PUBLIC HEALTH INTERVENTIONS – MENTAL HEALTH AND OLDER PEOPLE

Draft Scope Consultation – Stakeholder Response Table

4 December 2006 to 12 January 2007

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
Age Concern England		General	Age Concern England welcomes this draft scope. We believe that mental health problems are not an inevitable part of growing old and much can be done to promote good mental health and well-being in later life.	We thank you for your support and welcome your comments.
		General	We recommend that the promotion of good mental health in older people should be implemented through programme guidance. In narrowing the parameters of this topic to make it appropriate for intervention guidance, the scope excludes activities that play an equally important part in maintaining good mental health, such as improving public safety or public transport, and excludes some older people who could most benefit from mental health promotion, such as those with diagnosed mental health problems. Mental health is affected by the complex interplay of factors and conditions such as spiritual faith, supportive family relationships, and poverty that can not be influenced through interventions alone. Everybody's Business and Securing better mental health for older adults (Department of Health, 2005) recommend that the promotion of older people's mental health requires a broad comprehensive approach across a range of services and throughout the life course.	Thank you for your helpful comments and for taking the time to comment on the draft scope document. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people and acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. It is the intention of the Institute to provide guidance that will be useful to all members of this population. However, if you feel that there are particular issues that warrant separate attention, we would

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				warmly encourage you to use the facility on the NICE website to suggest topics for future guidance development. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		General	We recommend that the referral from the Department of Health be interpreted broadly and that the guidance should apply to all types of both primary health care and social care services, irrespective of the point of access. An integrated approach to health and social care is consistent with Department of Health policy (Standard 2 of the National Service Framework for Older People, 2001). A broad approach to services benefits those older people who do not access conventional health services but receive informal support or other low-level services. Making the guidance more inclusive of older people supports the public health function of the guidance.	Thank you for your comments. We note your suggestion and will consider this approach to the remit. This document is referred to in the scope. Section 4.3.1 of the scope directly refers to informal support.
		1	We recommend that this section be reviewed to: • Support a broader, more inclusive interpretation of the referral for reasons outlined above, and • To remove ambiguity about the level of support, the type of services, and the setting covered by the guidance. We propose the existing paragraph be replaced by:	Thank you for your comments and helpful suggestions.

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			Guidance on interventions that promote good mental health and well-being in older people who access primary health and social care services.	
		2c	We recommend the wording of the penultimate sentences be amended to clarify the scope in relation to carers as follows: 'And/or responsibility for, *supporting* older people *who access primary health and social care services.*'	Noted, thank you.
		3b	We request that the reference in the first sentence to the UK 'Inquiry into Mental Health and Well-being in Later Life' be amended to reflect the accurate title of the Inquiry as follows: UK Inquiry into Mental Health and Well-being in Later Life	Noted, thank you. We will amend accordingly.
		3c-d	We recommend the deletion of the text in paragraphs 3c and 3d in support of the above recommendation for a broad interpretation of the guidance.	Noted, thank you.
		3c-d	We recommend clarifying the rationale for delivering the guidance through the primary care setting to aid interpretation of the scope. We suggest the inclusion of a new paragraph 3c as follows: *As the first and often only point of contact that many older people have with the health and care systems, primary health and social care services provide the most effective channel for the delivery of a mental health promotion programme for older people.*	Noted, thank you.
		3f	We recommend the inclusion of a statement about the broader responsibility across government departments and the wider	Thank you for your comments and suggested amendments, duly

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			community for mental health promotion in later life. The factors that influence older people's mental health identified by the UK Inquiry into Mental Health and Well-being in Later Life (Promoting Mental Health and Well-being in Later Life, 2006) go beyond the scope of health and social care and cut across the responsibilities of a variety of government departments. The Department of Health has also recognised the responsibility of all sectors for health promotion activities and the need for a 'whole systems' approach (Securing better mental health for older adults, 2005). We propose the inclusion of a new paragraph 3f as follows: *The promotion of good mental health in later life involves action in a range of areas including health and social care, education, housing and communities. It requires a 'whole systems' approach at all levels of government, and across the private and not for profit sectors.*	noted.
		4.1.1	We propose this paragraph be reviewed for consistency with paragraph 1. We recommend the existing paragraph be replaced with: *Older people who access primary health and social care services*.	Noted, thank you.
		4.2	We propose that the first and third bullet points of paragraph 4.2 be deleted for the following reasons: • Treatment for mental health problems does not necessarily include activities that assist the individual to maintain good mental health and well-being in the longer term. Promoting	Thank you, we note your concerns and have considered your proposals very carefully. The treatment of mental health problems, including dementia, is

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			good mental health for individuals with a diagnosed mental health problem supports the service delivery principles outlined in the Emerging Best Practice in Mental Health Recovery (NIMHE, 2004) and can contribute to the individual's journey of recovery. • The exclusion of people with a diagnosed mental health problem contradicts current NICE guidance which states that people with dementia should not be excluded from any services because of their diagnosis (Dementia - Supporting people with dementia and their carers in health and social care, NICE/SCIE, 2006). • Excluding people with diagnosed mental health problem would contribute to and reinforce the stigma attached to mental illness and this is contrary to the aims of the National Service Framework for Mental Health (Department of Health,1999). • The exclusion of older people who reside in long stay nursing homes for the elderly mentally infirm or equivalent is arbitrary and discriminatory. In practice, around 60% of people in all care homes have one or more mental health problems (Developing a whole new systems approach to older people's mental health: A check list for local health and social care systems, Care Services Improvement Partnership, 2006).	considered by NICE in its clinical guidelines. For this reason, the treatment of mental health problems will not be included in this public health guidance on the promotion of older people's mental health and well-being.
		4.3.1	We recommend that the interventions and activities that promote mental health and well-being are widely considered. Mental health promotion involves the complex interplay of many factors and	Noted, thank you.

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			conditions that often require a more holistic response than can be achieved through specific interventions (*Promoting Mental Health and Well-being in Later Life*, UK Inquiry into Mental Health and Well-being in Later Life, 2006).	
		4.3.2	We recommend amending bullet point 4 to remove ambiguity in relation to pharmacological and psycho-social interventions that can be used as both a treatment for mental health problems and as an intervention for mental health promotion. We propose: • Treatment of mental health disorders and conditions, including pharmacological and psycho-social interventions *when used for treatment purposes*.	Thank you for your comment, however all guidance related to treatment is referred to another part of NICE and is not considered to be within the remit of public health guidance. For a comprehensive description of NICE guidance please see: www.nice.org.uk/guidance/type
		4.3.2	We recommend that bullet point five be deleted. Older people who are dying should not be excluded from mental health promotion activities.	Thank you, we note your concerns. We recognise the difficulties in developing general guidance for such a diverse population. We will try to be as inclusive as the evidence allows, however, it may be that this particular group require specific guidance outside the scope of the current document. Again, if you feel this topic warrants particular investigation we would warmly encourage you to visit the

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				topic suggestion page on the NICE website. www.nice.org.uk/page.aspx?o=ts.home
		4.5	We recommend that the outcomes developed should reflect how older people think about their own mental health and well being. We suggest amending the paragraph as follows: *Outcomes will be assessed using:* • *The available evidence on what older people consider good mental health and well-being; and* • *The definition of mental well-being set out in 'Monitoring positive mental health'.* (NHS Health Scotland 2006; Parkinson 2006). *They will include but are not limited to standardised and validated measures (including self-report) of:* • *Quality of life* • *Psychological well-being* • *Self-esteem.*	Thank you for your suggestions, we note your comments. NICE is committed to including an individual perspective (e.g. self-report or qualitative work) when gathering evidence to support Public Health guidance. This is an integrative part of our broader remit to address health inequities. Further information about NICE process and methods, please visit: www.nice.org.uk/page.aspx?o=300576
		4.6	We recommend that the wording of the key question be amended for consistency with paragraph 1 as follows:	Noted, thank you. We very much appreciate your helpful comments. We hope you will continue to

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			What are the most effective and cost effective ways of promoting the mental well-being of older people who *receive primary health and social care services*?	engage with the process to develop current guidance and suggest topics for future guidance.
Age Concern Oxfordshire		1	"Good mental health and well-being" – see below	Thank you.
		3 - Introduction	I have some issues with the use of the terms "mental health", "mental ill health", "mental well being" and "mental ill-being". There is a tendency for the words 'health' and well-being' to be used interchangeably, and, indeed, I guess that there is a semantic argument that they both mean the same thing. However it could also be argued that one can be in a state of poor mental health and yet still experience a sense of mental wellbeing so the problem probably lies in the subjective/objective nature of mental health and wellbeing and also in the nature of both as a continuum. I feel that there is room for greater clarification of terms here.	Thank you, your comment is noted. There is much debate about the use and meaning of both these terms in the literature. We will clarify the scope appropriately.
		3b, 4.1.1., 4.2	'Residential institutions' 'residential care homes'; 'long stay nursing homes' I found the use of these terms confusing. I assume that by 'residential care homes' you mean the old definition of residential care for people who are relatively independent and need minimal assistance with personal care – as opposed to nursing homes which provide nursing care but this is not made clear in the scope. My comments on this classification are that it is somewhat woolly and confusing. It is my impression that this type of distinction between residential care establishments is not totally in keeping	Thank you for your feedback. We will amend or clarify the scope appropriately.

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			with the realities of residential care in that there are very few residential care establishments which do not come under the heading of 'long term nursing care'. Further comments will be made under section 4.2 regarding the discriminatory nature of these classifications.	
		4.1.1	This ignores the very large numbers of older people who live at home and do not receive domiciliary help and support because: • They have not requested it • They have refused it • They do not know that they care entitled to it • They receive help and support from families or private agencies	Thank you. We recognise that there are broader issues that need to be addressed with regard to older people who do not receive domiciliary care services. We do refer to support from unpaid carers, family or peers in the scope document section 4.3.1. We would direct your attention to the facility on the NICE website to suggest topics for our future guidance. www.nice.org.uk/page.aspx?o=ts.home
		4.2	***Long stay nursing homes*** I am very concerned at the exclusion of people who live in long-stay nursing homes. The high levels of depression and other forms of mental ill health in nursing homes are well-documented and in my experience, these institutions are very poorly equipped to deal with this. I realise that this would make the scope of the document very unwieldy but I would like to see some recognition	Thank you for your comment. We acknowledge the complexities surrounding this issue. Guidance related to treatment is referred to another part of the Institute and is not generally

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			of the needs of this section of the population and some discussion of potential future action. ***Hospital or hospice in-patients*** An in-patient admission to hospital is, for most older patients, a brief experience, but one which can have major impact on their mental well-being, lasting for a longer or shorter period post-discharge. ***Clinically diagnosed mental illness or dementia*** As discussed at the scope meeting this seems to be a clear indicator of discrimination against the group, in contravention of the NSF and "Everybody's Business" guidelines.	considered to be within the remit of Public Health guidance. For a comprehensive description of NICE guidance please see: www.nice.org.uk/guidance/type Please visit the NICE website to make suggestions for topics you feel we should consider for future guidance - we would welcome your input. www.nice.org.uk/page.aspx?o=ts.home
		4.3.1 and 4.6	***Areas that will be covered and Key Questions*** Again as I pointed out at the scope meeting, one of the major concerns of Age Concern was summed up in the **Joseph Rowntree Foundation 1998 report "That bit of help".** This report looked at the effect of low-level preventive services on people's health and well-being and concluded that these services had an impact far in excess of their cost in enabling older people to remain independent and maintain their quality of life. The report concludes: "Quality of life may not easily lend itself to measurements oif cost-effectiveness but if the meaning of "best value" is to be judged in terms which extend beyond short-term financial exigencies then the value older people accord low-level preventive services cannot	Thank you for bringing this report to our attention.

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			be ignored. "	
Brighton and Hove City Teaching PCT		general	The age band cut offs are important. 0ver 50s to 65 have specific mental health issues as do older bands. The problem with missing out the 50-65 in this guidance is where will their issues go? I believe they are more closely linked with older groups than younger and need to be looked at in a way to develop better mental health in older people by starting in mid-life.	Thank you. We acknowledge that the diversity of this population and would comment that this is unlikely to be the only occasion NICE will be asked to consider Public Health Guidance for older people. We would encourage you to put forward this suggestion as a topic requiring specific guidance. The web link to this particular section on the NICE website is: www.nice.org.uk/page.aspx?o=ts.home
		4.1.1	Considering the ages of the people in this group, this population seems very limited	Thank you, duly noted.
		4.2	Ill health, whether mental or physical is not any more a natural state for older people than younger people. People in or in and out of nursing homes or hospices or people going through short term or long term pharmacological treatment for mental illness are being left out? I think this needs to be rethought as people going through treatment for a long term illness or disability at any age will have mental health and wellbeing issues which should be addressed.	Thank you, your concerns have been noted. We would point out that best practice guidelines for mental illness and treatment come under the remit of NICE clinical guidelines, please see: www.nice.org.uk/guidance/type

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		4.3.2 Palliative Care	Think again about the right of people who are dying to have good mental health and wellbeing. Just because someone is dying doesn't mean they don't care about the quality of the life they have left. Despite popular belief, happiness is not necessarily just the preserve of the fit and young.	Thank you, we note your concerns and acknowledge the difficulties in developing general guidance for such a diverse population. We will try to be as inclusive as the evidence permits; however, it may be that this particular group require specific guidance outside the scope of the current document. Again, if you feel this topic warrants particular investigation we would warmly encourage you to visit the topic suggestion section on the NICE website www.nice.org.uk/page.aspx?o=ts.home
British Dietetic Association		General	Thank you for giving the BDA the opportunity to comment on the draft scope.	Thank you for taking the time to examine the scope and visit the website.
			We do not have any comments to make on the draft scope for the guidance.	

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BUPA Care Homes		**General**	As the scope excludes mental illness and dementia adults in receipt of primary care and other services while living in either residential care or the community must mostly be physically ill, frail or disabled. Given the observations on age in the row below is the referral from the Department of Health less to do with age and more to do with promoting mental health and well-being among adults with illness and disability. For example, out of a population of 168,745 in permanent residential care in England 25.9% (43,775) are **under** 65 years (Community Care Statistics 2006, Supported Residents (Adults), England, The Information Centre, Adult Social Care Statistics, London, 2006). A re-interpretation of the referral would be in accord with the principle of age inclusivity.	Thank you for commenting on the scope and bringing these figures to our attention. We would point out that best practice guidelines for mental illness and treatment come under the remit of NICE clinical guidelines Team, please see: www.nice.org.uk/guidance/type
		General	Old age is presented as 65 years plus. This is out of step with contemporary beliefs about old age that embrace not only chronology, but also biology, psychology and social attitudes **(ref. On Being Old, Stokes, G., Taylor & Francis. London, 1992.** In 1894 Alois Alzheimer joint-published a paper that defined old age as commencing between 45-50 years of age. This was unsurprising as life expectancy in, for example the UK in 1901 was 49 years for a woman and 45 for a man. By 1950 average life expectancy in the United Kingdom had reached 68 years and so a person in their sixties was now seen as old. **The Rising Tide report (Health Advisory Service 1983)** clearly saw old age as commencing at 65. Its apocalyptic predictions talked of a 'demographic time-bomb' that would explode in 2011 when the first 'baby-boomers' born in 1946 reached pensionable age.	Thank you for your comments and the reference documents. We acknowledge the complexities involved in addressing the issue of older people and mental well being. We will consider your suggestions and clarify the scope as appropriate.

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			Today average life expectancy is around 80 years, yet a person who today is 65 years old should expect to live into their mid-80s, while a person who is 25 years old has a life expectancy of 94 years. So when does old age commence? Whatever age boundary is chosen will be an ephemeral and arbitrary dividing line that may serve to perpetuate ageist assumptions. However, it is not simply that people are living longer they also remain in better health for longer. In 2002 average 'healthy' life expectancy in England for women was 70 years, and for men 67.5 years **(Office for National Statistics, Annual, On-line edition).** As such people in their 60s and early 70s are healthier, more active and youthful in outlook than ever before and hence do not see themselves as elderly for perception of old age evolves with improvements in 'healthy' life expectancy. Instead they regard themselves as being in late middle age and recent legislation to address age discrimination as well as proposals to redefine retirement and pension eligibility fosters this perception. While such discussion and examination is essential, for the Guidance to have meaning a point in the lifespan must be chosen (if the scope is still to be governed by age) after which we can refer to adults having entered old age. **75 years old** is an arbitrary boundary but one after which notable physical disability becomes prevalent and poverty and poor housing are common. The client characteristics of Council supported residents in Permanent residential care in England support this interpretation **(Community Care Statistics 2006, Supported Residents**	

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			(Adults), England, The Information Centre, Adult Social Care Statistics, London, 2006). Out of a total residential care population of 168,745 (31st March 2006), 14,295 are aged between 65-74 years (8.5%) while 110,675 (65.5%) are aged over 75 years. The corresponding proportions for nursing care are 12.2% and 76.1% respectively. BUPA Care Home's 2006 census revealed that 76.4% of residents in residential care homes were over 80 years old (the proportion in nursing homes was 64.4%). For the investigation to include people between 65-74 years in receipt of care, and in particular those aged between 65-69 years, would not only be at variance with current attitudes on ageing but would be making reference to a markedly atypical population.	
		Section 4.2	The exclusion of people in nursing homes implies that residents in residential care constitute a distinct population when in reality local authority budgetary constraints, a commercial need for residential care home proprietors to maintain occupancy, the skills development of social care staff and the wish on the part of providers, purchasers and families to provide 'a home for life' means there is a significant resident profile overlap between the two care home sectors. **The Continuing Care Conference's 2006 census of 32,301** people living in residential and nursing homes revealed that 58% of people living in residential homes were either immobile or only mobile with assistance (compared with 78% in nursing homes), 65% had severe sensory impairment (64% in nursing homes), 46% were incontinent (80% in nursing homes) and 10% had a diagnosis of either Parkinson's disease or	Thank you for your comments, duly noted. We acknowledge the diversity of people in receipt of services. Again, we would warmly encourage you to visit the website and suggest specific topics for future guidance. www.nice.org.uk/page.aspx?o=ts.home

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			stroke ((26% in nursing homes). BUPA's 2006 census categorised 642 residents living in residential care as being 'totally dependent' (16.6%). Residential care no longer provides sanctuary for the isolated, insecure and benignly forgetful. Nowadays it addresses the challenges of frailty, disability and ill health. As these are not exclusion criteria then it begs the question why residents with similar needs in longstay nursing care are not also to be covered by the Guidance? Similarly many people in receipt of local authority domicilary care nowadays present with complex care needs in order to have satisfied the increasingly stringent eligibility criteria set by local authorities as evidenced by the greater provision of homecare hours being accessed by fewer people.	
		Section 4.2	The exclusion of "older people undergoing pharmacological and/or non-pharmacological treatment for a clinically diagnosed mental illness or dementia" is understandable. But • Labelling can masquerade as diagnosis • The diagnostic criteria of both mental illness and dementia are imprecise in mild pathology. For example, 42% of people over 85 years suffer from Mild Cognitive Impairment – a state of exaggerated forgetfulness within an intact cognitive profile that resembles early Alzheimer's disease (AD) - but the conversion rate to Alzheimer's disease is around 10% per annum, and not	Thank you for your comments, we note your concerns, we would refer you to our earlier response and information about NICE Clinical Guidelines team on: www.nice.org.uk/guidance/type

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			all will convert (ref. Yesavage JA et al. Modeling the prevalence and incidence of Alzheimer's disease and mild cognitive impairment, J. Psychiatr. Res. 2002, 36 (5), 281-86; Metastasio A et al., Conversion of MCI to dementia, Neurobiology of Aging, 2006, 27, 926-32). • Most people with dementia in residential care would not be considered to be in receipt of any form of treatment, but instead would be seen as living in a place of safety where their personal care needs are met. • Would we not learn about interventions that promote good mental health and well- being by also talking to those people who are depressed, anxious and poorly adjusted to the experiences of later life? Again this begs the question whether this Guidance is addressing adjustment to ageing or adjustment to illness and disability.	
		Section 4.2	An internal report commissioned **by Elizabeth Finn Care in 2004** suggests there is a constituency of professional elders who do not access community care services. The barriers are many but include a belief that they are ineligible for community support and a belief that social services are culturally insensitive to the needs of relatively affluent families. The outcome is exclusion from mainstream service provision. How will excluded populations such as the above, as well as older adults from ethnic minority communities be covered by the Guidance?	Thank you, we note your concerns. We acknowledge that the topic of promoting mental wellbeing for older people not receiving services is complex. The Public Health Interventions Advisory Committee (PHIAC) will be examining all available evidence to inform the guidance with particular emphasis on available evidence from ethnic

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				communities and other seldom heard groups. We would invite you to suggest topics for future guidance on the NICE website. www.nice.org.uk/page.aspx?o=ts.home
		Section 4.2	Are older people with learning disabilities and stroke to be excluded? The answer has implications for people with mild dementia who may be similarly impaired, yet are currently excluded.	This guidance will focus on the well-being of all older people over 65, as far as the available evidence permits. It will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.

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Centre for Aging and Mental Health, Staffordshire University		General	This guidance will be aimed at people living in residential care or in the community. We are concerned by the exclusion of people in nursing care and strongly believe that they should be included. Their exclusion implies that it is not possible to promote mental health in this group and there is an urgent need to address the mental health needs of people in nursing care whether or not they are being treated for mental illness.	Thank you for your comments. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people and will seriously consider your comments when re-drafting the scope. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. www.nice.org.uk/page.aspx?o=ts.home
		4.2	This paragraph states that residents of long stay nursing homes and home registered as offering EMI care will be excluded from the scope. There is an urgent need to promote mental health in this group of people and we strongly believe that the scope should be extended to cover interventions aimed at improving their mental health. This is equally true of people undergoing pharmacological or non-pharmacological treatment for a mental illness or dementia. Treatment of a mental illness should not exclude people from measures to promote their mental health: these people may be those who most need measures to promote mental health.	Thank you for highlighting this important issue, we note your concerns. Please see our previous comment on topic suggestions for future guidance. www.nice.org.uk/page.aspx?o=ts.home The scope is being revised to focus on the well-being of all older people, as far as the available evidence permits. However, it will not address the treatment and care

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				of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.
College of Occupational Therapists Specialist Section – Older People		**General**	This Scope is welcomed by occupational therapists (OTs) working with older people. We would suggest that the guidance covers 65+ not 70, to enable easier comparison with other documents and statistics. However we are concerned that the following are excluded: • People residing in "long stay nursing homes and homes registered to care for the 'elderly mentally infirm' or equivalent." • "Older people undergoing …… for a clinically diagnosed mental illness or dementia." **In practice, many care homes have dual registration to provide residential and nursing care, for physically frail and elderly mentally infirm residents.** As three quarters of all care home residents have some degree of cognitive impairment, a huge population is effectively excluded from this scope. People with a diagnosed mental illness or dementia should be included in mental health and mental well-being promotion activities and intervention in order to prevent further deterioration	Thank you for your helpful comments and suggestions, we very much welcome your support. We acknowledge the diversity of needs among this group and the complexities surrounding the promotion of mental wellbeing, which we will consider very carefully in the production of the guidance. However, all guidance related to treatment is referred to another part of the Institute and is not generally considered within the remit of Public Health guidance. For a comprehensive description of NICE Guidance please visit: www.nice.org.uk/guidance/type If you feel that there are particular areas that NICE should consider for future guideline development, please submit suggestions at the

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			or relapse.	NICE website. www.nice.org.uk/page.aspx?o=ts.home
		General	Are older people involved in this consultation process?	Thank you for your question. Organisations registered as stakeholders for each topic are invited to comment on NICE consultation documents. In this case many of the stakeholder organisations represent and/or are composed of older people and they may choose to comment. The list of registered stakeholders can be seen on the NICE website. There is scope for further consultation during our fieldwork phase. Further explanation of NICE methods are detailed in our process and methods manuals at: www.nice.org.uk/page.aspx?o=300576
		General	Assessment and person-centred care is not mentioned which is an omission.	Thank you we note your concerns.
		General (repeated at 2)	The terms mental well-being and mental health are used interchangeably. The title refers to mental well-being (which is	Thank you for your comments. We will clarify the scope appropriately.

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			probably more appropriate as the document has established the scope as *not* including those with particular mental health problems (see other comments on this issue) – or – the document needs to refer to 'mental health and well-being' throughout.	
		General	Engaging in purposeful activity in order to promote mental well-being is a basic philosophy to OT and is considered a vital component to positive daily living. In recent years the link between participation in occupation and health has been evidenced in occupational therapy research. References: Horowitz et al. (2004) Promoting well-being and engagement in life through occupational therapy lifestyle redesign. A pilot study within adult day programs. *Topics in Geriatric Rehabilitation 20(1)*: 46-58. Matuska et al (2003) Brief Report - Outcomes of a pilot occupational therapy wellness program for older adults. *American Journal of Occupational Therapy57*: 220-224. Furthermore, health promotion programs and preventive health services (e.g. preventive occupational therapy) are beneficial to support older people living at home. References: Clark et al (1997) Occupational therapy for independent living Older Adults. *JAMA 278:*1321-1226.	Thank you for your very helpful suggestions and supporting literature. These documents may be helpful in developing current or future guidance. Again, thank you for these comprehensive suggestions.

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			Jackson et al (1998) Occupation in lifestyle redesign: The well elderly study occupational therapy program. *American Journal of Occupational Therapy, 57*: 326-236. Plus we must highlight The Lifestyle Matters study at Sheffield Hallam University, based on the Clark et al (1997) study referred to above. The contact for this is Dr Gail Mountain. A paper has been submitted summarising the issues arising from this Study that highlights some of the omissions in this Scope, however this is not yet publicly available. Volunteer programmes: contributing to society (having a "role", giving something) – receiving something (gratitude, social status). Suggestions for Literature Search: For preventive aspects of programmes there are several keywords such as independence, choice, active later for older people, engagement/participation in occupation. Also: physical environment, age appropriateness, purpose-built.	Thank you. Thank you.
		2 (repeated at general)	The terms mental well-being and mental health are used interchangeably. The title refers to mental well-being (which is probably more appropriate as the document has established the scope as *not* including those with particular mental health problems (see other comments on this issue) – or – the document needs to refer to 'mental health and well-being' throughout.	Thank you, we will amend or clarify the scope where appropriate.

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		2b	The newly published 'Recovering Ordinary Lives: The strategy for occupational therapy in mental health services: A vision for the next 10 years' (COT, 2006), outlines how the occupational therapy profession plans to develop mental health services in support of these key drivers.	Thank you for this helpful reference.
		2c	A distinction needs to be made between unpaid/paid support – very often the support provided by families, friends, neighbours is invisible.	Thank you, duly noted.
		3 b/c	Approx 75% of residents in care homes have some degree of cognitive impairment with similar statistics for other mental health problems, but this is not taken into account in the scope. On occasions the two may be linked, i.e onset of depression following onset of dementia due to insight into loss. Is poor mental health in care homes (60%) linked to lifestyle and loss, or an undetected/detected diagnosis? Additionally, older people who live in the community often experience mental health problems but remain undetected. This group of people would clearly benefit from preventive programmes provided /offered by a range of agencies (statutory, voluntary) as mentioned earlier.	Thank you, your concerns have been noted.
		3d	Many care home admissions are in response to decreased level of independence. All residential care homes need to provide expert reviews of resident's levels of independence, social activity, risk of falls, equipment needs and occupational (meaningful activity) needs. Occupational therapists' assessment and intervention skills	Thank you, noted.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			have much to offer to this process.	
		3d	Expectations of life may be low if staff do not enable residents to reach and maintain their potential. Staff, ideally following OT assessment, should be enhancing the quality of life and helping residents reach their max independence (See 'My Home Life' (Help the Aged, 2006), enabling residents to lead a fulfilled life through activities, outings, giving to others/contributing eg selling own made products, making cakes for the groups, running film clubs, lunch parties. Care homes need Activity Co-ordinators to promote the importance of activity for all residents (regardless of severity of impairments) to staff of all grades and roles. When moving from living in the community (own home) to an institutional setting, the transition from independence to dependence should be a gradual one and can be facilitated through: training of staff in different settings, opportunities for older people to choose meaningful activities as well as engage in them are crucial for this process.	Thank you for your helpful comments and suggestions.
		4.1.1	The receipt of domiciliary care is not always a reflection of need – some people remain undetected in the community.	Thank you for your comments; we recognise the complexities of producing guidance for those not receiving domiciliary care services.
		4.2	Will those residents of long stay settings be covered in another document? It is acknowledged that a higher percentage of this group experience poorer mental health. This might be seen as a	Thank you for your comments, your concerns are noted.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			result of poorer mental health in the first place within the community – but not necessarily so.	Long stay residential facilities are referred to in the scope section 4.1.1.
		4.2	As "hospitals" and people "undergoing treatment for a clinically diagnosed mental illness or dementia" are not included, this excludes all the people specialist Mental Health trusts are working with. The specialist trusts may have a key role to play in training and expertise.	Thank you for your comments, duly noted. Please see our earlier comments with respect to clinical guidelines, which deal with treatment guidance. www.nice.org.uk/guidance/type
		4.2	It seems inappropriate to not cover all residential institutions (nursing as well as care) as the need for guidance has already been established in 3b. Indeed, many care establishments have dual registration – residential and nursing, as well as physically frail and elderly mentally ill. In reality it is often difficult to differentiate between the categories. A diagnosis of dementia does not rule out the potential to achieve mental well-being.	Thank you for your comments, duly noted. We will amend the scope accordingly.
		4.3	Access to free podiatry would help with this goal.	Noted. Thank you.
		4.3	Free transport within the control of the individual and their carers would support improved range of choices.	Noted. Thank you.
		4.3.1	Of the 15 recommendations made in Promoting Mental Health and Well-being in Later Life 2006, the ones that are appropriate to this document (in terms of the brief by the DoH to NICE for guidance on public health interventions) are:	Thank you for your suggestions.

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			▪ Local Authorities ▪ Health Authorities ▪ Education Authorities ▪ Voluntary organisations ▪ Public and Business. It may be helpful if this NICE Guidance document is set out in sections for each of these.	
		4.3.1	Promoting Mental Health and Well-being in Later Life 2006 makes recommendations for interventions in 5 main areas: ▪ Discrimination ▪ Participation in Meaningful Activity ▪ Relationships ▪ Physical Health ▪ Poverty It would make sense that these areas are covered in this NICE Guidance document to make the links but go further into the actual interventions to promote mental health and well-being in each of these areas. This could be by section as in the above point. We would strongly emphasise the need to include *all* types of meaningful activity within the Scope, not just work and	Thank you for your comments. Noted. An inclusive definition is given in the Scope document, section 4.3.1.

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			volunteering as in the UK enquiry.	
		4.3.1	Choice is vital but also important is the sense of community when living in a residential home. If everyone had their meals at different times/places it could be like the modern family that does not sit down together and eat. Importance of seating, like with like, at the dining table/choosing where to sit etc. Look at balance between choice and maintaining relationships. Some value company, some don't. Maintain a 'complete' community atmosphere not a 'controlling or cosmetic' community. Complete communities enable, nurture, support, facilitate, are person centred, ability focused, address emotional needs, society of equals, purposeful, imaginative, motivate, value environment, balance between safety/risk/freedom, value importance of outside community reciprocity eg projects with schools, church, local picture gallery, golf club. *Residents can give to the community and in turn receive satisfaction that they still have something to give.*	Thank you for these comments and the reference.
		4.3.2	If we exclude certain areas not specifically targeting older people we may miss opportunities for prevention. This might be especially relating to child education and design of buildings.	Thank you, noted.
		4.5	No reference has been made as to describe the meaning of mental well-being from the older person's viewpoint. We question the suggested outcome measures. On the one hand it is proposed to exclude a diagnosed population (to avoid the concept of a medical model, professional jargon) – yet the	Thank you for your comment, duly noted. We will include self-report where evidence allows (section 4.5 of the Scope document). Our intention is

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			outcomes such as 'psychological well-being', etc mirror just that.	indeed to capture evidence from multiple sources. A more detailed description of NICE process and methods may be found at: www.nice.org.uk/page.aspx?o=300576
		4.5	Outcome measures should include one for each of the 5 areas as listed in our comments relating to 4.3.1, to determine if the recommended interventions are being implemented.	Thank you, duly noted.
		4.6	Again, we would strongly emphasise the need to include *all* types of meaningful activity within the Scope. Interventions that are known to, and frequently used by occupational therapists, but needing increased research to establish the evidence-base include: baking, gardening, music, art, walking, PAT schemes, reminiscence, sensory enhancement, Life story work, falls and fracture reduction work.	Thank you for your comments, duly noted.
		4.6	Interventions can have adverse side effects when hopes are raised that something can be available to help and then it either cannot be sustained or because it may be something simple like having a certain food available or "getting nails cut" then it is not seen as important or serious enough. People need support and assistance in achieving their own goals. Occupational therapists are ideally suited to lead on client centred practice in all settings. All GPs should have better access to an effective OT service.	Thank you for your comments, duly noted.

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		4.6	The need to measure outcomes of health promoting interventions, and the development of tools to do so, is a glaring omission. We also need to ask: where should the intervention be provided?	Thank you for your comment. The nature and detail of interventions and the best delivery mechanism will be based upon current, best available evidence.
		4.6	Training is necessary to teach staff that they are 'enablers', not just basic needs carers. They would also benefit from training in managing people, groups, difficult behaviour, basic psychology (eg Maslow), sensory loss. Balance of intervention—allow for independence and choice as well as outlets for creativity, learning new skills. In my experience older people enjoy being grouped like with like re interests and abilities. They are less likely to tolerate those of differing abilities due to frustration and impatience eg poor hearing, slow motor skills, talking too much, different social classes. Groups tend to be more successful with similar levels although that may be seen as discriminatory. At least a common denominator of the task in hand and a good leader can span the differences. Duration—one hour groups, to half day outings, to long term group work eg on a bed quilt, can all be effective – dependent on individual's needs, interests and abilities. Specialist intervention maybe needed for exercise groups for safety reasons, pottery, visiting musicians but 'in house' in residential homes can enable staff and residents to contribute at very little cost, eg running a video club twice a week followed by a	Thank you for your very helpful comments and specific interventions listed below. We would be grateful if you would provide NICE with the details of any documentation that highlights the impact and benefits of such training.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			discussion group. Adverse effects may include highlighting lost skills, so careful selection is needed to prevent sense of failure. A similar but new activity may need to be suggested eg an artist with a tremor taking up pottery. Barriers to effective implementation include not allowing staff the time to value mental wellbeing as much as physical needs, lack of training, funding, leading, lack of imagination. Ethos as 'minders' not facilitators. Change of thinking that spending an hour in the garden with a resident is highly valuable and not seen as skiving (sensory value, fresh air, Vitamin D, reminiscence, sense of space, opportunity to talk and build friendship with staff member etc). Lack of knowledge of an older person's background i.e. life history, can be a barrier. Many people are perceived by carers by what they see, without the knowledge of their past lives, achievements, losses, of *who they are*. Care staff can facilitate effective implementation with the above resources (money, leadership, imagination, training and education life history etc) in addition to visiting/employed activity coordinators/OTs/volunteers/community links to enable meaningful activity and fulfilled lives throughout an older person's years.	
		4.7	Will CSCi be part of the target audience or involved in the	Yes, both.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			measurement of implementation of the guideline?	CSCI is also on the list of registered stakeholders, as is the Social Care Institute for Excellence (SCIE). We will be working with SCIE in the development of this guidance.
Commission for Social Care Inspection		4.1 & 4.2	By limiting the scope of your work to only those receiving domiciliary care and support, sheltered housing or short-term residential care (presumably respite care), we feel that you will be severely limiting the evidence that can be gathered to inform your research and the usefulness of the final guidance. A large, and increasing, number of older people do not fall within the FAC criteria (as reported in CSCI's State of Social Care in England 2005-06) and do not receive any formal support or social service provision. It is these people, who may attend primary care services such as GP surgeries or clinics, who would benefit from any early intervention guidance on maintaining mental health and well being. Limiting the scope to only those receiving services would also pose the risk of excluding older people from BME communities or other groups that traditionally find it more difficult to access or receive appropriate services, who may have mental health needs and require social care and support, but who often fail to access or receive a service.	Thank you for your very helpful comments and suggested relevant documentation.
			Failing to include people who are undergoing pharmacological or other treatment for clinically diagnosed mental illness or dementia will also exclude large numbers of people from your work. The proposal to do this does not take account of the extent to which	Thank you, we note your concerns.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			medication is often combined with other more 'social' interventions to maintain and improve the functioning and independence of individuals in the community, particularly those at the earlier stages of dementia. By focusing on the clinical diagnosis of mental illness and dementia your study could pay too much attention to the use of 'labels' and diagnosis, rather than on the actual needs and experiences of individuals.	
			It is currently unclear from the draft scope whether you will be considering older people permanently living in residential settings or not. If you decide to include this significant group of people in your study, then it will be important to recognise that many people who do have mental health needs will be accommodated within mainstream services not necessarily registered for EMD – either because of the recognised shortage of residential care places for people with dementia or other mental health needs, or because the individual's mental health has deteriorated significantly following their move to the home.	Thank you, noted.
		4.5 & 4.6	With regards to outcomes and key questions, you may find it useful to make links with the various pilot projects currently taking place nationally on improving the experience of social care for older people. In particular, the POPPs and LinkAge Plus pilots which are concentrating on improving the participation of older people in local initiatives, as well as improving the services being designed and delivered to the local older population. Both of these pilot projects could offer significant evidence for your	Thank you for these helpful suggestions. We would be grateful if you could provide NICE with details of any published documents reporting the outcomes of these projects.

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			subsidiary questions regarding peer group interventions, the effectiveness and benefits of involving older people in service design and delivery, the barriers and facilitators for effective participation and partnership working with older people, etc. The contact names for these pilots are: [X] [X] Other sources of evidence for your study questions may be found in the Older People's blocks in councils Local Area Agreements. This resource may also shed light on how the wider council departments can share the responsibility for improving and maintaining older people's mental health and well being. Although your draft scope suggests you do not wish to cover community interventions that are not directly targeted at older people, the direction of travel for national and local government is for more inclusive and joined up working across departments – it is vital we highlight the needs of older people, including their mental health and well being, in all activities across council departments. This also links in to the current Transformational Government agenda, aiming to improve older people's experience as citizens within their community.	
Crossroads Caring for Carers		2b	Document asserts the value of preventative strategies but by the end of page 6 is asking about the mental; well being of those already affected. Crossroads would like to see stronger prevention strategies, earlier intervention being easier and cheaper. Suggest	Thank you for your comments. Please use the facility on the NICE website to suggest topics for future

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			investing in older people's engagement with their communities as suggested in research by Age Concern.	guidance if you feel there are particular issues that should be addressed separately. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		3d	Mental well-being of residents is impacted upon by staffing ratios e.g. waiting for assistance to lavatory leads to pre-occupation with incontinence. Mental well being also impacted by degree of choice exercised over decision to enter residential; care. Introduction of mentors could assist. (Refer to campaign for Professional Transition Support for Older People c/o [X])	Thank you, we note your comments. We would be grateful if you could submit any relevant documentation to NICE via the website.
		4.3.2	Age Concern identified 'having enough money' as critical, so omitting pre-retirement & financial planning seems short sighted especially when it could ease pressure on the public purse.	Thank you for your comments. Duly noted.

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Cruse Bereavement Care	Evidence 2	General	Population should not be limited to those receiving domicilary care and support. For the following reasons: 1. NICE's remit is preventative as well as about interventions when there is mental illhealth 2. There may be those not receiving domicilary support who have needs and they should be considered as part of the scope 3. With respect to the evidence base if the population is restricted then there is the loss of data on what does help mental well-being and mental illhealth	Thank you for your helpful comments and the attached document. We note your concerns and recognise the complexity of issues surrounding older people and mental wellbeing. If you feel there are topics that warrant separate guidance, please visit the NICE website to suggest topics for future investigation. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		General	Training and support and provision of information in order to improve mental well-being and health appears not to be included in scope	Thank you for your comment, noted.
		General	Just as the population and scope are currently being restricted as mentioned above and need widening so does consideration of the interventions that may be helpful. All talking therapies (eg counselling, bereavement counselling, bereavement support and listening) should all be included not some. Also the interventions should include as wide a consideration as possible and should not underestimate what Age Concern call "a little helping hand". Also organisations such as Cruse offer services that cross the boundaries between "talking therapies" and social or they may be social alone. For example some Cruse branches will offer support	Thank you for your comments, we note your concerns and appreciate that interventions may be many and varied.

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			groups after bereavement which are social but also have on hand experienced counsellors who can give one to one counselling	
		General	Cruse offers a number of services across the country to many bereaved people which then improves the mental well-being and mental health of bereaved people. This applies to people of all ages. I have sent a letter with two attachments: Bereavement Care in Practice which was commended by the Chief Medical Officer. Also a copy of our annual report to show the breadth of services offered by Cruse. Gallagher, Tracy & Millar (2005**)** give details of outcome measures from service users. Please refer to these Cruse publications and to this research on outcome measures.	Thank you for bringing this information to our attention.
		General	Please refer to the Cabinet Office report "Bereavement-making a difference" March 2005 in which Cruse was involved. This report talked about bereavement and the implications across all departments and is therefore relevant in your work on promoting mental health and well-being for older people. Participants in the work included many government departments including the Department of Health.	Thank you for your suggestion.
		General	Current scope excludes those in long stay nursing homes and homes registered to care for the 'elderly mentally infirm' or equivalent. Their mental well-being is important and should be considered as part of this work.	Thank you for your comments and concern. The scope is being revised to focus on the well-being of all older people over 65, as far as the available evidence permits. However it will not address the treatment and care of older people

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				with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.
		General	Needs to be consistency in document ie needs to be emphasis on mental health and well-being throughout the document	Thank you, we will amend and clarify the scope appropriately.
		General	Scope should include carers because caring for someone affects mental well-being and mental health of carer	Thank you for your comments, duly noted.
		General	Using the term mental well-being rather than mental health gives the work greater scope	Noted.
		General	Because the scope (areas to be covered) excludes the treatment of mental health disorders this may exclude valuable evidence that could be relevant to improving the mental well-being of older people in general. If older people are sometimes inappropriately diagnosed with depression they would not be included in the areas to be covered by this scope. This therefore ignores the possibility of promoting mental health by less medical treatment and more other interventions such as the talking therapies, befriending etc	Thank you for your comments, your concerns are noted.
		General	Scope doesn't refer to "end of life issues" (palliative care etc). This may affect the survivor's(eg surviving partner's) ability to grieve healthily and whether or not they then have good or less good mental wellbeing and mental health. Please see the attached	Thank you. Please see our earlier referral for topic suggestions at the NICE website.

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			submission by Cruse to the Department of Health "Proposals for end of life care strategy for adults"	
		General	Ways of enhancing service access needs to be addressed in scope and outcomes	Noted.
		General	Volunteering by older people makes a difference to their mental health. Please refer to www.ivr.org.uk/mentalhealth.htm where there is an article titled "Volunteering for mental health" and www.socialexclusion.gov.uk/downloadable.asp?id=206 where there is an article titled "Volunteering and mental health: A review of the literature". Refer particularly to section 5 The impacts of volunteering- In the section "What impact has volunteering had on your mental health it stated "Almost all respondents said that it had a positive effect"	Thank you for your helpful suggestions and recommended literature.
		General	In your literature search please consider referring to: A strategy to promote mental well-being in Berkshire 2010-2010 Ref **http://www.bhps.org.uk/documets/BerksMentalStrategy.pdf** A search in the document on the word bereavement would give Section 1.4 where the Health Education Authority (now the Health Development Agency), suggests the social and psychological causes of mental illness: HEA (1997). This includes the predisposing factors (including bereavement) and precipitating factors (including bereavement) and Section 7 is about promoting mental health to individuals at risk in the community including	Thank you for this helpful suggestion.

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			bereaved people. Section 7.1 talks about bereaved people and "what *needs to be done for bereaved people?* • Work with Cruse to train GPs & community professionals to be trained in the detection of post bereavement depression • Professionals to be made aware of existing support resources e.g. CRUSE, selfhelp groups, church support" Also the document gives references to bereavement and the effect on for example widows and widowers.	
		General	In your literature search please consider referring to: The British Medical Journal has articles concerning older people and bereavement and particularly *BMJ* 1997;314:1609 (31 May) ABC of mental health: Common mental health problems in primary care T K J Craig**,** A P Boardman That article looks at emotional symptoms and not just mental disorder. It emphasises stresses in people's lives such as a bereavement. It looks at the doctor's most appropriate responses. Sometimes the appropriate response of the doctor is compassion and reassurance rather than drug treatment. Cruse would like to emphasise our role in the community in promoting mental health and well-being and in particular the referral by many GPs of their patients to Cruse in addition to or instead of drug treatment. The referral is either directly by the	Again, thank you for your suggestions. Thank you, duly noted.

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			doctor or the doctor suggests that the individual contacts Cruse. Besides the referrals by doctors we have referrals from other health professionals such as social workers and community psychiatric nurses.	
		General	In your literature search please consider referring to work of St Christopher's Hospice and Cruse Bereavement Care Reviews in Clinical Gerontology 7: 47-53 Cambridge University Press doi:10.1017/S0959259897000051 Published online by Cambridge University Press 01Jan1997 Bereavement and mental health in the elderly Colin Murray Parkes [a1] St Christopher's Hospice, London, UK Abstract Because women die at an older age than men, and marry men older than themselves, widows outnumber widowers and the average woman can expect to survive her husband by five to six years. In fact, widows make up a substantial proportion of the elderly population. In this paper the current state of our knowledge of the reaction to bereavement in the elderly will be reviewed and its implications for the provision of services considered.	Thank you, we note your suggestion.
		General	In your literature research please refer to experience in Scotland where bereavement support is available from Cruse and is	Thank you for your helpful

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			referred to in the health Scotland report http://www.healthscotland.com/documents/browse/349/334.aspx Mental health and primary care: a needs assessment GPs were more likely to refer to practice based counsellors and to a few other well known services such as …., Cruse and … in the 'suburban' case study area.	suggestions, duly noted.
CSV (Community Service Volunteers)		Section 2, b), page 1	CSV thinks it is important that the document references and is informed by the work of the Cabinet Office/DWP led *Transformational Government for Older People* initiative. This project is taking a whole systems approach to the delivery of better outcomes for older people and emphasises the important relationship between public, private sectors, local community interests and the development and sustenance of social capital in delivering those outcomes.	Thank you for your comment and suggestion. Duly noted.
			The guidance should also refer to the document 'Opportunity Age' (DWP, March 2005. This paper is, of course, intended to initiate the development of a 'coherent' strategy to manage the change required to meet the needs of an ageing society. It suggests that in the years after 50 older people want three main things. • Career opportunities that suit family circumstances • Independence and control over their own lives • Active involvement in society The document pays particular attention to the importance of volunteering as a means of achieving the latter of these three	Thank you, noted.

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			ambitions.	
			The Help and Care publication '*Moving Out of the Shadows: A report on mental health and well being in later life'* (Help and Care Development Ltd, January 2005) is also an important reference for those concerned with improving the mental health and promoting the well being of older people. The report, the result of a BGOP and Older People's Programme led alliance, pays specific attention to the inter-dependency between (and the multi-faceted nature of) mental health *and* quality of life and the need for service provision (including and beyond health and social care) to understand and respond to this interdependency.	Thank you, duly noted.
			CSV hopes that the development of this guidance will be used as an opportunity to promote the value of active engagement by older people in enabling and sustaining their well being. There is increasing interest in the positive impact of volunteering (as referenced, for example, in 'Opportunity Age' and 'A Sure Start to Later Life') as a key feature of 'active engagement' by older people. There is an emerging consensus that volunteering benefits older people by: • helping maintain a sense of purpose and self-respect, particularly for those who have retired from paid work • lessening the isolation felt by those cut off from social networks in the workplace and from their families • having beneficial effects on physical and mental health.	We share your hopes and thank you for commenting on the document at this stage in the process. Thank you for your suggestions.

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			The positive impact of volunteering on the physical and mental well being of older people is underlined by a significant body of North American research which suggests that the benefits of volunteering '*may be more significant for older adults than for younger people'* and that '*the benefits of volunteering go well beyond just making the participants feel better about themselves; it helps them stay healthy and may even prolong their lives'* ('The Volunteer Factor', Richard Adler, Aging Today, Volume XVX, No 4, July-August 2004).	
		Section 2, c), page 2	CSV's view is that the last line should read "responsibility for, the care and/or support of older people in residential care and via primary care services". This will allow consideration of interventions that help promote and sustain independence and not just those concerned with "care".	Thank you, we note your comments.
		Section 3, a) page 3	The statistics here appear instructive and underline the value of enabling and providing the support to enable people to live in their own homes.	Thank you, we welcome your support.
		Section 4, point 4.3.1, page 5	CSV's view is that the guidance should include activities by older people to help peers and self help groups.	Thank you, noted.
		Section 4, point 4.3.2, page 5	CSV would urge that pre-retirement schemes are included. This is particularly important given the fact that DH has, in the recent past, funded an action research action initiative on pre-retirement interventions and aimed them at improving the long term health of retirees.	Thank you, we note your comments. We would invite you to suggest topics for future guidance through: www.nice.org.uk/page.aspx?o=ts.h

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				ome
			CSV would also wish to emphasise the importance of including community interventions to improve the physical and social environment. It is becoming increasingly evident that this does have an impact on older people's quality life and their ability to live independently lives and consequently their mental health and well being. For example, research undertaken under the ESRC's Growing Older Programme published in 2003 confirmed the poor quality of life and inequalities experienced by older people living in deprived neighbourhoods. Specifically, this research considered the extent to which older people in these neighbourhoods experienced exclusion from social relations, civic amenities, basic services and exclusion from the neighbourhood itself. In relation to the latter, those who regarded their neighbourhood as unsafe or a place where they might be vulnerable to crime were clearly 'restricted in their ability to participate in important social roles',(T Scharf, C Phillipson, A E Smith and P Kingston, '*Older People in Deprived Neighbourhoods: Social Exclusion and Quality of Life in Old Age,* ESRC, 2003). The wider physical and social environment, the quality and accessibility of other local public services *beyond* health and care e.g. parks, leisure, libraries, arts, education and learning, are all relevant to the well-being of older people and must, in our view be considered when looking at measures to promote better mental	Thank you for your comments and recommended documents. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. Again, these are topics your organisation might like to suggest for future guidance development via the NICE website.

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			health in later life.	
		Section 4.6, page 6	CSV would suggest the definition of "cost effective" should embrace the notion of social benefits as set out in the Treasury Green Book, so that the long term benefits of mental well being are properly measured.	Thank you for this helpful suggestion, duly noted.
		General	In general terms, CSV's view is that the parameters of the guidance are too narrow. We feel very strongly that to restrict the relevance of the guidance to those receiving health or social care services as it odds with wider policy objectives of prevention and the promotion of independence. It will mean that the guidance overlooks all those who do not take up services but need them (including carers).	Thank you for your comments, your concerns are duly noted. We will carefully consider your suggestion. Thank you for taking the time to comment on the draft Scope document.

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Culture East Midlands			Culture East Midlands is a non-departmental public body sponsored by the Department for Culture, Media and Sport. The organisation is based on a consortium model with membership with the purpose of championing and furthering the role of culture in regional development. Membership consists of the regional cultural sector funding and development agencies, as well as other regional agencies partnering involved in ensuring culture plays a central role in regional development: Arts Council England East Midlands; EM Media, English Heritage East Midlands; English Heritage East Midlands; Museums, Libraries, Archives East Midlands; Sport England East Midlands; Big Lottery Fund; Heritage Lottery Fund; East Midlands Tourism; Regeneration East Midlands; Government Office for the East Midlands; East Midlands Development Agency; East Midlands Regional Assembly, Local Government East Midlands. Culture East Midlands is member of East Midlands Mental Health Forum and has worked with other regional partners including the Care Services Improvement Partnership (CSIP) to develop a growing recognition in regional policy and strategy of culture's contribution to mental health and well being. Indeed at 2006's East Midlands Public Health Conference, Culture East Midlands led a workshop on the role of culture in mental health and well being. To this end, Culture East Midlands, working with Government	Thank you for your comments and helpful suggestions. We welcome any documentation you may provide or recommend. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home

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			Office East Midlands and CSIP, consulted with health sector professionals and cultural sector organisations to develop ***Culture and Well Being: How cultural activity is supporting health and well being in the East Midlands*** **(2006).** The document describes the policy framework within which cultural activities can meet health and well being outcomes, presents some of the evidence, and offers good practice examples. The document (attached) outlines the role cultural activities can play in personal identity, reducing isolation and social participation and networks, and more broadly in social inclusion. There is growing support from health and social care professionals to working with cultural services, providers and professionals across sport, libraries, museums and the arts, to deliver innovative responses to users' complex needs. In order for a greater number of older people to access the mental health benefits associated with a range of cultural activities, the establishment of referral schemes from primary care will be paramount. It is recommended that through the process of development of this Guidance, that specific good practice guidance for the involvement of cultural sector services in the promotion of mental health for older people should be developed.	

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
Derbyshire County PCT	Evidence 1	General	Specific issues to consider in scope: • Alcohol and substance misuse • LBG and sexual health • End of life • Spirituality and well being • Learning disabilities • Elder abuse • Physical activity and mobility – e.g. chair based / wheel based exercise. • Older people who are carers themselves • Medication/polypharmacy	Thank you for your suggestions, duly noted.
		General	Need to define age range at which guidance is to be aimed. Suggest 65+ is most pragmatic. Guidance should recognise different needs of age groups within above (e.g. 85+ will have different needs to 65+)	Thank you for your comment. We recognise that the term used to describe this group inadequately expresses the diversity of its membership. We would encourage your organisation to use facility on the NICE website to suggest topics for future guidance. Please visit:

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				www.nice.org.uk/page.aspx?o=ts.home
		General	Need a reality check in the literature – e.g. working in later life may be ok for some but may be the last thing someone who has been in manual work all their life needs!	Thank you for your comment.
		4.1.1	We feel the scope should include people who are not accessing services/ in receipt of support. This is because there may be an element of unmet need. Also public health interventions can help prevent or delay the need to access services.	Thank you for your helpful comments. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. We also acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		4.2	Scope mustn't be too exclusive – mental health promotion is equally important for those with a diagnosed condition. For example in the dementia guidelines it specifies that people with dementia should not be excluded as a group. Therefore scope	Thank you for your comments, duly noted. The scope is being revised to focus on the well-being of all older people

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			should include people with a clinically diagnosed mental illness or dementia.	over 65, as far as the available evidence permits. However it will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.
		4.3.1	Will this include services that are delivered on discharge from hospital?	Thank you for your question, guidance will include evidence from all services.
		4.3.2	Concerned that that the guidance will only consider evidence on interventions that are specifically aimed at older people. If there is evidence that something works in the general population (e.g. arts initiatives/ CAB sessions) then we suggest such interventions are included in the guidance if they have the potential to be targeted at older people. This would still differentiate interventions such as street lighting which don't have the potential to be targeted at specific groups.	Thank you for your comment, we note your concerns.
		4.3.2	Why are pre-retirement schemes not being included?	We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. We also acknowledge that the term used to describe this group inadequately expresses the diversity of its membership.

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				We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		4.5	Problems with definitions – need to be wary when mental health and well-being are used interchangeably – they need to be defined more explicitly. E.g. someone could be diagnosed with dementia (and therefore have a 'mental health' problem) but still have a great deal of 'well-being'.	Thank you for your comment, we note your concern. These terms are used interchangeably throughout research literature and there is much debate on the use of either or both terms.
		4.6	Need to be specific about: home-based activities or community based activities/group or individual etc	Noted, thank you.
		4.6	Scopes needs to include those not in receipt of support/services (see comment re 4.1.1 above) in order to adopt a whole population perspective	Thank you. We recognise that there are broader issues that need to be addressed with regard to older people not receiving services. We will consider this issue very carefully.
		4.6	Subsidiary questions - 2nd bullet point – add sexuality and gender issues	Thank you for your comment.
		4.6	Evidence for supported walking programmes: Hirst J (1997) Peak Park Leisure Walks: A model for increasing	Thank you for this reference.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			physical activity in low participation groups through regular social walking. International Journal of Health Education Vol. 35 No. 3 91 – 96	
		Section 4.6	Evidence for CAB sessions in primary care Citizens Advice Bureau sessions via primary care reach many older people in the groups to be studied. There is evidence that CAB via primary care reaches people who do not otherwise access that service (Paris JAG, Player D (1993) 'Citizens' Advice in general practice'. *British Medical Journal*, 306, 1518-1520) and that CAB users via primary care tend to have higher levels of illness and disability. There is other evidence that CAB in primary care delivers measurable physical and mental health gains and that the intervention has a low cost per contact: • Abbott S, Hobby L (2002). What is the impact on individual; health of services in primary health care settings which offer welfare benefits advice? Health and Community Care Research Unit, Liverpool University, Research Report 87/02. Aug 2002). The above study also obtained a limited amount of data which suggested that services in primary care attract older clients than services located elsewhere. Similar findings are also reported in: • Abbott S, Hobby L (1999) *'An evaluation of the Health and Advice Project: its impact on the health of those using the*	Thank you for your helpful comments and supporting documentation. We appreciate your suggestions and references.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			service'. Liverpool: Health and Community Care Research Unit. • Moffat S, White M, Stacey R, Hudson E, Downey D (1999) "If we had not got referred and got the advice, I don't know where we'd be, it doesn't bear thinking about". The impact of welfare advice provided in general practice. A qualitative study. Newcastle upon Tyne: University of Newcastle. CAB in primary care has been shown to work in urban and rural settings. The service is highly accessible; for people who can't get to their GP surgery the CAB will do home visits. This intervention is likely to address health inequalities. Contact: [X].	
		4.7	Scope needs to include those not in receipt of support/services (see comment re 4.1.1 above) in order to adopt a whole population perspective	Thank you, noted. Please see our response to your earlier comment on the same issue.
		General	Re: Participation in cultural activity to improve mental health in older people. The evidence quoted in 3e) states 'The UK inquiry into mental health and well-being in later life (2006) identified five factors that influence the mental health of older people:… participation in meaningful activity; relationships; physical health (including physical capability to undertake everyday tasks)'	Thank you for your comments, suggestions and references for relevant literature. These will be very helpful in the development of current and future guidance.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			A major way of achieving the above 3 elements and reducing social isolation and exclusion is participation in cultural activity such as the arts, (see 'Culture and Well-being (Culture East Midlands, http://www.culture-em.org.uk/documents/uploads/CultureHealthadvdoc%20.pdf), 'Action on Mental Health: A guide to promoting social inclusion' (ODPM) and Scottish Executive Social Research (2005) Quality of life and wellbeing: Measuring the Benefits of culture and Sport: Literature Review and Thinkpiece', http://www.scotland.gov.uk/Publications/2006/01/13110743/0.) Though this may be covered by 'interventions delivered directly to older people by professionals, practitioners, their carers, family or peers, for example, to promote physical activity and improve mobility', this is not clear and seems more over focused on physical activity and home adaptations /social visits. I would welcome participation in cultural activities to be explicitly included in the consultation.	
Isle of Wight Council – Directorate of Adult and Community Services		general	I support the guidance and particularly the groups identified to be covered - those people in residential care or receiving domiciliary support. If the remit is widened then this could mean the guidance is watered down by providers of those services for people with higher needs. Rather than guidance - I would like to see this become legislative. As a Contract Manager, I would like to see local authority contracts to become outcome focused to promote activities and stimulation rather than the residential "hotel" type service	We welcome your support and thank you for highlighting the complexities surrounding this topic. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. We would encourage your

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			traditionally offered. People entering into services should be supported in continuing activities they were involved in prior to admission to a residential home. If not driven by Contracts, then this should become a CSCI requirement, rather than a recommendation. It would be useful to specify training to ensure that the way care is delivered promotes choice fulfillment and wellbeing for older people with a mental illness.	organisation to use the facility on the NICE website to suggest particular topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
Leeds University, Institute of Health Sciences and Public Health Research			We think it would be important to include interventions to prevent delirium. Although delirium is usually thought of in the context of hospitalised patients, research evidence suggests that more than half the cases are present before hospitalisation. In residential institutions for older people, many of routines and conditions can predispose to delirium. Moreover, prevention of delirium is more successful in improving outcomes than treatment of established cases. For these reasons, we think that any guidance to prevent mental illness in older people should also specifically address delirium prevention.	Thank you for your comments, duly noted.
London Development Centre		General	Interested about why age boundary when we are striving to make Services ageless and open to all.	Thank you for your comments and very helpful suggestions. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. We also acknowledge that the term used to describe this

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				group inadequately expresses the diversity of its membership. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		General	Tension regarding what is mental illness; depression is referred to as mental illness it is such a common treatable illness in older people. To exclude people receiving antidepressant or cognitive therapy would miss an opportunity and possibly important data would be lost.	Thank you, your concerns have been duly noted.
		General	That little bit of help (difficult to identify) which makes so much difference to managing at home or not. How will this be captured and measured. My own snap shot research has identified this is what makes the difference between existing and well being and often the help is minimal and very cost effective. In this same snap shot I have found that environmental issues, lighting, safety, buses, transport have a major impact on social inclusion. They can increase isolation and therefore have a negative impact on well being.	Thank you for your helpful comments, duly noted. It would be very useful if you could submit or direct NICE towards any published documentation outlining this information.

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Mental Health Foundation		General	The Mental Health Foundation welcomes this as an important first piece of guidance. Older peoples' needs have historically often been neglected and it is vital that the mental health and well-being of this large section of our population is promoted effectively. However, overall there are some problems of definition in this Draft Scope. NICE needs to define terms such as 'older' people, 'support' & 'good mental health and wellbeing' to ensure that these are clear and consistent throughout the scope. The Mental Health Foundation acknowledges that defining 'mental well being' as distinct from 'mental health' is an area of debate. However, if this NICE does not make a clear distinction mental health and mental wellbeing in this scope, perhaps using the term good 'mental health' meaning the absence of mental health problems could suffice. If however the promotion of mental well-being, as distinct from Mental health, is included in the scope of this guidance, then there should be no need to limit the population studied to people who don't have mental health problems. The Mental Health Foundation asserts that people with formal mental health diagnoses can still achieve and maintain broader mental well-being including concepts such as peace of mind, sense of purpose and identity, self-worth, belonging, acceptance as markers of mental health recovery even alongside concurrent mental health problems/ diagnoses.	We welcome your comments and thank you for your support. We have read your suggestions and comments with interest and recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. We also acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. We appreciate that interventions delivered in settings other than those referred to in the scope also impact on the mental wellbeing of older people and will consider your suggestions very carefully. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home Thank you for taking the time to

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				comment on the draft document.
		1 & 4.1	In the title and in the Populations section of the Guidance Scope the age boundary of the term 'older people' also needs definition. It could be argued that within the broadest definition of 'older people' 50-100+ years, some of the needs and risks to people's mental health and well being vary in different age groups. For example, newly retired people experience fewer physical health problems and therefore more ease of physical access to social networks and activities than more frail and elderly people. Age is also a factor in risk of developing dementia and in the likelihood of older people being or becoming a family carer. Therefore, increasing age has an impact both on ease of access to and need for support in the promotion of mental health and wellbeing. In addition, using the example of 60 or 65yrs as an age cut off, people from a number of generations and cultural mindsets would still be encompassed by the guidance. These different generational groups might best be reached by tailored mental health promotion initiatives. The Mental Health Foundation therefore argues that NICE should make some distinction within the guidance regarding the specific age groups (if any) that mental health promotion interventions are recommended to be directed towards. The age groups which interventions have been piloted or implemented with should be attended to when NICE is examining the evidence and preparing the guidance.	Thank you for your comment, duly noted. Please see our response above. Duly noted, thank you. Thank you, noted.

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			Having a lower age limit to the guidance for example, including over 50s may also be beneficial in terms of being able to include evidence such as the health Scotland work on mental health and well-being in later life which, included focus groups with people aged 50-65 and then with 65+. Mental health promotion initiatives directed towards the needs of younger older people in transitional phases, which might include building towards the final stages of a career; becoming grandparents; finishing paid employment; adjusting to family and friends finishing work; and facing the identity and lifestyle adjustment challenges that these transitions can pose to mental health and well-being should be explored in this guidance. In addition a third group older group such as the 80/85+ year olds could be included.	Thank you for your suggestion, noted. Noted, thank you. Thank you, noted.
		1.1	The short title of this guidance refers only to promoting mental 'wellbeing' rather than mental 'health' as included in the longer title. As stated above, it is therefore important that terms 'mental wellbeing' as opposed to 'mental health' is defined for the purpose of this guidance	Thank you, duly noted.
		2a	In this paragraph the term 'promoting mental health' is used. NICE needs to make it explicit whether the terms 'mental health' and 'mental wellbeing' are being used interchangeably in this Guidance. If NICE is indeed referring to two different things by the two terms this distinction again needs to be made explicit.	Thank you, we note your comment and are aware of the debate around both terms.

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		2b	This paragraph indicates that the guidance supports the implementation of the *preventative* aspects of National Service Frameworks. It seems therefore that this guidance should cover the promotion of mental *health* in addition to mental wellbeing since the purpose of public health interventions and this NICE guidance is stated as the prevention of mental health problems.	Thank you, we will clarify this in the scope document where necessary.
		4.1.1	This current draft scope of NICE guidance is limited only to those receiving home care & support, living in sheltered housing or residential care. It is recommended however that this also includes interventions aimed at older people living in their own homes who are not currently recipients of any support (in addition to basic access to primary care) or who are not receiving any support from people outside of that received from their friends family and peers (as mentioned in 4.3.1) In Section 1 Guidance Title – 'recipients of primary care are included' however they are not mentioned here in 4.1.1. This much broader inclusion criterion would widen the scope out to older people in general which is more appropriate. Making an inclusion distinction based on the kind of support people receive is not sensible. This is because in many cases, there is no qualitative distinction between the *needs* of those who are and are not receiving support. The distinction rather is in support made available and in the accessibility of information	Thank you for your comment. We recognise that there are broader issues that need to be addressed with regard to older people not in receipt of services. We will consider your suggestions. We would direct you to the facility on the NICE website to suggest topics for future guidance. See www.nice.org.uk/page.aspx?o=ts.home Noted, thank you. Thank you for your comment, duly noted.

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			about this support to older people and their family members. In addition the current list of support that people must be receiving in order to be included in this guidance does not include support similar to paid homecare but given informally by family and friends, faith and community groups. Attendance at day centres/community activities for the elderly (which promote their mental health) by those who are living in their own homes also should be included in this list.	Thank you for your suggestion, noted.
		4.2	In the current NICE Guidance Scope the place of residence is used as an inclusion/exclusion criterion. For example residents of 'residential care homes' are included but residents of 'nursing homes or homes registered to care for people who have dementia are excluded. This criterion could also be seen as quite arbitrary since mental health (and especially mental well-being) promotion interventions may be of equal relevance to people living in nursing homes whether or not they have physical or mental health problems. Equally, interventions to promote mental health and well being of people in the older populations covered by this scope could be equally relevant to those in hospital or hospices. However, it is recognised that this group may better be served by separate NICE public intervention guidance regarding the promotion of mental health and well being of older people in hospital or hospices, since the greater burden of suffering and bereavement/ end of life issues may be more acute in groups who are in hospital or	Thank you for your comment, duly noted. Thank you for your comment, please see our previous response. Again, we would encourage your organisation to use the topic suggestion facility at the NICE website if you believe that there are topics requiring further guidance.

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			hospices. As people age, all must all deal with bereavement and end of life issues and the promotion of mental health and wellbeing of people who are dying or have long-term health conditions should be covered by this scope, wherever people are currently residing, since, death comes to every person and can feel closer as age increases and more personal bereavement is experienced. Lastly in this section on exclusions, the Mental Health Foundation would also question the exclusion of people being treated for a mental health problem from this guidance. Drawing a boundary which is dependent on whether someone has accessed support services, been assessed as having a mental health problem and is receiving a treatment for it again appears quite arbitrary. This would exclude a body of evidence which refers to the promotion mental well-being in people whose needs are already recognised. It also excludes the promotion of future mental health in people who have a long-term psychiatric diagnosis. Examples of this might be the prevention of depression due to complicated bereavement in a person with schizophrenia or prevention of anxiety/stress caused by being and elderly family carer in a person with diagnosed and treated bipolar disorder. People with long-term mental health problems have the same kinds of need for mental health and well-being promoting interventions as people who have not been diagnosed and are not currently being treated for these problems.	Thank you for these helpful comments, noted. The scope is being revised to focus on the well-being of all older people over 65, as far as the available evidence permits. However it will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance. Thank you for raising your concerns and these helpful comments.

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		4.3.2	Older people's mental health and well being can be affected by their social relationships with younger people and their place in the whole community. Community interventions that are targeted at all ages and which specifically include older people should be included in this guidance even if they do not *exclusively* target an older age group. Examples of these kinds of mental health and well being promoting schemes might be an all age lunch club or community café or a befriending scheme that works with the housebound or long-term physically disabled/people with mental health problems/ learning disabilities of all ages. These programmes and interventions may not be directly targeted at older people – however they are relevant and should be included as mental health promoting interventions. Access to public transport services/minibus shopping or faith based activity pick-up schemes should also be included since they can have an effect on mental health and well-being by offering access to facilities though not being targeted solely at older people.	Thank you for your comments, duly noted.
		4.5	Intermediary or process-outcomes should also be included in the assessment of the effects and effectiveness of mental health promotion interventions for older people. Examples of these might be increased awareness and take up of support, benefits or	Thank you for your very helpful suggestions and comments on the draft scope document.

[1] Older People's Programme (2006), 'Disregarded and overlooked': Report from the '*Learning from Experience'* Research into the needs, experiences, aspirations and voices of older people with mental health needs, and carers, across the UK. Produced for the **UK Inquiry into Mental Health and Wellbeing in Later Life.** www.mhilli.org/index.aspx?page=stage2services.htm#fieldwork

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			learning opportunities available to the older people; improved social networks; newly learned coping skills or strategies; reduced perception of stigma and feelings of social exclusion; increased feelings of family role and being a valued member of the older person's community; greater involvement and voice in choices about care and support services which the older person or their family member receives. The above suggested intermediary outcomes refer to needs which older people have identified for example through the Mental Health in Later Life Inquiry (2006)[1]. In evaluating the effects and effectiveness of interventions greater attention should be paid to outcomes which older people themselves have defined as important for example via qualitative studies which have involved older people directly. The voices of older people themselves should be heard as a key part of evaluating outcomes, and care should be taken to ensure that this is a fundamental part of any process. It is important therefore that high quality rigorous qualitative evidence drawn from studies which explore older people's experience of public health interventions is given credence alongside quantitative or controlled intervention studies. Story and narrative is important in the later stages of life as is the fact that older peoples' voices are often not heard. In addition attention should be paid to whether standardised scales are designed with older people in mind and to the problems of	All your comments have been duly noted and, again, we will consider your suggestions very carefully. Thank you for your comment, duly noted. Thank you for your comment, where appropriate and relevant, such evidence will be included

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			methodological flaws in conventional quantitative designs due to high attrition/ drop out rates in elderly and vulnerable populations for example due to sickness and access difficulties.	
NIACE (National Institute of Adult Continuing Education)		General	NIACE welcomes this consultation and is pleased to be able to respond to it. We are pleased that NICE have undertaken this public health consultation into mental health and older people and believe that it signals the importance of cross-government and cross-sector working. We hope it will be underpinned by a strong implementation process based on joined up strategy, partnership working, awareness raising and capacity-building in services and among professionals across a broad range of public services, voluntary organisations and public and patient involvement programmes.	Thank you for your support, we warmly welcome your comments and suggestions.
		General	NIACE works to encourage more and different adults to engage in learning of all kinds. Its functions include research, development, publishing and consultancy; advocacy to inform and influence public policy; information services, conferences and dissemination; campaigning for and celebrating the achievements of, adult learners.	Thank you for your comments and introducing your organisation.
		Point 4.3.1	NIACE is pleased that the guidance defines mental health promotion as any activity or action that strengthens or protects mental health and well-being. Research shows that participation in learning impacts positively on health and well-being through a series of mediators such as improving socio-economic status,	Thank you for your very helpful comments and suggested publications.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			improved access to services, building confidence and self-esteem and in developing greater resilience to stress.[2] It also shows that the positive impacts have both a rehabilitative as well as a preventative dimension. NIACE's own research into the impact that participation in learning has on older adults confirms these findings as learner after learner will report positive outcomes such as increased confidence, greater feelings of being able to cope, wider social networks, improved skills, increased assertiveness, a greater sense of hope and optimism for the future, lifted mood, improved quality of life as well as many other physical benefits such as improved mobility, distraction from dwelling on pain and discomfort. However we hope that the guidance will seek to include a broad definition of lifelong learning. Different types of learning impact on health and well-being in a number of ways. The subject matter may promote health and well-being such as through increased physical activity in dance or exercise classes. Participation in group and interactive activities also promote health and well-being by providing opportunities for developing friendships and wider social networks, by promoting fun and enjoyment, by giving people a reason to get out of the house and talk to other people and by decreasing social isolation. Learning also promotes health and well-being because it gives people a sense of achievement and success thereby building self-esteem, confidence and a sense of self-empowerment. Learning also promotes health and well-being because it provides people with	

[2] Hammond, C. (2002) '*Learning to be Healthy.'* The Wider Benefits of Learning Papers: No.3. Institute of Education, University of London

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			the opportunity to acquire the underpinning skills that enable people to take control over their lives, particularly in the development of literacy, numeracy, language and IT skills and also through health literacy and financial literacy skills. Learning in later life also enhances people's chances of remaining in useful and fulfilling employment, which is associated with a number of health outcomes, particularly mental health. The positive impact of participation in learning also have wider benefits beyond the confines of any one particular class or subject and often have effects which can often be hard to predict but nevertheless have profound effects of people's lives. One woman, aged 58, with depression and lack of confidence wrote *"It gives you back a purpose in life. It allows you to blossom and become what you want to be and not always in the shadow of someone else."*	
		Point 4.3.2	We understand that there has to be some boundaries to the remit of the guidance but we would hope that the guidance, in promoting life long learning, acknowledges that learning and skills empower people to tackle and cope with their own concerns and issues or to be more active participants in the development of services. Learning and skills engenders a greater sense of self-determination, which in itself has a powerful effect on health and well-being, but also through greater involvement it improves service delivery.	Thank you for your comment, we note your concerns and support your view of the benefits of lifelong learning.
		Point 4.6	In asking the questions about the most effective and cost effective ways of promoting the mental well-being of older people, we hope	Thank you for highlighting these important issues, NICE is

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			that the guidance will be mindful of the wider inequalities that exist within society. Participation in learning declines with age, from only 34% of adults aged 55-64 being current or recent learners, to 19% of adults aged 65-74 and 10% of those aged 75 and over being current or recent learners. So older adults are less likely to be accruing the positive benefits that participation in learning can provide. Overall, adults are more likely to participate in learning if they have had successful and fulfilling experiences of initial education, therefore it may be supposed that those older adults who are participating in lifelong learning are those who always have been more ready to do so and have been able to reap the benefits of lifelong learning over a period of time. Those for whom initial education was not fulfilling or successful are less likely to feel able to participate in learning as an adult for a host of reasons, and have therefore not been able to avail themselves of the wider benefits. Leaving school without qualifications, low skilled, and probably lower paid, occupation increases vulnerability to ill-health and disability in later life. Consequently, when we think about promoting learning opportunities for older adults we need to be aware of these factors or we may unwittingly compound a life time of inequalities. Many of the most positive benefits that result from participating in learning are for those adults who return to learning for the first time.	committed to improving health inequalities. We note your concerns.
		Point 4.7	Participation in learning does not just happen for many adults, particularly for those with negative experiences of previous learning. Other social factors such as transport, cost, lack of appropriate opportunities can also create barriers to learning.	Thank you for your helpful comments, duly noted.

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			Mental health problems can also be a barrier to accessing learning as they can rob individuals of confidence, self-esteem and motivation. Adult learning providers may employ a range of strategies to engage with older adults, but the most effective means is often in partnership with other organisations, such as health and social care providers and voluntary and community groups. Health and social care professionals, carers and health and social care agencies have a valuable role to play in encouraging and supporting people to access learning and in making the important first links with learning providers. This is particularly important for people with mental health problems. Therefore NIACE hopes that in targeting the guidance at professionals, and practitioners working in the NHS, in other public sector organisations, the private sector and the voluntary and community sector, NICE will strongly advocate for partnership working across the relevant sectors. NIACE already has established strong networks that support partnership working and capacity building in services and among professionals. For example the networks to support access to and success in learning for people who experience mental health difficulties has a membership of over 1200 professionals, practitioners and service users. Such networks have proved to be effective mechanisms to advocate on behalf of particular groups of learners and to disseminate good practice.	
		General	Despite the recognition that access to lifelong learning for older adults promotes health and well-being as well as other social and economic benefits, provision for this group of learners is seriously	Thank you for your comments, your concerns are duly noted.

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			under threat. Never has there been more need to develop joined up thinking and joined up approaches in order to protect the opportunities available to older people but also to ensure that the maximum benefits to the health and well-being of individuals are safe guarded. Cutting provision and opportunities in one sector may have significant cost implications in another, or alternatively, protecting provision in one sector may result in cost savings in another. NIACE hopes that in developing public health interventions for older adults with mental health problems, NICE will seek to engage with the Department for Education and Skills and the Learning and Skills Council and to advocate for older learners with mental health problems.	
		General	NIACE acts as an independent voice advising on policy and strategy to government departments, collaborates with other agencies to advocate for older learners and seeks to secure funding to undertake further development and research work. NIACE would be pleased to work with NICE on the issue of mental health, older people and lifelong learning.	Thank you for taking the time to comment so constructively on the scope document. We hope you will continue to engage with the guidance development and suggest topics for future work (see www.nice.org.uk/page.aspx?o=ts.home)

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PSIGE & BPS		**General** **4.2** **4.3**	Age used should be 65+ as that is the age generally used to define old age and how services are divided at present. There is the need for an inclusive approach to the SCOPE emphasising the continuum of mental health and well being. People who have been discharged from mental health services should not be discharged. Preventative strategies may also aid those who are not identified as having a mental health problem. Medical model tends to dichotomize health and disease, regarding health as the absence of disease or disorder but psychological models offer a different perspective e.g. • Diener, E., Suh, E. Lucas, R.E., & Smith, H.L. (1999) Subjective well-being: Three decades of progress. *Psychological Bulletin*, **125**, 276-302. • Hupert, F. & Whittington, J.E. (2003) Evidence for the independence of positive and negative well-being: implications for quality of life assessment. B.J. Health Psychology **8,** 107-122. Typical indices of health status focus on illness, disease, disability and negative mental states, and epidemiology studies address rates of morbidity and mortality rather than rates of wellness and positive functioning. Hupert et al challenge the medical model of disease as they point out that symptoms of mental disorder are distributed in a continuous manner throughout the population and	Thank you for taking the time to comment on the draft scope document so comprehensively, and for your recommendations. We have noted your comments and concerns listed on the following pages. We would be delighted to hear from you at the evidence consultation stage of guidance development. For further information about NICE process and methods, please visit: www.nice.org.uk/page.aspx?o=300576

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			clinical diagnosis is equivalent to an arbitrary cut off point along this continuous distribution. Furthermore they maintain that the prevalence of psychiatric disorder in a population is related to the mean number of psychiatric symptoms in the population and that if the mean number of symptoms in the population changes then the prevalence of disorder changes accordingly.	
		4.5	**DEFINITIONS OF WELL-BEING** Ryff suggests that the structure of psychological well-being consists of: 1. Autonomy 2. Environmental mastery 3. Personal growth 4. Positive relations with others 5. Purpose in life 6. Self acceptance • Ryff, C.D. (1989) Beyond Ponce de Leon and life satisfaction: New directions in the quest for successful ageing. International Journal of Behavioural Development, **12**, 35-55. • Ryff, C.D. & Singer, B.H. (1996) Psychological well-being: Meaning measurement, and implications for psychotherapy research. Psychotherapy and Psychosomatics, 65, 14-23.	Thank you this is very helpful.

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			GENERAL WELL-BEING AND AGEING • Noriega-Jose-Ángel-Vera, Quiñones-Teresa-Iveth-Sotelo, Guedea-Miriam-Teresa-Domínguez (2005) Subjective well-being**,** confrontation and social support networks in older adults. *Revista Intercontinental de Psicología y Educación*, vol. 7, no. 2, p. 57-78. A subjective **well-being** scale and one of confrontation strategies, a structured interview of social support and a sociodemographic data questionnaire were applied to this sample. Results find that persons perceived with higher scores are those that report a greater use of the direct confrontation strategy, who report having more social support, a high frequency of contacts and a wide network of social support • Collins, A.L. (2006) Subjective **well-being** in old age: An investigation into the role of flow and creativity. *Dissertation Abstracts International: Section B: The Sciences and Engineering***, 67**, no. 3-B, p. 1741. Hierarchical Linear Modeling (HLM) was used to investigate the hypotheses that positive relationships exist between feelings of subjective **well-being** (positive affect, affect balance, and life satisfaction) and flow (perceived flow experiences; perceived flow experiences rated as involving above average challenges and skills; perceived flow experiences rated as intense), as well as lifetime creativity. A positive relationship was found between	Thank you for this information, and list of references.

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			perceived flow experiences and positive affect. Intensity of flow was positively related to positive affect, affect balance and life satisfaction. Perceived flow rated as involving above average challenges and skills did not predict subjective well-being**.** Finally, lifetime avocational creativity was a significant predictor of positive affect and vocational creativity was a positive predictor of life satisfaction.	
			Older peoples physical health impacts on well-being and hence their mental health. It is important to include preventing physical health problems in the guidelines and also include managing chronic conditions. **Aging and Health.** . • Rook-Karen-S, Charles-Susan-T, Heckhausen-Jutta (2007). Ch. In Friedman-Howard-S, Silver-Roxane-Cohen (EdS) '*Foundations of health psychology',* , p. 234-262, pp. ix + 402. Oxford University Press, New York, NY, US. General textbook to be published this year on relation of health and aging and is advertised as including a chapter that explores two scenarios that researchers have projected for the health and well-being of future cohorts of older adults See also • Bishop-A-J, Martin-P, Poon-L. (2006) Happiness and congruence in older adulthood: A structural model of life satisfaction. *Aging & Mental Health*, vol. 10, no. 5, p. 445-453,	Thank you for your comments and suggestions. Duly noted. Noted, thank you.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			eISSN: 1364-6915, Findings from this study support a relationship between social resources and subjective well-being in later life. In particular, the association between social resources and life satisfaction was mediated through health impairment. These findings offer understanding relative to how health and social resources influence past and present assessments of subjective well-being among the elderly **Stress and Coping** • Lazarus, R.S. & Folkman, S. (1984) *Stress, appraisal and coping*. New York: Springer. Adaptation to stress is mediated by appraisal of stress and by coping strategies employed by the individual. Coping strategies are considered to be of two types: emotion–focused (e.g. avoidance, minimization, distancing, selective attention, positive comparison, and wresting positive value from negative events) and problem focused (e.g. defining the problem, generating alternative solutions, weighting the alternatives in terms of costs and benefits, choosing among them and acting).	Thank you for your comments.
			Multi-dimensional health locus of control (MHLC) MHLC is a measure of individual differences in general health expectancies. It consists of: 1. Internal health LOC – extent to which individuals believe	Thank you for taking the time to outline this information about psychological models for behaviour change. NICE is in the process of conducting a programme of work examining evidence for different

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			that their health is within their personal controls 2. Chance health LOC- extent to which individuals believe that their health status is due to chance or fate 3. Powerful others LOC - extent to which individuals place their health in the hands of 'powerful others' (usually health professionals) • Wallston, K.L., Wallston, B.S., & de Vellis, R. (1978) Development of multidimentional health locus of control (MHLC) scales. *Health Education Monographs,* **6**, 160-170.	approaches to behaviour change. This may be of interest to you and further details may be found at the NICE website: www.nice.org.uk/page.aspx?o=BehaviourChangeMain Two other NICE websites may also be of interest. The NICE methods and processes information page: www.nice.org.uk/page.aspx?o=300576. And the facility for suggesting new topics for guidance development. www.nice.org.uk/page.aspx?o=ts.home
			Theory of Reasoned Action TRA purports that a generalized measure of Attitude towards a particular behaviour derives from an interaction between 'expectancy' beliefs about the likelihood of that behaviour leading to a particular consequences, and evaluations about the desirability of those consequences. • Fishbein, M. & Ajzen, I. (1975). Belief attitude, intention and behaviour: New York: Wiley	Thank you for your comments.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			Ajzen, I. & Fishbein, M. (1980) Understanding attitudes and predicting social behaviour. Engelwood Cliffs, NJ: Prentice –Hall.	
			Theory of Planned Behaviour (TPB) TPB used to explain a number of health–related behaviors which are in turn associated with increased mental and physical well-being. e.g. taking regular exercise. TPB tries to explain informational and motivational influences on behaviour. It suggests that the proximal determinant of volitional behaviour is one's intention to engage in that behaviour. Attitudes and subjective norms are thought to exert their effects upon behaviour through intentions. Attitudes are the overall evaluations of performing the behaviour by the individual. Subjective norms assess the social pressures on the individual to perform or not perform a behaviour • Ajzen, I. (1985) From intention to actions: A theory of planned behaviour. In J. Kuhl & J. Beckmann (eds), action –control: From cognition to behaviour (pp. 11-39). Heidelberg: Springer. • Ajzen, I. (1991) The theory of planned behaviour. In Organizational Behaviour and Human Decision Processes, 50, 179-211. Ajzen, I. (2002) Perceived behavioural control, self-efficacy, locus of control and the theory of planned behaviour. Journal of Applied social Psychology, 32 665-683.	Duly noted, please see our earlier comment.
			Theory of Transtheoretical Model of change (TTM)	Duly noted, please see our earlier

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			TTM is also a social cognition model of health behaviour but of a stage type unlike the continuum model of TPB and TRA. It involves four concepts thought to be essential for behaviour change: 1. Stage of change 2. Self-efficacy 3. Decisional balance 4. Process of change • Prochaska, J.O. & Marcus, B.H. (1994) The Transtheoretical Model: Applications to exercise. In R.K. Dishman (Ed.), *Advances in exercise adherence (pp 161-180).* Champaign, IL, Human Kinetics.	comment.
			Illness Representations Chronic illnesses can have a significant impact on the well-being of older people. Dealing with the transition from diagnosis of treatment and management of a chronic illness can be difficult. How people perceive their illness can have implications for healthcare interventions that can maximize their quality of life. Illness perceptions are thought to set the goals or targets for coping and coping is appraised or evaluated against these targets. Coping is assumed to play a mediating role between illness and patients' well-being. Early theory – **Self-Regulatory Model of Illness –**	Duly noted, please see our earlier comment.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			• Levanthal, H., Nerenz, D.R. & Steele, D.J. (1984) Illness representations and coping with health threats. In A. Baum & J. Singer, (Eds.) A handbook of psychology and health pp 219-252. hillsdale, NJ: Erbaum.	
			Common Sense Model of Illness Representations According to the Common Sense Model, the individual is an active problem solver who has to deal simultaneously with the perceived reality of the health threat and the emotional reactions to that threat. The individual constructs a representation of the illness which may change over time and determine actions, such as coping strategies. Finally the individual appraises the outcomes of the coping strategies that he/she have tried to cope with both the cognitive representation and the emotional representation of the illness. This then feeds back to influence the cognitive and emotional representations of the illness. The Cognitive Representation has five components: 1. Identity 2. Cause 3. Timeline 4. Consequences 5. Controllability/cure The Emotional Representation creates feeling states such as depression, annoyance, anger or anxiety. Emotions can motivate	Duly noted, please see our earlier comment.

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			individuals to engage in health care activities or if they cause the individual to feel overwhelmed, or result in no action being taken at all. • Leventahl, H., Diefenbach, M. & Leventhal, E.A (1992). Illness cognition: Using common sense to understand treatment adherence and affect cognition treatment. *Cognitive Therapy and Research, 16 (2),* 143-163 • Brownlee, S. Levanthal, H. & Levannthal, E.A. (2000). Regulation, self-regulation, and construction of the self in the maintenance of physical health . In M. Boekaerts, P.R. Pintrich, & M, Zeidner (Eds.) *Handbook of self-regulation.* (pp. 369-416) San Diego: Academic Press	
			Theory of Sense of Coherence • Antonovsky, A. (1979) Health stress and coping: New persepectives on mental physical well-being. San Francisco, CA: Jossey-Bass • Antonovsky, A. (1987) Unravelling the mystery of health. How people manage stress and stay well. San Francisco, CA: Jossey-Bass. • Antonovsky, A. (1993) The structure and the properties of the sense of coherence Scale. *Social Science and Medicine, 36 (6), 725-733.* Antonovsky introduced the 'salutogentic model' concerned	Duly noted, please see our earlier comment.

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			with how to become or stay health, which highlighted the inadequacy of the pathogenetic orientation in health care and proposed a health-related, resource orientated perspective. Model's core construct is 'Sense of Coherence' which is composed of three components called comprehensibility, manageability and meaningfulness. SOC is defined as .. a global orientation that expresses the extent to which one has a pervasive enduring though dynamic feeling of confidence that (1 the stimuli deriving from one's internal and external environments in the course of living are structured, predictable and explicable; (2) the resources are available to one to meet the demands posed by these stimuli; and (3) these demands are challenges, worthy of investment and engagement. • Schneider-Gudrun, Driesch-Georg, Kruse-Andreas, Nehen-Hans-Georg, Heuft-Gereon. (2006) Old and ill and Still Feeling Well? Determinants of Subjective Well-Being in >=60 Year Olds: The Role of the Sense of Coherence. *American Journal of Geriatric Psychiatry*, vol. 14, no. 10, p. 850-859. This study confirms the inefficacy of multidimensional programmes for preventing functional decline in the older population. More effort should be devoted to improving the efficacy of specific interventions for conditions causing functional decline**.**	
			Doctor-Patient Relationship If it is assumed that seeking help from GPs is useful in promoting	Duly noted, please see our earlier comment.

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			good physical and mental health then it is important to look at how people make the decision to seek formal care and to examine the quality of the doctor-patient relationship and how this in turn affects treatment compliance. In primary care there is a considerable literature on decision to seek medical help or to self-medicate/explore alternative therapies. See early work: • Chappell, N. & Guse, L.W. (1989) Linkages between Informal and Formal Support. In K.S. Markides & C.L. Cooper (Eds.), '*Aging, Stress & Health',*Chichester. Wiley & Sons. There is evidence that anti-professional beliefs affect the decision to seek medical care from doctors. See: • Haug, M.R. (1986) Doctor-patient relationship and their impact on elderly self care. In Dean, K, Hickey, T. & Holstein, B.E. (Eds) *Self-care and Health in Old age.*London: Croom Helm	
			SPIRITUAL WELL- BEING There is a growing body of work that suggest that meeting spirituality plays a part in improving or maintaining well-being in older people. One's spirituality or religious beliefs and practices are thought to have a profound impact on how the individual copes with the suffering that so often accompanies advanced disease. See Sadler & Biggs (2006) for a review.	Thank you for your comment, duly noted.

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			• Sadler, E. & Biggs, S. (2006) Exploring the links between spirituality and 'successful ageing'. *Journal of Social Work Practice,* vol. 20, no. 3, p. 267-280, ISSN: 0265-0533. Publisher: Taylor & Francis, United Kingdom. Also see a review by P. Dalby • Dalby, P. (2006). Is there a Process of Spiritual Change or Development associated with Ageing? A Critical Review of Research. *Aging and Mental Health* **10**(1) 4-12. • Graskamp, P.J. (2006) Personal ideology: A unifying framework for relating religiosity, religious coping, and **well-being.** Dissertation Abstracts International: Section B: The Sciences and Engineering, 2006, vol. 67, no. 3-B, p. 1700, ISSN: 0419-4217. A dissertation by Graskamp (2006) examined a new theoretical model that uses Tomkin's personal ideology construct and its underlying dimensions of humanism and normativism to connect aspects of religiosity, religious coping, and **well-being.** Significant relationships were evident among religious motivation and religious practices; religious beliefs and motivation; religious beliefs and coping; and between religious beliefs, motivation, coping and **well-being** variables	
			Other references on Spirituality including some on dementia Acton, G. J., & Miller, E. W. (2003). Spirituality in Caregivers of Family Members with Dementia. *Journal of Holistic*	Thank you for referencing this useful literature.

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			Nursing, 21, 117-130. Ansari-Gazala-A. (2006),Dealing with negative life events: The effect of individual and collective religious participation and religious coping on mental and physical health in Muslims. *Dissertation Abstracts International*: *Section B: The Sciences and Engineering*, **67**, no. 3-B, p. 1691. Aponte, H. J. (2002). Spirituality: The Heart of Therapy. *Journal of Family Psychotherapy, 13*(1/2), 13-27. Bell, V., & Troxel, D. (2001). Spirituality and the Person with Dementia - A View From the Field. *Alzheimer's Care Quarterly, 2*, 31-45. Davis, R. (1973). *My Journey into Alzheimer's Disease*. Wheaton, Illinois: Tyndale House Publishers. Everett, D. (2000). Spiritual Care - Stretching the Soul. *Journal of Dementia Care*(Jan/Feb), 20-21. Froggatt, A. (1994). Tuning in to Meet Spiritual Needs. *Dementia Care*(March/April), 12-13. Hughes, D. E., & Peake, T. H. (2002). Investigating the value of Spiritual Well-Being and Psychosocial Development in Mitigating Senior Adulthood Depression. *Activities, Adaptation and Aging, 26*, 15-35. Jewell, A. (1998). Caring for the Spiritual Aspects of Later Life. *Journal of Dementia Care*(July/Aug), 10.	

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			Lawrence, R. M. (2003). Aspects of Spirituality in Dementia care: When clinicians tune into silence. *Dementia, 2*, 393-402. MacKinlay, E. (2001). Understanding the ageing process: A developmental perspective of the psychosocial and spiritual dimensions. *Journal of Religious Gerontology, 12*(3-4), 111-122. McFadden, S. H. (1995). Religion and Well-Being in Aging Persons in an Aging Society. *Journal of Social Issues, 51*(2), 161-175. McFadden, S. H. (1996). Religion, Spirituality, and aging. In J. E. Birren & K. W. Schaie (Eds.), *Handbook of the psychology of aging* (Fourth ed., pp. 162-177): Academic Press. Musick, M., A., Traphagan, J. W., Koenig, H. G., & Larson, D., B. (2000). Spirituality in Physical health and Aging. *Journal of Adult Development, 7*(2), 73-86. Nightingale, M. C. (2003). Religion, Spirituality and Ethnicity: What it means for caregivers of persons with Alzheimer's disease and related disorders. *Dementia, 2*, 379-391. Ortiz, L. P. A., & Langer, N. (2002). Assessment of Spirituality and Religion in Later Life: Acknowledging Clients' Needs and Personal Resources. *Journal of Gerontological Social Work, 37*(2), 5-21. Smith, A. L., & Harkness, J. (2002). Spirituality and meaning: A Qualitative Inquiry with caregivers of Alzheimer's Disease.	

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			Journal of Family Psychotherapy, 13, 87-108. Snyder. (2003). Satisfactions and Challenges in Spiritual Faith and Practice for Persons with Dementia. *Dementia, 2*, 299-313. Stuckey, J. C., Post, S. G., Ollerton, S., Fallcreek, S. J., & Whitehouse, P. J. (2002). Alzheimer's Disease, Religion, and the Ethics of Respect for Spirituality: A Community Dialogue. *Alzheimer's Care Quarterly, 3*, 199-207. Tornstam, L. (1996). Gerotranscendence - A Theory About Maturing into Old Age. *Journal of Aging & Identity, 1*(1), 37-50.	
			Stuckey, J. C., Post, S. G., Ollerton, S., Fallcreek, S. J., & Whitehouse, P. J. (2002). Alzheimer's Disease, Religion, and the Ethics of Respect for Spirituality: A Community Dialogue. *Alzheimer's Care Quarterly, 3*, 199-207. Tornstam, L. (1996). Gerotranscendence - A Theory About Maturing into Old Age. *Journal of Aging & Identity, 1*(1), 37-50	
		4.6	**RESIDENTIAL CARE** **Coping** • Schanowitz, J.Y. & Nicassio, P.M. (2006) Predictors of positive psychosocial functioning of older adults in residential care facilities. *Journal of Behavioral Medicine*, **29**, no. 2, p. 191-201, (61 ref), ISSN: 0160-7715. Study in residential facilities. Active coping was correlated with	Thank you for your helpful suggestions.

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			higher positive affect, whereas passive coping was associated with higher negative affect and self-acceptance. Positive reappraisal, a meaning-based coping strategy, was uniquely associated with higher positive affect, positive social relations, and self-acceptance. The results confirm the separate importance of health-related and meaning-based coping strategies in explaining positive psychosocial functioning in older adults living in residential care settings. • Worden, A , Challis, D.J. & Pedersen, I. (2006) The assessment of older people's needs in care homes. *Aging & Mental Health*, **10**, (5), p. 549-557, There were clear differences in the assessment approaches employed in different types of home that were used to place older people appropriately and ensure rehabilitation take s place where possible. The lack of inclusion of certain key health areas on some assessment forms suggests that the well-being and quality of life of some residents may be poorly addressed, and that further work is required for the standard of assessment in care homes to match that in community-based care.	
			DEMENTIA AND WELL-BEING **Assessment scales** • Burgener-SC, Twigg-P, Popovich-A (2005) .Measuring psychological well-being in cognitively impaired persons. *Dementia*, vol. 4, no. 4, p. 463-85.	Thank you for these comments and suggestions.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			Psychological Well-being in Cognitively Impaired Persons (PWB-CIP) scale was examined as a measure of one dimension of quality of life (QoL) as persons progress dementia. Because both rural (55%) and urban populations were sampled and the PWB-CIP was used across care settings, the findings support the PWB-CIP as a psychometrically sound measure of psychological well-being for diverse populations of persons with dementia. • Thompson-L, Kingston-P. (2004) Measures to assess the quality of life for people with advanced dementia: issues in measurement and conceptualisation. Quality in Ageing, vol. 5, no. 4, p. 29-39. • This paper presents five QoL measures that have been designed or used to measure the QoL of patients with severe dementia who are unable to provide self-reports and to examine whether these measures are a valid and reliable means of assessing QoL in patients with severe dementia. It was found that all of the QoL measures have moderate to good reliability and validity.	
			CARERS **CARE-GIVING STRESS** Older people provide care to relatives with a range of chronic physical and mental health problems. In UK there are estimated to be about 300,000 people caring for a relative with a dementia in the community. Caring produces considerable stress on the care-	We note your concerns and thank you for highlighting these issues. As you quite rightly point out there is a wealth of literature concerning care giver burden. We would recommend you visit the topic suggestion facility at the NICE

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			giver. • Kneebone, I.I. & Martin, P.R. (2003) Coping and caregivers of people with dementia. B.J. Health Psychology 8, 1-17. Reviewed existing studies in the context of stress and coping models. General conclusion was that there is a general tendency for problem solving and acceptance styles of coping to be advantageous to caregivers of people with dementia but advised that the ability of the research to advise the clinician was severely limited. • Hagedon, M. Sanderman, R, Buunk, B. & Wobbes, T. (2002) *Failing in spousal caregiving: The 'identity-relevant stress' hypothesis to explain sex differences in caregiver distress.* BJ Health Psychol. 7(4) 481-494. Examined stress in carers of spouses with cancer. Previous literature suggests female care-givers perceive more distress than male caregivers with respect to care –giving. Found that only in female partners were self-efficacy an personal accomplishment regarding care giving found to be positively linked to distress. In contrast to men women reported more distress when they acted less supportively. ** • Larson-J, Franz-n-Dahlin, Billing-E, von-Arbin-M, Murray-V, Wredling-R. (2005) The impact of a nurse-led support and education programme for spouses of stroke patients: a	website: www.nice.org.uk/page.aspx?o=ts.home

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			randomized controlled trial. *Journal of Clinical Nursing*, vol. 14, no. 8, p. 995-1003, A nurse-led support and education programme might have a positive effect on spouses of stroke patients' well-being**,** on condition that they attend at least five times. • Toye-C, Kristjanson-LJ, Helmes-E. (2003) Factors influencing the well-being of family members of aged care facility residents. *Australasian Journal on Ageing***,** vol. 22, no. 1, p. 26-30. Results: Family members' **well-being** was predicted by their physical health, pressures from competing commitments, and residents' adjustment. Conclusions: Interventions should target residents' family members at risk of poor **well-being.** Grant information: Edith Cowan University, Olive Anstey Nurses' Fund, and the Nurses' Memorial Centre	Duly noted, thank you.
			Carers- Relation-ship centered care: Dementia Café Initiatives This approach suggests that it is important to work with couples as relationships are fundamental to successful caring. It purports to supersede person-centered care which is criticized for being to individualistic. Adams, T. & Gardiner, P. (2005) Communication an dinteraction within dementia care triads: Developing a theory for relationship centered care. *Dementia* **4** (2) 185-205.	Thank you, duly noted.

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			Hellstrom, I, Nolan, M. & Lundh, U. (2005) We do things together. A case study of 'couplehood' in dementia. *Dementia* **4** (1) 7-22**.** Kuhn, D.R. (1998) Caring for relatives with early stage Alzheimer's : An exploratory study. *A.J. of Alzheim. Dis.,* **13**, 189-196. Meisen, B. & Jones, G. (2004). The Alzheimer Café Concept: A response to the trauma, drama and tragedy of dementia. Caregiving in Dementia, 3, Nolan, M., Lundh, U., Grant, G., & Keady, J.. (2003) *Partnerships in Family Care: understanding the caregiving career.* Maidenhead, Open University Press. Redwood, P. Robinson, D. & Price, J. (2005). De Caf: a meeting place and therapeutic resource. Journal of Dementia Care, July/August, 20-22 Sheard, D. (2004) Bringing relationships into the heart of dementia care. Journal of Dementia Care, July/August, 22-24 Whiting, S. & Hibberd, P. (2005). The Coffee Shop: Supporting couples living with dementia. Unpublished paper available via the author & produced by West Kent NHS & Social Care Trust Zarit, S.H., Femia, E.F., Watson, J., Rice-Oeschger, L.& Kakos, B. (2004) Memory Club: A group Intervention for people with early-stage dementia and ther care Partners *The Geronltologist,* **44**, (2) p262-269.	
			SPORTS AND ACTIVITY	This is an extremely useful

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			Lampinen-P, Heikkinen-R-L, Kauppinen-M, Heikkinen-E. (2006) Activity as a predictor of mental well-being among older adults. *Aging & Mental Health*, **10**, no. 5, p. 454-466, This eight-year follow-up study examines the roles of physical and leisure activity as predictors of mental well-being among older adults born in 1904-1923. These findings suggest that mental well-being in later life is associated with activity, better health and mobility status, which should become targets for preventive measures.	suggestion, thank you.
			ACTIVITY AND EXERCISE A review of the literature on exercise therapy in osteoarthritis and rheumatoid arthritis identified only six studies focusing on osteoarthritis (Dekker et al, 1993). It was concluded that aerobic exercise and recreational exercise (e.g. walking) were of benefit in improving functioning in the majority of osteoarthritis sufferers. A comparison of aerobic walking and aerobic aquatics with a range of motion control group in rheumatology outpatients found that the first two produced significant improvements in anxiety and depression and also maintenance of activity in 60% at 12 month follow-up (mean age 64 years) (Minor et al, 1989). Improvements in functioning, a reduction in pain and medication use have been demonstrated after fitness walking or aerobic exercise programmes for osteoarthritis of the knee (mean age 69 years in both studies) (Kovar et al, 1992; Ettinger et al, 1997). Only a minority of doctors provide advice about exercise and	Thank you for these suggestions and highlighting these issues.

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			fewer still follow up their patients regarding the advice given (Bradley, 2000) Self-management has been defined as 'the day-to-day tasks an individual must undertake to control or reduce the impact of disease on physical health status….[and]…cope with psychosocial problems generated or exacerbated by chronic disease' (Clark et al, 1991). There are three components to successful self-management: (1) sufficient knowledge and informed decision-making; (2) performing activities to manage the condition; (3) maintaining adequate psychosocial functioning. In their review of self-management in a range of chronic diseases (asthma, Chronic Obstructive Pulmonary Disease (COPD), diabetes, heart disease and arthritis), Clark et al (1991) noted that many studies were not explicitly focused on older adults and that differences and/or commonalities may be found in how older adults cope with chronic disease.	
			Arthritis self-management programmes developed from research by Lorig and colleagues (Lorig & Gonzalez, 1992, Lorig & Holman, 1993, Lorig et al, 1993). They incorporated both a patient education role and attempts to improve psychosocial functioning. The programmes, in their original form, comprised 12 hours of group intervention incorporating information about the disease and medical treatment, exercise plans and cognitive pain management. At four month follow-up, reduction in pain, disability and depression was found as well reduced frequency of visits to the general physician (mean age 64 years) (Lorig &	Noted, thank you.

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			Holman, 1993). Replication of these studies in a UK setting (mean age 60 years) (Barlow et al, 1997, 1998) found a reduction in pain, disability and depression and reduction in visits to the general practitioner. Both studies included arthritis of other types, and recruited participants through community advertising. More recently, an examination of the cost effectiveness of arthritis self-management programmes was undertaken. This found that participants in the self-management groups (mean age 70 years) displayed reductions in feelings of helplessness and also health care costs increased less than in the control group (treatment as usual) (Groessl & Cronan, 2000)	
			Reviews of group cognitive behavioural interventions in hypertension (Boulware, 2001; Linden & Chambers 1994) have found that stress management techniques and counselling approaches are beneficial in improving mood and improving blood pressure. The counselling approach focused on sharing personal experiences, and the stress management approach included cognitive behavioural techniques such as monitoring thoughts, behavioural activation, and problem-solving. Similar findings are present in the angina literature (Bundy et al, 1994, 1998; Dusseldorp et al, 1999; Gallacher et al, 1997) with improvements in symptoms, reduction in reliance on medication, and improvements in anxiety. The stress management programs included problem solving, and CBT techniques. The duration of the programmes ranged from one session intervention lasting up to 60 minutes to over 50 sessions over a year long period. The average duration was longer in the chronic heart disease groups	Noted, thank you.

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			(28 weeks, 18 sessions (Dussledorp et al, 1999)) compared to shorter programmes in angina and hypertension (reported ranges two 12 weeks, 10 sessions). The benefits of exercise in preventing illnesses in the elderly are well known (Bassey, 2000; Greig et al, 1994; Department of Health, 2001).	
			REFERENCES Barlow, J.H., Williams, B., & Wright, C. (1997). Improving arthritis self-management among older adults: Just what the doctor didn't order. British Journal of Health Psychology, **2,** 175-186. Barlow, J.H., Turner, A.P., & Wright, C.C. (1998). Long-term outcomes of an arthritis self-management programme. British Journal of Rheumatology, **37**, 1315-1319. Bassey, E.K. (2000). The benefits of exercise for the health of older people. Reviews in Clinical Gerontology, **10**, 17-31. Boulware, L., Daumit, G., Frick, K., Minkowitz, C., Lawrence, R., & Powell, N. (2001). An evidence-based review of patient-centered behavioral interventions for hypertension. American Journal of Preventative Medicine, **21**, 221-232. Bradley, J.D. (2000). Osteoarthritis treatment approaches, research methodologies, and agenda: do we need to re-invent the wheel? Arthritis Care & Research, **13**, 252-254. Bundy, C., Carroll, D., Wallace, L., & Nagle, R. (1998). Stress	Thank you.

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			management and exercise training in chronic stable angina pectoris. Psychology and Health, **13**, 147-155. Bundy, C., Carroll, D.L. , Wallace, L., & Nagle, R. (1994). Psychological treatment of chronic stable angina pectoris. Psychology and Health, **10**, 69-77. Clark, N., Becker, M.H., Janz, N.K., Lorig, K., Rakowski, W., & Anderson, L. (1991). Self-management of chronic disease by older adults. Journal of Aging and Health, **3**, 3-27. Department of Health. (2001). The National Service Framework for Older People. London: Department of Health. Dusseldorp, E., van Elderen, T., Maes, S., Meulman, J., & Kraaij, V. (1999). A meta-analysis of psychoeducational programs for coronary heart disease patients. Health Psychology, **18**, 506-519. Gallacher, J.E.J., Hopkinson, C.A., Bennett, P., Burr, M.L., & Elwood, P.C. (1997). Effect of stress management on angina. Psychology and Health, **12**, 523-532. Greig, C.A., Young, A., Skelton, D.A., Pippet, E., Butler, F.M.M., & Mahmud, S.M. (1994). Exercise studies with elderly volunteers. Age and Ageing, **23**, 185-189. Groessl, E.J. & Cronan, T. (2000). A cost analysis of self-management programs for people with chronic illness. American Journal of Community Psychology, **28**, 455-480.	

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			Kovar, P.A., Allegrante, J.P., MacKenzie, C.R., Peterson, M.G.E., Gutin, B., & Charlson, M.E. (1992). Supervised Fitness Walking in Patients with Osteoarthritis of the Knee. Annals of Internal Medicine, **116**, 529-534. Linden, W. & Chambers, L. (1994) Clinical Effectiveness of Non-Drug Treatment for Hypertension: a meta-analysis. Annals of Behavioural Medicine **16**, 35-45. Lorig, K. & Gonzalez, V. (1992). The Integration of Theory with Practice: A 12-Year Case Study. Health Education Quarterly, **19**, 355-368. Lorig, K. & Holman, H. (1993). Arthritis Self-Management Studies: a twelve-year review. Health Education Quarterly, **20** , 17-28. Lorig, K., Mazonson, P.D., & Holman, H.R. (1993). Evidence suggesting that health education for self-management in patients with chronic arthritis has sustained health benefits while reducing health care costs. Arthritis and Rheumatism, **36**, 439-446. Minor, M. A., Hewett, J. E., Webel, R. R., Anderson, S. K., & Kay, D. R. (1989). Efficacy of physical conditioning exercise in patients with rheumatoid arthritis and osteoarthritis. Arthritis and Rheumatism, **32**, 1396-1405.	
			Mindfulness-Based Stress Reduction to promote mental health and well-being in older people **Mindfulness-Based Stress Reduction (MBSR)** helps people learn to control their attention by focusing non-judgementally on	Thank you for drawing our attention to this work. We note your comments.

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			physical sensations, emotions and thoughts. This frees many troubled people from the tyranny of worrying about the future or regretting the past. MBSR includes: quiet sitting while directing the focus of attention; mindful movement; practice being fully present during everyday activities; and aspects of standard cognitive therapy. It has been shown to promote more self-awareness and acceptance, less reactivity to thoughts and emotions, and ability to respond better to difficulties. MBSR courses usually involve 8 weekly 2-hour sessions, and daily home practice. Research shows they help people cope with chronic pain, general stress, and anxiety. MBSR is highly appropriate for primary prevention and the promotion of mental well-being, while the related Mindfulness-based Cognitive Therapy is for mental health interventions. Best delivered to large groups, both are cost-effective. MBSR is for any age group, yet is found particularly congenial by older people, in community and residential settings (McBee, 2003; Smith, 2004). Being deliberately mindful helps develop a 'decentred' perspective, so that though still involved, we are no longer overwhelmed by emotions or thoughts. This can help to prevent stress responses (e.g. to the stress of being an older carer) or pain escalating into exhaustion, anxiety or depression, so is suited to primary preventative interventions. Mindfulness also improves well-being and enables older people to progress towards	

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			their personal goals (Smith, in preparation). MBSR is provided in primary care in Central Lancs. with excellent initial outcomes. People finding life stressful (including many carers) are helped to avoid anxiety or depression, while those already so affected learn to cope better and their symptoms/distress reduce. Many visit their GPs less and some no longer take anti-depressants – one noted "They must be saving a packet, the NHS"! People who would not accept being labelled 'mentally ill' but whose suffering is potentially disabling, are greatly helped.	
			Local mindfulness course participants have said: *"I practice every day, it has been superb. The pain is slowly getting worse, but I cope so much better."* *"It gives you energy, a clearer mind, settles you down: a lot of things rolled into one"* *"It opened my eyes … I was getting very little from my life, it all focused on the past and the future … I've realised how pleasurable life is when you don't dash through … and, you know, it's wonderful."*	
			Key references **General references re clinical application of Mindfulness Training** Kabat-Zinn, J. (1990) *Full Catastrophe Living: How to cope with*	Thank you for this information.

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			stress, pain and illness using mindfulness meditation. London: Piatkus. R. A. Baer (ed) (2006) *Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications*. New York: Academic Press. **References specific to Mindfulness Training for older people** McBee, L. (2003) Mindfulness practice with the frail elderly and their caregivers: changing the practitioner-patient relationship. *Topics in Geriatric Rehabilitation*, 19, 257-264. Smith, A. (2004) Clinical uses of mindfulness training for older people. *Behavioural and Cognitive Psychotherapy*, 32, 423-430. Smith, A. (2006) "Like waking up from a dream": mindfulness training for older people with anxiety and depression. Chapter 9 In R. A. Baer, *Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications*. New York: Academic Press. Smith, A. (in preparation) Back in charge: achievement of personal goals following mindfulness training.	
			MAINTAINING WELL BEING – THE IMPACT OF CRIME ▪ Distraction burglary (also sometimes called bogus caller or artifice crime) is defined by the Home Office as: "Any crime where a falsehood, trick or distraction is used on an occupant of a dwelling to gain, or try to gain, access to the	Thank you for your comments. We would encourage you to consider referring this topic to NICE for investigation at a future date: www.nice.org.uk/page.aspx?o=ts.h

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			premises to commit burglary" (Association of Chief Police Officers, 2003). ▪ The offender often assumes the identity of an official, salesperson or worker, or someone in need of help. ▪ Although older people are less often the victims of almost all types of crime compared to younger people (Mawby, 1982), this pattern is reversed with distraction burglaries, where the average age of victims is 81, with few crimes reported against younger people (Home Office, 2001). ▪ Whilst there is a general awareness within the NHS of the impact of crime on the health of individuals, "these concerns and initiatives do not seem to be supported by much information, research or policy" (Robinson et al., 1998). ▪ There is both a paucity of health posts aimed at supporting victims of crime, and a lack of literature demonstrating the benefits of health intervention on the well-being of older crime victims (Thornton et al., 2003). ▪ Within police and older adult services, there is a recognition that multi-agency partnerships provide the key to preventing this crime and responding to the secondary disabilities it can trigger (Thornton et al., 2005). ▪ In a National Survey, and following an exhaustive awareness raising campaign, 49% of older people	ome

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			interviewed were still unaware of Doorstep Crime (Thornton et al., 2005) and were doing little to protect themselves from it. ▪ In the same survey, 3.3% of respondents suggested that, within the last 12 months, they had been approached by someone suspicious on their doorstep. If this is true, then 390,000 older people may be being approached by these criminals every year (Thornton et al., 2005). ▪ In terms of outcome of the crime, research shows that 40% of victims report that the incident had a significant impact on their quality of life, with 3% meeting the criteria for PTSD 4 months later. Additionally, victims who continued to feel like 'puppets in the burglars hands' fared worse (Thornton et al., 2003). ▪ A pioneering Nurse for Older Victims of Crime Scheme (created in Islington in 2004) demonstrated its effectiveness in identifying unmet needs and potential risks for older crime victims. Once identified, the Scheme allowed for the facilitation of new services to meet the unmet needs of the crime victims. The Scheme Nurse provided a useful interface between the police and health and social care systems – where older people wanted their health practitioners to know – but indicated they did not want to be the one to inform them (Thornton et al., 2006).	

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			References Association of Chief Police Officers. (2003). *Counting Rules for Recorded Crimes.* At www.homeoffice.gov.uk/rds/pdf52/countburglary03.pdf Distraction Burglary Taskforce. 2001. *Distraction Burglary Good Practice Guide*. London: HMSO. Mawby, R. I. 1982. Crime and the elderly: A review of British and American Research. *Current Psychological Reviews*. 2: 301-310. Robinson, F, Keithley, J et al., (1998). Exploring the impacts of crime on health and health services: A feasibility study. Durham: University of Durham Thornton, A. Hatton, C. Erol, R. 2003. Distraction burglary amongst older adults and ethnic minority communities. *Home Office Findings* **197**. London: Home Office. www.homeofice.gov.uk/rds/rfpubs1.html Thornton, A. Hatton, C. McGraw, C. (2006). *Nurse for Victims of Distraction Burglary: An Evaluation of the London Borough Islington Project.* In preparation. Thornton, A. Hatton, C. Ralph, L. Owen, T. (2005). Understanding the Older Person's Awareness and Experience of Doorstep Crime: Results of a National Survey. *Crime Prevention and Community Safety: An International Journal,* **7** (1), 31-42.	Thank you for this list of useful references.

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		1 Title	The short title does not reflect the remit given. Particularly the emphasis on "public health interventions". There is a potential inconsistency between the title and the draft scope which specifically seems to exclude "interventions". There is an inconsistency in the remit and the draft scope about whether or not specific interventions to manage people with mild mental health problems and return them to a state of mental well-being should be included.	Thank you for your comments, we note your concerns.
		3 Need for Guidance	The need for guidance is outlined adequately, but in (c) the increased morbidity and mortality in older people with chronic physical disease and co-morbid mental health problems should be mentioned.	We note your concerns, thank you.
		3e	Epidemiological studies of depression in older people identify loneliness as a major factor in the aetiology of depression. This factor should be mentioned in this section.	Duly noted.
		4.1	It is a pity that residents of long-stay nursing homes are excluded, as there is significant morbidity due to mental health problems in this population, as well as training needs in care staff.	The scope is being revised to focus on the well-being of all older people over 65, as far as the available evidence permits. However it will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.

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				Thank you for comment, we note your concern. If you feel there are topics suitable for future guidance development, we would your encourage your organisation to use the topic suggestion facility on the NICE website. Please visit: www.nice.org.uk/page.aspx?o=ts.home
			Why are older people in hospital excluded from the guidance? Again there is a high prevalence of mental health problems in patients admitted to hospital (which causes significant additional morbidity and mortality).	Thank you, we note your concerns. Guidelines for patients in receipt of treatment are covered by separate guidance developed by the clinical guideline teams. For a comprehensive description of NICE guidance please visit: www.nice.org.uk/guidance/type
			Why are people in receipt of treatment for mental health problems excluded from the guidance? It is known that depression in older people is under-treated, and that depression and anxiety in patients with dementia (and their carers) is common. Adequate detection and management of these populations would improve mental well-being of older people.	Please see our previous response. We acknowledge that promoting mental wellbeing for older people is a complex issue.
		4.3.2	As loneliness, physical environment and fear of crime are	Thank you for your comment. It is

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			significant causes of mental ill-health, it is a pity that community interventions are excluded from the guidance.	indeed the case that this is outside the current scope, but please see the NICE website topic suggestion facility: www.nice.org.uk/page.aspx?o=ts.home
			It is a pity that the treatment of mental health problems such as anxiety and depression are not covered by the guidance. There is much evidence [Chew-Graham CA, Burns A, Baldwin RC. Treating depression in later life: We need to implement the evidence that exists. [Editorial] BMJ 2004; 329: 181-2.] USA and some from UK that there are interventions which could be implemented which would improve outcome.	As noted above, the scope will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.
			Why is palliative care excluded? This is an important omission: depression and anxiety are common symptoms in patients who are in the palliative stage of their illness and detection and appropriate management would improve mental well-being of these groups of older people.	Thank you for your comment. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people and acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. If you feel that there are particular issues that warrant separate attention, we would encourage you to use the facility on the NICE website to suggest topics for future

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				guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		4.5	One of outcomes listed is psychological well-being. This is vital but seems at odds with the guidance which states that it is not covering treatment of mental health problems such as anxiety and depression.	Thank you, we note your concern. Outcome measures of psychological wellbeing are also used in non-clinical research.
			Other (validated, objective) outcome measures should include: social networks, loneliness and isolation, physical morbidity, health and social care use, use of voluntary sector services as well as self-report measures (such as PSYCLOPS)	Noted, thank you.
		4.6	The key question is an important one, but the guidance needs to address not only the interventions that promote well-being, but also interventions that treat individuals with mental health problems and return them to a state of mental well-being.	Thank you, we note your concerns. Again, treatment topics are covered by the NICE clinical guideline teams.
			Subsidiary questions might also include: Role of primary care staff in detecting mental health problems Effective interventions for managing people with mild-moderate mental health problems (and returning them to mental well-being) ~ recognising that this guidance is *public health* rather than *clinical.* Role of secondary care, particularly the collaborative care approach in the management of patients with depression, and in	Thank you for your suggestions.

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			the education and training of staff in detection and management of people in residential care. What type of interventions work best in different groups (e.g. ethnicity, and cultural variations)?	
			Draft Subsidiary questions: If the guidance is not looking at specific interventions for patients with mental health problems, how are the questions about different groups, frequency of intervention or use of generalist vs. specialist practitioners to be addressed?	Thank you for your question. We acknowledge the complexities surrounding the evidence for promoting mental wellbeing among such a diverse group and the difficulties in identifying appropriate, evidence based research to develop guidance.
		4.7	The guidance is aimed at a broad audience, including patients and carers, which is excellent. It is vital that the guidance covers health, social care and the voluntary sector and not biased towards one sector.	Thank you very much for taking the time to comment on the draft document. Public Health guidance does cover all sectors.
			The effectiveness of domiciliary versus practice, clinic or hospital based interventions. The effectiveness of CBT in the community, via therapist, computer and internet. The effectiveness of group, music and craft therapies. The effectiveness of exercise as a therapeutic intervention. Interventions to prevent loneliness.	Thank your for your very helpful suggestions. Duly noted.

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			Remote medical monitoring, telemonitoring. Prevention of admission to hospital. Prevention of falls and consequence of false hip protectors.	
			I think it is very good. I like the strong focus on promoting mental well-being, and on definitions of outcomes in terms of quality of life, psychological well being and self esteem, rather than on presence or absence of formal psychiatric diagnosis. I also like the generic descriptors of interventions, which may but do not need to include pharmacological approaches; and the emphasis on increasing choice and control.	Thank you for your support and kind comments.
Royal College of Nursing		General	The RCN is a board member of the Age Concern Enquiry into Mental Health and Wellbeing in Old Age. We welcome the opportunity to review this document.	Thank you, we are grateful to your organisation for taking the time to comment on the draft scope document. We hope you will continue to engage with the guidance development process at all stages.
		4.1.1	NICE should resist pressure to consider specific client groups, as this will detract from true focus of the Guidance. A significant flaw in the draft scope at 4.1.1 is the suggestion that only those people currently receiving domiciliary care, or living in sheltered housing or residential care homes, are to be considered. Bearing in mind that over half of all those clients in residential care	Thank you for your comments and drawing our attention to these issues, duly noted.

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			homes present with some evidence of mental illness, this wholly contradicts 4.2 of the draft scope.	
		4.1.1	For those clients in receipt of domiciliary care, one can safely assume that their 'wellbeing' is already compromised by some form of physical/cognitive debility. We are already well aware of the effects of pain, physical debility and isolation upon mental functioning, so once again the experiences of this potential 'population' will be skewed by illness. Already then, the scope is heading towards a treatment domain as opposed to prophylaxis.	Thank you for highlighting this issue.
		4.2	The RCN seeks clarification as to the rationale for excluding patients in Nursing Homes and Hospitals. There is ample evidence to suggest that patients in Hospitals and Nursing homes would benefit from public health interventions and we do not understand why this guidance would exclude these groups? For example-what about someone with a mental health need, living in a residential care home who is admitted to Hospital for surgery-this would not result in their mental health needs disappearing. It has also been established that the palliative care needs of patients with mental health needs are frequently under recognised and therefore not met-this would fit within the public health arena in our view.	Thank you for comments, we note your concern. We would encourage you to use the facility on the NICE website to suggest specific topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		4.2	During the initial Stakeholder Meeting on 15th December 2006 a comment raised suggesting that a significant proportion of older people, including those from ethnic/minority groups, do not seek	Thank you for your comment. We note your concerns and recognise that there are broader issues that

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			regular assistance from their General Practitioner. The assumption being is that there exists unidentified and unmet mental health need among these elements. The flip side of the coin, of course, is that it is this very group who may indeed hold the key to mental wellbeing in later life. To exclude this element of society from the study then, appears both naïve and discriminatory. To this end and in our view the patient population excluded in 4.2 should be included and pigeon holing of population groups should be avoided.	need to be addressed with regard to older people not in receipt of services. We also recognise the need to include evidence from studies that examine the approaches of different groups to mental wellbeing. For further information about NICE methods and processes please visit: www.nice.org.uk/page.aspx?o=300576
		4.31	The examples given are limited. The RCN believes that having choice over access to good quality mental health support is more important than bed utilisation.	Thank you, noted.
		4.32	Palliative care must be included.	Thank you, we note your concern.
		4.6	The document refers mainly to interventions. There is no reference to the environment. This is a key area when providing residential care for older people with mental health needs, particularly Dementia. The environment and design of a building can enable a person to have increased independence and well being, and perhaps should be considered as part of this document.	Thank you, we note you concerns. We would refer you to the NICE topic suggestions facility on our website: www.nice.org.uk/page.aspx?o=ts.home
		4.7	Why not older people as well?	Thank you for your question. NICE does not generally develop guidelines for individuals. For a

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				comprehensive description of NICE guidance please visit the weblink: www.nice.org.uk/guidance/type
		General	It is not acceptable that older adults with mental health needs are discriminated against due to age or diagnosis. Their needs should be included in other relevant guidance. The whole of society has physical, psychological, spiritual, financial and social needs.	Thank you, we note your concerns. The guidance will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance. NICE has developed a number of clinical guidelines specifically for these groups. Please visit the NICE website for more information.
Royal College of Psychiatrists, **Faculty of Old Age Psychiatry**		General	The Faculty of Old Age Psychiatry welcomes the development of this guideline and is glad to be invited to be a member of the Stakeholder Group and comment on the scoping document. We would like to commend the document "Raising the Standard" published by the Royal College of Psychiatrists in August 2006 and available from [X] at the Royal College as a reference source for the guidance developers.	We warmly welcome your support and comments. We note your recommendation, thank you.
		1	We suggest that the third line of the main guidance title should refer to: '(a) residential care and (b) the community' rather than 'or the community' to emphasise that residential care should be a	Thank for your suggestions. We hope you will continue to engage with the process of guidance

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			seamless part of the wider community. For far too long the care home sector has been isolated and cut off from the wider community. Residents in care homes have little opportunity to leave their care home with no access to community services and many lose contact with friends and sometimes even their family. If the Faculty can be of any further help in preparing this guidance we would be glad to do so. Please contact [X]	development, we value your contribution.
		1(c)	We believe that housing, particularly sheltered housing, and the role of the warden is a neglected area, often falling between home and care home. The definition of sheltered housing is often vague and the available support services are often below the expectation of residents and their relatives. Moreover, older people often move away from their own local community, increasing isolation and loneliness. We hope the guidance will provide good practice advice in this area.	Thank you for your comment. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people. We would encourage your organisation to use the topic suggestion facility on the NICE website: www.nice.org.uk/page.aspx?o=ts.home
		3(b)	We are pleased that the scoping document has highlighted the high level of poor mental health amongst older people, particularly in care homes. Pages 30-35 of "Raising the Standard" describe how secondary older people's mental health services can help and work with others to improve mental health in this age group.	Thank you, noted.
		3(d)	Maintaining independence in a care home is difficult. Maintaining dignity and respect, while at the same time enjoying	Thank you for your comment, duly

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			independence, is a skilled task requiring training, experience and high levels of staff morale. This contrasts with the low skills base, high staff turnover and low staffing levels within much of the care industry. Institutionalisation, first described by Barton in 1959, remains common.	noted.
		3(e)	We are pleased the guidance will look at ways of reducing discrimination. Age and culture are mentioned and we would like to add "diagnosis" and "living in a care home". People with certain diagnoses are still often excluded from services simply because of their diagnosis rather than need. Registration is often cited as the reason. This widespread practice is unacceptable. Living in a care home frequently bars people from access to normal services, for example Social Services day care, visiting clubs, attendance at the GP surgery or even some outpatient clinics. Reasons given include transport costs and an expectation that residential homes should provide all the activities a resident should require and that the care home itself should be all that a patient needs in the way of psycho-social activity. This contrasts with the wider population which enjoys a variety of different social environments.	Thank you for highlighting these issues.
		4.1.1	We know that NICE will be focussing on promoting wellness. Therefore the word domiciliary should include care from informal carers such as neighbours, family and friends.	Thank you. This group is referred to in the Scope document section 4.3.1.
		4.2	The definition of 'elderly mentally infirm' (EMI) remains problematic. It is often taken to include anyone with a diagnosis of dementia or Alzheimer's disease. The Royal College of Psychiatrists has long advocated a needs based definition rather	Thank you for your comments, duly noted. We recognise that there are wider

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			than a diagnosis/labelling definition. The British Geriatrics Society **report "**Hospital Discharge of Older People with Cognitive Impairment to Care Homes" http://www.bgs.org.uk/Publications/Compendium/compend_4-13.htm states: ***'***_The Nursing Home and Residential Home sector is dominated by the care of people with dementia'_ and _'Sometimes residents will have been given a formal diagnosis of dementia, and sometimes not. We need to recognise that this is the reality of care, and that, when someone is given a formal diagnosis of dementia, they should not automatically have to move to a home providing specialist psychiatric care.'_ The proportion of people with cognitive impairment is likely to rise, as more people with physical frailty will be able to remain within their own homes for longer. We are worried that those described as elderly mentally infirm are already discriminated against (see Section 3(e)) and excluding them from this guidance will increase this discrimination. Elderly mentally frail patients, no matter what the disability, should have access, as much as possible, to mainstream services. This has long been advocated in all other areas of the disability movement and should also apply to dementia. The definition of hospital care is changing. Continuing NHS Healthcare funding, traditionally confined to long stay hospital care, can now be delivered in any setting. It is important that people receiving this type of care funding are not excluded from other mainstream services.	issues to be addressed in promoting mental wellbeing among older people and acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. We will consider your suggestions very carefully. Thank you, duly noted, see our previous response. Thank you we recognise your concerns and thank you for your comments.

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			A high proportion of elderly people receive psychotropic medication for widely different clinical conditions. Many are clinically stable and are taking maintenance treatment to help optimise their level of function or reduce the risk of relapse. The Royal College of Psychiatrists advocates a holistic approach to the treatment and maintaining wellness. This holistic approach should include pharmacological, psychological and social treatments. Therefore excluding this group of people from the guidance will significantly reduce the number of properly assessed treatment interventions available to them.	Noted, see previous response.
		4.3.1	We strongly support the interventions listed in this section. We particularly advocate the opportunity for the care home residents to have access to normal community facilities.	Thank you for your support.
		4.3.2	We understand that pharmacological interventions should be outside the scope of this guidance. However, the fundamental objective of the guidance is to promote mental well being for all elderly people. For the vast majority of elderly mentally ill people the corner stone of psycho-social interventions should be within mainstream services rather than specialist services. Therefore psycho-social interventions for this group of people should be included within the guidance.	Thank you for your suggestions, duly noted.
		4.6	We warmly support the key question, together with the subsidiary questions, laid out within this section. As the guidance will be targeted towards a multi-agency audience we suggest that good inter-agency communication and working	Thank you. Thank you, noted.

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			could also be assessed against mental well-being.	
Royal College of Speech and Language Therapists		General	The document is well-structured and the key question both timely and relevant	Thank you, we welcome your involvement in the guidance development process.
		General	The RCSLT are concerned that the guidance is heavily led by service perspective, instead of being person-centred.	Thank you, we note your concerns.
		4.1	The conclusions of this review will be very relevant for all SLTs who work in intermediate care. This includes those working in 'Reablement Teams' and 'Community Rehabilitation Teams'. SLTs frequently have to address wider psychosocial issues such as quality of life, participation and engagement than more impairment-based issues. These findings would assist SLTs in developing both outcome measures and therapeutic interventions for those on their caseloads.	Thank you for your comments. Duly noted. Thank you for your comment, noted.
		4.2 General	The aim of such guidelines is to reduce inequalities in services for older people. However there are too many inequalities in-built into the scope by the exclusion criteria. Please note that the RCSLT's concerns with the exclusion criteria are detailed below.	Thank you for your comment. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people and acknowledge that the term used to describe this group inadequately expresses the diversity of its membership.

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				It may be that NICE will be requested to develop specific guidance for this group in the future, but you may wish to visit the topic suggestion facility on the NICE website: www.nice.org.uk/page.aspx?o=ts.home
		4.2	The population that will and will not be covered is arbitrary as people receiving services in their own homes are often disabled.	Noted, thank you.
		4.2	People may be having treatment for anxiety or depression that are being managed in primary care and would benefit just as much from activities promoting mental health and well being as people who are not receiving medication.	Noted, thank you.
		4.2	The RCSLT disagrees with the exclusion of people living in a nursing home. These older people are more vulnerable to mental health problems due to their additional physical restrictions. These people would benefit from many of the interventions that would be appropriate for people living in residential homes. The RCSLT believes that older people in nursing homes and elderly mental infirm facilities should be included. It would be more equitable to include all older people and to acknowledge that the mechanisms for providing mental health support might be different for certain groups such as these.	We note your concerns and thank you for highlighting this important issue. Duly noted. Thank you for your comments. Please see our earlier direction for topic referral, but note that we will consider your suggestions very carefully.

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		4.2	To be receiving primary care services as an inclusion criteria would exclude many older people who would benefit from this guidance, which is targeted at prevention and promotion of mental health in older people. Currently often an older person's needs have to have reached crisis point before primary care services are brought in.	Thank you, we note your concerns.
		4.2	The RCSLT believes that an older person should be supported, by having services or interventions available, whether they are living independently, with informal carer support, formal carer support, in residential, or nursing homes, as long as they are able to benefit from the intervention. In this case the only constraint would be difficulties of access and how this could be overcome and how activities and interventions could be tailored to a specific persons needs.	Thank you for your comment, we note your concerns.
		4.3.1 Bullet one	This bullet correctly includes interventions delivered by professionals and carers and families. However it is important to include the voluntary sector as organisations such as Age Concern and Help the Aged provide many opportunities and activities designed to promote well-being for older people.	Thank you, noted. The groups referred to in section 4.3.1 of the scope are intended to be inclusive, as is the definition of mental health promotion.
		4.3.1 Bullet two	The RCSLT believes that all older people should have control over their life and choice over the activities in their life. However even if someone is given a choice many older people may struggle to exercise this choice.	Thank you for your comments, your concerns are duly noted. We acknowledge the complexities surrounding the promotion of

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			In order to exercise choice, older people need adequate communication skills (comprehension and expression). Many people in this population have dementia, dysphasia or communication problems due to stroke etc and they would not necessarily be able to make the choices without visual or written cue cards etc or without access to a communication book or chart.	mental wellbeing and the diversity of older people as a group. Your concerns are duly noted.
		4.3.1 Bullet two	Often it is only the behaviour of the individual in the new situation that would demonstrate whether they were enjoying it, many older people are reluctant to try new activities especially if they are not sure what they are signing up to due to receptive problems. To enable such people to participate would probably require specialist training that many care staff currently do not have.	Thank you, noted.
		4.3.1 Bullet two	Giving a verbal choice only is not going to involve those older people most at risk. The RCSLT recommends that the guidelines make particular recommendations for older people who are experiencing communication difficulties.	Thank you, duly noted.
		4.6 General	As well as evaluating the time needed for interventions, NICE should also consider ongoing availability and how easy it is for older people to access interventions- do these always need to be accessed via a 'medical model' referral route?	Thank you, we note your comments and concerns.
		4.6	Effectiveness also needs to be evaluated in terms of whether it meets the needs, wants and wishes of older people themselves.	Thank you, noted. NICE is committed to including an individual perspective in public health

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		Bullet one		guidance wherever possible as part of its broader remit to ameliorate health inequalities. As mentioned in section 4.5 of the Scope, we will include appropriate evidence from relevant research that includes self-reported outcomes.
		4.6 Bullet two	When considering the most cost effective and appropriate interventions for different groups, it would be important to consider the impact on neuro-disability, stroke, Parkinson's disease on mental health and well-being.	Thank you, noted.
		4.6 Bullet two	There is a question around whether language and cognitive difficulties associated with stroke are construed as disabilities.	Noted, thank you.
		4.6 Bullet six	NICE guidelines for all mental health difficulties strongly advocate the involvement and inclusion of family and this must include people who the older person regards as having a significant close relationship in interventions, for example carers, partners and even neighbours or friends.	Thank you. These issues are addressed as subsidiary questions in section 4.6 of the Scope.

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Royal Institute of the Blind (RNIB)		**4.1.1**	Groups that will be covered is artificially designated as people who are in receipt of domiciliary care rather than older people who would benefit from the intervention guidance e.g. older people who are affected by age related life changes such as bereavement and disability many of whom have requested but cant get domiciliary services. For example most sight loss is acquired in older age. The incidence of depression amongst older people with acquired sight loss far higher than in the peer older population. Many older people with sight loss either have not applied for or have not been assessed as in need of domiciliary care, or are on long waiting lists for assessment following registration as blind or partially sighted and are at risk of depression, anxiety and increased isolation/withdrawal. Older people who are carers are also excluded under the current scope Suggestion: 4.1.1 is revised to include older people who are in receipt of or eligible for primary or social care including those living in sheltered housing/residential homes. This reflects more accurately the definition of the guidance tile 1.	Thank you for your comments your concerns are duly noted. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people, and also acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. We will carefully consider your suggestions. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		4.2	The current scope excludes older people undergoing pharmacological and or non-pharmacological treatment for a clinically diagnosed mental illness. This medical model approach denies the value of interventions to older people who may move in and out of treatment at different life points. Therefore under the current proposals an older person who is	Thank you for your comments, we note your concerns.

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			recently been diagnosed with sight loss, living at home, prescribed with antidepressants for depression or having NHS counselling or psychotherapy would be excluded from interventions to promote good mental health and wellbeing-. This is contradictory as many older people come into this category and would benefit form interventions to maintain or improve mental wellbeing. For example as in 4.1.1 the incidence of depression amongst older people with acquired sight loss is high, with associated high levels of suicidal ideation. Counselling has been shown to benefit and reduce depression and anxiety for this client group and interventions to improve and maintain mental wellbeing for is essential. However under current proposals clients in receipt of counselling or anti depressants to support an individual manage this life transition would be excluded from interventions to maintain or improve mental wellbeing. Suggestion: People who are undergoing treatment should not be excluded from the guidance however this will need to be taken into account when considering appropriateness of particular interventions. Consultation may be needed between the provider of the intervention and the person responsible for delivering treatment.	Thank you for highlighting these issues. Please see our previous response. Thank you for your comment, duly noted.
		4.3.1	Counselling is included as a possible intervention that promotes mental health and wellbeing-, which contradicts 4.2 older people undergoing non-pharmacological treatment for a clinically diagnosed mental illness.	Thank you for your helpful suggestions and comments. Guidance interventions will be based on the best available

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			Suggestion: If 4. 2 is amended to include this client group this contradiction will be removed. Suggestion: Whilst the list of possible interventions is not exhaustive, training for social and primary care staff, and for carers is a key intervention and should be included in the scope guidance.	evidence. If you would like further information on NICE process and methods please visit: www.nice.org.uk/page.aspx?o=300576
		4.3.2	Areas that will not be covered include treatment…. including psychosocial interventions. This potentially contradicts 4.3.1, which includes counselling support, depending upon how counselling support/counselling is defined.	Thank you, duly noted.
		General	Scope consultation meeting requested info on organisations re the built environment. The Thomas Pocklington Trust have undertake research into the housing and physical environment for older people with sight loss.	Thank you very much for this information.

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Social Care Institute for Excellence		General	This whole subject area is key to improving the quality of life for older people, and it is good to see an emphasis on some preventative work to address the needs of older people who do not have a formally diagnosed mental illness but who do experience poor mental well-being. Given that mental and physical health are so inextricably linked, some preventative interventions would be very valuable. Services that promote good mental health and well being effectively prevent or delay the onset of mental illness so NICE guidance in this area is welcomed. This guidance would be particularly important for those older people with lower level mental health needs or those prone to mental illness who are not recognised by services. It is also encouraging to see a focus on different settings: living at home; sheltered housing; and residential care.	We welcome your comments and support, and thank you for taking time to comment on the draft scope document. Please see our earlier responses to comments from your organisation at the start of this document.
		1	While the guidance title is appropriate, there does not seem to be consistency between this and the key question (in 4.6). The key question does not explicitly refer to primary care which presumably should be acknowledged within the body of this question. TITLE: Guidance on interventions that promote good mental health and well-being in older people receiving support through primary care and other services and living in a) residential care or b) the community KEY QUESTION: What are the most cost effective ways of	Thank you for drawing our attention to this area.

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			promoting the mental well-being of older people who live in residential care or receive support to live in the community?	
		2c 4.7	This is an extremely broad audience with quite diverse needs in terms of information provision and it is not clear how all these needs can be met within one document. Domiciliary carers, family members and people providing care within residential homes are most likely to be in frequent contact with the group of older people this document is concerned with and could be particularly well-placed to utilise the guidance. However, they may well be less likely to find official guidance easy to use and may need a different type of information provision.	We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people and acknowledge that the term used to describe this group inadequately expresses the diversity of its membership.
		3	This section provides a very persuasive set of reasons why the guidance is needed. It is also perhaps relevant that current levels of service provision and support fall short of the rising levels of need, which tends to result in a narrow focus on those with high level complex needs. A lack of mental well-being is therefore often not addressed before it becomes a more significant problem, making the need for this guidance all the greater.	Thank you for your kind comments and support.
		Page 3, Section b)	The two statements in this paragraph are not comparing like with like: i.e. 'mental health' comparison with 'overall health'.	Thank you, duly noted.
		Page 3, Section d)	It is encouraging to see the inclusion of residential care which for some older people can be a life changing and traumatic experience, very often preceded by a major life changing event such as death of a spouse. However, it is necessary to also acknowledge the enormous impact on the mental well being of	Thank you for your comments, duly noted.

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			some older people during the transitory phase, i.e. prior to moving from the community and into residential care. The needs of older people living in residential care homes seem to be overlooked even more frequently and can be particularly hard to address, given that they may well be in a situation that they did not choose with a very strong emphasis on their physical care needs and often little else. Those involved in their care may well benefit from some targeted guidance.	
		4.3.1	It is important not to overlook all the various services provided under the umbrella of primary care which make a significant impact on the quality of life and mental well being of older people. These include podiatry, oral health, continence care, opticians, etc. The effects of more recent technological interventions such as telecare should also be assessed for their effectiveness in promoting the mental well being of older people. Will community transport also be considered because of its vital role in alleviating social exclusion and promoting mental well being?	Noted, thank you. Guidance will be drawn from best available current evidence. Thank you, transport may be outside the scope of the current guidance. We would encourage your organisation to use the facility on the NICE website to suggest topics for future guidance. Please visit: www.nice.org.uk/page.aspx?o=ts.home
		4.4	It is unclear how the comparison of interventions will be managed, given the challenges of comparing very individual responses and the likely impact of multiple factors on the experience of the	Thank you for your comment. As mentioned earlier, guidance will be based on best evidence available,

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			intervention. It may be worth considering that existing research evidence may be limited in terms of inadequately developed methods for measuring effectiveness which could make comparisons between interventions difficult.	though we acknowledge the complexities of the evidence base for this area.
		4.6	All of the identified subsidiary questions cover very interesting areas and would provide valuable information. For interventions of limited length, it would also be worth considering if and how aspects of the intervention could be built into the daily lives of older people to ensure the beneficial effects continue. • In regards to the term 'most effective' what definitions will be employed, e.g. will this include effectiveness as perceived by older people? It is likely that older people's views will differ from those of practitioners. It is therefore necessary that the evidence that will support this guidance should include material that provides insights into older people's feelings, experiences and views on service interventions. • It is also important to acknowledge that many older people are carers and this should be included in the second bullet point. • A sub –question on interventions that prepare people for life transitions is recommended. A further sub-question could also look at the issue of accessibility to, and acceptability of, interventions by older people.	Thank you for these very helpful comments, we note your concerns.

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		4.7	As this guidance is targeted for different audiences a single version would not be appropriate. It would be worth considering different formats.	Thank you, duly noted.
		4.1.1	The inclusion of older people living in sheltered housing is interesting, given that they are often in receipt of very little support and may well be quite fit. It may however provide a valuable comparison with those living at home who may perhaps receive more formal support, but without the possible benefits of a communal setting.	Thank you, duly noted.
Tameside and Glossop PCT		General	Need clearer definition for 'mental health', well being' and 'mental well being'.	Thank you for your comment, duly noted. The definition and use of both terms is much debated in the literature. We will do our best to clarify the Scope where possible.
		4.1.1	Must remember that we now have high criteria for access to social care services. Will exclude many people not 'in the system'. Where is the preventative element, particularly those hard to reach and BME communities? How does primary care feature? Third bullet point – This contradicts Everybody's Business guidance, i.e. being needs led not diagnosis led.	Thank you for your comment, duly noted. We recognise the complexities of this area and that there are broader issues that need to be addressed.
		4.3.1 and 4.3.2	Second bullet point (4.3.1) and first bullet point (4.3.2) - conflicting	Noted, thank you.
		4.3.2	There is confusion as to who should be included / excluded, therefore everyone's 'fighting for their own corner'. Should be considered as a whole system approach to highlight that everyone	We note your comments and thank you or taking the time to comment on the draft scope document. We

Stakeholder Organisation	Evidence submitted	Section number Indicate **section number** or **'general'** if your comment relates to the whole document	Comments	Response
			has the right to 'well being' through mental health promotion – otherwise we have inequity across the board. Need to emphasise that this is everybody's business, therefore cannot be seen as purely the domain of health and social care.	are considering all suggestions very carefully.
Victim Support		1 Guidance Title	By defining the scope of the guidance as pertaining to older people receiving support the guidance sets up a service-led, rather than person-focused, approach to promoting good mental health and well-being. It might be a good idea to include older people who are not in receipt of services in the scope of the guidance. If there are specific reasons why this cannot be done – e.g. cost - this could be explicitly noted in the scope.	Thank you for your comments, noted.
		1 Guidance Title	The statement that the guidance applies to people living in residential care or the community seems to imply that where one lives is immaterial. If that's the case perhaps the phrase can be left out or it can be rephrased to show that it is inclusive.	The scope is being revised to focus on the well-being of all older people over 65, as far as the available evidence permits. However it will not address the treatment and care of older people with mental health problems or other clinical conditions as this is beyond the remit of NICE public health guidance.
		2 (c)	Perhaps this paragraph could be turned around so that carers and family members are mentioned first as they may be very much involved in older people's day to day care. Perhaps older people themselves could be mentioned as any guidance could also be aimed at them.	Thank you for your helpful comments. Duly noted. NICE guidance is not generally aimed at individuals. For a comprehensive description of NICE guidance

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				please visit the weblink: www.nice.org.uk/guidance/type
		3 (c)	This paragraph could be explained a bit more. Does it mean that mental health problems are common amongst people in 'care settings' and not amongst those in their own homes? If the intention is to put across that they exist in both is it worth making the comparison between the two here? Also, overall the phrasing of the paragraph could be clearer and more sensitive, using the word 'addressed' rather than 'managed' for instance.	Thank you for your comments, duly noted.
		4.2 Groups that will not be covered	We are concerned that people who live in long stay nursing homes, hospital/hospice patients and older people with clinically diagnosed mental illness are to be excluded. It seems inappropriate to exclude people who might be experiencing poor mental health or well-being who may live in these other types of homes. We believe that people who live in this type of accommodation, and also people with mental health problems or disabilities should not be denied access either to the criminal justice system or adequate care after a crime. These groups are particularly vulnerable and it is a matter of concern if the guidance does not underpin the proper provision of support and care to maintain good mental health and wellbeing to these groups. It is also interesting to note that 'Establishing national mental health and well-being indicators for Scotland', which the scope	Thank you for your comments. We recognise that there are wider issues to be addressed in promoting mental wellbeing among older people We also acknowledge that the term used to describe this group inadequately expresses the diversity of its membership. We will consider your suggestions very carefully. Thank you, noted.

[3] Parkinson, Jane. 'Establishing national mental health and well-being indicators for Scotland'. In *Journal of public health*, volume 5, issue 1 pp 42-48

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			refers to, is explicit in observing that: 'Positive mental health and negative mental health are considered as two dimensions of mental health, recognising that mental health is not a euphemism for mental ill health or the absence of mental health problems and should not be used as such (Herron & Mortimer, 1999; Herron & Trent, 2000)'[3]	
		4.3.1	It could be useful to include older people themselves as being able to intervene to improve their own mental health	Thank you for your suggestion. NICE is committed to including an individual perspective in public health wherever the evidence allows (e.g. as self-reported outcomes or from qualitative research). This is part of its broader remit to ameliorate health inequalities.
		4.3.2	It would be helpful for the scope to cover community interventions to improve the physical and social environment that are not directly targeted at older people and their carers. Physical, social and environmental issues may present barriers to participation for older people in particular. Crime and fear of crime are significant factors in preventing older people from leaving their homes and in making them feel isolated and excluded. It is a major issue affecting health, quality of life and older people's experience of their neighbourhoods[4]. Therefore, wider community interventions	Thank you for your comments and concerns. Duly noted. This area may be outside the scope of the current guidance; however, we would welcome your suggestions at the topic suggestion facility on the NICE website. Please visit: www.nice.org.uk/page.aspx?o=ts.h

[4] ODPM (2005) Social Exclusion Interim Report – Excluded Older People

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			may make extremely important contributions to the mental well-being of older people. For example, crime and disorder reduction strategies may not be solely directed at reducing crime and the fear of crime experienced by older people and their carers, however these strategies have the potential to provide important opportunities to enhance older people and their carers' mental health and wellbeing. There has been much debate about the effects of crime and the fear of crime on older people, and this remains an issue of concern.	ome
		4.7	It could be useful to include older people themselves as a target audience.	Noted, thank you. Please see our earlier response for further information on NICE guidance.
		General	What is meant by 'domiciliary care and support'? Hopefully this definition includes friends and family who care for older people as well as employed carers.	Noted. These groups are defined in section 4.1.1 and section 4.3.1 of the Scope respectively.
		General	It is not clear whether the same definition of the word 'care' applies throughout the draft scope, perhaps it could be clarified? Hopefully the definition includes friends and family as well as employed carers.	Thank you for your comment, duly noted.

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Wandsworth Pensioners Forum		4.6	Mental well-being & improving independence should be worked on together. There needs to be a better preventive service to avoid older people with depression being placed in a residential home or left isolated at home with only the occasional carer coming in. Paid carers generally prefer to carry out tasks rather than waiting for the person cared for to do it for themselves with encouragement. As well as the paid carer some form of befriending should be available, who would be able to talk to the person about the outside world, help them with letters, encouraging them to keep in touch with friends, often all distant and getting older themselves, take the person out for walks if they cannot go themselves through fear of falling or just of going out. This intervention should go on as long as the person needs it. Age Concern Wandsworth has a very successful befriending system which will do all or any of the above	Thank you for taking the time to comment on the draft document, we welcome your input. Thank you for your comments, your points are duly noted. If your organisation has any published documentation the success of these schemes, we would be glad to receive them via the website.
			For people who are blind help with incoming correspondence as well as with replies is vitally necessary to prevent depression and anxiety about what incoming letters are about and about urgent ones not being dealt with People who are deaf or hard of hearing need one-to-one conversation to help them remain in touch with the real world and avoid isolation and depression People who have long-term mental illnesses may well need some kind of counselling, psychological or psychiatric help which they will not get from the staff of a residential home.	Thank you for highlighting these areas of concern. Duly noted.

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			Some people with long-term mental illnesses end up in nursing homes. They may not themselves be demented but it is likely the other residents will be demented and the person will be very isolated. Carers are used to people with dementia who cannot usually make choices and will tend to treat everyone in the same way, i.e. often like children and certainly being told what is to happen the next minute, rather than looking further ahead. This is not conducive to good mental health for a person who is intellectually fairly intact but mentally unwell. They often need psychiatric or psychological help and do not get it from the staff. It is unfortunate that this scoping excludes those in nursing homes	Thank you, we note your comments and concerns.
			Older people who need care in their own home or in a care home need stimulation. They would be the better of fresh air and some exercise outside. They need a variety of activities and not just Bingo which seems to be the usual and often the only activity (although it may be of some benefit intellectually). Reminiscence therapy is very beneficial, preferably from an outside trained person, but if not, from a member of staff who has been trained for this therapy	Thank you for your helpful suggestions. We note your comments.
			The numbers of older people with long-standing mental health problems which persist in older age need to be known. They will often end up in nursing homes where usually all the other residents are demented. They do not get a good service from staff used to dealing with people with dementia. In my capacity as [part of] Wandsworth Pensioners Forum I have had two people	Thank you for commenting on the draft document, we welcome your input to the guidance process. If you feel there are particular topics that NICE could develop guidance for in the future, we would

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		General	in this category brought to my attention, but my knowledge is not comprehensive. Wandsworth Social Services do not seem to know how many people are in this situation.	encourage your organisation to visit the topic suggestion facility at: www.nice.org.uk/page.aspx?o=ts.home