

All things being equal

Age Equality in Mental Health Care
for Older People in England

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Overview

Older people with mental health problems in England do not receive the same level or quality of care as younger people. The government's Equality Bill will place a duty on health and social care services not to discriminate on age grounds. This is likely to place extra pressure on services at a time when numbers of older people are increasing year on year and the costs of care, especially for those with dementia, are expected to increase significantly.

The need for specialist expertise and care in older people's mental health remains. However current dividing lines between services for 'adults of working age' and 'older people' need to be dismantled. It is important that eligibility and access to such care should not be age-based, but rather that is most suited to addressing the particular problem that develops for each individual. Age should play no part in allowing or restricting access to the most appropriate care and treatment. This issue will increasingly come into focus as the more demanding post-war 'baby boomer' generation, with its higher expectations, reaches older age.

There are a number of drivers to support change, but there are also many barriers to change, such as ageism and entrenched professional boundaries. These need to be addressed as a matter of urgency to ensure not only that services do not discriminate in law, but that older people get the best possible personalised care when they experience mental health problems.

Introduction

Older people with mental health problems in England do not receive the same level or quality of care as younger people. Despite policies and guidelines setting out the importance of age equality in mental health care, both direct and indirect discrimination has continued to occur within services (Care Services Improvement Partnership, 2005; Healthcare Commission et al, 2006; Royal College of Psychiatrists, 2005; Department of Health, 2005a; Age Concern, 2007; Joint Committee on Human Rights, 2007; Mental Health and Older People Forum, 2008). This has been due in part to the way in which divisions have traditionally been created in services between care for working age adults and older people within mental health and social care. Age thresholds, usually set at 65, have meant that some older people are unable to receive or access a range of services and treatment available to younger adults.

This paper sets out the background to the current situation, based on evidence published by a range of organisations with an interest in the provision of older people's mental health care. It looks at the challenges and implications for the future posed by the increasing number of older people in England, and makes recommendations aimed at ensuring older people receive the best possible health and social care and support on a fair and equitable basis.

1. The current problem

A number of reports in recent years have highlighted the different levels of mental health care offered to adults of working age and older adults (65 plus). In 2006 a joint review of older people's services by the Healthcare Commission, the Audit Commission and the Commission for Social Care Inspection found that in some key respects older people's mental health services compared poorly against services for younger adults:

"The organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system as the range of services available differs for each of these groups. Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available"

(Healthcare Commission et al, 2006).

In response to the Joint Committee on Human Rights' inquiry into the human rights of older persons in healthcare (Joint Committee on Human Rights, 2007), the Royal College of Psychiatrists said that the existence of age discrimination against older people

"can be strikingly demonstrated with mental health care as older people do not have access to the range of services available to younger adults despite having the same, and often greater, need"

(Royal College of Psychiatrists, 2007a).

Additional factors associated with inequality experienced by older people in mental health services include lack of investment and ageist attitudes that continue to exist within some services. The incorrect notions that mental health problems are an inevitable part of ageing and therefore will not respond to similar types of intervention as are needed in younger age groups, or that mental health interventions should primarily be focused on the working population (partly for economic reasons, to ensure a healthier workforce), are barriers to older people's right to equitable care.

Ageism involves prejudging or making assumptions about people simply on the basis of their age. Age discrimination occurs when that prejudice is allowed to influence law, policies or practices. It can become institutionalised either explicitly through rules and regulations or implicitly through custom and practice (Help the Aged, 2007). Almost half of doctors specialising in the care of older people think the NHS is institutionally ageist (Help the Aged, 2009). Direct age discrimination against older people is any action which adversely affects the older person because of their age alone and which cannot be justified on other grounds. Indirect age discrimination is practice that on the face of it appears neutral but that in fact disadvantages older people, for example when mental health and social care services are organised and designed around the needs of younger people without taking into account older people's needs and preferences (Age Concern and Mental Health Foundation, 2006).

Providing appropriate care to older people that is both non-discriminatory and age sensitive will pose a significant challenge for mental health care as things currently stand. In some cases direct

discrimination prohibits access on the basis of age, while indirect discrimination occurs when older people are overlooked for referral to potentially helpful services or, if referred to generic adult mental health services, do not have their needs adequately met.

Forthcoming changes to legislation are likely to address these problems, but may at the same time impose significant service pressures on providers. After years of campaigning by key organisations representing older people and people with mental health problems, legislation making it illegal to discriminate on the basis of age in the delivery of goods and services is being introduced via the Equality Bill, which will be debated in Parliament in 2009.

Two of the issues the Bill is designed to address are the perceived unfair differences in the mental health services available to those below state pension age compared with older adults, and a perceived lack of priority given by local authorities and primary care trusts to the needs of older people when planning and commissioning services (Department for Communities and Local Government, 2007). The legislation, if passed, should have a significant impact on the way in which health and social care services organise and deliver care to older people in the future, bringing levels of provision up to those offered younger people.

2. Growing numbers of older people and prevalence of mental health problems

The UK is experiencing a significant population shift. The size of the older population and projected life expectancies are both rising considerably faster than previously expected, with a person's life expectancy at 65 set to continue rising by more than one year each decade (Age Concern, 2008a). The growth amongst those over 65 is estimated to be 2.3 million people over ten years and 4.9 million over twenty years, with the oldest age groups, 85 and over, growing proportionally the fastest. The percentage of people over 60 in the general population will grow from 21.2% to 29.4 % by 2050 (Mental Health and Older People Forum, 2008).

Mental health problems among older people

As the population over 65 increases, the number of older people with mental health problems is estimated to increase by a third over the next 15 years to 4.3 million (Age Concern and Mental Health Foundation, 2006). The largest increase in numbers of any mental health problem will be seen in the rise of the numbers of people with depression, but there will also be significant increases in the number of people with dementia. By 2026, nearly 1 million people will have dementia, rising to 1.8 million in 2050. This will also account for the greatest cost increase in care, from £23.8 billion in 2007 to around £34.7 billion by 2026. By this time, dementia services will account for 73% of all mental health and social care costs (King's Fund, 2008).

2.4 million people over 65 currently experience depression and this is expected to rise to more than 3.1 million over the next fifteen years (Age Concern and Mental Health Foundation, 2006).

Co-morbidity with substance misuse

Around 1-2% of over 55 year olds currently have alcohol dependence per year, rising to 23% in clinical settings (Royal College of Psychiatrists, 2006). Substance misuse is usually regarded as a problem affecting younger adults, where there are increasing levels of co-morbidity involving mental health problems and drug/alcohol misuse problems. However it can be overlooked in older people, and there are likely to be increasing numbers of older people exhibiting co-morbid symptoms as the population ages, and as alcohol and drug users from the baby boomer generation¹ get older.

Unmet Need

A significant population group to take into account when considering prevalence is those whose needs go unmet. Data are less easy to collect on this group. However it is estimated that

- nearly half of older people who take their own lives visit their GP in the previous month and only a very small number are in contact with specialist services;
- fewer than half of people with dementia will receive a diagnosis;
- only a third of older people with depression discuss it with their GP; of the third that have raised it, only half (or about 15 per cent of all older people with depression) are diagnosed and receive treatment.

(Age Concern, 2007).

Given the current challenge to address the high levels of both identified and unmet need, an increasingly ageing population will have significant resource consequences for mental health and social care services for older people that are struggling to provide care at present.

Unless there are major breakthroughs in new cost-effective treatments, or prevention and promotion initiatives are successful in reducing the incidence and prevalence of mental health problems among older people – neither of which appear likely in the foreseeable future – services will need significant extra resources to meet this demand.

3. The cost of addressing age discrimination

The Government has estimated that there will only be minimal costs associated with introducing anti-age discrimination in mental health (Department for Communities and Local Government, 2007). However in the light of the potential impact on mental health and social care services, this assumption can be challenged. If services are to achieve age equality across the board they will need to improve both access and availability. This might include a wider range of services such as home treatment and assertive outreach teams, unlimited access to NICE-approved drugs which may be helpful, for example in the early stage of dementia, and increased provision of psychological therapies. The current Improving Access to Psychological Therapies (IAPT) programme promises to “ensure that access is equal to groups who traditionally miss out, for example older people and those from black and minority ethnic communities” (Department of Health, 2008a).

1. Baby boomers in England were born during two main periods – period 1 from 1945-50, peaking in 1947, people now aged between 58-63; period 2 from 1956-64, peaking in 1964 (but very rapidly declining after), now people aged between 44-52. Note: other countries experienced a more sustained baby boom throughout the 1950s. (Office of National Statistics, 2009)

The Department of Health has itself suggested that service improvement will need to be accompanied by additional resources:

“In many areas this will require new investment in addition to modernisation of services... Ultimately, better mental health for older people will only be secured by having sufficient resources and the close working of all organisations at a local level”

(Department of Health, 2005a).

The National Audit Office has suggested that services for people with dementia are not currently delivering value for money to taxpayers or people with dementia and their families, and the rapid ageing of the population means costs will rise and services are likely to become increasingly inconsistent and unsustainable unless redesigned to be more effective (National Audit Office, 2007).

A 2008 report commissioned by the Department of Health on age discrimination in mental health found that generally it is people aged over 65 who are receiving lower cost support packages compared to younger adults (Beecham et al, 2008). The report adds that it is in relation to common mental health problems such as depression and anxiety where the discrepancy is most notable. The Royal College of Psychiatrists has also reported that at a time when services are facing large increases in numbers, some older people's mental health services have seen cuts (Royal College of Psychiatrists, 2007b).

It has been estimated that eliminating age discrimination in mental health services could require extra expenditure of around £2 billion at 2006/7 figures (Beecham et al, 2008). Age Concern has calculated that for equal access for people with severe and enduring mental health problems over the age of 65 the cost alone would be around £800 million (Age Concern, 2007) and it has been estimated that including older people in the planned rollout of a new talking therapies service by 2010/11 will add an extra £100 million to the cost. However it has also been estimated that by 2021, not meeting the mental health needs of older people would cost the UK economy far more in terms of older people as lost consumers, carers and volunteers (Age Concern and Mental Health Foundation, 2006).

4. Current service structures

Thresholds and eligibility

Standard One of the National Service Framework for Older People (Department of Health, 2001) states that decisions about treatment and care should be made on the basis of each individual's needs, not their age. This central tenet should underpin all care for older people, but as we have seen above, it is not always followed in practice. The Framework warns that policies which permit age to influence the access of older people to any specific service inevitably raise concerns that age is being used to deny access, and that age discrimination occurs when there are low relative rates of access of older people to specialist services compared with younger people.

The way in which many mental health services are currently structured makes it difficult for people to cross thresholds to access, or continue using key services. For many older people with mental health problems, and a minority of younger people who would benefit from some older people's services such as people with early onset dementia, thresholds set at age 65 can lead to either a loss of an existing service or the unavailability of an appropriate service.

There is, rightly, a strong focus on specialist dementia care in mental health services for older people. However this focus can lead to services for common mental health problems such as depression and anxiety, and substance misuse being limited for this age group. It can be extremely difficult for older people to access helpful services such as talking therapies, assertive outreach, crisis teams, home treatment teams, occupational therapy and alcohol services that are more readily available to younger adults (Age Concern, 2007).

For those people subject to an older age threshold, quality and equality is compromised in a number of ways. Continuity of care is interrupted. People who have been in contact with mental health services for many years may find that once they reach 65 they are required to move into older people's specialist services, in the process losing key services and important relationships with staff and other service users. Service users have spoken of being unable to access their drop-in and day centres once they turned 65, resulting in feelings of loneliness and isolation, a lack of interaction with peers and reduced staff support (Age Concern, 2007). Protocols to manage this transition from adult to older age services are not consistently used and practice varies across services (Mind, 2005).

Older people who experience mental health problems for the first time may also be disadvantaged by current service structures. Their problems may not be recognized within primary and secondary care, or if they are, may be considered to be just a normal part of ageing, not requiring a targeted intervention. They may be less likely to be referred for or receive appropriate treatment or support if they have not been treated in the mental health system before.

Additionally, if there has been no contact with services prior to the age of 65, most people will be referred to older people's services straight away. In a survey of senior and middle managers of eight mental health organizations, in every instance those aged 65 and over were routinely referred directly to the Older Persons Mental Health team for assessment (Beecham et al, 2008). While high quality older people's services certainly exist, problems caused by the age thresholds and local eligibility criteria for different services are acknowledged by staff, who reported both "blatant" and indirect discrimination. Some services were not open to people over the ages of 65 or 70, or they were open in theory but not in practice. Others were not promoted within older people's mental health services or staff were either unaware of them or did not consider them to be relevant for older people.

According to one old age psychiatrist who fed in to the Age Concern Inquiry,

"Adult mental health teams have better access to occupational therapy, occupational therapy assistants, day centres in the community, psychotherapy services... so when patients are transferred over to us they will sometimes get a reduced level of care"

(Age Concern, 2007).

Another study found that less than a third of mental health trusts provided older and younger adults the same crisis resolution service and only one in six areas frequently provided crisis services to older people (Cooper et al, 2007). There was also concern that services available to older people tend to be institution-based and that in the absence of appropriate community based services older people were entering residential and nursing care settings unnecessarily.

The poorer level of mental health care appears to be reflected in other service areas as well. A British Geriatrics Society survey, on behalf of Help the Aged (Help the Aged, 2009) has found that two thirds of doctors specialising in the care and treatment of older patients agreed that older people were less likely to have their symptoms fully investigated and to be considered and referred on for essential treatments.

While the Government has invested significant extra resources in mental health crisis, assertive outreach and home treatment services for working age adults over recent years, the National Service Framework for Older People has not led to equivalent new investment towards the development of similar services for older people.

Service integration

Historical service structures are partly to blame for the inequalities in access and support for older people cited above. There are inherent problems in the way that services have been developed, managed and funded, which have created barriers, with age being used as a factor for determining eligibility (Beecham et al, 2008). This can be a particular problem if an older person with mental health needs is using other services (for example, is in a general hospital) and mental health services are unable to identify or assist them.

To overcome some of these problems, a number of areas are seeking to integrate services through the amalgamation of older peoples' and adult mental health services. This might be seen as a positive development in terms of recognising the challenge of providing equitable services for older people, and tackling the organisational divide between adults of working age and older people (Healthcare Commission et al, 2006).

The Care Quality Commission (into which the Healthcare Commission has now been subsumed) is currently undertaking a study of how well mental health trusts are providing and commissioning services for older people with mental health needs, which should identify any benefits that come through the integration of services. If providers do move towards integration, this may allow opportunities to develop new and innovative services for adults of all ages and for mutual learning to occur amongst staff with expertise in working with different age groups.

However the solution is unlikely to lie in simply placing older people in services designed around the needs of younger adults under the banner of inclusivity. There is a risk that discrimination will simply continue if, while losing specialist older people's mental health services, older people's particular needs are poorly understood in services primarily designed around the needs of working age adults.

The need for specialist expertise and care in older people's mental health, such as for dementia in older age, has not been challenged. However it is important that eligibility and access to such care should not be age-based, but rather that is most suited to addressing the particular problem that develops for each individual. Age should play no part in allowing or restricting access to the most appropriate care and treatment.

However services are ultimately structured, whether integrated or kept separate, what is essential is that they are flexible. The key to successful service provision lies in the delivery of comprehensive and quality care appropriate to the individual and chosen by them, delivered by staff equipped with the necessary expertise, experience and understanding.

5. What is old age?

The life stage of 'old age' covers a potential expanse of some 30-40 years of life and the point at which mental or physical functioning may start to become impaired varies greatly. A woman aged 70 may be nearer in both health, and outlook, to a woman aged 55 than someone aged 85. Symptoms of age decline can begin in the fifties while many octogenarians maintain very good physical and mental health.

Attitudes and definitions in relation to ageing and retirement are changing rapidly. A focus on healthier lifestyles and advances in medicine means significant numbers of people are staying well for longer. For many people, 70 today represents being much younger than it would have been as little as 20 or 30 years ago. The 'retirement line' is also shifting conceptually and in real terms. From 2010 the state pensionable age for women as well as men will move to 65, and there are proposals to increase it in phases to 68 by 2044. However, people are also making the decision to work past the 'official' retirement age out of either necessity or desire. For those who do retire from work, this later stage of life may for many bring optimism and new opportunities, time and space to 'do' – not merely a slow decline into dotage.

In this context, maintaining age based service distinctions and treating older people as a homogenous group requiring standardised care makes little sense.

'Baby Boomers'

Our perception of old age will once again undergo a shift as the post war generation of the so-called 'baby boomers' progress into later life. This is a post World War Two generation characterised by an expectation of a significantly longer life than their parents and grandparents, and the experience of living through a period of increased individualism, liberalism, rebellion, rights, and consumerism.

Baby boomers reflect the strong sense of individualism through being more demanding citizens and consumers with higher expectations of goods, services and customer care, and less sense of deference than their parent's generation. 'Doctor knows best' is a view that has much less credibility with the baby boomers. This shift in social attitudes and behaviours is already resulting in changing relationships between service providers and service users as the latter become more assertive for themselves, or as family carers of older relatives in receipt of care (Biggs et al 2007).

One area where this individualism is likely to manifest itself is in the 'personalisation' agenda that is currently being promoted so heavily in social care services. The relatively low uptake of direct payments among older people may soon change as the baby boomers grow older, are more demanding as individual service users (and perhaps also less trusting of services to get things right on their behalf) and opt for self-directed care to meet their needs.

This could have an enormous impact on social care services, many of which will have to change dramatically to meet changing demands of both service users and commissioners. If health care services for long term conditions follow suit and allow individual service users to be in control of much of their own health care, as seems likely, services for older people may be facing as big a change as the community care reforms of the late 1980s. These potential changes need also to be considered in the context of the current debates around how social care will be paid for in the future, reflecting the enormous financial pressure that will be placed upon social care services with an increase in the older population.

While a strong sense of individualism may also reflect the legacy of the Thatcherite politics of the 1980s, an emphasis on equality and tackling discrimination is perhaps the ideology one associates with the radical politics of the baby boomers in the 1960s. Many baby boomers were certainly at the forefront of political campaigns to secure rights and recognition on issues such as gender, race, sexual orientation, and more recently disability.

An increase may also be seen in numbers with substance misuse problems (sometimes with co-morbid mental health problems) as the baby boomer generation gets older. Some baby boomers who were young at a time of increased popularity and availability of illegal drugs and more liberal use and availability of alcohol may have developed a dependency, or remain heavy users. Drug and alcohol services which to date have largely focused on younger adults are likely to see an increase in numbers of older people with particular needs and issues associated with older age. Services for older people will have to adapt to manage this changing situation and services for younger people will need to take into account older substance users who may also have complex physical health issues.

6. Implications for services

Structure

As suggested above, commissioners and providers need to review where some services are organisationally and managerially located and how they are defined. Removing age barriers to services, as the Equality Bill is expected to do, means that health and local authorities will need to decide how to structure both mainstream mental health care and specialisms which are based on need, not age, and which can be accessed equitably.

In some cases the creation of entirely new specialist services may be the way forward. Such a specialism might offer expert care for people experiencing the transition from one phase of life to the next or for active and / or employed people over 65 who are experiencing common mental health problems. It might be staffed by counsellors who are closer in age, culture and life experience to the people they are treating and who may be more able to relate to their particular issues and experiences.

Primary Care

Advancing age brings with it an increase in physical health problems and greater contact with both primary and secondary health services. These services need to become better at recognising mental health problems amongst their older patients. As noted above, while significant numbers of older people experience depression, relatively few discuss it with their GP and only half are treated, with an even smaller number receiving specialist mental health care. Many older people feel uncomfortable discussing emotional issues with their doctors and often present with physical symptoms, when the underlying and most significant problem may in fact be depression (Age Concern, 2008b).

Ways will need to be found to support doctors and nurses in primary care to recognise when an older person may be experiencing mental health problems. In response to findings that non-mental health staff have insufficient training on the specific needs of people with dementia or other mental health problems (Joint Committee on Human Rights, 2007), there appears to be a clear case for extending training on mental health issues to all primary care health staff. This would complement the recent Review of Child and Adolescent Mental Health Services (CAMHS), which recommended the training of the whole children's workforce in child development and mental health and psychological well-being, in order to improve the identification of mental health problems among children and young people (Department for Children, Schools and Families, 2008).

It is also necessary to give greater consideration to the ways in which problems such as depression and anxiety in older people are currently treated. Older people need to be made aware of alternatives to medication and supported to access the greater number of psychological therapies that are becoming available, as well as other approaches found to be helpful such as self-management techniques and social prescribing (for example, exercise referrals and membership of local social clubs).

Acute Care

We should improve mental health liaison and support within acute general hospital wards. Approximately 60 percent of people over 64 admitted to acute general hospital experience a mental health problem during that admission, the majority of such problems include depression, dementia and delirium (Royal College of Psychiatrists, 2005). Signs of depression in an older person are often accepted as a normal part of ageing and liaison with mental health services in a general hospital setting is limited. As a result, attention to the mental health needs of older people on hospital wards is often neglected.

Efforts have been made to address these problems, such as the Care Services Improvement Partnership's Let's Respect project, creating a toolkit primarily for healthcare staff who care for older people with mental health needs in acute hospitals (Care Services Improvement Partnership, 2008). However the consequences of a lack of awareness among staff can be far reaching. Experiencing both physical and mental health problems simultaneously can increase the length of stay, exacerbate illness and shorten life. There is loss of independence with reduced likelihood of a return to living independently as well as general quality of life being negatively affected.

This challenge might best be met by different professionals with specific skill sets and expertise. This could include on-ward expertise in the diagnosis and management of dementia, detection of depression through community mental health 'inreach' workers visiting people in hospital and identifying any who may be thought to be experiencing or at risk of a mental health problem, or the provision of counselling or occupational therapy to see an individual through the transition from hospital back to independent living.

The bringing of appropriate community support services currently provided by Community Mental Health Teams into hospital, regardless of a patient's age, could not only improve patient outcomes and lead to earlier discharge, but could also lead to equitable community support following discharge.

The secret in all this will be to get hospital staff to think beyond the individual's primary physical health diagnosis and to see all patients holistically in terms of having both physical and mental health needs that are interconnected and need addressing simultaneously.

Ageism within services

Ageist attitudes have added significantly to the maintenance of inequality within mental health services. Older people with mental health problems are faced not only with the stigma that can be associated with mental illness, but also with a way of thinking that exists in many areas of health and social care, that mental health problems such as depression, anxiety and dementia are a natural part of ageing.

This suggests an inevitability about the occurrence of mental health problems in later life and that the associated confusion and distress is something older people have to accept. As set out in the Department of Health's report on age discrimination in mental health,

"Particular concern about discrimination within health services was expressed by one interviewee who stated that health staff have the attitude towards older people presenting with depression and anxiety of 'what do you expect ... they're old', as though it was inevitable that they will suffer with these problems and nothing can be done"

(Beecham et al, 2008).

This attitude is incorrect and ageist and, where it exists in the health and social care workforce, needs to change if services are to become non-discriminatory. While specialists in existing mental health services for older people will have an awareness of this issue, a comprehensive training programme would help to tackle discriminatory attitudes in staff across all levels of health and social care where they come into contact with older people.

Older people from Black and Minority Ethnic Groups

There are particular issues around older people from Black and Minority Ethnic (BME) communities. Many older people from BME communities are at risk of experiencing multiple disadvantages based on age, income, ill health, having a mental health problem and from belonging to a BME group. Surveys show that some BME communities are over-represented in inpatient mental health services. Admission rates for BME groups at older ages (65 plus) show broadly similar patterns to those reported for all ages (Healthcare Commission, 2008). The Government has established a Delivering Race Equality (DRE) programme to tackle acknowledged inequalities around BME mental health and to help deliver more appropriate and responsive services (Department of Health 2005b).

Some BME groups, and people from African-Caribbean groups in particular, have historically had a troubled relationship with mental health services and services have not always engaged well with people from minority ethnic groups. (Sainsbury Centre for Mental Health, 2002). Fear and mistrust were identified as factors that prevented black people from engaging with services that are often viewed as being a last resort and these fears, often developed in early adulthood, may stay with many individuals as they move into older age.

There remains a debate over whether NHS mental health services are institutionally racist, and the causes of high levels of use of some mental health services by people from Black communities. Black people are more likely to stay in hospital longer, and less likely to have their psychological needs addressed than other groups. Mental health outcomes for Black patients are shown to be poorer in terms of re-admission and they are over-represented in high and medium secure settings (Mind, 2008). Older people are specifically referenced in the DRE programme and a key measure of the programme's success will be whether it leads to more equitable mental health care for older people from BME communities, as well as for younger adults.

Promotion and Prevention initiatives

Mental health promotion and prevention must play a central role in future service planning for older people's mental health. Investment in these areas could yield long term benefit, in particular by reducing the overall prevalence rates of mental disorders throughout the population. Even a small reduction in the prevalence rate of dementia, for example, would lead to significant cost savings in the future (King's Fund, 2008). However at present less than one-tenth of one per cent of NHS mental health spend on adults of working age in England is targeted at mental health promotion (Mental Health Strategies, 2008). This suggests that the new generation of people approaching older age will have had little opportunity to benefit from mental health promotion and prevention strategies and initiatives that might help protect them from mental health problems in later life.

The case for developing a strengthened strategy for promoting the mental capital and wellbeing of older people has been rigorously developed in a report commissioned as part of the Government's Foresight project, Mental Capital and Wellbeing (Government Office for Science, 2008). The report argues that unlocking the mental capital of older people need not incur net costs, while interventions could benefit families, business, wider society and Government, as well as older people themselves. The evidence suggests that there is considerable potential benefit in carrying out mental health promotion and prevention activity amongst the older population. Even simple

information and awareness campaigns may go some way in addressing unmet need and in delaying the onset of more serious problems.

7. Resources

Investment

Over the long term we would expect there to be significant financial benefits from investment in redesigning mental health services for older people, with potential for savings in administration and management costs. Investment in staff training to improve the identification of mental health problems in older people, mental health promotion work, early intervention approaches and more appropriate treatment should all help to prevent and postpone more serious and costly problems later on. Resources committed to the maintenance of older people's mental wellbeing will encourage their continued engagement in the community, better physical health and greater independence, and delay any need to provide expensive residential or hospital care.

Investment to bring about attitudinal change towards older people may also result in cost savings. Perceived discrimination experienced by older people can itself have a detrimental effect on their mental health, which in turn contributes to a negative spiral of decline (Yuan, 2007).

If there is to be real improvement in services for older people, local authorities and primary care trusts will need to be properly resourced to meet the challenge. The passing of new legislative duties in the Equality Bill, without adequate resources to ensure equitable provision of care to older people, will create further pressure on already stretched services which also face additional demand as the older population grows. Equitable care for older people should be achieved by levelling up resources for this group, not levelling down in other areas of mental health care.

It will be particularly important to protect investment in the development of a range of specialist older people's mental health services that are available to all older people as appropriate, regardless of age. By the same token, investment in other mainstream priority areas, such as the Improving Access to Psychological Therapies (IAPT) programme, or the Delivering Race Equality (DRE) programme, needs to be adequate to ensure there are no age restrictions as to who can benefit from these programmes.

The huge increase in the cost of caring for people with dementia over the next 20 years (King's Fund, 2008) suggests that focusing on more effective treatment for people with dementia, and delaying the onset of dementia, should be a key area of current investment. The recently published National Dementia Strategy (Department of Health, 2009) could provide the springboard for both immediate service improvements and longer-term savings, with its proposals to introduce a dementia specialist into every general hospital and care home and for increasing numbers of memory clinics. However while an initial backing of an extra £150 million over the first two years is welcome, this commitment gives no guarantee that improvements will be sustained by commissioners and providers in the medium to long term.

In addition, the pressing need to invest in dementia research, early identification, treatment and care should not divert attention and resources away from the needs of older people with

non-dementia related mental health problems. Commissioners will need to ensure that they have the ability, experience and expertise to invest limited resources wisely (especially at a time of economic downturn and the expectation of small year-on-year increases in public spending) and ensure provision of a comprehensive and appropriate range of local services for older people with mental health needs from diverse communities. There should be a focus on commissioning evidence-based models of care, and requiring providers to demonstrate positive outcomes for both individuals and communities.

Voluntary and Private sectors

Alongside statutory health and social care services, voluntary and private sector health and social care providers will also be under a duty (via the Equality Bill) to review the way in which their services are delivered to ensure they provide non-discriminatory and equitable care to all older people. Age thresholds exist in these sectors, as do variations in the expertise and understanding of staff in providing good quality care to older people from diverse backgrounds. The same resource issues apply to all providers, whether from the public, voluntary or private sector. Given the reliance of government on many voluntary sector and private sector organisations to provide health and social care services to older people, there may need to be extra support offered to help these providers meet the challenge posed by the new legislation.

The cost of social care for older people

At present, there is a good deal of uncertainty about the future of social care funding. This has arisen mainly because of the growing costs of residential care, especially for older people, variations in local authorities' eligibility criteria for care, and the widely held view that social care should focus more on enabling people to live in their own homes as long as possible.

The Government's personalisation agenda, focused on self-directed care, direct payments and individual budgets, is beginning to have an impact on how social care funding is spent, with service users themselves having an increasing say in what services are commissioned. We know that as things stand older people are at present sometimes reluctant to take up opportunities to operate their own individual social care budgets, and that it may take time for many older people to develop the confidence to assume greater control (Department of Health, 2008b). However this reluctance is likely to diminish as the baby boomer generation, with its higher expectations and demands, reaches old age.

At a national level, the Government is considering how future social care costs will be funded. A consultative Green Paper is expected in 2009, which will look at the balance in resources that is required between the state, families and the individual to meet future needs based on an increasingly aging population.

Separately, proposals are being drawn up around pilots of personal health budgets, to allow some individuals with long-term conditions to control aspects of their own health budgets as well. If these go ahead, then it will be important for older people to be included as well as younger adults.

Monitoring Improvements

Effective mechanisms to monitor the commissioning and delivery of mental health services for older people need to be developed. To date there has been a lack of clear performance indicators or targets in this area (Mental Health and Older People Forum, 2008). The newly created Care Quality Commission will play an important role in ensuring strong and consistent mechanisms are in place to eradicate the current discriminatory imbalances between services for older people and those for younger adults.

8. The challenge to change

It is no longer tenable to accept that older people may receive a worse service than younger people simply on age grounds. Given changes to the way in which later life is lived and defined and the continuing growth in numbers of the older population, the time is right to reconsider the provision of services with an age threshold, and raise some key questions about mental health care for older people.

If, as expected, the Equality Bill makes age discrimination unlawful in service provision, this will be a positive step so long as it leads to the provision of appropriate high-quality services for adults of all ages based on needs, and does not cause commissioners and providers to plump for an equitable but uniformly diminished level of care.

Specialist mental health services for older people are valuable. They are designed to protect and care for often vulnerable people with particular mental health needs. However we need to ask if this kind of service is appropriate to every older person with a mental health problem or whether containing care within specialist old age services discriminates and unfairly differentiates the old from the young, or most effectively meets individuals' needs. We also need to consider whether current specialist services are equipped to reflect societal and generational change and the expectations of new generations of older people.

Drivers for change

There are a number of strong drivers for change to the current structure and provision of care and support for older people experiencing mental health problems. These include

- new legislation in the Equality Bill that will outlaw age discrimination in goods and services
- rapid growth in the numbers of older people – and therefore the numbers of older people with mental health problems
- Government efforts to reduce health inequalities between different groups in society, particularly by focusing resources on the most deprived areas
- criticism of current poor provision and quality of services for many older people with common mental health problems, whether in adult services or specialist older people's services
- a lack of specialist care for people who develop dementia under the age of 65. This includes younger people with learning disabilities who have higher rates of early onset dementia

- the increasing numbers of baby boomers who are 'graduating' into older people's mental health services and have higher expectations and demands, and who do not regard being over 65 as 'old'
- the increasing flexibility in working patterns and lives, with many people working beyond 65, meaning distinctions between 'adults of working age' and 'older people' are becoming redundant
- the benefits that can accrue from early detection and treatment of mental health problems among older people in terms of maintaining good mental health and independent living, reducing pressures on specialist services and bringing financial savings
- consistency with key legislation and policies (for example the Mental Health Act, Mental Capacity Act, Disability Discrimination Act, NHS & Community Care Act, direct payments and personalisation of care) that apply to adults of any age.

Barriers to change

However there are also some barriers that militate against change. These need to be addressed as a matter of urgency if services for older people are both to improve and become more equitable. They include:

- indirect age discrimination - in removing service thresholds, some older people's needs may go unaddressed in services designed primarily for younger age groups
- older people being seen as a lower priority for non-age specific mental health services than working age adults (where interventions often have a stated purpose of helping someone return to work) and children and young people
- dementia, primarily but not exclusively an illness of old age, being seen as 'organic' and qualitatively different to other mental health problems
- the existing mental health service structure, divided between services for adults of working age and older people's services in terms of staffing and resources
- the cost and disruption caused by reconfiguring services
- the cost of bringing services for older people up to the level that others receive
- the cost of additional training for the health and social care workforce to recognise, and better meet the needs of, older people's mental health
- a desire not to risk losing expertise from specialist mental health services
- entrenched professional boundaries between different services
- the ageist attitude that mental health problems are an inevitable part of ageing
- mental health being covered in separate National Service Frameworks (NSFs) for adults of working age and for older people.

9. Conclusions and recommendations

The Mental Health Foundation believes the lack of clarity and inconsistent practice within current service structures is an issue in need of serious attention. The introduction of the Equality Bill provides a timely opportunity for Government and mental health and social care commissioners and

providers to rethink the way in which mental health care for older people is delivered and to take action to eradicate age discrimination against older people. It is unjustifiable that one of society's most vulnerable groups should be subject to ageist and inequitable treatment within services whose purpose is to provide care during periods of distress.

Recommendations

Based on the evidence cited in this briefing, we believe that, if properly implemented and resourced, the following recommendations would ensure the equitable provision of high quality mental health care and support for older people:

- 1** All statutory, independent and voluntary sector services dealing with older people should reaffirm in their strategy documents and operational plans Standard One of the National Service Framework for Older People (Department of Health, 2001), which states that decisions about treatment and care should be made on the basis of each individual's needs, not their age.
- 2** Older people should be consulted and included in any local review, planning or monitoring of older people's services.
- 3** All primary and secondary health care staff should be capable of recognising mental health problems (including dementia) amongst older patients, and understanding the links between physical health and mental health.
- 4** Commissioners of health and social care services should commission mental health promotion and prevention activity amongst the older population, challenging the inherently ageist notion that mental health problems are a natural and inevitable consequence of ageing.
- 5** More research should be funded to expand the database of evidence on the most effective service models for older people with mental health needs, and the clinical, social and economic benefits of mental health promotion and early intervention among older people.
- 6** Commissioners should ensure that they have the ability, experience and expertise to invest resources for older people's mental health wisely (especially at a time of economic downturn and the expectation of small year-on-year increases in public spending), and ensure provision of a comprehensive and appropriate range of local services for older people with mental health needs from diverse communities.
- 7** Easily accessible advocacy and advice should be made available to older people and their families to help them navigate the complex health and social care system, alongside support on issues such as housing, benefits and leisure opportunities.
- 8** If older people's and younger adults mental health services are integrated, all staff working in those services need to be trained in how the needs of adults of all ages may differ, so they can provide the most appropriate care to each individual regardless of age.
- 9** The expertise of staff working in specialist older people's mental health services must be maintained, regardless of any integration or reconfiguration of services.
- 10** There should be a political commitment from all parties that the National Dementia Strategy will be adequately resourced in the medium to long term to enable full and equitable implementation across England.
- 11** While respecting professional competencies and qualifications, there should be greater flexibility for staff working with older people to work across professional and service boundaries to ensure older people get the best possible personalised care and support.

- 12 The replacement for the National Service Framework for Mental Health, for adults of working age, due to be published in October 2009, should be uncompromisingly age-inclusive in terms of ensuring the best possible care and support for older people.
- 13 The Care Quality Commission should establish appropriate Quality of Life (QOL) outcome measures against which older people's mental health services can be judged, and ensure that older people are receiving an equitable level of care to younger adults, particularly in the light of forthcoming Equality legislation.

References

- Age Concern and the Mental Health Foundation – Promoting mental health and well-being in later life (2006)
<http://www.mhilli.org/index.aspx?page=stage2promotion.htm>
- Age Concern (2007) Improving services and support for older people with mental health problems
<http://www.mhilli.org/documents/Inquiryfinalreport-FULLREPORT.pdf>
- Age Concern (2008a) The Age Agenda: Public Policy and Older People
http://www.ageconcern.org.uk/AgeConcern/Documents/AA_2008_Report.pdf
- Age Concern (2008b) Undiagnosed, untreated, at risk: The experiences of older people with depression
http://www.ageconcern.org.uk/AgeConcern/Documents/PA0130708_depression_campaign_report.pdf
- Beecham, J., Knapp, M., Fernandez, J.L., Huxley, P., Mangalore, R., McCrone, P., Snell, T., Winter, B., Wittenberg, R. (2008) Age Discrimination in Mental Health services <http://www.lse.ac.uk/collections/PSSRU/staff/knappPublications2008.htm>
- Biggs S., Phillipson, C., Leach, R. & Money, A (2007) Baby boomers and adult ageing: issues for social and public policy. *Quality in Ageing* 8, 3
- Care Services Improvement Partnership (2005) Everybody's Business. Integrated mental health services for older adults: a service development guide <http://www.olderpeoplesmentalhealth.csip.org.uk/everybodys-business.html>
- Care Services Improvement Partnership (2008) Let's Respect project.
<http://www.olderpeoplesmentalhealth.csip.org.uk/lets-respect.htm>
- Cooper, C., Regan, C., Tandy, A., Johnson, S. and Livingston, G. (2007) Acute mental health care for older people by crisis resolution teams in England, *International Journal of Geriatric Psychiatry*, 22, 263-265
- Department for Children, Schools and Families (2008) Final report of the national CAMHS Review
<http://www.dcsf.gov.uk/CAMHSreview>
- Department for Communities and Local Government (2007) Discrimination Law Review – A Framework for a Fairer Future: Proposals for a Single Equity Bill for Great Britain. London: Department for Communities and local Government
- Department of Health (2001) National Service Framework for Older People
http://www.dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/DH_4003066
- Department of Health (2005a) Securing Better Mental Health for Older Adults
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114989
- Department of Health (2005b) Delivering Race Equality in Mental Health Care
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4100773
- Department of Health (2008a) Health Inequalities: Progress and Next Steps
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_085307
- Department of Health (2008b) Moving Forward: using the Learning from Individual Budget Pilots
http://networks.csip.org.uk/_library/DH_response_to_IBSEN_evaluation.pdf

- Department of Health (2009) Living Well with Dementia: a National Dementia Strategy.
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058
- Government Office for Science (2008) Foresight report – Mental Capital and Wellbeing: Making the most of ourselves in the 21st century http://www.foresight.gov.uk/Mental%20Capital/Mental_capital_&_wellbeing_Exec_Sum.pdf
- Healthcare Commission, Audit Commission and Commission for Social Care Inspection (2006) Living well in later life: A review of progress against the National Service Framework for Older People
http://www.healthcarecommission.org.uk/_db/_documents/Living_well_in_later_life_-_full_report.pdf
- Healthcare Commission (2008) Count Me In 2008 http://www.healthcarecommission.org.uk/_db/_documents/Count_me_in_census_2008_Results_of_the_national_census_of_inpatients_in_mental_health_and_learning_disability_services.pdf
- Help the Aged (2007) Policy Statement 2007: A Positive Equality Duty for Age
<http://policy.helptheaged.org.uk/NR/rdonlyres/A92B1AE1-6B3A-4A6E-9B25-635AD81B5147/0/pstatepositiveduty030807.pdf>
- Help the Aged (2009) Specialist doctors label the NHS institutionally ageist and demand a law to bring it to an end. Press release, 27 January 2009. London: Help the Aged
- Joint Committee on Human Rights (2007) The Human Rights of Older People in Health Care
<http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/5/502.htm>
- Kings Fund (2008) Paying the Price: The cost of mental health care in England to 2026
http://www.kingsfund.org.uk/publications/the_kings_fund_publications/paying_the_price.html
- Mental Health and Older People Forum (2008) A Collective Responsibility to Act Now on Ageing and Mental Health – A Consensus Statement. London: Mental Health and Older People Forum
- Mental Health Strategies (2008) The 2007/08 National Survey of Investment in Mental Health Services
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_088701
- Mind (2005) Access all ages
<http://www.mind.org.uk/NR/rdonlyres/3A6122F7-0401-4BB7-B544-558016831CC9/3946/MindAccessallagesreport.pdf>
- Mind (2008) Factsheet: The Mental Health of the African Caribbean Community in Britain
<http://www.mind.org.uk/Information/Factsheets/Diversity/The+African+Caribbean+Community+and+Mental+Health.htm>
- National Audit Office (2007) Improving Services and Support for People with Dementia
http://www.nao.org.uk/publications/0607/support_for_people_with_dement.aspx
- Office of National Statistics (2009) <http://www.statistics.gov.uk/CCL/nugget.asp?ID=761&Pos=1&ColRank=1&Rank=160>
- Royal College of Psychiatrists (2005) Who Cares Wins. Improving the outcome for older people admitted to the general hospital: guidelines for the development of liaison mental health services for older people.
<http://www.bgs.org.uk/PDF%20Downloads/WhoCaresWins.pdf>
- Royal College of Psychiatrists (2006) Raising the Standard: Specialist Services for Older People
<http://www.rcpsych.ac.uk/PDF/RaisingtheStandardOAPwebsite.pdf>
- Royal College of Psychiatrists (2007a) The human rights of older persons in healthcare: response from the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists
<http://www.parliament.the-stationery-office.com/pa/jt200607/jtselect/jtrights/156/156i.pdf>
- Royal College of Psychiatrists (2007b) Old age psychiatrists call on government to urgently address inequalities and cuts in older people's mental health services. Press Release 7 March 2007. London: Royal College of Psychiatrists
- Sainsbury Centre for Mental Health (2002) Breaking the Circles of Fear.
http://www.scmh.org.uk/pdfs/Breaking_the_Circles_of_Fear.pdf
- Yuan A S V (2007) Perceived age discrimination and mental health. *Social Forces* 86 (1) : 291-312

Mental Health Foundation

Founded in 1949, the Mental Health Foundation is the leading UK charity working in mental health and learning disabilities.

We are unique in the way we work. We bring together teams that undertake research, develop services, design training, influence policy and raise public awareness within one organisation. We are keen to tackle difficult issues and try different approaches, many of them led by service users themselves. We use our findings to promote survival, recovery and prevention. We do this by working with statutory and voluntary organisations, from GP practices to primary schools. We enable them to provide better help for people with mental health problems or learning disabilities, and promote mental well-being.

We also work to influence policy, including Government at the highest levels. We use our knowledge to raise awareness and to help tackle stigma attached to mental illness and learning disabilities. We reach millions of people every year through our media work, information booklets and online services. We can only continue our work with the support of many individuals, charitable trusts and companies. If you would like to make a donation, please call us on 020 7803 1121 .

Visit www.mentalhealth.org.uk for free information on a range of mental health issues for policy, professional and public audiences, and free materials to raise awareness about how people can look after their mental health.

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