

# **The need to tackle age discrimination in mental health**

## **A compendium of evidence**

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## **1 Introduction**

- 1.1 In 2009, publication of the first National Dementia Strategy in the UK (1), an Equality Bill (2) dealing with age discrimination before Parliament and a Green Paper (3) on reforming care services suggests that government is realizing the importance of mental health and an ageing population. This demographic change is the major challenge facing health and social care services now and in coming decades.
- 1.2 There are many aspects to the health and well being of older people and many partners with crucial roles to play. Despite everybody's best efforts mental ill health will befall some older people and this paper is about them and how mental health services should respond to their need.

## **2 Is there age discrimination in mental health?**

- 2.1 The answer is yes.
- 2.2 In 1999, the National Service Framework for Mental Health (NSF MH)(4) saw the beginning of much needed investment in mental health services and the creation of new specialist teams that would prove to be effective in delivering better treatment to people with mental illness. 2 years later the National Service Framework for Older People (NSF OP) (5) was published with one section (Standard 7) focused on mental illness. The NSF MH was the policy position for working age adults only (age 18-65), but, NSF OP only addressed dementia and depression and for older people with other mental health problems reference was the NSF MH. The NSF MH is 149 pages long and Standard 7 in the NSF OP 17.
- 2.3 Not only did the NSF's favour younger adults but in the time between production of the two policies the implementation approach changed. In 1999, targeted service development was accompanied by new money to put those in place and Department of Health sponsored performance management ensured that commissioners and providers delivered the necessary change. By 2001, this was no longer the approach and service development shifted to local prioritisation, and so, no targeted money came with the NSF OP where mental health was concerned. New services for stroke, falls and intermediate care were introduced, but, subsequently intermediate care was to exclude older people with mental illness, though, this was never policy. A national survey of old age psychiatrists in 2004, reported that only 17% thought implementation of the NSF OP had improved mental health services (6). A joint inspection report in 2006 (7) confirmed failure to make progress in mental health and with 2 years of its lifespan remaining the NSF-OP has yet to be delivered (8).
- 2.4 The adopted approach of subsidiarity shifted decision making to local commissioners and the force of national policy diminished. The mental health contract had little to say about older people's mental health and inevitably the

- drivers in the system left younger adults as the only mental health agenda item. This was compounded by the lack of sophistication in the commissioning process and its inability to view the wider health and social care field or make necessary whole system change. Tackling the important and complex area of older people's mental health, which cuts across commissioning boundaries, was neither expected nor required. Rather, change was made that would prove to disadvantage older people further.
- 2.5 And so, over the last decade there has been discrimination against older people in mental health and against older people with mental illness in the general context of health care. In 2004, The National Directors for Mental Health and Older People acknowledged that older people had not benefitted from important developments for younger adults and this should be addressed (9,10). Up to the present time little has changed.
  - 2.6 The discrepancy in access to mental health services and social care is confirmed by 2 reports commissioned by the Department of Health showing that, to make older people's access equal to that enjoyed by younger adults based on equivalent need, would cost an additional £2-4 Billion per year (11,12). This was especially evident for depression and anxiety disorders. These reports conclude that the balance of resourcing should change.
  - 2.7 Several recent authoritative reports have confirmed various aspects of discrimination, infringement of human rights, unmet need or neglect of older people (7,8,13-24). Deep rooted cultural attitudes to ageing were particularly evident in mental health (7).
  - 2.8 Yet, the biggest challenge to the health and social care services in coming decades is the ageing population. Despite the pressing need to tackle this challenge the focus of government policy has continued to be young people and the economically productive (19). Age discrimination and the increasing need of an ageing population is a national priority that will require more than superficial attention and more than a piecemeal approach to address.
  - 2.9 In relative terms at least, older people with mental illness are worse off now than 10 years ago. Not only excluded from investment and developments but their increasing number is not matched by extra resource. In some areas the resources and funding of older people's mental health services have been reduced (13).
  - 2.10 Despite many good policy initiatives and national guidance very little effort has been made to improve services to older people, even when good evidence shows their effectiveness and potential to deliver better care and value for money (13,19). There appears to be a lack of clear national leadership and great variation in the quality of local commissioning decisions to the detriment of older people. If the goal of commissioning is to meet the needs of a local population then, in most

areas, it is clearly failing older people. Need is not being met and evidence not translated into practice.

### **3 Does this make sense?**

- 3.1 The answer is no.
- 3.2 Already, health and social inequalities increase in later life and the gap between socio-economic groups is widening in the UK (19,25), where 18% of pensioners live in relative poverty and income declines with increasing age after retirement (19, 26). These are important indicators of poor well-being. Self reported general health declines with increasing age (27) and the care needs of people over age 65 will rise by an estimated 87% between 2002 and 2051 (28). When data collection is based on a single grouping of people over age 65 this leads to an underestimate of poor emotional well-being, life satisfaction and mental health problems by concealing higher rates among the older old whose numbers are increasing the most (19).
- 3.3 Worldwide, by 2040, it is projected that those aged 65-84 will rise by 164%, 85-99 by 301% and centenarians by 746%. In the USA in 2010 there will be 131,000 centenarians projected to rise to 1.1 million by 2050 (29).
- 3.4 In 2007, for the first time in the UK, the number of people aged 65 or more was greater than those aged under 16. The population over age 65 in the UK is projected to increase by 15% in the next 10 years and those over age 85 by 27%. By 2072, the number over 65 will double and those over 80 will treble (30). Because the older old are increasing the most the increase in mental health problems will be disproportionately greater. It is estimated that the number of centenarians in the UK will rise from the current 9000 to 58000 by 2032.
- 3.5 The prevalence of mental disorder in people over age 64 in the UK is about 20-25% and dementia accounts for about 20-25% of that morbidity (31). In the UK, mental health problems are present in 40% of older people attending their GP, 50% in general hospitals and at least 60% in care homes (8). A report from the Kings Fund (32) shows that by 2026 the only increase in the number of people with any form of mental disorder will be by virtue of ageing. In younger adults some will decline.
- 3.6 The European Union strategy Together for Health (2008-13) identifies, as a key priority, the development of more age related medical specialities, requiring an average 25% increase in health care spending by 2050 to meet the need of an ageing population (33). The number of older people in the UK with a high level of social care need is projected to increase 54% by 2025 (34).

#### 4 Are older people different?

4.1 The answer is yes but not always.

4.2 Age is a continuous variable and there is no point at which populations become discretely separate, but, there is no doubt that age affects the prevalence and nature of illness and people's lifestyle. While individuals differ, increasing age is a proxy marker at a population level of a set of needs that is different from younger adults. This becomes increasingly true the older the population considered and this changes the context in which mental ill-health occurs (35).

Box 1 – 10,000 population of people aged over 64 years

2500 people with a diagnosable mental illness

1350 people with depression (1135 receiving no treatment)

500 people with dementia (333 not diagnosed)

650 people with other mental illness (need poorly met)

#### 4.3 Dementia and cognitive impairment

In mental health this age related effect is most evident with disorders of cognitive function. Dementia is the most strikingly age related medical diagnosis with 2.2% developing before age 65, 1.3% age 65-69 but 32% over 90 (36). A further 5% will have Mild Cognitive Impairment (MCI) of which 5-10% per year convert to a diagnosis of dementia but most will not even after 10 years (37). And so, dementia has attracted the most attention.

#### 4.4 Delirium (acute confusion)

Delirium, predominantly a condition of later life and, affecting up to 50% of older people admitted to hospital, is significantly more common in people over age 65 and people with dementia. The risk of developing delirium after age 65 is 3 times higher and rises rapidly with increasing age thereafter (38,39). This condition increases mortality, length of hospital stay, disability and cost (40).

#### 4.5 Depression

While dementia has been the highlighted age related condition the number of people over age 75 with depression will increase by 30% and those over 85 by 80% by 2026 (32). The prevalence of depression in people over age 64 years, averaged across Europe, is 13.5% (41) being almost 3 times more common than dementia and increasing with age after 65, especially in those living alone with poor material circumstances (15,32,42). Mental disorder is over represented in older people receiving community care, but, particularly serious depression and it is not recognized (43).

- 4.6 The World Health Organisation expects depression to be the 2<sup>nd</sup> highest cause of health burden by 2020, it produces a greater decrement in health than other long term conditions and co-morbid depression incrementally worsens health status more than depression alone or any combination of chronic diseases without depression (44). This association with co-morbidity is particularly pertinent to older people where co-morbidity is the norm (45). Depression in later life is strongly linked to physical ill health and disability, when only 10-15% is treated (46), and the number of people over age 85 with disability will double by 2025 (47).
- 4.7 Late onset depression has different associations from early onset, particularly, with physical ill health and vascular brain disease (48). Only 1 in 6 older people with depression receive any treatment and while 50% of younger people with depression are referred to mental health services it is only 6% of older people (15). Of 1 million older people with depression 850,000 receive no treatment. Given that depression in later life is the major risk factor for suicide (49), increases natural mortality 2-3 times (50), impairs independent function (51), and loss of independent function predicts need for long term care (34), worsens the outcome of medical conditions (48) and incurs considerable cost then the consequences of this situation are serious. As treatment, by and large, has similar efficacy in older people (48), 50-90% relapse over 2 years yet maintenance treatment reduces this by half (52) and mortality is lower when treated (50) this situation makes little sense.
- 4.8 It is not clear whether bipolar affective disorder beginning in later life is the same condition as that which affects younger adults (53).

#### 4.9 **Suicide**

While the rate of suicide at all ages in the population has declined between 1997-2006, the proportion over age 65 has not changed while that in younger people has reduced. The suicide rate in people over 65 is double that of people under 25 in the general population and has increased, as a proportion, among patient suicides (those in contact with mental health services within 12 months of death) from 12% in 1997 to 15% in 2006 (54). Depression is by far the most common associated mental illness and present in 80% of people over the age of 74 who commit suicide (55). While antidepressants have been associated with an increased risk of suicidal behaviour and suicidal ideation in young people, this is not the case for people over age 64 where they reduce the risk of both (56).

#### 4.10 **Self harm**

Self harm is predominantly a problem of younger age groups but when occurring in later life the associations are quite different. The profile of older people who self harm is very similar to older people who die by suicide, most having a mental disorder, and this is quite different from similar comparisons of younger people

where only the minority will have a serious mental disorder. The risk of completed suicide after self harm is much higher with older people (49).

#### 4.11 **Psychosis**

Psychosis is much more common in older people than younger adults with 20% of people over age 65 developing psychotic symptoms by age 85 and most are not a precursor to dementia (57). These high rates of hallucinations and paranoid thoughts remain high in people of 95 years of age without dementia (58). The Charles Bonnet syndrome (complex visual hallucinosis) is almost only seen in older people. These conditions are not necessarily classed as schizophrenia and a study in London shows the needs of these older people with persecutory and perceptual symptoms in the community are poorly met (59).

- 4.12 Schizophrenia beginning in early adult life is much more common than in later life but the annual incidence of late onset schizophrenia-like psychosis increases by 11% with each 5 year increase in age over 60 (60). A study of people aged 95 without dementia reported 2.4% met the criteria for the diagnosis of schizophrenia making it more common at this age than among younger people (58). Because of consistent differences, there remains considerable doubt whether this condition affecting older people is the same as that which affects younger adults (60).

#### 4.13 **Alcohol and substance misuse and other disorders**

Neuroses and personality disorder, conversely, are less common with increasing age. When neurotic symptoms develop in later life they are more likely to be symptomatic of another mental disorder or physical health problem.

- 4.14 Eating disorders and use of illicit substances are predominantly conditions of younger people though a significant increase in older people needing treatment for substance misuse, if only by virtue of ageing, is predicted. In the USA, the number of older people needing treatment for illicit drug use is projected to rise from 1.2 million in 2000 to 4.4 million in 2020 (61). The pattern of misuse is quite different from younger adults and age appropriate treatment is important to outcome though the outcome of treatment seems just as good for older people (62). The use of alcohol declines with ageing at all levels of consumption but misuse or dependence (conservative estimate) affects 2-4% of older people. There is reason to believe that our approach to definition, diagnosis and treatment needs to be different for older people and the effects of alcohol misuse do not become less serious (63).
- 4.15 In less than 20 years the number of older people in the prison population in England and Wales has increased six fold. Though older people are only responsible for 1% of offending they pose particular problems and have different characteristics from younger people (64).

#### 4.16 **Co-morbidity**

Physical co-morbidity is much more common in later life and affects treatment. For example, depression with age related conditions like cardiovascular disease, stroke, frontal dysexecutive syndrome, vascular brain disease, Parkinson's disease or chronic obstructive pulmonary disease show rather different patterns of response to antidepressant treatments (65).

#### 4.17 **Pharmacological treatment**

Delivering treatment is affected by ageing. Physiological changes, co-morbidity and polypharmacy (multiple prescribed drugs) increase the susceptibility of older people to adverse effects of pharmacological treatment in general and some with particular age related differences. For example, hyponatraemia (lowered blood sodium) induced by serotonin reuptake inhibitor antidepressants and risk of cerebral ischaemia with antipsychotic drugs increase with age and may have serious consequences. Lithium treatment is frequently in the context of chronic kidney disease, or drugs that increase risk of toxicity, and a lower therapeutic index is used. The risk of weight gain, glucose intolerance and dyslipidaemia induced by atypical antipsychotics is much less (66). Use of medications requires different thinking.

#### 4.18 **Psychological treatment**

Psychological treatment is affected by stage in the lifecycle and a fundamental principle of psychiatry is to recognize that a patient's condition occurs in a unique context defined by the individual themselves, their circumstances and their life experience (13). The delivery of psychosocial intervention will depend on the psychosocial context and requires therapists with specialist knowledge and expertise of ageing to provide age appropriate treatment (35,67,68).

#### 4.19 **In-patient care**

The National Audit of Violence (69) in mental health in-patient services found higher rates in wards for older people and the highest on wards for people with dementia but with qualitative differences and different response. It states that some of the report makes "bleak reading particularly when compared to the results from services for working age adults" and calls for "improvements that are so desperately needed". Sudden unexplained deaths on psychiatry in-patient wards are highest among people aged 65-74 (no data for greater ages) being 8 times higher than people under 45 years of age (54).

#### 4.20 **General hospitals**

The nature of mental health problems in general hospitals is substantially different between young and older adults where levels of serious mental illness are



particularly high for older people and this predicts a poor outcome (21,65). Older people with mental illness, regardless of other factors, are more likely to die, will stay in hospital longer, more likely to lose independent function and be discharged to a care home (21). The range of mental disorders, needs assessment and clinical problems at different ends of the adult age spectrum are completely different (21,65,70).

#### 4.21 **Abuse**

Elder abuse, is particularly common in people with mental illness and the characteristics of abuse by individuals or within organizations are recognized and differ from younger adults. This needs age appropriate skilled approaches to management (71-74).

4.22 Qualitatively and quantitatively the picture of mental disorder is different at different points in the life cycle which suggests different need and approach.

### **5 What of services and informal care?**

5.1 Because the policy approach of the NSF's has been so different, older people, in the main, have been denied access to assertive outreach, crisis resolution home treatment and early intervention services available to younger adults and introduced by the NSF MH (4). A national survey in 2006 (75), showed that only 8.8% of mental health providers had a crisis home treatment service specifically for people over age 65 (only one operating 24 hours) and 21.5% provided the same service for all adults. There were very few older people on the generic service case loads and all but 2 of 17 excluded people with dementia.

5.2 Services that have developed as specialities of general and community psychiatry (working age adults) like general hospital liaison, rehabilitation, psychotherapy and addictions typically, though not invariably, exclude people over age 65.

5.3 The Improving Access to Psychological Therapies programme will bring an investment of £173 million, is age inclusive and recognizes the particular needs of older people and for therapists working with older people to have specialist knowledge and expertise (68). We have yet to see how it will roll out to benefit older people and whether there will be fair distribution. Almost 20% of older people's mental health services have no access to clinical psychology at all and only 31% of community teams include a clinical psychologist (6). The evidence shows that psychological therapies are equally effective for older people (67).

5.4 A significant amount of the burden of care and cost of mental illness is borne by informal carers. With dementia they contribute 36% of the £17 billion cost to the UK per year (36). The hours of informal care required by older people with dementia rises from 13.1 per week in mild (4.6 in people without dementia) to

- 46.1 in severe (34). Overall, older carers save the economy £15 billion each year (15).
- 5.5 Swiss data, comparable in the USA, has shown the declining availability of informal care such that the ratio of people aged 50-74 (the typical age of informal carers other than partners) to those over age 85 was 68.9 in 1950, 8.7 at present and will be 3.5 by 2050 (76). In the UK in 2006, the ratio of people of working age to those of pensionable age was 3.3 and will decline to 2.9 by 2031 (34).
- 5.6 Increasing geographical movement of younger generations away from older relatives, changing family structure and roles within society will magnify this difference (13,19). The shrinking availability of informal care will impact on all disabling conditions including the functional (non-dementia) mental disorders of later life. This is important, not only for the provision of care, but also for social interaction and social exclusion (77). The number of people living alone is increasing (78) and, already, nearly one fifth of older people report feeling lonely and isolated (79). These are important risk factors for developing depression in later life (80).
- 5.7 Impaired independent function, more than cognitive function, predicts need for long term care. For older people with cognitive impairment alone 12% reside in care homes, those with impaired activities of daily living alone 25% and those with both 85% (34). It has been estimated that with successful transfer to community care and more specialised homes for people with dementia the number of care homes for people with dementia will still need to rise by 20% by 2023 (81). This takes no account of any reduction in informal care. As it stands, the capability of care homes to meet need and provide quality care is very limited (18).
- 5.8 Reduction in informal care rarely features in predictions of need. Inevitably, as this occurs the demand for care from the other providers will rise more than that predicted by ageing alone.

## **6 Why have older people's mental health services?**

- 6.1 Despite the lack of attention paid to older people most areas in the UK have a specialist mental health service for older people though the composition of services differ considerably (6). Where evidence exists, specialist older people's mental health services demonstrate greater effectiveness than comparators in community, in-patient (particularly for depression), general hospital liaison and care home liaison settings (82,83). Specialist medical services for people over age 65 also produce better outcomes than general medical services (84).
- 6.2 This need is obviated by knowledge that general practitioners find it difficult to diagnose and manage mental illness in older people (16,85), 70% of the social care workforce have no training or qualifications (13) and detection and treatment

- in general hospitals is poor (21). Specialist services are not only crucial for the delivery of treatment, but also, training and liaison with other health and social care providers.
- 6.3 Delivering older people’s mental health services to care homes improves quality of life, reduced prescribing of antipsychotic drugs, use of GP time and days spent in hospital (86,87). There is serious concern about excessive prescribing of antipsychotic drugs to people with dementia and it is estimated that reducing prescribing to clinically indicated levels may save £14 million per year (17).
- 6.4 Older people’s hospital liaison services improve outcomes including clinical improvement, length of hospital stay, readmission, health care utilisation and produce cost savings (21,65,88). It is estimated that proactive management of people with dementia and a hip fracture alone could save £64-102 nationally per year (89). Despite hospital liaison services being recommended by the Department of Health (1,90,91), National Institute for Health and Clinical Excellence (92), Royal College of Psychiatrists (21) and the Healthcare Commission (8) even a basic service is only provided by 27% of services (93). This begs the question of the purpose of commissioning and the influence of national policy and guidance.
- 6.5 A prospective study of older medical admissions in London found 42.4% suffered dementia, 50% undiagnosed and they were 3 times more likely to die in hospital, yet, 43% suffered medical conditions for which admission is thought to be avoidable or manageable with prompt medical care (94). The National Audit Office survey (16) found that up to 68% of people with dementia in general hospitals would have had their needs better met by other services and only 41% had evidence of a mental health assessment, despite, there being a recommendation that all cases of suspected dementia in hospitals receive a specialist assessment (92). This report estimates that relocating people with dementia to more suitable forms of care would save the local acute hospitals in the area of Lincolnshire £6.5 million per year.
- 6.6 30-40% of delirium (acute confusion) acquired in hospital is considered preventable with better approaches to care (95). This could prevent 1000 episodes of illness in a UK teaching hospital per year yet this evidence for prevention approaches is not implemented.

**Box 2 - 500 bed District General Hospital**

**On an average day:**

- 330 beds occupied by older people**
- 220 older people will have a mental disorder**
- 102 older people will have dementia**
- 96 older people will have depression**
- 66 older people will have delirium**
- 23 older people will have other diagnosable disorders**

- 6.7 Preliminary evidence suggests that crisis home treatment teams for older people reduce hospital admission (up to 31%), length of hospital stay, unplanned admissions, admission to care homes, have high carer satisfaction and are clinically viable (96-99). They variously incorporate elements of intensive home treatment and assertive outreach and work with high risk groups.
- 6.8 The separation of dementia and functional services for older people is unhelpful and described in the National Dementia Strategy (1) as a “false dichotomy”. There are many reasons why it is in the interest of older people to provide comprehensive older people’s mental health services at this point in time to those with dementia and functional illness. Comprehensive services are recommended by the NSF OP (5), Department of Health (100), National Dementia Strategy (1), Healthcare Commission (8) and a consensus including the Royal Colleges of Psychiatrists, Nursing, General Practice, PRIMHE, British Geriatrics Society, PSIGE (Psychology Specialists Working with Older People) and Age Concern (13).
- 6.9 Co-morbidity, typical of later life, applies to co-morbid mental health as well as physical health. Depression, visual hallucinations, late onset schizophrenia and alcohol misuse increase the risk of dementia (50,101,102). Behavioural and psychological symptoms of dementia, including depression and psychosis, affect most people at some time (103). Some people growing old with mental illness will develop dementia. Unless people with co-morbidity are to attend multiple services or transfer between services then comprehensive services and training will be needed. Or, would the older person with alcohol misuse, depression, psychosis and cognitive impairment attend a dementia service, a community mental health team and addictions service? Will the person with schizophrenia or bipolar affective disorder who develops dementia be transferred to the dementia service or attend a mental illness and dementia service?
- 6.10 With an ageing population there will need to be more health and social care professionals trained in the mental health care of older people, in both specialist and mainstream services. Specialist older people’s mental health services will be essential as that training resource and to stimulate the pressing need for more research in this area and service innovation.
- 6.11 Because older people are less likely to be included in research studies evidence on treatment is often extrapolated from younger populations or absent. This, in itself, is deeply unsatisfactory, particularly where young and late onset disorders prove to be different, but it is where good evidence is lacking that the expertise of

specialist practitioners, familiar working with a set of circumstances, is most important.

- 6.12 It has been suggested that the existence of specialist older people's services may create discrimination (20). But, it was serious neglect of older people when there was a single, age inclusive approach to all in mental health that resulted in the need for old age specialist services. Recognition of the unmet need and significance of older people's mental health in the UK dates back to the 1940's but it was a very long time before specialist services developed to address that unmet need (104). Rather, inertia in a previous era, the manner in which mental health policy has been framed, interpreted and commissioned in the immediate past and present and failure to respect and value older people in both is the more likely explanation.

## **7 What is age discrimination?**

- 7.1 The Equality Bill (2) aims to prohibit unjustifiable discrimination on grounds of age in goods, facilities, services and public functions. The NSF OP declares that NHS services will be provided "regardless of age, on the basis of need alone". Provision of service purely on the basis of need reflects the health equity concepts of horizontal equity (the equal treatment of equals) and vertical equity (the unequal, but fair, treatment of unequals) (20). Equity is not treating all people the same, rather, equity recognizes that different needs should be addressed differently but fairly.
- 7.2 Direct age discrimination occurs when a direct difference in treatment based on age cannot be justified. A direct difference in treatment is a situation in which a person is, was or could be treated in a less favourable manner than another person in a comparable situation based on his/her age. Indirect discrimination occurs when a seemingly neutral provision, measure or practice has harmful repercussions on a person (20).
- 7.3 For older people the skill set of staff may need to be different from those working with younger adults and the needs of these 2 groups may be considerably different (105). Given that specialist older peoples mental health services have developed specifically to meet the need of older people, and the available evidence shows these services are more effective than alternatives, then a single age inclusive mental health service that provides for all people in the same way, when they are different, is likely to constitute indirect age discrimination (the neutral position). Nevertheless, this has and is being contemplated in some commissioning areas (13).
- 7.4 However, to treat all older people the same when their needs are different would be similarly discriminatory. On the one hand we have a set of needs that identify a

population of people where age is a proxy marker and, on the other, variation between individuals in that population. This will have to be addressed.

## **8 What needs to happen?**

- 8.1 There are clear opportunities for the prevention of mental ill-health in later life and for promoting good mental and social capital and well-being. This must receive great attention and is discussed in detail elsewhere (35,106).
- 8.2 A number of government departments have a significant impact on older people's mental health and well-being which need better co-ordination. The Government's Ageing Strategy (107) has created a UK Advisory Forum on Ageing with Ministerial leadership and this will need a significant representation from mental health. The prioritization of older people through local area agreements with robust monitoring is important, and, the implementation plan intention to extend the health prevention plan to include depression in 2010 is helpful, but, other mental health problems cannot be ignored..
- 8.3 The Equality Bill (2), if enacted, would provide a legal framework that means unjustifiable age discrimination can be challenged in the courts, but, will need to be unambiguous in ensuring that mental health services for older people are not unlawful. Providing different services to people on the basis of age would need to show that this is a proportionate means of achieving a legitimate aim (objective justification). The terms "proportionate means" and "legitimate aim" are not defined in the Bill and in the final reckoning would be a matter for the courts to decide. There is the power to take positive action and this paper would argue that the evidence base for mental health problems, benefit of age appropriate services and the approach outlined here would be proportionate, a legitimate aim and positive action to remove discrimination.
- 8.4 New Horizons (100) will replace the NSF MH (4) in 2009 and will be age inclusive. It will be important in guiding the commissioning and delivery of mental health services to adequately address the discrimination that has arisen from earlier approaches. It promises to recognize the different needs arising across the adult life span and communicate the consequent need for specialist older people's mental health services which must leave commissioners in no doubt about their responsibilities.
- 8.5 The National Dementia Strategy for England (1) provides a clear set of recommendations to improve dementia care across all communities and ages where there are people with dementia. It will be important that these recommendations are fully implemented.

- 8.6 The Improved Access to Psychological Therapies (68) will have to demonstrate equity in supporting the availability of age appropriate therapy and therapists with specific training and expertise working with older people.
- 8.7 There will need to be a more informed workforce that better recognizes and understands the differences of mental health problems in older people, in particular, those in primary care, general hospitals, care homes and social care (13,18,21). The separation of health and social care, physical and mental health care is a barrier to providing good services to older people and leads to inefficiencies. Integration of services is of paramount importance and the liaison function of older people's mental health services will be crucial (13). Only 56% of community mental health teams for older people report integration of health and social care despite the Department of Health's target for all communities to have an integrated service by 2004 (16).
- 8.8 There will need to be better collection of data, monitoring, inspection and methods of measurement if we are to be sure that older people are being treated fairly (8).
- 8.9 Commissioners and providers of mental health services must be required to show that their services are capable of meeting the needs of different populations and individuals within them. They must show that services are age appropriate. A one size fits all approach will not provide equality. This is important in the light of some commissioners and providers of mental health services considering the withdrawal of specialist services for older people in favour of a single mental health service for adults of all ages believing this would remove discrimination (13). This approach, the neutral position of indirect discrimination, has been condemned as discriminatory and has no support (1,8,13,15,100,105,108). It is interpreted by some as a cynical means of claiming equality with no obligation to tackle the real issues of fair access and distribution of resources (13).
- 8.10 Comprehensive older people's mental health services provide the best foundation to construct services that will best assess and meet the need of the majority of older people with mental health problems developing in later life and prevent discrimination. Described as "the bedrock on which other services can rely" (105) the organizational features of services that are age appropriate and non discriminatory are beginning to emerge (8). They must be provided in all commissioning areas and maintained regardless of integration or reconfiguration (108).
- 8.11 In the case that alternative services would best meet the need of an individual then they should have access to those services regardless of age to prevent direct discrimination. Within these considerations the choice of the individual is crucial. People should be better informed about the nature of services, advised on those most likely to meet their need and able to make an informed choice where equivalent options exist.

- 8.12 The old practice of transferring people between services based solely on their age is incompatible with the discussion so far and is not supported by the Royal College of Psychiatrists (109,110).
- 8.13 Because older people's needs are different services need to be different. The answer is not to simply replicate all younger adult service for older people. The answer lies in creating better and more innovative specialist services, improving access for older people to services out-with older people's services and providing individuals with choice. Greater involvement of older people who use services and carers for older people with mental illness in service design and delivery will bring dividends. Securing the involvement of older people in this way has been less evident than with younger adults (19,100).
- 8.14 To respond to this, mental health services will have to be more sophisticated in the way they are constituted, the way they interact, the way they are organized and how they show effectiveness. An age definition is administratively simple with clear lines of accountability and process. Needs are more difficult to define but mental health services must rise to that challenge and remain accountable.
- 8.15 While accepting the need for choice and non-discriminatory access it is likely that, for the majority of older people developing mental health problems in later life, assessment by a specialist older people's service will best serve their needs, identify if other services would be more appropriate, be the most effective and efficient use of resources, maintain clarity about the process of referral to secondary care services and accountability.
- 8.16 There is clear opportunity and accumulating evidence that more specialist services can be developed to better met the needs of older people and build on the effectiveness of existing services. For some, this can be achieved by providing multi-competency teams that include health professionals trained in older people's mental health, and, in others there will need to be a more specific focus on older people.
- 8.17 Service deficiencies that need the most urgent attention, and, where there is reason to believe that there would be substantial gains, are crisis resolution home treatment with specialist service access out of routine office hours, care home and general hospital liaison, and, early diagnosis and intervention. There are sufficient indicators that making these available will not only improve quality of care but has the potential to improve efficiencies and value for money.
- 8.18 Despite this evidence these services are available in few areas. A survey by the National Audit Office (16) found formal outreach arrangements by older people's community mental health teams for care home liaison (29.1%), Accident and Emergency Departments (19%) and acute hospitals (23.6%) only, with, 29% of mental health services providing limited access to crisis home treatment (75).



- 8.19 There is an accepted need for a redistribution of resources to address current discrimination and match increasing demand of an ageing population (11,13,35). At the present time community mental health teams for older people do not approach recommended levels of resource with only 56% reporting the recommended number of social workers, 55% community mental health nurses, 33% clinical psychologists, 32% support workers and 23% occupational therapists (16).
- 8.20 Rather than dismiss age as an irrelevance, anymore than one should dismiss a persons gender, ethnicity, religion or other personal characteristics, we should respect it. There is not only a moral imperative for this to happen now but also a pressing business need as more of us progress into later life.

## 9 Case Studies

### 9.1 Mr. M (111)

Mr. M, a 78 year old man attended a local hospital Emergency Department with his daughter at 10pm on a Friday evening. He had become depressed and was expressing suicidal thoughts. He was seen by the junior psychiatrist working the night shift who was concerned about Mr. M's mental health, confirming he was severely depressed, feeling hopeless about the future and worried about the risk of self harm.

Mr. M had not consulted anyone before this and had received no treatment. He had a painful arthritic condition that was being treated by his GP but he had not brought his depression and thoughts to the GPs' attention. Mr. M's wife had died 6 months earlier and, though his daughter was trying to support him, he was finding life alone a very difficult adjustment. Not only dealing with his emotional loss but also the practical difficulties arising from the loss of his partner. He had no cooking or domestic skills for which his wife had taken responsibility during their 52 year marriage.

The junior psychiatrist recommended his admission to hospital but neither Mr. M nor his daughter wanted that. They were seeking treatment and support at home. Because the 24.hour crisis resolution and home treatment service provided by the mental health trust will only see people younger than 65 years of age, and there is no equivalent service for older people, no immediate support was available to Mr. M and his daughter until the following working week.

Though the junior psychiatrist was anxious about the risk of self harm Mr. M went home with his daughter and a referral was made to the local older people's community mental health team for action the following Monday. The junior psychiatrist ensured this information was conveyed to the older people's service

but felt it was wrong that if Mr. M had been under 65 years of age he would have been seen by a home treatment team throughout the weekend covering 24 hours

## 9.2 **Mr. P** (112)

Mr. P, an 85 year old man, attended the Emergency Department of his local hospital feeling unwell for the previous 4 months but much worse in the previous few days. The ED medical assessment did not find a physical cause and asked for a mental health opinion. He was seen by the junior psychiatrist who had only been working in mental health for 2 weeks and had never assessed an older person for mental health problems.

There was nobody with Mr. P who lived alone. His GP had never seen Mr. P who had no medical history on record and he had only recently moved into the area.

The junior psychiatrist could not detect any abnormality in Mr. P who was just a little vague. Though not obvious to her she wondered if he may be depressed. She reassured him that there was nothing seriously wrong but that she would arrange for him to be seen by the specialist older people's mental health service as an outpatient.

Mr. P was admitted to hospital 24 hours later when found wandering in the street during the night. He was suffering from delirium (acute confusion).

Delirium predominantly affects older people and can be difficult to diagnose. In the Emergency Department there is no access to specialists in older people's mental health because the 24 hour mental health service provided by specialist mental health practitioners is only available to people under age 65 and older people are seen by a rota of junior doctors. The original diagnosis would have been suspected by a specialist older people's practitioner.

Delirium in older people is often missed in Emergency Departments and nearly one third are sent home.

## 9.3 **Mr. R** (113, 114, 115, 116, 117)

Mr. R is an 86 year old man who suffers from moderately severe Alzheimer's disease and lives with his wife. He was admitted to the general hospital with a severe chest infection and while awaiting a bed spent several hours on a trolley in pre-admission areas. He was incontinent and his wife found it difficult to get him drinks. He was very confused and because the staff were busy Mrs. R attended to her husband who repeatedly attempted to get off the trolley and leave.

During his admission he was moved between 3 wards and at times was resistive to care despite recovery from the infection. The medical team recommended he move into long term care as he would be too difficult for his wife to manage. His

wife was very distressed at the suggestion and wanted her husband to return home. He was referred to the older people's mental health liaison team, a multidisciplinary team working in the general hospital. Mr. R and his wife were seen the same day though he had now been in hospital 3 weeks.

The liaison team social worker was able to get access to immediate specialist domiciliary help for Mr. and Mrs. R, link with the community mental health team and Mr. R returned home successfully the next day. Mrs. R wrote a letter of thanks saying that everyone in this position should be referred to the team to prevent the indignity they had experienced.

Mr. and Mrs. R were fortunate that this hospital is one of the few in the country to have a specialist older people's liaison mental health team (despite national guidance), even so it is only available during office hours and does not have sufficient staff to cover the Emergency Department. In most areas the mental health assessment would have had to wait days or weeks for someone from the older people's community service to attend, and, securing a safe and prompt discharge would have been much more difficult to achieve.

#### 9.4 **Mrs. A** (118, 119)

Mrs. A is a 72 year old lady who has become depressed over the previous 12 months following the suicide of her son. She returned home to find him hanging in his bedroom. She had stopped going out and spent the entire day ruminating on her loss and unable to adjust. She was unable to change anything in his bedroom and was still washing and ironing his clothes. She neglected her diet and personal care needs and contemplated suicide.

Mrs. A was suffering from a complicated reaction to traumatic bereavement but was willing to receive psychological treatment. She had taken antidepressant medication from her GP for 6 months but this had been ineffective. The older people's community team did not have the resource to deliver intensive psychological treatment and had no access to specialist clinical psychology advice. The local service for psychological therapy was limited to people under the age of 65. IAPT recognizes that therapists working with older people require specialist knowledge and expertise.

Her condition remains chronically distressing and she remains at risk.

#### 9.5 **Mrs. X** (120, 121, 122, 123)

Mrs. X is 78 year old lady who attended medical outpatient services for 3 months being investigated for a range of physical symptoms. When no satisfactory explanation came to light she was referred for a mental health outpatient assessment. It was clear that Mrs. X was severely depressed and felt life was no longer worth living. During outpatient treatment she took a serious overdose of medication and was briefly admitted to the mental health unit but wanted to go home. There was no crisis home treatment for older people as there as was for younger adults which may have prevented admission.

Her condition improved with antidepressant medication but unresolved problems in her personal relationships inhibited further recovery. Though she managed the basic requirements of daily living her life was without pleasure, she isolated herself from other people and continued to have suicidal thoughts. She agreed that thoughts and feelings toward relatives who had financially abused her and been involved in other forms of abuse were an obstacle to further improvement. She thought that a more psychologically focused treatment approach may be of benefit.

Mrs. X was referred to a specialist clinical psychologist for older people who provides a service to 3 older people's community mental health teams. Mrs. X has been placed on a waiting list and it could be up to 6 months before she can be seen. Most older people's mental health teams will have no access to this sort of service at all.

#### 9.6 **Mrs. B** (124, 125)

Mrs. B is 56 year old lady who developed a frontotemporal dementia. She was living at home with her husband and 2 grown children who all worked full time. This condition leads to a neglect of personal care, decline in personal and social standards and disinhibited behaviour. Mrs. B's behaviour was becoming increasingly difficult for her family, her actions being irrational and becoming evident in public.

She was being seen by the general adult mental health team who had no experience of dementia and no access to more specialized care. Mrs. B became aggressive and destructive at home and professional carers could not meet her needs. She was eventually admitted to a general adult mental health ward where the staff were equally inexperienced treating this condition. Her family and the general adult team felt that she was inappropriately placed in an environment not able to meet her needs. There was no specialist service for young dementia sufferers.

In many areas older people's mental health services take responsibility for young dementia sufferers as they have expertise with these conditions and some will have a team specifically for young sufferers within the older people's service. Even then, few have access to suitable inpatient care for this group who can seem

equally out of place on inpatient units for older people with dementia which already have the highest levels of violence in mental health services.

9.7 **Mr. C** (126, 127, 128)

Mr. C is an 82 year old man with early Alzheimer's disease who lives alone. He was admitted to the general hospital after falling in the local town. No other acute medical problem was found but he did have other important long term conditions and was taking a number of medications erratically. His son and daughter lived in the locality and supported Mr. C's wish to return home but concerned about his safety.

There were practical difficulties at home and because he suffered from diabetes, chronic pulmonary problems and arthritis immediate discharge was difficult. In the hospital he had lost some of his personal care skills but the mental health assessment felt these could be improved with occupational and physiotherapy. They recommended a brief admission to intermediate care for rehabilitation. Because he had a diagnosis of dementia intermediate care would not accept him.

Because a satisfactory and safe discharge was not possible and there was no home treatment service Mr. C had to be transferred to the older people's mental health inpatient unit to complete his rehabilitation before returning home. This was not the best environment for Mr. C as other inpatients were receiving treatment for disturbed behaviour and there are high levels of violence but was felt to be the only arrangement available to the team. A high proportion of people with dementia wait in general hospitals when their needs would be better met in other ways.

9.8 **Mrs. F** (129, 130, 131, 132)

Mrs. F is an 82 year old woman with Parkinson's disease living with her 86 year old husband who has insulin dependent diabetes. She has developed problems with her memory and visual hallucinations over a 6 month period. She falls regularly, sleeps badly and needs assistance with personal care because of the severity of her Parkinson's disease.

She sees men in her home and this has led to escaping into the street in the early hours of the morning and ringing the police. These hallucinations are prominent and she becomes physically aggressive to her husband when he tries to reason with her or stop her leaving the house. Her daughter lives one hour away but is regularly called during the night by her distressed father.

Parkinson's disease is an age related condition and psychosis like that of Mrs. F affects 50% of people with the condition and is treatable. This had received no attention and the family had no other support services. With medication, carer

support and specialist treatment at home her condition could be improved. There was no crisis home treatment team for older people as there was for younger adults and despite the efforts of a community mental health team with little resource Mrs. F was admitted in crisis to the older people's mental health inpatient unit.

Her admission lasted 3 months and she returned home with social care and her hallucinations completely controlled with medication. The admission may have been prevented if crisis and home treatment had been available for older people. Mental health problems will affect 50-80% of people with Parkinson's disease, the majority being older people, yet less than one in eight people see a mental health professional and one third of those with mental health problems are never referred to a mental health service.

Sadly, the intensive home treatment team for older people was in operation in South Wales in 1988 and described as a mobile rapid response team to avoid hospital admission. These services were later to become commonplace, but, for younger adults only.

#### 9.9 **Mr. G** (133, 134, 135)

Mrs. G is 89, lives alone and has undiagnosed dementia. She has no family locally. A neighbour calls emergency services when she finds her on the floor in her flat at 11pm. The Emergency Response General Nursing Team who work out of hours are involved and concerned because she is confused. They have no knowledge of dementia and in the absence of a crisis service for older people's mental health take Mrs. G to the hospital Emergency Department. The doctor in the department has little knowledge of dementia and there are no services available to support Mrs. G and so she is admitted to an acute bed.

2 weeks later after medical tests are completed the conclusion is that Mrs. G had a simple fall but in her time in hospital has seemed more confused and needs assistance. There is no older people's mental health liaison service, the hospital occupational therapist and social worker have no expertise in the risk assessment of dementia or people with dementia managing at home and it is concluded that Mrs. G will need to go to long term care despite the fact that before this admission she was managing well at home.

Older people with dementia can deteriorate quickly in the unfamiliar hospital environment where they become more confused and are at risk. One study in London found that 43% of admissions of people with dementia were due to medical conditions that could be prevented or managed without recourse to hospital admission. Up to 68% would have their needs better met in other ways.

#### 9.10 **Mr. T** (136, 137, 138)

Mr. T. is a 90 year old man with severe dementia who had been residing in a care home for 6 weeks. He needs assistance with all activities of daily living and can be resistive to care because he cannot understand the care situation. He was previously living with his wife who, despite carer support, was unable to meet his needs due to her own failing health. For the same reason it is difficult for her to visit him.

Over 3 weeks he becomes increasingly physically aggressive and accusing care staff of trying to kill him. Consequently, he attacks people and refuses to eat. There is evidence that he has visual hallucinations of people he perceives to be a threat.

The care home staff know nothing about Mr. T's character, likes and dislikes or the way he has lived his life. Over a weekend he is involved with an assault on another resident and the on call general practitioner asks for an admission to hospital. The care staff have no training managing disturbed behaviour even though most of their residents suffer from dementia and feel unable to manage Mr.T.

Mr. T. is skillfully managed in hospital. The staff contact Mrs. T. promptly to gather information about her husband and develop a personalized care plan which enables them to intervene and reassure him when he is distressed. With treatment his paranoid ideas and hallucinations subside and with that the aggression. Despite his recovery the care home refuse to take him back and Mrs. T. and the social worker have to find an alternative for her husband. Though his condition improved quite quickly it is a further 6 weeks before another care home is able to take him and he spends a total of 9 weeks I hospital.

A care home liaison service would have been able to work with staff in the original care home to develop a personalized care plan and intervened with Mr. T's problems before they reached the point at which hospital admission was contemplated and staff training would have given the staff greater confidence and skills to benefit all their residents. Even if Mr. T. had required admission to hospital it is likely that the care home would have been confident to take him back, thereby, reducing his time in hospital and negating the need for him to move to a new home environment. Behavioural and psychological symptoms of dementia are common as the condition becomes more advanced.

## **10 What works: new opportunities for service development**

### **10.1 Liaison psychiatry services for older people (139, 140)**

- 10.11 Liverpool created a specialist liaison mental health team for older people in 1999. This became fully multidisciplinary in 2003 with older people's mental health

nurses, an old age psychiatrist providing sessional input, occupational therapy and social work all dedicated to this work and based in the general hospital. The hospital had a high readmission rate for older people.

An analysis of 324 people referred to the team social worker because they had complex needs found this cohort of high risk people had a 7% lower 6 month readmission rate than for the hospitals older people in general, 96% of referrals were assessed on the day of referral and, of those readmitted, only 13.5% were considered inappropriate admissions.

- 10.12 Investment under the Programme for Older People's Project in Leeds created a multidisciplinary older people's mental health liaison team and support services to prevent admission and facilitate early discharge. 90% of hospital referrals were seen the same day.

Unplanned admissions with a primary diagnosis of dementia reduced substantially, length of hospital stay for this patient population reduced from 30 to 13.9 days with a saving of 1056 bed days per year.

## **10.2 Crisis resolution home treatment (141, 142, 143, 144)**

- 10.21 In Liverpool in 1998, a 25 bed acute dementia ward was closed to redistribute resources into the community and develop an intensive home treatment team to manage people in crisis without hospitalization. As there was little precedent, the new service was externally evaluated by the Applied Research Centre of a local university using quantitative and qualitative methods with interviews, questionnaires and focus groups.

The team operated flexible person centred care 8am-9pm, 365 days per year. In one year 231 people were referred with mean age 81, two-thirds with dementia, 72% living alone, 44% receiving only informal care (compared to 7.6% of 206 people admitted to the ward the previous year), 57% due to neglect and 60% at other risk.

While only 10% of ward admissions returned home 63% of crisis team admissions remained at home after completion of intervention. Cost per patient per day for admission was £71.60 and crisis team £32.48. Average ward stay was 29 days and team involvement 58 days (median 36 days).

Carers were overwhelmingly positive about home treatment reporting it reduced stress, gave them peace of mind, made them better informed about mental health, feeling involved and supported and only 2 thought hospital admission preferable. They felt patients benefitted by less environmental change and consistent faces, being empowered, having a sense of equality with professionals, improved their



lives and prevented admission to hospital or care homes which they would not have liked.

A survey of patients still admitted to hospital suggested a further 25% could be managed at home by extending the team. Against clinical opinion and evidence managers disbanded the service 4 years later just as home treatment had become a requirement for younger adults under the National Service Framework for Mental Health.

- 12.22 A London older people's mental health service created a home treatment team providing an everyday service between 8am and 8pm with 8 week time limited involvement to prevent admission and facilitate early hospital discharge.

Using the comparison of a neighbouring service without this facility and the local situation before inception of the home treatment team there was a reduction in unplanned admissions from 43% to 27%, discharge to care homes from 10% to 3% and length of hospital treatment from 71 days to 35 days with reduced mortality.

- 12.23 An older people's home treatment team established in Wolverhampton provides an average of 34 visits to 87 patients, mostly suffering mood disorders, with an average number of face to face contacts of 32 hours per person over 36 days. There is high patient satisfaction and measurement using General Health Questionnaire, Health of the Nation Outcome Scale and Mini Mental State Examination demonstrates clinical improvement. Half were discharged with completed treatment and half transferred to other services. In total, 50% required no further treatment, 9% hospital admission, 4% acute hospital admission, 5% nursing home admission and 20% a community mental health nurse.

- 12.24 In 2006, the Crisis Resolution Home Treatment Team for working age adults in West Suffolk was extended to include people over 65. Before this there had been an 18% reduction of psychiatric admissions for younger adults. Crisis was defined as any situation where admission to hospital was considered. Previously, for older people, there was no alternative and all people in crisis were admitted.

Most referrals of older people occurred during working hours and the average time of team involvement was 10.5 days. Most people were suffering depression. The number of older people admitted fell by 31% without any loss of patient or carer satisfaction measured by a standardized instrument.

### **12.3 Care home liaison (145)**

- 12.31 In 2006, following reconfiguration of services in Doncaster, a specialist older

people's mental health care home liaison team was established to deliver person centred care and training to local registered care homes. The primary outcome was to reduce admission to hospital, improve quality of care and provide training to care home staff.

In the first year this award winning team received 460 referrals, admissions to hospital reduced by 75% and 28 training sessions were delivered. Over 2 years nearly 600 care home staff attended person centred training. The team has fostered a care home managers network and local awards and effective partnership between social services, older people's mental health services and the independent sector.

## 12.4 Early diagnosis memory services

12.41 See National Audit Office (2007) Improving services and support for people with dementia, for examples.

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