

View point

Ageless mental health services and the future of old age psychiatry in the UK

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Abstract

The introduction of the Equality Act by the UK in 2010 has brought into focus issues of how old age psychiatry is defined. Ageless services have been promoted; one cannot use age as a criterion for access to or denial of a service. This development has attracted international criticism in that old age services are becoming dementia-only whereas functionally ill older patients are being managed by general adult services. The needs of functionally ill older people surround a complex mixture of social and cognitive problems mainly due to ageing which may not be met by ageless services. Old age psychiatry training posts have reduced over the years. A weak workforce growth will fail to meet the needs of a fast growing elderly population. This article discusses the possible effects of ageless services, the reaction to their development, what is being done to reverse them and what else needs to be done.

Key words

age-inclusive, ageless, mental health services, older people, old age psychiatry, specialty training

Introduction

Mental health services have to be provided on the basis of need rather than age in accordance with the Equality Act that was enforced by the UK in 2010.¹ The interpretation of this led to the gradual realignment of services such that older adults with functional illnesses tend to be managed by general adult services. Thus older adult services risk becoming focussed on the management of dementia. The merging of general and older adult services has often been referred to as ageless (also labelled as all age or age-inclusive) mental health services. These services were developed to avoid breaching the Equality Act 2010. However ageless services may not be able to treat everyone equally. Compared to younger adults older people tend to have more physical health problems as well as psychological, cognitive and social issues mostly related to ageing which older adult services are better skilled at managing. By integrating older adult services into ageless services old age psychiatry is at risk of becoming extinct.²

The response to the development of ageless services

A survey of old age psychiatry consultants in the UK was undertaken by the Faculty of Old Age Psychiatry at the Royal College of Psychiatrists (RCPsych) in 2013 in order to assess the evolvement of ageless services. Seventeen percent reported that there were plans to create ageless services within their organizations. Around 52% were not in favour of the move.^{2,3}

The potential disintegration of older adult services prompted the Faculty to clarify their criteria of older adult services in 2013.^{4,5} The new criteria were: 1) people of any age with a primary dementia; 2) people with a mental disorder and physical illness or frailty which contributes to, or complicates the management of their mental illness; 3) people with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over the age of 70. It was felt that the criteria obviated concerns about age discrimination while ensuring that older people get their needs fulfilled. During the same year the Royal College of Psychiatrists wrote to the chief executives and medical directors of mental health trusts advising against the move to ageless services. The letter was signed by various national organizations including the British Geriatrics Society.²

Old age psychiatric services were almost non-existent in the UK during the early 1900's. Older people were often admitted to back wards (wards for patients for which there was little hope) in psychiatric hospitals. In order to improve the situation an all age approach was tried on an acute ward in Crichton Royal Hospital, Dumfries during the 1950s with no success. The elderly were seen to have different needs compared to the young in addition to different sensitivities to medication and presentations of the same illness. An old age psychiatry service was established in the same hospital as a response to this situation and was considered to be a successful prototype for future old age services.⁶ The UK thus eventually became one of the first countries to develop the old age psychiatry specialty during the 1970's followed by the USA, Australasian and European countries (including the

Netherlands and Switzerland) within the subsequent decade.⁷

In 2014 the European Psychiatric Association wrote a letter to the British government stating a lack of evidence in favour of ageless services as well as international support for retaining older adult services.⁸ However, there are concerns that countries along with the UK may start dismantling their old age services.² In 2015 the Royal Australian and New Zealand College of Psychiatrists also decided to clarify the core entry criteria for an older adult service which were similar to those produced by the Royal College of Psychiatrists in 2013. There is also a concern that older adult services risk becoming dementia-only in Australasian nations.⁴

The potential effects of ageless services

The introduction of ageless services would prevent unlawful discrimination on the basis of age in accordance with the Equality Act 2010. Moreover, combining general adult and older adult teams would help to save money.^{5,9,10} However, the establishment of ageless services could have unintended consequences. An all age approach was tried at Crichton Royal Hospital, Dumfries during the 1950's with no success; placing older and frail patients in a ward with acutely disturbed younger people was not considered to be conducive to safety or wellbeing.⁶ Through the introduction of ageless services old age psychiatrists are either losing or diluting their skills leading to a lowering of morale.⁹ These concerns were also expressed by the respondents to the RCPsych survey in 2013 who also reported detrimental effects in the quality of care and patient safety.⁵

A large number of older people with long-established functional illnesses develop dementia.¹¹ Thus a transfer from an ageless service for functionally ill adults to a dementia service would interrupt the continuity of care. People with young onset dementia differ from their older counterparts in that their health and social care needs are more complex. Young onset dementia services risk becoming absorbed into ageless dementia services.¹²

With the arrival of the ageing baby boomers there will be increasing demands for services in older people to play a crucial role in managing functional illnesses especially depression.⁴ Old age psychiatry training posts have reduced over the years.⁵ A weak workforce growth will fail to keep up with the strong growth and needs of the older age group.¹³

Is there any evidence for ageless services?

Evidence shows that older adult services are effective and have the potential to deliver better care and value for money.^{6,14,15} Evidence to support ageless services is lacking.^{8,10,14} Commissioners argued that there was no evidence to say that old age services are better.² However Abdul-Hamid et al published a study comparing the ability of general adult and old age mental health services to meet the needs of older people with enduring mental illness. Using a standard needs assessment

schedule in a group of older patients, the number of unmet needs was found to be twice as many in the group managed by general adult services compared with bespoke old age services.¹⁶

Protecting the specialty and the needs of older adults

As of now ageless services are being reversed in some areas and set up in others. The latest criteria of old age services are being used successfully around the country.¹⁷ In October 2015 the Faculty again wrote to chief executives of Trusts requesting the discontinuation of age inclusive services. The survey of old age services will be repeated to identify the present state of older adult services.¹⁸ The guidance for commissioners of older people's mental health services was published by the Faculty in 2013.

Since the 1970s policies for older people have appeared after those for younger people supporting the notion that the needs of older people are less crucial. Such policies include The National Service Framework for older people that was produced in 2001 and stimulated little development of older people's services.^{6,10} For at least a decade there has been relative underfunding of older adult services compared to general adult services.⁵ There should be equitable distribution of resources within mental health services that takes account of an ageing population. All commissioners and providers of mental health services should subject their policies and procedures to an age discrimination assessment.¹⁹

A problem faced by the Faculty in promoting the move against ageless services is the shortage of evidence that supports old age services in conferring benefits to older people. Thus more research is needed to protect the speciality.⁵

An increased focus on the service needs of people with dementia has been achieved but there has been little advocacy for older people with other mental health problems. There is a need for assertive leadership within the speciality along with a need for old age psychiatrists to link closely with other psychiatric and geriatric associations on a national and international level.²⁰

Ageless services present potentially serious long term threats to mental health care for older adults, not only through immediate withdrawal of specialist service provision, but also through longer-term loss of specialist training. The Royal College of Psychiatrists asserts that a radical change in provision should be evaluated and demonstrated to represent an improvement before it is allowed to proceed further.¹⁹

The Five Year Forward View for Mental Health produced by the independent Mental Health Taskforce in 2016 sets out a vision for improving the mental health of people of all ages through parity of esteem. It states that bespoke older adult services (i.e. designed to meet the needs of older people) should be the preferred model until general adult services can be shown to provide age appropriate

care.²¹ Until there is enough evidence to support old age services as we know them, one must not forget that lack of evidence does not equate to the evidence of absence of an effect. The Five Year Forward View is underpinned by the aspiration to integrate mental and physical health care through multiple providers and prevention initiatives. Could a new model of care be created to form the basis of a future older adult service?

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