The Royal College of Psychiatrists is the leading medical authority on mental health in the United Kingdom and is the professional and educational organisation for doctors specialising in psychiatry.

We are pleased to respond to this consultation. This consultation was prepared by the Old Age Faculty.

The Consultation was approved by Prof Sue Bailey, Registrar.

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NATIONAL REVIEW ON AGE DISCRIMINATION IN HEALTH & SOCIAL CARE

Introduction

This response is from the Old Age Faculty and thus concentrates on areas of discrimination which may be relevant to the care and treatment of older people. The Faculty of Old Age Psychiatry welcomes the opportunity to respond to this important consultation.

The Faculty notes the Equality in Later Life report from the Healthcare Commission (2009) on age discrimination in mental health services which illustrates many of the problems. The Faculty fully endorses the reports 14 recommendations. Rather than repeat all of these we strongly commend the report to the consultation. However we note from its findings:

“Older people were denied access to the full range of mental health services that are available to younger adults. In particular, there was poor access to out-of-hours and crisis services, psychological therapies and alcohol services. Services for younger adults indirectly discriminated against older adults, even when, in theory, there was no obstruction to their access (for example, by providing services that are open to older people, but are not sensitive to their age-related needs). The visits also emphasised how older people’s mental health services are falling behind services for younger adults in terms of priority. In addition, it showed some clear evidence of age discrimination in access to services, age-appropriateness and lack of specialist input to services.”

The problem of discrimination is not new. In 2003, the Commission for Health Improvement, in its summary of findings from assessments of Mental Health Trusts, noted the lack of priority given to older people’s services: “the focus of policy, local priorities and the national performance indicators remain centered around adult mental health services.” The Social Services Inspectorate review of Older People’s Services also highlighted services for older people with mental health difficulties as an area that required urgent attention (Improving Older People's Services: an overview of performance”, Social Services Inspectorate, 2003).

A Department of Health assessment at Strategic Health Authority level of progress against the NSFOP standards for OPMH services in 2003-4 found:

“There is a limited level of service available for older people with mental health (MH) needs, with overall poor service development, poor co-ordination and lack of clarity where the responsibility for planning, commissioning and providing services should be. MH for older people is not given high priority within any service and therefore has attracted very little investment.”"
It would be wrong to give an entirely negative view of the priority given to OPMH services nationally or the progress that has been made locally. The Faculty knows of examples of excellent practice and is aware of the high level of commitment in our workforce. There has also been some clear advancement in policy and support for service development over the last few years. Amongst these we would include the interest shown by National Directors for Older People and Mental Health, the publication of Everybody’s Business, the Care Services Improvement Partnership OPMH programme, the Mental Capacity Act, the inclusion of the dementia register and depression screening in physical illness in the Quality and Outcomes Framework, the inclusion of OPMH services in the annual service and financial mapping exercise, the NICE / SCIE Dementia Guideline, the National Dementia Strategy and importantly the forthcoming Equality Bill.

The National Dementia Strategy for England, already national policy, affirms the central importance of older people’s mental health services providing treatment for all mental health problems in later life and not only dementia. Though 98% of people with dementia are over age 65 years the National Dementia Strategy has already taken an age inclusive approach which is supported by the Royal College of Psychiatrists (2006).

Discrimination against older people reflects the values of our society and government. While we determine value on the basis of economic productivity older people will remain vulnerable. The contribution that older people make to society, which itself has important economic benefits (Secretary of State for Health, 2009), needs to be more widely recognized and respected.

We believe that older people with mental health problems suffer the effects of stigma, ageing discrimination and social economic disadvantage. Removing these problems will require a genuine change in the culture of delivery or health and social care in the UK. It is not merely a matter of improving the dignity and respect afforded to older people. Several authoritative reports demonstrate the very serious problem of age discrimination in mental health services (Age Concern, 2007; Centre for Policy on Ageing, 2007; Beecham et al, 2008; Royal College of Psychiatrists, 2008; Healthcare Commission 2009) and social services (Forder, 2008).

Furthermore, we believe it is no coincidence that concerns about human rights and standards in care homes essentially relate to older people with mental health problems (Joint Committee on Human Rights, 2007; Alzheimer’s Society 2008; All-Party Parliamentary Group on Dementia, 2008).

It is not the existence of specialist older people’s mental health services which has created this discrimination but the way in which national policy has been delivered. Commissioners and trust providers have implemented that policy, despite knowing that older people have been excluded.
The best protection against ageism in mental health services may well be to encourage patient choice over which service is to be used. Particularly given recent concerns about patients with dementia in some care home settings, one particular area for relatively direct comparison will be the extent and cost of community care packages prior to institutional care being mooted. Older people with psychiatric disorders often appear to have a lower “tariff” than younger adults with complex medical conditions or learning disability.

Public sector equity and equality of access / opportunity now appear likely to depend on redistribution of increasingly scarce resources in the current economic climate. With the sheer level of shared difficulties anticipated there will never be a more important time to demonstrate that age discriminatory practice is unacceptable and Psychiatry has a particular responsibility in this regard.

1. Time Table for Action

When considering demographic changes in the country it is common to look at long-term trends with an emphasis on the increase in the number of people over 65 by 2030 or even 2050. However, the growth in the number of older people is not new but has been inexorably rising particularly over the last generation. Consequently although reduction of discrimination might involve progressive change over 3, 5 or 10 years a clear programme for change will be required within twelve months. It is likely to take health and social care services 2-3 years to make the necessary changes though the process should begin immediately with a review of their current policies and practices and clear plans to address age discrimination produced. From the time of legislation all public bodies should be required to perform an impact assessment of all new policies and practices in relation to age discrimination and identify an Equality Lead at Board level in their organization.

So the College recommends that a date (April 2010 possibly) should be set by which Trusts and SHAs should have drawn up Action Plans to cover a 3 year period. These should be undertaken with stakeholders, in particular service users and carers who will help to identify local priorities for the 3 year period. Specific milestones should be included and regulations should require immediate action as part of the plan to start the process of reviewing all policies and practices with a view to eliminating discrimination. Impact assessment on all new policies and practices should also be required and a standardised framework for undertaking impact assessment established, perhaps at a national or at the least an SHA level.

2. Positive differentiation
Mental Health Services for Older People need to develop in a way which recognises the special needs associated with the complex mixture of physical, mental, cognitive and social problems affecting older people. The Faculty recognises and applauds the initiatives taken at Government and Commissioning level which have improved considerably the services available to people of working age who have mental health problems. However, many of these services, including crisis management, assertive outreach and psychological therapies are currently designed in such a way that they are inaccessible to people over 65. Discrimination has been increased as these services have expanded. We know that simply insisting that current services from working age adults should also be offered to older people is in itself an inadequate solution. The psychological approach to a person with more than 80 years of life experience, who in addition to depression has some degree of intellectual impairment and physical disability, requires a different set of skills than the delivery of a talking therapy to a young adult, but it is important that the best elements of services developed for the working age population are identified then modified appropriately to deal with older adults. This will require prominent emphasis on learning and education for services providers.

By contrast Old Age Psychiatry Services are uniquely well placed to deal with people with the complex presentations described above. Old age psychiatry is a recognized specialty by the NHS and for the purpose of training by the Postgraduate Medical Education and Training Board (PMETB). The model of long term involvement with an unwell person, their carer, their family and the social support surrounding them together with the ability to co-ordinate multidisciplinary and multiagency involvement allows a constant overview and review of needs to be taken with service provision adjusted accordingly. Those providing services are uniquely trained to do so and this model requires to be continued even if the population served by it requires tighter definition.

All the existing evidence demonstrates the superior effectiveness of specialist older people’s mental health services when compared with any other approach or provides the only evidence for effectiveness. The benefit and superiority of specialist older people’s mental health services has been shown in community, inpatient and day hospital services (Draper, 2000) general hospital liaison psychiatry (Royal College of Psychiatrists, 2005; Anderson, 2005a) and care homes (Ballard et al, 2002; Fossey et al, 2006). Specialist inpatient care is of higher quality (Draper & Low, 2005) and preferred by patients and carers (Healthcare Commission, 2009). In parallel, the superiority of providing specialist geriatric medicine services to older people is superior to non-specialist treatment (Baztan et al, 2009). This contrasts with a complete lack of evidence that providing mental health services to older people by non-specialist services has a better outcome.
There is a constant argument about whether services should be focused on “age” or on “needs”. In reality the older a person becomes the more likely it is that their needs are complex. However the current profile of Old Age Psychiatry Services in the UK is not set up for people with highly specialised needs which they carry into old age from contact with other services i.e. mentally disordered offenders, people with learning disability and those with very long and enduring mental illnesses. Good Practice would suggest that a conjoint system of care provision lead by one specialist area e.g. Forensic Services but assisted by Old age Services should lead to a better provision of care that individual. Conversely the services provided by Old Age Psychiatry would be enhanced by conjoint management with colleagues in learning disabilities services if required.

3. Actions for Public Bodies

a. Dementia Services

To reduce discrimination and promote equality there must be better community awareness of dementia, more appropriate and timely diagnosis, an ethos of risk management rather than risk avoidance and recognition that older people with dementia in special environments such as care homes or general hospitals are a group with highly complex needs. In particular, entry into a care home must no longer be seen as the end of the patients journey, but an indication that specialist input needs to continue.

Of all mental health problems affecting older people dementia is the most feared. Despite this the main length of time between the onset of symptoms and seeking help is 18 to 24 months, although stigma plays a part there is still an undue level of inappropriate explanation of key symptoms of dementia as being associated with age alone. Although health and social services can play a part in improving awareness, particularly at Primary Care level, much can be done by the third sector and mental health charities.

Raising awareness is of limited value if diagnosis is delayed. Potentially irreversible changes in the relationship between a person with dementia and their family occur in that key 18 to 24 months prior to referral. The statement within the English National Dementia Strategy that memory services should be much more accessible is strongly supported by the old Age Faculty. We would recommend that simple assessments of cognition, function and behaviour are under taken at a primary care level with a low threshold for onward referral to specialist services. This basic assessment could be done either by the training and education of primary care staff or by inreach to primary care from community based Old Age Psychiatry Services. Many Old Age Psychiatry Services have had a presence on the
primary care premises for in excess of 20 years and they need to be accepted by primary care more as partners rather than specialist visitors.

Diagnostic services in turn will have their benefit limited if services to support older people with dementia exist at a low level. A low level of service provision does not encourage intensive input with newly diagnosed people, such as is seen in early intervention for psychosis services geared towards young adults nor does it encourage appropriate risk management. Consequently there is virtually nothing available to older people with dementia to match the level of provision which can be given to younger adults with learning disability through the commissioning of intensive individualised and person centred packages provided by organisations such as Enable. Too many people with dementia are left to rely on low levels of home care which often replace rather than enhance the individuals own living skills. For example a home care assistant is much more likely to undertake shopping rather than take the older person to the shops, such a situation would not be tolerated when dealing with younger people with learning disabilities.

The consequence of poor risk management is that entry to care is seen as an early rather than late solution to the problems associated with managing a person with dementia in the community. For every long stay hospital bed which has closed in the country three care home places have been opened and now people with dementia account for more than two thirds of those in care. The institutionalisation of people with dementia contrasts markedly with services which enable younger people with severe and enduring mental illness to remain as independent as possible in the community. A major drive involving health, local authority and third sector agencies is required to address this situation.

Unfortunately care homes tend to attract poor publicity from the media and the general theme of inspection reports, such as that recently jointly completed by the Mental Welfare Commission and Care Commission Scotland or the Alzheimer’s Society report “Home from Home” are also very negative. The mortality from the inappropriately prolonged use of anti-psychotic drugs in care homes is ten times the mortality from suicide, yet the level of response to this report from the government or from health and social services does not in any way parallel the attempt to reduce the suicide rate in younger people.

Factors affecting carers stress amongst care home staff are poorly researched and ill understood and a major improvement in care home intervention, education and specialist liaison will be required to resolve this issue. It should not be left to primary care nor should there be an assumption that enhanced payment for primary care will create an optimum solution.
The problems with managing people with dementia in general hospitals are also well recognised. Even basic needs such as nutrition might not be met unless awareness is high, yet this position contrasts with the care overview of problems of younger people with cancer or other long-term conditions. Schemes such as the Butterfly Scheme in Leicester have helped to help the identification of people with dementia and ensure their needs in general hospitals are met more appropriately. However, dementia, delirium and depression are all grossly under recognised and inappropriately treated in general hospitals with many mental health services supplying only a rudimentary consultation service to assist with the recognition and management of these problems. Again this is a marked contrast to the mushrooming of dedicated liaison psychiatry services for people under 65 in the same general hospitals. Links between general hospitals and community services tend to be of limited effect leading to opportunities for the prevention of readmission being overlooked. To resolve the problem of the care of people with dementia in general hospitals each health authority should ensure that any strategic development involving general hospital services considers carefully the increasing need to manage people with dementia in these environments. Heath, local authorities and the third sector should strive for the same level of recognition for people with dementia as has been obtained from the “Same as you” approach for younger people with learning disability over the past decade. Health authorities should also be mandated to ensure that hospital design becomes more dementia friendly to mirror the improvements that have been made in dealing with people with physical limitations through the progressive implementation of legislation.

b. **Other mental illness in old age**

Depression affects 10% to 15% of people over 65 though those with physical handicap or neurological disease have rates much higher. Anxiety is recognised more poorly in older people than in younger people and more likely to be considered “understandable” and thus less likely to be treated effectively. Psychotic symptoms increase with age and 20% of those reaching the age of 85 will have a first onset of psychotic symptomatology. Whilst absolute numbers are low 2% of people aged 95 will meet diagnostic criteria for Schizophrenia a rate twice that seen in younger adults.

Only one third of older people with depression discuss this with their General Practitioner and less than half of these will receive treatment. Only 2% primary care practise nurses have received any mental health training. Psychological services and counselling in primary care are frequently offered only to those aged under 65 despite equal efficacy being demonstrated when dealing with older people.

Older people are denied access to services such as rehabilitation, assertive outreach, crisis home treatment and early intervention, all of which are
available to younger people in an increasingly widespread way across the country. Older people with mental health problems are also excluded from intermediate care developments. Members of the College Scottish Division report that it is common for people to be excluded from mental health services, in particular those offering psychological therapies on the grounds of age. The failure of health budgets to adapt to the changing demography of the population is a further example of ageism which we would wish to see challenged.

At the centre of better treatment for older people there must be an improved social fabric, improved knowledge and skills in primary care, better access to specialist mental health services for older people and more effective collaboration across health, local authority and third sector services. A failure to provide older people with specialist services which are organised and staffed by people trained and skilled to meet their needs is unacceptable. There is recognition that children and adolescents require specialist services because they are not mini adults. It is important that service commissioners and providers remember that although older people are clearly adults they can and do have specialist needs.

Although the setting of targets for performance is controversial there can be little doubt that setting these targets has driven improvements in the care provided to the target population. However, there is a striking absence of targets relating to older people, particularly those over 75. For instance people over 75 are more likely to have successfully suicide attempts and their suicide is more likely to be associated with depression than in younger people and yet there is not target for suicide prevention in this age group. It is unacceptable to simply say that services for older people will improve vicariously as a result of targets set for younger people.

4. **Actions for change**

   a) **National**

   The mental health of older people must become a national priority.

   In mental health services it is essential that national policy considers the needs of older people alongside those of younger adults recognizing their differences. The Care Quality Commission should be charged with responsibility to confirm there is no age discrimination when services are inspected.

   There should be an independent observatory charged with responsibility of monitoring data relating to discrimination and there is a need to develop better measures of age discrimination.
If the inevitable increasing demand & cost of health & social care is to be addressed there will need to be a much clearer national steer that directs the commissioning and delivery of mental health care for older people. This will need a greater prominence & direct accountability for older people’s mental health at senior advisory & ministerial level. Leadership from senior levels in the Department of Health is urgently needed.

The Department of Health should be deeply concerned about local health & social care plans to disinvest in older people or transfer the care of older people from specialist to general mental health services in the absence of any evidence of advantage to older people.

A clear statement is needed from the Department of Health that to deny older people access to age appropriate specialist services is unacceptable.

If the government is to deliver a respect & dignity agenda it must show much greater clarity & understanding of the needs of older people, the needs of the workforce & improve access to specialist mental health services and mainstream services that are better equipped to meet the needs of those with mental health problems.

The Royal College of Psychiatrists should lead a collaborative approach, with other relevant organisations, to develop models of service in specialist services, based on needs not age. This should include a self-assessment toolkit.

In preparation for the forthcoming Equality Bill, and while awaiting the work of the Royal College of Psychiatrists on age-appropriate services, commissioners and providers should assess their services for evidence of discrimination in access to services and start planning on how to address this. Plans should consider how to equitably meet the needs of older people with mental health problems, not simply provide access to services designed for younger adults.

b) Local commissioning

Health & social care commissioners are held to account & demonstrate that any service purporting to deliver a specialist service for older people has the expertise & competencies required. Idiosyncratic service delivery without evidence should be challenged by the health regulator.

There should be an equality lead in every commissioning and provider organisation charged with the responsibility to demonstrate age
discrimination is not occurring. Contracts should be required to confirm that services provided are age appropriate and take account of the different needs of older people. There should be impact assessment of all policies which includes age discrimination.

Local commissioning needs clear lines of accountability for the lead of commissioning older people’s mental health services. This must not be allowed to fall between the stools of “older people’s services” on the one hand and “mental health services” on the other.

Joint commissioning will need to align health & social care services more closely at a local level if the necessary continuity & a whole system approach are to develop.

There must be an investment & distribution of resources across primary & secondary health & social care that accurately reflects the increasing numbers of older people.

c) Professional & third sector organizations

All healthcare professionals receive appropriate training & skills development in the problems of ageing & multi-morbidity.

Through a joint forum, the Royal Colleges of General Practitioners & Psychiatrists in collaboration with other professional & third sector organizations will work more closely to develop & propagate models of best practice that will produce better treatment for older people with mental health problems.

Health & social care organisations & the third sector work more closely with government to develop the most effective & efficient means of meeting the needs of older people & evidence based models of care are implemented. Early intervention & care management will be important.

Within individual services we believe that service redesign could make an important contribution to addressing age discrimination.

(a) older people’s mental health services, themselves, could adopt some practices that have been possible for younger adult services though they have not received the resources or leverage needed to make these changes.

(b) some services could be adapted quite easily to make them appropriate to older people by including professionals with the competencies
and expertise to manage older people’s problems, for example, out of hours crisis services who currently exclude older people (Cooper et al, 2007).

(c) the traditional practice of transferring people in mental health services purely on the basis of age should stop and transfers of care should only be on the basis of need (Royal College of Psychiatrists, 2009).

(d) by the very fact that older people’s problems differ from younger adults it is not necessary to replicate all the services for younger adult services for an older age group. Older people’s mental health services need to develop change within them to meet the needs of particular sub-groups of older people and should be resourced to do that.

(e) fully integrating social care into mental health services would substantially improve efficiency and effectiveness and facilitate a common approach to combating age discrimination between mental health and local authority services.

(f) commissioning of services should become a single process for all adult ages in order that older people are considered on an equal basis.

(g) the delivery of services by trusts should, similarly, be determined through a single decision making process that considers older people on an equal basis recognizing their differences from younger adults.

5. **Incentives**

There is substantial benefit to older people and public services by providing specialist mental health services for older people. Reference has been made to the superior effectiveness of these services but there are also demonstrable gains in terms of efficient use of resources and cost savings by attending to older people’s mental health in this way.

By addressing older people’s mental health problems in general hospitals by specialist attention it has been shown that the incidence of mental disorder and length of hospital stay can be reduced, maintenance of independent function improved, greater return to independent living, less health care utilization and cost savings (Kominski et al, 2001; Anderson, 2005a; Anderson, 2005b; Royal College of Psychiatrists, 2005; Holmes et al, 2009). Specialist liaison services for older people in general hospitals are already recommended in national policy and guidelines (NICE/SCIE, 2006; Department of Health, 2009). Older people’s mental health services in-reach to care homes reduce drug prescribing, improve quality of life, use of GP time and days in hospital (Ballard et al, 2002; Fossey et al, 2006) and
specialist domiciliary care improves quality of life and reduces carer stress (Rothera et al, 2007).

A vital lever to change must come from knowledge of an ageing population. The increasing age of the population will be the biggest challenge facing health and social care services in the coming decades and only a focused approach to the needs of older people will find the means to address that challenge (Royal College of Psychiatrists, 2008). An important report from the Kings Fund has shown that by 2026 there is no predicted change in the number of people with any mental health diagnosis other than by the effect of ageing (McCrone et al, 2008). This means the absolute number of older people with every mental health diagnosis will increase.

A final, but essential, point is the need for specialist services as the training resource that will enable the development of future generations of professionals with the skills and expertise to work appropriately with older people and to achieve the greatest effectiveness and efficiency of services provided by public bodies. The ageing population dictates that more of this expertise will be needed and specialist training schemes will be crucial to the development of age appropriate services (House of Lords, 2007).
REFERENCES (some references are summary publications that cite relevant studies)

Age Concern (2007) *UK Inquiry into mental health and well being*.

All-Party Parliamentary Group on Dementia (2008) *Always a last resort*.


Anderson D (2005a) Liaison psychiatry and mental disorder in older general hospital patients. CME Geriatric Medicine, 7,65-69.


Centre for Policy on Ageing (2007) *A literature review of the likely costs and benefits of legislation to prohibit age discrimination in health, social care and mental health services and definitions of age discrimination that might be operationalised for measurement*.


