should be available to older people with depression.¹

Age Concern believes that the fight to end age discrimination took a massive step forward in June 2008 when the Government released details of its planned Equality Bill. We strongly welcome the Government's intention to outlaw age discrimination in health and social care, and to introduce a duty on the public sector to promote age equality.

Removing the discriminatory age barriers will remove one obstacle older people face: access to the full range of treatments available. However, the findings of the Mental Health Inquiry, and the experiences of individual older people, show that this alone cannot end the scandalous treatment of older people with depression.

Age Concern is calling for immediate action. The problem of depression in later life must become a priority for the NHS.

We are proposing a three-point plan to improve the lives of older people with depression:

① Encourage older people with depression to seek help.

- Aim public education programmes at older people and their families so that they know how to recognise the symptoms of depression, know it can be treated and know where to seek help.
- Include older people in campaigns that challenge negative attitudes towards mental health problems.
- Offer support at times when older people are at increased risk of depression, such as bereavement.

② Ensure older people with depression are correctly diagnosed.

- Get rid of the ageist attitudes held by some GPs that prevent older people with depression from receiving the help they need.
- Improve the training and development of GPs to enable them to recognise and treat depression in later life.
- Develop the GP contract to incentivise the identification and treatment of depression in all patients.

③ Ensure older people with depression get the treatment they need.

- Plan and commission mental health services that take into account the prevalence of depression among older people and the evidence of effective interventions.
- Ensure that access to treatments for depression are planned and implemented to give fair access to older people.
- Remove the insulting, arbitrary and ageist rules that deny older people access to effective treatments.

One in four older people – two million over the age of 65 – living in the community have symptoms of depression that are severe enough to warrant intervention.²

Half of this group have symptoms of clinical depression.³

Depression increases the risk of physical illness, abuse and suicide.

Depression is the leading risk factor for suicide among older people.

Older men and women have some of the highest suicide rates of all ages in the UK.

The term “depression” is commonly used to describe a temporary depressed mood when one “feels blue”.

Health professionals, however, use the term to describe a serious and often disabling illness that can significantly affect general health and quality of life, sleeping and eating, family life and social activities.

Symptoms can include loss of confidence, loss of concentration, feeling tired all the time, distancing yourself from other people, especially those close to you, and a feeling that life is pointless.

In older people, depression tends to last for longer periods and have shorter intervals without symptoms.

Depression in later life is very common but it is not an inevitable part of ageing.

A quarter of people over the age of 65 (22% of men and 28% of women) have symptoms of depression which are severe enough to warrant intervention.⁴ The occurrence of depression increases with age from around 1 in 5 among the 65 - 69 age population to 2 in 5 among those aged 85 and above.⁵

Of the one in four older people with symptoms of depression, around half (12-15% of those aged 65 and above) meet the clinical criteria for a diagnosis of depression.⁶

40% of people in care homes have depression.⁷

Depression has many causes.

The risk of experiencing the illness is increased for, among others, those with a physical disability or illness; a past history of depression; other mental health problems such as dementia; those who drink excessive amounts of alcohol; or those who act as carers.

Episodes of depression can be triggered by problems, such as money worries, and stressful events, such as moving into a care home. Losing a loved one, which is common in later life, is a significant cause of depression: recently bereaved older people are three times more likely than married older people to show signs of depression.⁸

Social isolation, and the accompanying feeling of loneliness, is also an important factor. 45% of men and 34% of women over 80 living alone describe feeling lonely, compared to 4% of men and 10% of women living with a partner.⁹ It is little wonder, therefore, that levels of depression are high among isolated people in their 80s.¹⁰

Depression increases the risk of physical illness, abuse and suicide.

Older people with depression are at increased risk of physical illnesses such as heart disease, diabetes and stroke.¹¹ People with depression take longer to recover from illness and are more likely to be readmitted to hospital after a previous stay.¹²

They are also three times more likely to be the victims of elder abuse than those without depression.¹³

Depression is the leading risk factor for suicide. Older men and women have some of the highest suicide rates of all ages in the UK.¹⁴

Depression can be treated.

There is a range of options which can be used in treating depression including medications and psychological treatments such as counselling or other talking therapies. Simpler interventions, such as advice on sleep and anxiety management, may be effective in cases of mild depression. Physical activity can also aid recovery as well as prevent depression.

Unfortunately, many older people must overcome a series of obstacles if they are to receive the appropriate treatment.

Obstacles to recovery: lack of awareness, negative attitudes and silence

Depression is the most common mental health problem in later life.

Only a third of older people with depression discuss it with their GP.¹⁵

Nearly half of older people who take their own lives visit their GP in the month before suicide.¹⁶



There is a lack of awareness of depression among the general public.

Even though depression is the most common mental health problem in later life, awareness is low among older people themselves and their relatives.

For older people with physical illnesses, it can be difficult to know whether some of the symptoms are due to the illness or depression:

“I did not know I was depressed - I thought I had a physical health problem and it worried me.”¹⁷

Many older people identify the symptoms of depression as a natural consequence of ageing (unfortunately so do some doctors, see page 10). They feel that there's nothing that can be done to help them and see little in the way of information about treatments to convince them otherwise.

Negative attitudes towards depression are a powerful obstacle to seeking help.

For many older people, and the wider public, depression is a “*sign of weakness*”:

“The thing is if you've got a broken arm you've got people wanting to help – ‘Let me cook you a meal’. But if you've got a broken heart and a broken head they just don't want to know.”¹⁸

“Mental illness is still stigmatised whether you are young or old but older people have a double whammy!”¹⁹

This perception can prevent older people with depression from seeking and getting the help they need.

Older people from black and minority ethnic (BME) groups also have to contend with other negative cultural perceptions of mental health problems. Beliefs about the origin of the illness and the high value placed on family reputation results in many BME elders, and their families, keeping the depression a secret.²⁰

Families are an important source of both support and distress.

Support from family, and friends, can be vital in helping to prevent depression from developing at times of great stress, such as bereavement. They can also stop depression getting worse by their support and encouragement to seek help. In many cases, family and friends may be the only people that an older person turns to for help:

“One of the main reasons that I do so well is that I know I have my family behind me... I know that if anything should happen, if I was frightened or something, that all I would have to do is call.”²¹

However, family members can also have their own negative attitudes towards depression, generating greater feelings of loneliness and isolation in the older person with depression:

“I did not want to talk to my friends or family as they won’t want to hang around with me if I say I am depressed.”²²

Only a third of older people with depression discuss it with their GP.

Given all the obstacles above, many older people don’t know they have depression and do not mention their symptoms to their GP. Others think that it is inappropriate, or find it difficult, to mention non-physical problems to their GP:

“I kept going to the GP about my physical symptoms, but I could not tell him about the [mental] stress I was under at that time.”²³

GPs report that older patients rarely mention psychological difficulties. However, practice nurses feel that older people are more able to talk to them about “non-medical” problems. Older men can be particularly reluctant to discuss their feelings. They are more vulnerable to severe depression and suicide.

But what of those who do seek help?

Ninety per cent of GPs agree it is important to detect the early signs of depression and make a diagnosis.²⁴

Of the third of older people with depression who discuss it with their GP, only half are diagnosed and receive treatment.²⁵

This means that only about 15 per cent of all older people with clinical depression receive treatment. 850,000 out of 1 million people don't.

An even smaller number, six per cent, of older people with depression receive specialist mental health care.²⁶

Only half of older people in care homes who are diagnosed with depression receive any kind of treatment.²⁷

Lack of awareness and ageism go hand in hand to prevent diagnosis.

The vast majority of GPs recognise the importance of diagnosing depression. However, this clearly contrasts with the low number of older people with depression who are actually diagnosed and receive treatment.

This can partly be accounted for by the difficulty of distinguishing between physical and mental health problems which present similar symptoms. Older people themselves can hinder their GP in making a diagnosis by concentrating on describing their physical problems.

However, there is no avoiding the fact that some older people encounter health professionals with ageist attitudes that prevent diagnosis and block their access to treatments.

Just as the general public, and older people themselves, can dismiss symptoms of depression as an inevitable consequence of ageing, so can GPs and other health professionals. When "*being down*" is mistakenly seen as part of the ageing process, GPs may see little point in diagnosing and treating the illness. So, for many older people with depression, rather than diagnosis and treatment, they experience ageism and defeatism in their GP's surgery.

Even when correctly diagnosed, there is no guarantee that older people with depression will receive appropriate treatment.

Ageist attitudes can also influence what treatments GPs believe are suitable for older people with depression. This can mean that treatments such as counselling and other talking therapies are denied to them in favour of antidepressants.

*"I feel I am treated differently because of my age. It feels like I'm invisible now and I think sometimes I don't get offered services because I'm old."*²⁸



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Some GPs admit that they have prescribed antidepressants to older people even when they knew another treatment might be more effective.

*"I had a doctor who would already be writing the prescription as I walked into his office. There was never any mention of therapy."*²⁹

*"I went to my doctor and he suggested Prozac. I told him no medication, especially Prozac. He's a nice enough guy usually, but when I said I just wanted to talk to someone, he totally patronised me."*³⁰

GPs' choice of treatments can also be influenced by ageist obstacles in the wider NHS.

When an older person with depression has decided to seek help, and their GP has correctly diagnosed their illness, sadly there is one further major obstacle that can deny them receiving treatment: their age.

In some cases, GPs are unable to refer older people onto other parts of the NHS that could help them because of discriminatory rules that exclude people over the age of 65.

When diagnosis is not followed by treatment simply because of a person's age

Arbitrary divisions in mental health services, based solely on age, have created an unfair system for older people.

Older people have more limited access to psychological therapies than younger people.³¹

Fewer than 10% of older people with clinical depression are referred to specialist mental health services³² compared with about 50% of younger adults with mental and emotional problems.³³

The National Institute for Health and Clinical Excellence (NICE) has emphasised that older people should be offered the full range of services including psychological treatments.

In 2004, NICE issued guidance that a full range of psychological treatments are effective and should be available to older people with depression “*because they may have the same response to psychological interventions as younger people*”.¹ (See pages 18 - 21 for examples of the impact of such interventions).

Despite this guidance, older people have been neglected by an unfair system.

The Government has repeatedly stated its commitment to promote age equality in mental health. The Department of Health’s document *Securing Better Mental Health for Older Adults* (2005) states that services should be based on need and not solely on age. However, the document contained the following analysis:

“Older adults with mental illness had not benefited from some of the developments seen for younger adults, and some of the developments seen in older people’s services were not fully meeting the mental health needs of older people.”

In 2006, *Living Well in Later Life*³⁴, a review of the National Service Framework for Older People found continuing evidence of unfair treatment:

“The organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups.”

This was followed by another Department of Health document, *A New Ambition for Old Age* (2006), which again declared the Government's commitment to age equality in mental health.

Older people miss out on treatments in favour of “adults of working age”.

In 2006, the Government published a White Paper, *Our health, our care, our say: a new direction for community services*, with a commitment to “a health and social care system that promotes fairness, inclusion and respect for people from all sections of society, regardless of their age, disability, gender, sexual orientation, race, culture or religion, and in which discrimination will not be tolerated”. This should have been good news for older people with depression. However, the same White Paper announced pilots of psychological therapies which actually excluded older people in favour of so-called “adults of working age” (aged 18 to 65).



The Government has continued to introduce mental health initiatives that focus exclusively on “adults of working age”.

Sadly, the reality for many older people with depression is that, for all the Government's stated commitment to age equality in mental health, treatments and services that could improve their quality of life are denied to them simply because of their age. This arbitrary, ageist division has created an unfair system where older people with depression have access to fewer and lower standard services than those under the age of 65.

Age Concern has a three-point plan to tackle the obstacles experienced by older people with depression

Age Concern's three-point plan to improve the lives of older people with depression



Point 1: Encourage older people with depression to seek help

As described previously, older people with depression can be reluctant to discuss their mental health problems with their GP for a variety of reasons.

Public education programmes must target those older people who confuse the symptoms of depression with their physical illness, or don't believe anything can be done about it, or think the problem will just get better by itself. They, and their families, need information and advice to be able to recognise the symptoms of depression. They also need to be convinced that effective treatment is available and that it can start by talking to their GP: that they are not "*bothering their doctor*" but getting help that will improve the quality of their lives.

Older people with depression who are embarrassed to discuss their problems or worry that they will be seen as weak, are reacting to the negative attitudes prevalent in our society about mental health problems.

As well as public education programmes, which themselves can help to overcome these negative attitudes, wider initiatives must challenge the stigma attached to depression and other mental health problems. Surveys regularly show that older people themselves have negative attitudes about mental health problems. Yet, to date, very few campaigns have focused on older people.

As well as encouraging older people with depression to seek help, more support must be offered to older people at stressful times that can trigger depression, such as losing a loved one or when suffering from a physical illness. Those who have regular contact with older people, such as GPs, must actively intervene to provide support and minimise the impact of these life-changing events.

Age Concern recommends that:

- Public education programmes are aimed at older people and their families so that they know how to recognise the symptoms of depression, know it can be treated, and know where to seek help.
- Campaigns that challenge negative attitudes towards mental health problems must include older people.
- Support is offered at times when older people are at increased risk of depression, such as bereavement.

Later this year, Age Concern will launch a public awareness campaign aimed at older people with depression and their families. The campaign will aim to encourage more older people to overcome their reluctance and to seek treatment for their depression.

Point 2: Ensure older people with depression are correctly diagnosed

GPs are the main point of contact older people have with the NHS. On average, older people visit their GP seven times a year. GPs, therefore, have the key role in ensuring that older people with depression are diagnosed and treated.

It is essential that GPs have a clear understanding of the prevalence of depression in older people, and the obstacles that prevent them seeking help. When so many older people are reluctant to discuss mental health problems, GPs must adequately explore all the symptoms, physical and mental, of older patients.

It is also essential that GPs are aware of the obstacles they themselves may create based on ageist attitudes. It is unacceptable for depression to be dismissed as a natural consequence of ageing. Never again should a GP explain to an older person that depression is “something they should expect at their age”.

Improvements in the education and training of GPs are crucial to improving the diagnosis and treatment of older people with depression. All GPs should receive sufficient training to be able to identify the symptoms and triggers of depression and follow NICE guidance. They should also understand the effectiveness of psychological therapies in treating older people with depression.

As well as improving education and training, GPs should be encouraged via incentives to diagnose depression in older people. Providing incentives has worked for the diagnosis and treatment of all other common conditions. However, the GP contract currently limits incentives to the diagnosis of depression in people with diabetes or heart disease.³⁵ The GP contract should be developed to provide an incentive to diagnose and treat depression.

Age Concern recommends that:

- The ageist attitudes held by some GPs that prevent older people with depression from receiving the help they need are challenged and eradicated.
- The training and development of GPs is improved to enable them to recognise and treat depression in later life.
- The GP contract is developed to incentivise the identification and treatment of depression.

Age Concern will be working in partnership with GPs and other health professionals to raise awareness of the prevalence of depression in older people and to challenge the ageist attitudes that prevent diagnosis.

Point 3: Ensure older people with depression get the treatment they need

We have an ageing population. As the number of older people grows, so will the number of older people with depression unless action is taken. The next 15 years will see the fastest growth among the groups of older people who are most at risk of mental health problems. In that time, for instance, the number of people over the age of 85 will increase by 50%.³⁶

It is, therefore, essential that mental health services are planned and commissioned with this in mind. A key aim of mental health services must be to minimise the number of older people with depression.

NICE has issued guidance that a full range of psychological treatments are effective and should be available to older people with depression. To continue to deny older people access to these treatments is unfair and runs counter to the Government's repeated commitment to age equality in health services.

Age equality is not about receiving exactly the same services as everyone else. Older people are an extremely diverse group with many differing needs. Age equality is about removing the barriers to services which are based solely on a person's age. There is a need for specialist services for older people with depression and these should not be dismantled in the name of age equality.

Many older people are staying healthier for longer, while others who live in poverty, or are socially isolated, develop poor health earlier. Many continue to work longer, through choice or necessity. So why define millions of individuals, and the treatments available to them, purely on the basis of their 65th birthday? It is arbitrary, ageist and insulting to all older people to define them in this way. It must be eradicated from our health services.

Age Concern recommends that:

- Mental health services are planned and commissioned taking into account the prevalence of depression among older people and the evidence of effective interventions.
- Access to treatments for depression are planned and implemented to give fair access to older people.
- The insulting, arbitrary and ageist rules that deny older people access to effective treatments are removed.

Age Concern will be pushing the Government and the NHS to remove the ageist barriers that prevent older people with depression from receiving effective treatment.

Fixing the system: Talking therapies break down barriers

Age Concern Camden's Talking Therapies project offers a safe place for black and minority ethnic and refugee (BMER) older people to talk about their problems, thoughts, experiences and feelings in their own language.



Age Concern Camden has provided a counselling service for older people with emotional and psychological difficulties since 1998. The service is the only one of its kind in London.

Historically, it has seen a limited number of BMER older people. In response to this, a Talking Therapies project was developed specifically to provide therapeutic help to older people from BMER groups.

The accessibility of the service is a key issue and barriers to accessibility have been addressed.

The sessions take place at premises throughout the borough of Camden and home visits can be arranged if there are mobility issues.

The project involves volunteer counsellors who can speak languages present in the local community: currently Amharic, Arabic, Bengali, English, Gujarati, Hindi, Kacchi, Tigre, Tigrinya and Urdu.

The volunteers provide longer term, one-to-one counselling which aims to address issues such as isolation, trauma and loss, illness, ageing, and the impact of having moved to a new country.

David Richards, Counselling Services Manager at Age Concern Camden, explains why access to services like this is important for older people:

“As we age we may need to explore feelings about our past, present and future, and to address the roots of depression and other psychological problems. Members of BMER groups may have experienced painful or traumatic losses and be struggling to come to terms with ageing in a country not their own. The opportunity to explore their feelings and receive this support in their first language can be a hugely valuable experience.”

Anastasia Patrikiou, Coordinator of the Talking Therapies Project, describes how talking therapy helped one older person in Camden:

“Mrs A is a 60-year-old refugee, who fled from her war-torn country 14 years ago. Connections with her family and homeland were completely severed. She has not been in contact with her family since then.

When Mrs A joined the Talking Therapies Project in 2007, she was lost, isolated, lonely, depressed and overwhelmed by the painful events in her life. She suffered from diabetes and severe chronic pain, causing mobility difficulties, falls and injuries. She speaks no English.

We decided to offer Mrs A the service despite our concerns about her ability to feel comfortable in ‘opening up’ to her counsellor - a stranger - as this is not part of her tradition. We were proved wrong. In her year of therapy Mrs A was able to share and disclose, explore and understand.

During our final assessment with her I was struck by the changes in her. Her physical appearance had changed significantly. She had thrown away her walking stick and looked as if she had taken great care with her appearance. She described her diabetes as under control. She had recovered from her depression and seemed happy. She had started nurturing relationships and was going to join a women’s group. Her painful experiences had not disappeared, but she was able to understand and mourn, and able to see that it was worth engaging in life again.”

Mrs A calls her counsellor “doctor” in order to express her feelings of gratitude and respect. In Mrs A’s own words: *“‘Dr S’ has offered me more than any doctor could offer me. I was floating, disconnected and I was brought back to life.”*

In North Warwickshire, older people are helping each other to deal with depression and other mental health problems.

They have been recruited as Peer Support Volunteers by Age Concern Warwickshire, who are working in partnership with the Coventry and Warwickshire Partnership Trust (Mental Health) to improve access for older people to local primary care mental health support and services.

The project was set up by Dr Amanda Gatherer, Clinical Psychology Lead for North Warwickshire Primary Care Mental Health Team, in response to the relatively low number of older people who were participating in local psychological therapy services, despite the services being located in GPs' surgeries.

In most cases, the peer support volunteers, who are in their 50s and 60s, are motivated to help other older people because of their own experiences of, sometimes severe, mental health problems. Using these personal experiences, the volunteers are able to provide encouragement, support and hope of recovery to others.

Older people with depression can be referred to the Peer Support service by their GPs and other partners. In a recent example, GPs referred several older people living in rural settings to the Peer Support service. The older people had been prescribed antidepressants for a number of years and the GPs suspected that the treatment was no longer effective.

The Peer Support service was able to connect the older people with a volunteer who had similar experiences of long-term use of antidepressants.

The Peer Support service also allows older people who don't want to talk to their GP, or decline other mental health or social services involvement, to receive help dealing with their depression. One route is via Age Concern Warwickshire itself: older people with depression who approach the Age Concern on another matter can be encouraged to use the service.



Kate Richmond, Director of Psychological Services at Age Concern Warwickshire says:

"In broadening the range of support available to older people experiencing depression, we are already seeing a reduced level of antidepressant prescribing. We also expect to see a reduction in admissions to in-patient facilities and a further reduction in suicide rates in older people.

For those of our volunteers who have experienced depression, their role, the mutual support of each other and the knowledge that they are 'giving something back and making a difference in someone's life' has actually removed the stigma of mental illness they themselves felt. They have been able to demonstrate that having mental health difficulties need not be an entirely negative experience."

- ¹ National Clinical Practice Guideline Number 23, NICE, 2004.
- ² The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, August 2007.
- ³ Ibid.
- ⁴ Ibid.
- ⁵ R. Craig and J. Mindell(eds.), 2007; M. Godfrey et al, 2005; T.B. Van Itallie, 2005.
- ⁶ The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, August 2007.
- ⁷ Ibid.
- ⁸ Out of sight, out of mind: Social exclusion behind closed doors, Age Concern England, February 2008.
- ⁹ Ibid.
- ¹⁰ Ibid.
- ¹¹ Mentality, 2004.
- ¹² University of Liverpool, 2007.
- ¹³ M. O’Keeffe et al, 2007.
- ¹⁴ R. K. Ross et al, 1990.
- ¹⁵ M. Godfrey et al, 2005.
- ¹⁶ G. Tadros and E. Salib, 2006.
- ¹⁷ Peace of Mind, A resource pack for Bangladeshi Elders with Depression, Age Concern Tower Hamlets, 2008.
- ¹⁸ Ibid.
- ¹⁹ Response to call for evidence issued by UK Inquiry into Mental Health and Well-Being in Later Life.
- ²⁰ Mosaics of Meaning Summary Report, Glasgow Anti Stigma Partnership, 2007.
- ²¹ T. Katsuno, 2005.
- ²² Peace of Mind, A resource pack for Bangladeshi Elders with Depression, Age Concern Tower Hamlets, 2008.
- ²³ Ibid.
- ²⁴ M. Godfrey et al, 2005.
- ²⁵ Ibid.
- ²⁶ The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, August 2007.
- ²⁷ M. Godfrey et al, 2005.
- ²⁸ K. Langmead, 2006.
- ²⁹ Age Concern Research Services, 2005.
- ³⁰ Ibid.
- ³¹ The second report from the UK Inquiry into Mental Health and Well-Being in Later Life, August 2007.
- ³² M. Godfrey, 2005; K. Leason, 2005.
- ³³ M. Godfrey et al, 2005.
- ³⁴ The review was carried out jointly by the Healthcare Commission, Audit Commission and Commission for Social Care Inspection.
- ³⁵ The GP contract also incentivises the assessment of the severity of depression in those who are diagnosed.
- ³⁶ Government Actuary’s Department, 2005.



Age Concern is the UK's largest organisation working for and with older people to enable them to make more of life. In England, we are a federation of over 370 independent charities which share the same name, values and standards.

We believe that ageing is a normal part of life, and that later life should be fulfilling, enjoyable and productive. We enable older people by providing services and grants, researching their needs and opinions, influencing government and media, and through other innovative and dynamic projects.

Every day we provide vital services, information and support to thousands of older people - of all ages and backgrounds.

Age Concern also works with many older people from disadvantaged or marginalised groups, such as those living in rural areas or black and minority ethnic elders.



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