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# Suffering in silence: age inequality in older people's mental health care

COLLEGE REPORT

# Authors

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**We must  
respect age**

# Introduction

Age discrimination continues to blight our society, despite a decade of government policies designed to address it. For older people, age discrimination is associated with worse psychological well-being and poorer physical health outcomes. Ageism remains a major problem in the National Health Service (NHS), the very institution intended to promote health and well-being.

In mental health services professional and institutional biases has compromised treatment for older people. There is a serious and urgent need for change, especially with a growing population of older people (aged 65 and above), who are faced with increasingly complex mental health problems.

Government policy has tended to favour a mental health service for all adults, regardless of age. The *Five Year Forward View for Mental Health* (NHS England, 2016a) pays little attention to the specific needs of older people. If ageism and inequality in mental health services are to be addressed, government policy must turn its focus on services that can meet the specific needs of the older population.


This report examines the issue of age discrimination in the treatment of mental illness in older people, considering service design and delivery. It advances the argument that a generic approach to mental health services, serving adults of all ages, has resulted in age discrimination. The needs of older adults are best met in specialised mental health services, which understand the complexity of older people's needs and have the expertise to meet them.

We call for a clear vision of older people's mental health services to be included in the government's next mental health strategy, which will succeed the *Forward View* when it ends in 2020/21. This strategy should set out to rebalance resources towards older people's mental health care, rebuild services to meet older people's needs equitably

and effectively, place more emphasis on prevention and early recognition, strengthen the workforce, and raise public awareness of mental illness in old age.



**Age discrimination blights our society.**



**There is a serious and urgent need for change.**

# Services and demand: overview

## Numbers

Figures from the Office for National Statistics (ONS) (2016) show that older people are expected to make up a growing proportion of the UK's population (see Table 1) over the next 30 years. While the population overall is projected to grow by 12.7% from 2016 to 2046, the population aged 65 or over is forecast to grow by 55.1% and those aged 75 or over by 101.9%. In other words, the number of people aged 75 or over is expected to double in the next 30 years.

The increase is still more marked in the 85 or over age group. In 2016, 1.6 million people, or 2.4% of the UK population, were aged 85 or above. That figure is forecast to double in just 25 years, rising to 3.2 million (4.4% of the population) in 2041. Every day, 200 more people reach the age of 85.

**The number of people aged 75 or over is expected to double in the next 30 years.**

	2016	2026	2036	2046
<b>UK total population (millions)</b>	<b>65.6</b>	<b>69.2</b>	<b>71.8</b>	<b>73.9</b>
<b>Proportion aged 65+</b>	<b>18.0%</b>	<b>20.5%</b>	<b>23.9%</b>	<b>24.7%</b>
<b>Proportion aged 75+</b>	<b>8.1%</b>	<b>10.2%</b>	<b>12.1%</b>	<b>14.5%</b>

Source: Office for National Statistics (2016).

## Mental illness

Older people are no less prone to mental health problems than younger adults, although such difficulties often manifest differently in older age. The Department of Health has estimated that 40% of older people in GP clinics have a mental health problem, rising to 50% of older people in general hospitals and 60% of those in care homes (Social Care Institute for Excellence, 2006).


On an average day in a 500-bed hospital, older people occupy 330 of the beds. Of these, 220 will have a mental health disorder of some kind: 100 will have depression, 100 – dementia and 66 – delirium (Burns & James, 2015).

Depression is the most common mental health problem in this age group. It is estimated that it affects 22% of men and 28% of women aged 65 or over and 40% of older people in care homes (Age UK, 2016). Anxiety disorders affect 1 in 20 older people (Bryant *et al*, 2008). Less commonly, patients present to services with psychosis due to bipolar disorder or a psychotic disorder. Their psychotic illness may have been long-standing, but it may also present for the first time in later life.

A report from the King's Fund (McCrone *et al*, 2008) suggests that by 2026 ageing will be the sole driver for increasing the numbers of people with any form of mental disorder. The prevalence of depression alone is projected to increase by 43%, severe depression by 49% and dementia by 70% between 2017 and 2035, according to figures compiled by Projecting Older People Population Information (POPPI; [www.poppi.org](http://www.poppi.org)).

Another area to consider is the impact of frailty. Frailty has been defined as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves' (British Geriatrics Society, 2014). Around 10% of people aged 65 and over currently live with frailty, rising to between 35% and 50% of those aged over 85 (Age UK, 2017).

Clearly, mental health services are facing a great number of challenges. They must be equipped to meet the needs of a rapidly rising population of older people, among whom the prevalence of mental health problems is itself increasing.



**Depression is the most common mental health problem: it affects an estimated 22% of men and 28% of women over 65.**

## Services

A variety of services are involved in meeting older people's mental health needs. Primary mental health care is offered by GPs, counsellors, psychologists and other community practitioners, and is often focused on common mental health problems such as anxiety and depression. Many people with mental health problems in the community may have more frequent contact with Social Services than healthcare services, because their social care needs associated with co-occurring dementia or physical frailty have taken priority.

Secondary mental health care services, normally called older adult mental health services, can be hospital based or community based. They focus on mental disorders, such as severe depression, anxiety, psychosis, suicidal thoughts, as well as dementia, and usually rely on the expertise of old age psychiatrists, clinical psychologists and psychiatric nurses, among others.

Mental disorders in older people are commonly seen in general hospital wards and care homes. In acute hospitals patients with the

three common disorders – depression, delirium and dementia – are normally seen by liaison teams, who have specific expertise in older adult mental health. Many older in-patients in the acute hospital are already known to older adult community mental health teams.

There are several features which distinguish ‘older adult’ from ‘working-age adult’ mental health. They include different mental disorders, different presentations, multiple co-occurring medical or physical health conditions, different care plan needs and different contexts.



# Evidence of discrimination

## Ageism and age discrimination: definitions

Ageism is discrimination or unfair treatment based on a person's age. Given that age is one of the protected characteristics under the Equality Act 2010, age discrimination is unlawful in many contexts, including in the provision of health and social care.

Two types of discrimination are recognised: direct and indirect. Direct age discrimination occurs when someone is treated less favourably than others because of their age. For instance, if a doctor refused an older person a treatment purely on the basis that they were 'too old', despite the treatment's likely benefits, this would be direct age discrimination. The same would apply if the person were denied a referral to specialist services, such as counselling or cognitive-behavioural therapy (CBT), just because of their age.

Indirect age discrimination can occur when neutral arrangements that apply equally to everyone whatever their age put a particular age group at an unfair disadvantage. Let us suppose that a health service intended for every age group only employs staff with generalist skills in the belief that these are equally relevant to all patients. It is recognised that older people have unique mental health needs that require health professionals with specialist skills, distinct from the mental health needs of general adult population. Therefore, a generic service risks putting older people at a disadvantage, which would be a case of indirect discrimination (Department of Health & Care Services Improvement Partnership, 2007).

Both direct and indirect discrimination can be lawful if justified as a proportionate means of justifying a legitimate business or policy aim. A government White Paper emphasised that commissioners and providers of NHS and social care services could in appropriate cases, for example in allowing free flu jabs for older people, rely on this exemption and should not be discouraged from taking account of age when it would be right to take it into account (Government Equalities Office, 2011). The onus of proof for this is on the service provider. In addition, there are specific exceptions to the general rule against age discrimination. For example, it is lawful for an organisation to offer age-related concessionary pricing (Paragraph 30A, Part 7,

**Ageism is discrimination or unfair treatment based on a person's age.**



Schedule 3, Equality Act 2010) or to take positive action to encourage or develop people in an age group that is under-represented or disadvantaged in a role or activity (Section 158, Equality Act 2010).

Unfortunately, there is evidence of both indirect and direct discrimination in mental healthcare that is not, in our opinion, legally justifiable.

## Age discrimination and ageism in society

Age discrimination is rife, according to UK charity, Age UK (2017a), and continues to blight our society, including in areas such as healthcare, social care and the provision of many goods and services. In a major study, 60% of people aged 65 and over believed that age discrimination exists in the daily lives of older people, while 53% believed that once you reach very old age people tend to ‘treat you like a child’ (Age Concern & Help the Aged, 2009).

A 2018 survey of attitudes towards ageing and older people published by the Royal Society for Public Health (RSPH) found that ageist attitudes were widespread. For example, there was a significantly negative outlook on cognitive ability, with almost half (47%) of respondents believing that older people find it more difficult to learn new skills, while nearly two-thirds (64%) thought that forgetfulness is a natural part of growing older. Two out of five young people (aged 18–24) thought that ‘there isn’t any way to escape getting dementia as you age.’ Respondents were also asked for their views on happiness and emotional stability in old age. A quarter of 18- to 34-year-olds believed that ‘it is normal to be unhappy and depressed when you are old’. ‘Given how rife age discrimination is in society,’ the RSPH commented, ‘it is to be expected that ageism towards older adults can appear in health and care settings’ (p. 33).

A UK older people’s charity, Independent Age, has set itself a goal of ‘challenging our preconceptions of older people’ ([www.independentage.org/policy-and-research/doing-care-differently/time-to-make-a-difference-a-call-to-action](http://www.independentage.org/policy-and-research/doing-care-differently/time-to-make-a-difference-a-call-to-action)). It argues that older people suffer the ‘double whammy’ of discrimination both because of their age and because of their mental health needs. Mental health is a key theme of its Ageism Plus series, launched in summer 2018, which takes its cue partly from older people’s relatively poor experience of services ([www.independentage.org/ageism-plus](http://www.independentage.org/ageism-plus)).

## Impact of age discrimination on older people

Age discrimination may impact on older people’s perception of how they are treated and how their needs are being supported. Evidence collected over the past decade suggests that 68% believe that

politicians see older people as a low priority, whereas 76% believe that the country fails to make good use of their skills and talents (Age Concern & Help the Aged, 2009).

An analysis of 134 studies suggests that experiences of discrimination of any sort are associated not only with worse psychological well-being, but also with poorer physical health (Pascoe & Richman, 2009). Another study found that perceived day-to-day discrimination among 6377 older adults was associated with increased symptoms of depression, worse self-rated health, functional limitations (affecting actions related to daily living) and chronic illness (Swift *et al*, 2016). Ageism damages well-being.

Even though ageism is known as a pervasive form of prejudice and discrimination, the prevalence of experiences of ageism remains relatively under-researched and the phenomenon seems to be widely tolerated as an apparently inevitable consequence of growing old (Swift *et al*, 2017).

# Discrimination in health and care


## Unconscious bias and perceptions

Research from the USA, the UK and Europe more widely suggests that older people are stereotyped as ill, dependent and incompetent. Unfortunately, these stereotypes are likely to be confirmed in healthcare, because when they are seen by healthcare, most patients will be ill or temporarily dependent. This is likely to reinforce healthcare professionals' acceptance and internalisation of negative attitudes towards old age (Swift *et al*, 2017). According to a recent YouGov poll (2018), people from every age group (including those aged 65 and over) think that people over the age of 65 are less likely to recover from a mental health condition than people aged 18–64. Nearly half of older people themselves believe this.

These attitudes influence the decisions doctors make. Evidence shows that they are less likely to give the correct diagnosis and treatment to older patients than to younger ones.

Swift *et al* (2017) cite a randomised control trial by Linden & Kurtz (2009), in which 121 doctors were given case studies of two identical patients with depression and asked to assess, diagnose and prescribe treatment for them. The only difference was their age: 39 in one case, 81 in the other. Diagnoses and treatments given to the younger patient were more appropriate than those for the older patient. The younger patient was more likely to be diagnosed with depression and anxiety – broadly in keeping with the case study – but the older patient was diagnosed with dementia or a physical illness. Therapies prescribed for the younger patient were more likely to be relevant and included psychotherapy, pharmacotherapy and referral for in-patient or specialist treatment. In contrast, the older patient was prescribed supportive counselling.

If these diagnoses and treatments had been given to real people, rather than hypothetically in response to case studies, they would have been examples of direct age discrimination. The doctors involved were treating patients less favourably because of their age. When health professionals make decisions and judgements, they may be unaware that these can be affected by unconscious ageism or age



**Doctors are less likely to correctly diagnose and treat older patients than younger ones.**

biases that devalue older patients. And they may not notice the harmful consequences that follow (Swift *et al*, 2017).

Indirect discrimination can also be at the root of differences in treatment options offered to younger and older people. For example, funding for treatments and procedures may be distributed based on cost-benefit analyses that disadvantage older adults (Centre for Policy on Ageing, 2009; Swift *et al*, 2017), often because cost-effectiveness is calculated based on the quality-adjusted life years (QALYs) which are likely to result. QALYs reflect both an estimate of the years of life remaining to a patient and their likely quality of life.

However, QALY calculations can be problematic. The calculation works in the same way for everybody – in this respect it is neutral between people – but older people can be put at an unfair disadvantage just by being older and not because the treatment or procedure is intrinsically less effective in them than in younger people (Public Health England, n.d.). This form of indirect discrimination may not be justified.

Mindful that health professionals were as susceptible to the ageist stereotypes identified in its survey as anyone else, the RSPH (2018) recommended training on the effects of ageism in clinical and care settings. This would ‘make healthcare professionals aware of how implicitly held negative age stereotypes can affect diagnosis and treatment of older patients’.

## Age and mental health policy

Government policy has tended to overlook older people’s mental health services, despite the pressing need to tackle the challenge of an ageing society. Instead, it has tended to focus either generically on services for all age groups or on the specialised area of dementia care for older people.

For example, there is no specific mention of the needs of older adults in the Mental Health Act Code of Practice, even though there are specific sections to highlight the needs of children, adults with an intellectual disability and those with autism or a personality disorder.

Similarly, within the criminal justice system, there are specific pathways for children, those with an intellectual disability, autism or a personality disorder, but no pathway or recognition of the specific challenges facing older adults.

This then is another way that older people are placed at an unfair disadvantage by a generic approach to mental health policy-making. There is a long-standing bias in policy towards age groups deemed more economically productive. In 2011, the National Development Team for inclusion (NDTi; 2011) reported on the tendency of mental health strategies to emphasise the interests of ‘working-age adults’ and called for these strategies to be ‘both age inclusive and age

explicit'. Despite this, the government's current strategy, the *Five Year Forward View for Mental Health* (NHS England, 2016a), still adopts a cross-age approach that pays very little attention to the specific needs of older people. There are passing references in the government's roadmap for delivering the strategy, but again as part of 'adult mental health' viewed generically (NHS England, 2016b). If 'variation in outcomes and access to services' for older people (among other groups) is to be addressed, as the roadmap intends (p. 17), the evidence indicates that detailed consideration will have to be given to specialist services, followed by the necessary investment.

Similarly, the mental health workforce plan (Health Education England, 2017), intended to support delivery of the *Forward View*, while acknowledging that the older population is projected to grow, makes scant mention of how their needs may differ from those of other adults or how they are expected to be met. The little that it does say is telling:

**'The assessment and management of mental health problems in this age group [older people] requires bespoke competencies not always available in general adult psychiatric services. This results from the presence in individuals of comorbid physical illness, frailty and cognitive impairments coupled with unique social factors (e.g. post-retirement life changes and inevitable deaths of peers).'** (p. 7)

As the workforce plan implies, the necessary 'bespoke competencies' would be more reliably provided in a specialist service, especially given the range of age-specific conditions that may be present. Yet, despite the rising prevalence of physical and mental illnesses in older people, there is evidence that they are neglected in local strategies.

Age UK, investigating what strategies or policies the 55 mental health trusts in England had for supporting people with mental and physical illnesses, found that of the 51 that responded almost 40% had no overarching policy. Only three had policies that specifically mentioned old age or older people (Age UK, 2016).

If the goal of commissioning services is to meet the needs of a local population, then, in most areas, it is clearly failing older people. This is the case even when historically there is evidence that high-quality interventions tailored to older people deliver value for money, good outcomes and better care.

A study published in the *British Journal of Psychiatry* (Abdul-Hamid *et al*, 2015) is instructive in this regard. It compared how old age psychiatry and general adult psychiatry services met the needs of older people with mental illness that was not caused by dementia. Unmet needs among older people who had been in contact with general services were twice as high as for those who had been in

contact with specialist services. The authors concluded that old age psychiatry was better able to meet the older people's needs and that general services risked overlooking those needs, 'particularly when competing for resources with more disturbed younger patients'.

## Discrimination in service provision

There has long been evidence confirming various aspects of discrimination of older people: infringement of human rights, unmet need and neglect (Bowers *et al*, 2005; Royal College of Psychiatrists, 2005; Age Concern, 2006, 2007, 2008). Deep-rooted cultural attitudes to ageing have also historically been particularly evident in mental health care. More recent studies do not suggest that there has been any great change in this regard (Age Concern, 2008; Swift *et al*, 2016).


In some services, only 1 in 6 older people with depression receive any treatment, and whereas 50% of younger people with depression are referred to mental health services, only 6% of older people are (Tadros *et al*, 2013). Although treatment, by and large, has similar efficacy in older and younger people, research has shown that GPs are much less likely to refer older people to Improving Access to Psychological Therapies (IAPT) services, which are based in primary care and offer psychological therapies (Pettit *et al*, 2017). Yet, when older people are referred to IAPT, they are more likely than younger patients to both attend therapy clinics and benefit from them (NHS Digital, 2017a).

This pattern has been confirmed in a recent study that suggests old people who self-harm are less likely to be referred to specialist mental health services than younger adults, despite a higher risk of suicide in this group (Morgan *et al*, 2018).

Age UK reports that, between 2008/2009 and 2015/2016, the total proportion of over 64-year-olds referred to IAPT increased only from 4% to 6.1%, well below the government's expectation of 12% (Age UK, 2016). They conclude that at this rate of increase, it would take until 2031 to meet the target.

Two leading figures in old age psychiatry quote similarly alarming statistics. Among the facts listed by Alistair Burns, NHS England's National Clinical Director for Older People's Mental Health, and James Warner, former Chair of the Faculty of Old Age Psychiatry, are that 85% of older people with depression receive no help from the NHS, and that older people are a fifth as likely as younger age groups to have access to talking therapies but six times as likely to be on medication (Burns & James, 2015).

How can these facts be explained? Common preconceptions among GPs appear to include notions such as that depression is an inevitable consequence of ageing, that diverting resources to younger people



**85% of older people with depression receive no help from the NHS.**

is more cost-effective, that older people are unsuited to IAPT and its processes, and that addressing physical and social issues among older people should take priority over psychological therapies (Collins & Corna, 2018).

Meanwhile, studies have shown that patients aged 50–70 with pre-existing mental health conditions are particularly at risk if their continuing care is downplayed (Davies, 2016).

The importance of ongoing or ‘maintenance’ treatment can be seen in the case of depression among older people, where rates of recurrence in the range of 50–90% over 2–3 years have been found. However, when ongoing treatment is given, recurrence rates fall by half (Reynolds *et al*, 2006).

Among older people on acute hospital wards more than 60% have a serious mental disorder which often goes unrecognised and delays rehabilitation and discharge (Joint Commissioning Panel for Mental Health, 2013).

There are more examples of needs that a specialist service would be equipped to meet. Referring to the *BJPsych* study mentioned earlier, where unmet needs among older people were significantly higher in generic services, Burns & Warner (2015) argue that it is ‘clear evidence of the need for age-appropriate psychiatry services for older people with mental health problems’.

## Discrepancies in funding

Reported total overall cash investment in older people’s mental health services fell by 1% between 2010/11 and 2011/12, from £2.859 billion to £2.830 billion, according to the most recent audit (Department of Health and Social Care, 2013). Taking inflation into account, the overall real-terms investment in these services fell by 3.1%.

At the same time, older people’s services were already underfunded by as much as £2.3 billion compared with services for younger adults (Joint Commissioning Panel for Mental Health, 2013). Achieving parity in service provision for adults aged 55–74 with those aged 35–54 was thought in 2008 to require a 24% increase in NHS mental health spending (Beecham *et al*, 2008). There is no reason to think that the situation has improved since these figures were compiled. For example, in a 2017 survey by the Royal College of Psychiatrists’ Faculty of Old Age Psychiatry, taken up by old age psychiatrists from 91% of NHS trusts and local bodies, 42% of respondents said there had been a reduction in their funding for older adult services over the previous 3 years (Faculty of Old Age Psychiatry, 2017). Given the pre-existing funding gap and the rising demand for services, this reported decline in investment is even more disconcerting.

Looking at a broader picture, the European Union strategy Together for Health (2008–2013) identified the development of more age-related



medical specialties as a key priority, which would require an average 25% increase in healthcare spending by 2050 (Commission of the European Communities, 2007). This is a laudable aim and there are equally powerful reasons for focusing more mental health investment on older people. Parity with younger adult services remains an ambition that commissioners should be aiming to achieve, working alongside primary care and voluntary sector agencies to build service capacity. Since mental health problems affecting older people are often more complex, proportionally more investment is justified.

Yet the tide of events seems to be moving the other way. A recent study has shown that current plans in the NHS to replace block contracts with a single tariff for each group or 'cluster' of mental health conditions fails to take account of the potential additional complexity and costs of caring for older people. It will discriminate against older people in clusters that are not focused on illnesses involving psychosis (Nilforooshan *et al*, 2016).

In 2013, the government said it wanted to achieve parity of esteem between physical and mental health. That commitment was followed by a promise of £1.25 billion for child and adolescent mental health, a national strategy for adult mental health and an investment of £1 billion to support its delivery. But the *Five Year Forward View for Mental Health* made no mention of a funding pledge for older people's services (Gilbert, 2018).

The *Forward View* pays little attention to mental health care in the community, which is where most secondary mental health care is provided, including for older adults. Moreover, the services advocated do not distinguish between working-age and older adults, which has the unintended consequence of funnelling resources into services (such as crisis resolution teams) that work, with a few exceptions, only with the working-age population.

Not only is a focus on investment in older people essential for their well-being, it is essential financially, when the NHS will have to continue finding more economic ways of working, even with a government promise of 3.4% annual increases in funding (NHS England, 2016b). For example, the economic benefits from introducing the Rapid Assessment Interface and Discharge (RAID) model of mental health liaison in Birmingham lay predominantly in reduced length of hospitalisation for older people (Singh *et al*, 2013).

# Rising challenge for services

## Mental health disorders in older people

If services are to cope with rapidly rising demand and the special mental health needs of older people, politicians and policy makers will have to focus on ensuring there are services to meet these needs and provide the necessary investment. Until they rise to this challenge, the injustice of discrimination in service provision will continue to weigh on older people.

There are several features that distinguish 'older adult' from 'working-age adult' mental health. To assess the special demands on older people's services, we will briefly survey the range of mental health conditions in question, make some distinctions and raise some of the difficulties endemic to this group.

### Dementia

Although dementia is the disorder considered in the public consciousness as the archetypal disease of old age, it is by no means the only mental disorder occurring in older people.


Dementia frequently occurs alongside other mental disorders, in particular, depression and psychosis. There are 850 000 people with dementia in the UK, most of whom are aged 65 or over. It is estimated that up to 1 million people will have dementia by 2025, rising to 2 million by 2050 (Prince *et al*, 2014).

When an older person presents with mental health symptoms, dementia is one of the possible diagnosis that needs to be considered. Dementia will frequently affect the treatment of other mental health problems in a person.

### Depression

Depression is both the most common and most treatable mental illness in old age. It is estimated that up to a quarter of older people in the community have symptoms of depression serious enough that they may require therapeutic intervention (HM Government, 2011). This figure doubles in the presence of physical illness and trebles in hospitals and care homes.

Depression in later life is the major risk factor for suicide – 80% of people over the age of 74 who die by suicide have depression (Conwell *et al*, 1998; Hawton & Harriss, 2006). Depression also doubles, and sometimes triples, natural death rates (Ryan, 2008), impairs the ability to function independently, increases the likelihood of admission to long-term care and worsens the outcome of other medical conditions (Alexopoulos, 2006; Wanless *et al*, 2006; Licht-Strunk *et al*, 2009).



**80% of people over 74 who die by suicide have depression.**

Depression in older adults can present with the same symptoms as in younger adults, but it can also present in the form of physical rather than emotional symptoms and with prominent features of anxiety and agitation. Older people with depression will often experience difficulties in concentration and memory, making it difficult at times to rule out dementia,

particularly for physicians who are not specialist in dealing with older adults. Owing to the numerous physical illnesses the older person can also have, it is vital to ensure that all the potential underlying causes of depression, including side-effects of any medications, are excluded.

### **Anxiety disorders**

Anxiety disorders are common and may be present in 1 in 20 older people, frequently in combination with depression (Bryant *et al*, 2008). Anxiety in older people, like depression, is treatable.

### **Delusions**

Older people can experience delusions for many reasons, for instance depression, delirium, underlying neurological diseases, dementia, or alcohol or drug use.

Older people typically have more than one health condition. For instance, a person with Parkinson's disease can also have dementia and suffer distressing delusions and visual hallucinations. Delusions can be treated with antipsychotic medications, but because of the Parkinson's disease, the person will be particularly sensitive to antipsychotics. It is therefore essential to carry out a well-informed assessment of benefits and risks of available treatments to ensure that the person receives the best treatment with minimal negative consequences.

### **Late-onset psychosis**

A schizophrenia-like psychosis can arise for the first time in old age. The Epidemiologic Catchment Area study undertaken in the USA in 1980–1983 reported a lifetime prevalence of schizophrenia among people aged 65 and over at 0.3%.

## Delirium

Older people, particularly those with dementia, severe illness or a hip fracture, are more at risk of delirium. Delirium, along with depression and dementia, is the most common mental health problem for older people in hospital. Approximately 20% to 30% of people on hospital medical wards have delirium, as well as 10% to 50% of people who have surgery, although there is considerable variation across different types of surgery and settings (NICE, 2014).

In long-term care settings, delirium affects less than 20% of individuals, but the percentage tends to rise with age. Reporting of delirium is poor in the UK and awareness needs to improve (NICE, 2014), especially as the condition increases the risk of dying, length of hospital stay, disability, and the health and social care costs of the patients concerned (Cole, 2004).

Dementia is the strongest risk factor for developing delirium (Ahmed *et al*, 2014). People with dementia experiencing delirium account for 65% of all cases of delirium in hospital (Morandi *et al*, 2012). Delirium worsens existing dementia and is a risk factor for developing dementia (Davis *et al*, 2012). Over 80% of people who have experienced delirium continue to suffer reduced cognitive ability 3 months later (Jackson *et al*, 2016a). Those with dementia and delirium have the poorest outcomes (Jackson *et al*, 2016b).

## Alcohol and drug misuse

Alcohol and drug misuse is a growing hazard in older people and both substances are associated with mental health problems. The body's tolerance to alcohol decreases with age and this leads to a greater risk of intoxication.

The consumption of alcohol among older people in the UK has risen. Over the past 10 years 20% more people aged 65 and over admitted to exceeding the recommended drinking limits on any one day during the previous week. The 55–74 age group is also the only one in which the percentage of people drinking more than the lower-risk limit (14 units of alcohol for both men and women) has gone up over the past 5 years (NHS Digital, 2017b; Office for National Statistics, 2017).

In 2016–2017, people aged 65 and over accounted for 30% of patients admitted to hospitals in England because of alcohol. This proportion has risen markedly compared with 2010–2011, when it was at 14%. Over the same time frame, the proportion of alcohol-related admissions in the 16–44 age group fell from 43% to 30% (Public Health England, 2018). Our approach to the definition, diagnosis and treatment of alcohol-related mental health problems needs to be different for older people, for whom the effects of alcohol misuse are quite as serious as for younger people (Royal College of Psychiatrists, 2018a).

Trends in drug misuse among older people are equally disturbing. In 2016–2017, people aged 65 and over made up 8% of those admitted to

hospitals in England because of poisoning by illicit drugs (NHS Digital, 2017c), rising from 6% in 2010–2011 (Office for National Statistics, 2017). Older people are at highest risk of misusing prescription drugs, such as benzodiazepines – misuse remains disproportionately high in this age group (Farias *et al*, 2017). Patients aged between 66 and 80 are most likely to be prescribed opioid drugs (e.g. morphine), followed by those over 80 (De Wilde, 2007; Zin, 2014).

## Eating disorders

Eating disorders are a complex group of psychiatric disorders with significant negative impact on a person's physical and mental health if not adequately treated. Older people most often experience eating disorders as a continuation or relapse of a condition developed at a younger age, but in a small number of people an eating disorder may first occur in later life (Smink *et al*, 2012). There are specific triggers for eating disorders in older adults, in addition to those that apply generally to all age groups. They include menopause, falls and hip surgery, health problems in a partner, widowhood, bereavement and retirement (Lapid *et al*, 2010). Psychiatric and other illnesses, including depression, cardiac and neurological disorders, and loss of bone density, add to the complexity of the management of eating disorders in older people.

## Multiple illnesses

A person can have two or more long-term conditions, which can include mental illnesses. Conditions that commonly affect older people are diabetes, heart disease, depression, dementia, obesity, chronic obstructive pulmonary disease (COPD) and high blood pressure (hypertension).

Multiple illnesses are perhaps the defining need for old age services. The older the person, the greater their chance of developing multiple disorders: most people over the age of 65 live with a long-term condition and most people over 75 live with two or more (Barnett *et al*, 2012; Melzer *et al*, 2012).

Physical illness can have a psychological impact on a person, particularly when it is a long-term condition that requires life adjustments. Some physical health conditions can impair function, affect personal finances and result in social isolation, all of which can have consequences for a person's mental health.

Indeed, physical illness and medication side-effects (exacerbated by multiple drug prescriptions) are more likely to result in poor mental health in older people than in younger people. Equally, poor mental health can affect physical health; for instance, psychotropic medication can have physical side-effects, and a person with a mental illness may be less motivated to manage their physical health (Naylor *et al*, 2016).

A report commissioned by the Royal College of Physicians found that nearly two-thirds of people admitted to hospital were over 65 years old and that the number of those who are frail or have a diagnosis of dementia is growing as the population ages (Future Hospital Commission, 2013).

## Frailty

Frailty describes the gradual loss of the natural reserves of multiple systems in the body and is a state related to the process of aging. It is often, although not exclusively, present in people with more than one long-term illness. Around 10% of people over the age of 65 are frail, increasing to 25–50% of people over the age of 85 (NHS England, 2016c). Older people with frailty are at risk of dramatic changes in their physical and mental well-being after what may be an apparently minor health problem, for example an infection or a fall. Several frailty syndromes have been identified and all can complicate the identification and holistic care of mental illness.

Mental health services must be equipped to meet the needs of a rapidly rising population of older people, some of whom will be frail and among whom the prevalence of mental health problems is itself increasing significantly (Clegg *et al*, 2013).

## Social isolation and loneliness

Social isolation and poor physical health are risk factors for depression in any age group, but they are particularly common in older people. Nearly half of all people aged 75 and over live alone, nearly a quarter of pensioners do not go out socially at least once a month, and 1.2 million people aged 65 and over in England are chronically lonely (Age UK, 2017b).

Organisations as diverse as the Campaign to End Loneliness, Age UK and the Council of Europe have stressed the importance of participation in social, economic, cultural and civic affairs. The Council of Europe has said that '[to] combat loneliness and isolation, it is crucial to ensure that older persons remain integrated into society by promoting active ageing' (Committee on Social Affairs, Health and Sustainable Development, 2017).

## Violence and elder abuse

Older people are prone to being affected by violence and abuse, which are damaging to mental health. The National Audit of Violence (Healthcare Commission, 2008) conducted in mental health in-patient services found higher rates of violence (both against staff and

other patients) in wards for older people and the highest on wards for people with dementia.

Elder abuse in the general population is not uncommon. It can take various forms, including financial, physical, psychological, emotional and sexual abuse. It can have serious consequences by increasing the physical health problems, frailty and problems with memory experienced by older people.

Psychological abuse is believed to be the most common of all types of abuse experienced by older people, but it is hard to assess. Age UK has recently expressed concern that statistics on domestic abuse are often based on the ONS's crime survey for England and Wales, whose self-completion module reporting on violence tends to be completed by respondents aged 16 to 59 (Age UK, 2017).

## Implications for carers

Older people with dementia require more care than those with other mental health conditions: from 13.1 hours of informal care<sup>1</sup> per week in mild cases, up to 46.1 hours in severe cases. In contrast, older people who do not have dementia require 4.6 hours of informal care per week (McCrone *et al*, 2008).

Overall, the number of hours spent caring increases with age (Smith *et al*, 2014), and a significant proportion of the burden of the care and cost of mental illness is borne by informal carers. Overall, informal older carers save the economy £15 billion each year (Wanless *et al*, 2006), but this level of care may become unsustainable as carers themselves age, especially as they can also experience mental health issues.

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1. By informal care we mean care that is provided not by statutory agencies but often by family or friends.

# Ensuring we can meet the needs of older people

## The need for specialist services

Mental health problems in older people are common and often undiagnosed, but they can be as treatable as mental health problems in younger age groups. In the post-war years, this led to the development of specialist old age services in the UK (Hilton, 2005) and the discipline of old age psychiatry, which was recognised in the 1980s through the establishment of a Faculty of Old Age Psychiatry within the Royal College of Psychiatrists.

From the turn of the millennium, a fashion has begun for moving away from specialist services in favour of ‘ageless’ service models – services catering for all adult age groups – and indeed this is still being contemplated in some commissioning areas. But the pendulum has now swung back, so that there are fewer moves to ageless services and some of those NHS trusts that tried ageless services have discontinued the experiment.

The Faculty of Old Age Psychiatry’s 2017 survey reported that ageless services had led to deterioration in patient satisfaction and person-centred care, and resulted in more untoward incidents<sup>2</sup> and more distress for family carers. Only 26% of NHS mental health trusts today have day hospitals and – as noted earlier – 42% of respondents said that funding for older adult services in their organisations had fallen in the previous 3 years.

Part of the rationale for a move to ageless services was that the existence of specialist older people’s services might be considered discriminatory (Hilton, 2015). Equality between age groups required ageless services. But this argument relies on a superficial understanding of what discrimination involves.

Creating specialist services to meet the specialist needs of a particular group is a justified and practical approach to meeting those needs.

**Mental health problems in older people can be as treatable as in younger people.**

2. An NHS (UK) term for any event, incident, occurrence or accident, which could have or did lead to unintended harm, loss or damage to a patient, visitor or member of staff or hospital trust property (*Segen’s Medical Dictionary*, 2011).



In fact, as we have argued in this report, requiring everyone to use the same service makes discrimination more likely, not less. Indirect age discrimination of older people is more likely to result.

It is also much easier to avoid the problems of unconscious discrimination in a specialist unit where staff are specifically trained to meet the needs of older people. Specialist services are crucial not only for the delivery of treatment, but also for training and liaison with other health and social care providers.


Of course, services should be focused on the needs of individual patients and strict age demarcations are unjustified. For example, there may be special reasons why a person should stay with a younger adult service even when they reach age 65. A rigid and inflexible practice of transferring people between services based solely on their age – without regard for individual circumstances – is not supported by the Royal College of Psychiatrists (Royal College of Psychiatrists, 2009).

The superior record of age-appropriate services in meeting the needs of older people is well attested. To take just one example: depression can present with different symptoms in older people than in earlier adult life. When assessing the mental health needs of older people, it is essential to consider their physical health needs (which are often much more complex than in working-age adults), the medications they may already be taking (which can interact and cause side-effects) along with any sight of hearing or memory issues. All these factors, as well as each person's social and environmental factors, combine so that the symptoms and the treatment are different. Older people are particularly sensitive to the side-effects of psychotropic medications. If such medications are needed, they require careful dose adjustment and monitoring.

Indeed, where evidence exists, specialist older people's services show greater effectiveness than non-specialist services in community settings, general hospitals and care homes (Ryan *et al*, 2008; Licht-Strunk *et al*, 2009). As we have seen, in one study unmet needs among older people with enduring mental illness were twice as high for those in contact with general adult services as for those in contact with specialist old age services (Abdul-Hamid *et al*, 2015).

Specialist community-based mental health services for older people tend to perform well. The Care Quality Commission (2017) rated 76% as good and 10% as outstanding.

Delivering specialist older people's mental health services to care homes improves quality of life and also reduces use of GP time, days spent in hospital and prescribing of antipsychotic drugs (Barton *et al*, 2014). This last point is of considerable importance. There has long been serious concern about excessive prescribing of antipsychotic drugs to people with dementia. In 2008 it was estimated that reducing



**Specialist community-based mental health services for older people perform well.**

prescribing to clinically indicated levels may save £14 million per year (All-Party Parliamentary Group on Dementia, 2008).

## Combining services

Older age is characterised by health conditions that are multiple, overlapping and interacting, for which an integrated specialist service equipped to meet a range of need is necessary. Any attempt to sub-divide services for older people by diagnosis poorly reflects patients' experiences. Separating dementia and other mental health services for older people is unhelpful and was described in the National Dementia Strategy as a 'false dichotomy' (Department of Health, 2009).

Long-term physical health conditions often occur alongside mental health conditions and may be exacerbated by them. For instance, depression, visual hallucinations, late-onset schizophrenia and alcohol misuse all increase the risk of dementia (Saczynski *et al*, 2010; Diniz *et al*, 2013; Almeida *et al*, 2018), and illnesses such as depression and psychosis can affect most people with dementia at some point (Steinberg *et al*, 2008). Unless people with multiple conditions are to attend multiple services, which is neither patient-centred nor efficient, a single comprehensive service will be needed.

**Separating dementia and other mental health services for older people is unhelpful.**

## Health and social care needs

Older people's mental health services particularly benefit from an integrated approach with social care services and close working relationships with primary care and community services. Working relationships are easier to establish where all the organisations involved share as their dominant interest serving the needs of older people.

Success in implementing effective integrated care has been found to depend heavily on interpersonal relationships, therefore as much attention should be paid to the way organisations and individuals collaborate as to the service design or strategy (Faculty of Old Age Psychiatry, 2016).

# How the government should respond


## Changing attitudes, changing services

The UK government and the devolved administrations have all taken some action to tackle age discrimination in health and social care (Welsh Assembly Government, 2006; Department of Health Social Services & Public Safety, Northern Ireland, 2013; NHS Health Scotland, 2014). But the problem remains. Dealing with ageism so that it does not adversely impact how we adequately meet the needs of older people requires action on two fronts: one is changing public and professional attitudes, and the other is changing services and their funding.

Learning to see older people as contributors to, rather than a drain on, our society is essential if we are to end age discrimination in health and social care. We must come to view old age as a time of potential in our lives, to be employees, volunteers, carers, elected representatives and much else. Health and care services are there to restore and nurture this potential, wherever this can be done.

Changing attitudes will require a more informed health and social care workforce that better recognises the ways in which mental health problems in older people are distinctive and understands what care and treatment can be provided. Specialist older people's mental health services have an important role in changing attitudes across the health and care system, setting an example, providing a training resource and acting on the pressing need for service innovation and research in the mental health of old age.

Comprehensive mental health services for older people provide the strongest foundation on which to construct services that will best assess and meet the needs of older people with mental health problems developing in later life. They are 'the bedrock on which other services can rely' (Department of Health & Care Services Improvement Partnership, 2017) and the best way to prevent discrimination. If this



**Learning to see older people as contributors to our society is essential.**

is to happen, there needs to be investment in mental health services channeled to older people.

Finally, we must take advantage of opportunities for preventing mental illness, promoting well-being, and securing more mental and social capital for later life. While this should include universal interventions to promote mental well-being across whole populations, targeted interventions are required to address specific needs among this more vulnerable and at-risk group. Risk factors for depression and mental illness in older people, such as loneliness, alcohol and substance misuse, fuel poverty and vulnerability to violence, are well known and should be addressed. Early detection of mental illness in older people is vital in securing their well-being.

## Mental health strategy after 2021

When the successor strategy to the *Five Year Forward View for Mental Health* is drawn up, it must contain a clear and detailed vision to meet the needs of older people. The failure of the *Forward View* to focus on the specific and distinct needs of older people sent a message that this was not an area that required resources or reform. As this report has attempted to show, the very opposite is the case.

The new strategy must involve dedicating resources to meet these needs, but it is equally important that resources are mobilised in the best possible way. Older age is characterised by health conditions that are multiple, overlapping and interacting and best managed by specialist services.

As part of a detailed vision for the post-2021 mental health strategy, we propose the following set of recommendations.

## Recommendation 1

### Rebalance resources

Resources need to be redistributed to address the increasing demands of an ageing population. We are not asking for reductions in other mental health disciplines to fund this; we call for additional resources to meet the need. Older people's needs should be central to expenditure planning. Current proposals for integrated systems are promising in addressing the complex nature of mental and physical health problems, multiple drug prescriptions and social needs in older adults.

We welcome NHS England's announcement that every clinical commissioning group must meet the Mental Health Investment Standard in 2018/19, which postulates that investment must rise at a faster rate than the overall funding increase (NHS England, 2018). But moving forward, we believe that NHS England should ensure transparency about mental health spending locally, showing how much is being spent on older people, in all settings, basing it on the local demographics.

To ensure that the money is spent wisely, we need a better understanding of the needs of older people in each area. This should be based on solid data about the make-up of the population and its needs, having regard to ethnicity, cultural issues and the prevalence of different mental health disorders, particularly depression. NHS England should regularly collect this information on older populations and make it available locally to inform decision-making.

Any new plan should also consider the mental health needs of older people in care homes and in prisons. There are over 400 000 older people in care homes and there has been a 150% increase since 2002 in the number of people aged 50 or over in the prison population (*Constabulary*, 2018).

We suggest that the government should appoint a team of equalities champions, including one with a remit to tackle the mental health inequalities for older people across the health system and through cross-government action.

## Recommendation 2

### Develop services for older people

The needs of older people are complex and different to those of working-age adults. Better and more innovative specialist services are needed locally to meet these needs. Replicating younger adult services for older people is not the answer.

Crisis support for older people is at best patchy and frequently unavailable, a situation that must be recognised and addressed in the next strategy. It is also essential that the needs of older carers who often have mental health difficulties themselves are addressed.

The strategy should cover services for all old age mental health disorders, including dementia.

A greater emphasis should also be placed on preventive strategies for older people at risk, or in the early stages, of mental illness, including depression and dementia. Detecting cognitive difficulties and depression early in someone with one or more long-term physical health condition will have a beneficial impact on both their mental and their physical health.

We propose that any transformation plans in the post-2021 strategy should have explicit recommendations and metrics relating to services for older people.

### Recommendation 3

## Improve and expand the workforce

The UK government and the devolved nations should review their workforce strategies to ensure they are able to meet the needs of older people. The strategies should focus on training and promoting older people's mental health care as a valuable and exciting career choice for all health and social care professionals.

We do not have enough specialists in the short term to meet demand, and we need to train and support the wider health and social care workforce to identify mental health issues in older people at an early stage. Across health and care services there will need to be a more informed workforce that better recognises and understands the way mental health problems present in older people, in particular those in primary care, general hospitals, care homes and social care.

Recruitment rates for specialist old age mental health doctors and nurses need to improve. The message that old age psychiatry is a rewarding discipline that offers a secure future needs to be clearly and consistently delivered. This starts with the undergraduate curriculum for both doctors and nurses, which needs to find more room to address older people's mental health.

Retention of skilled staff should also be addressed, so we can meet the increasing demand from the ageing population. Too many specialist doctors and nurses are retiring early, resulting in tremendous waste of experience and training. The reasons for this should be understood and rectified.

### Recommendation 4

## Improve public awareness

Just as we have made progress in raising public awareness of dementia, we now need to do the same for older people's mental health generally.

Society should recognise the impact of mental health problems on older people and their treatability. It should be more widely understood that a person can have a mental illness, such as depression or psychosis, alongside dementia as well as many other illnesses.

Action should be taken to tackle the stigma of mental illness, not least among older people who may see depression and anxiety as 'weaknesses' to be concealed rather than problems to be treated. This is not just about government: we need to ensure that we are all working towards our own mental well-being and that of our older friends and neighbours.

The overnment should work across departments and with professional bodies, charities, patients and carers to raise awareness of mental health problems in old age and to tackle the associated stigma. There needs to be clear leadership in implementing this work and its impact should be monitored. It is important that the new strategy takes this issue seriously.

# Conclusions

Rather than perpetuate ageist stereotypes or dismiss age as an irrelevance, we must respect age. This is not only a moral imperative, but a social and economic necessity, as the numbers of people over 65 years of age are expected to grow in the next 30 years from a fifth to a quarter of the population.


As more of us progress into old age, so the prevalence of mental health problems in older people will rise. Attitudes to age will need to change radically, in health and care services as in wider society. We cannot allow a situation to continue in which people are denied the right treatment and services simply because they are 'too old'.

Age discrimination exercises a baleful influence on mental health strategy, funding and delivery. It disregards the real interests of older people, misunderstands their needs and results in inadequate care and treatment. Labels such as 'elderly' and 'vulnerable' are not a substitute for diagnosing and treating genuine mental health problems.

Conscious and unconscious bias, at professional and institutional level, is giving older people a raw deal. The solutions are numerous, but the first step is to recognise the issue. To start with, investment in older people's mental health services needs to be rebalanced towards specialised services. We need a strategy for services that clearly recognises older people's specialised needs, better data monitoring to ensure these needs are met, and a commitment to address the current inequality at all levels of the care system.

Overcoming age discrimination is a national priority. It should be approached as such.

**Overcoming age  
discrimination  
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