Chapter 14
Mental health (including dementia)

14.1 Key audiences

Primary care trusts:

- chief executives
- commissioners of mental health services
- commissioners of services for older people
- frontline staff.

NHS trusts and NHS foundation trusts:

- chief executives
- clinical directorate management teams
- medical directors
- frontline staff.

Third sector providers:

- chief executives
- frontline staff.

14.2 Introduction

This section includes both functional mental health and dementia. Both are important for older people and those who commission and deliver older people's services, whether in a specialist mental health setting, in hospitals, residential care and nursing homes, or in people's own homes. The population of older people is growing and, while poor mental health is not an inevitable part of ageing, a number of mental health conditions are common in old age, but may, nevertheless, be unrecognised or under-treated. In older people there may also be co-morbidities, with mental health and physical health conditions or frailty being present at the same time, so the mental health needs of older people may be complex.

14.3 Key issues and concerns

Age discrimination

- Mental health remains the area of health services in which age discrimination persists to the greatest extent. However, it can be addressed through a focused local approach.
- The combination of an ageing population and the under-diagnosis of mental health problems in older people add up to an urgent need to end age discrimination in mental health.
- Dual/multiple discrimination can be a significant issue for older people with mental health problems.

Demographics and prevalence

- The number of older people is rising and that will result in a greater number of people with mental health problems.
- Dementia is mainly a condition experienced by older people.
- A number of other mental health problems are more common in older people than in younger age groups; depression is particularly common. However, poor mental health is not an inevitable part of ageing.
- Co-morbidity of physical and mental health problems occurs frequently in older people.

Lack of awareness of the mental health needs of older people

- In the context of a historic lack of priority for the needs of older people, there has been a lack of awareness of their needs, which have often been considered only in terms of dementia.
- Mental health problems, particularly depression, and dementia are often unrecognised and under-treated in older people.
- The mental health needs of older people who are in hospital for any reason should be considered.
- There is limited availability of good quality national or local data in relation to the quality of specialist older people's mental health services.

The need for age-appropriate, non-discriminatory services

- New services have been focused on working age adults so older people have limited access to services that would meet their needs (talking therapies, crisis resolution etc). However, there is evidence that older people can benefit from a range of specialist mental health services.

- There is a lack of age-appropriate services for older people and for younger people with dementia.
- There are important differences in the nature, meaning, treatment and care needs of mental health problems developing in later life.
- There are concerns about the quality of care for older people for both functional mental health problems and dementia.
- Improved mental health care in care homes would be very beneficial.
- Liaison psychiatry is most often a service available only to adults of working age, although it is likely to be a benefit, if available, to older people too.

Age discrimination

The persistence of age discrimination

Mental health was recognised as an area of persisting age discrimination in the recent review by Sir Ian Carruthers and Jan Ormondroyd, whose recommendations include the need to consider how to achieve non-discriminatory, age-appropriate services.[342]

Specifically, *Achieving age equality* recommends*:*

> *"Every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age-appropriate services, drawing on insights from reports such as Equality in Later Life and other sources of good practice."*

A recent authoritative paper stated unequivocally that there is age discrimination in mental health. It also stated that in relative terms, at least, older people with mental illness are worse off now than 10 years ago. [343]

Essentially, the problem is that improvements in services for adults of working age have improved faster than services for older people, and the increasing number of older people has not been matched by proportionate increases in funding, so the gap has therefore widened.

There remains local variation in the way that services are organised, with some areas discriminating directly by age in continuing to operate a

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[342] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, 2009

[343] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009 www.rcpsych.ac.uk/PDF/Royal%20College%20of%20Psychiatrists%20-%20The%20Need%20to%20Tackle%20Age%20Discrimination%20in%20Mental%20Health%20Services%20-%20Oct09.pdf

compulsory transfer to older people's services at age 65 (or some other age) and local commissioning decisions, possibly inadvertently ageist, resulting in under-provision for older people's mental health services. In fact, mental health services for older people provide one of the few remaining examples, within the NHS, of the continued existence of explicit institutional 'direct' age discrimination – a fact that was noted in 2006 by the Healthcare Commission, Commission for Social Care Inspection (CSCI) and Audit Commission.[344] This direct age discrimination results from the age-based division into mental health services for adults and older people's mental health services.[345]

Older adults with mental health needs have not benefited from some of the developments in services experienced by younger adults and developments in services for older people do not always fully meet their mental health needs. The Healthcare Commission noted poor access to out-of-hours and crisis services, psychological therapies and alcohol services. Services for younger adults indirectly discriminated against older adults, even when, in theory, there was no obstruction to their access (for example, by providing services that are open to older people, but are not sensitive to their age-related needs).[346]

However, that is unlikely to be the whole story and specialist mental health services may be necessary in old age even if access to general mental health services is improved for older people. A paper from the Royal College of Psychiatrists points out that when there was a single, age inclusive approach to all in mental health, there were instances of serious neglect of older people that resulted in the need for old age specialist services. They state that 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 are all relevant explanations for age discrimination in mental health.[347]

Research commissioned by the Department of Health to explore the extent of age discrimination in mental health services found that despite a stated belief that older people should be able to access the same services as those under 65 years, often older people's teams did not know about services, such as supported employment or assertive outreach, which were managed by teams for working-age adults.

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[344] *Living well in later life: a review of progress against the National Service Framework for Older People,* Healthcare Commission, Commission for Social Care Inspection (CSCI) and Audit Commission, 2006

[345] *Ageism and age discrimination in mental health care in the United Kingdom – a review from the literature*, Centre for Policy on Ageing (CPA), 2009

[346] *Equality in Later Life - A national study of older people's mental health services, Healthcare Commission*, 2009

[347] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

The Mental Health Foundation (MHF) has also noted that older people with mental health problems in England do not receive the same level or quality of care as younger people.[348] The MHF states that it is important that eligibility and access to such care should not be age-based, but rather what is most suited to addressing the particular problem that develops for each individual. They state that age should play no part in allowing or restricting access to the most appropriate care and treatment.

Addressing age discrimination in mental health services – evolving views

As the Centre for Policy on Ageing (CPA) Review indicates, there is no universal agreement on whether older people's mental health services should be organised as a separate service or as a specialism, with protected funding, within adult psychiatric services. Opinions may vary as to whether the recognition of the specialty may be inherently age discriminatory or a case of reasonable age-based differentiation and therefore a proportionate means of achieving a legitimate aim. However, the Royal College of Psychiatrists believes it is essential that services sensitive to different needs continue to be provided and that specialist older people's mental health services, with unique expertise meeting a particular set of needs characteristic for later life, continue to be provided comprehensively in all commissioning areas. Failure to provide these services would deny older people access to services specifically designed to meet their need.[349] This is in line with the views of the Faculty of Old Age Psychiatry of the Royal College of Psychiatrists. [350]

The Equality Act recognises that different treatment of people of different ages can be the most appropriate way of providing services and is not automatically harmful discrimination. The test for NHS commissioners and providers is that the difference needs to be able to be "*objectively justified*" by showing that it is the least discriminatory approach and is a proportionate means of achieving the legitimate ends. High quality mental health services for older people should be able to demonstrate that they meet this test even where the service model retains a broad age-based pattern alongside comprehensive and fair assessment of the individual's needs and aspirations.

Dual/multiple discrimination

In the context of mental health, there are many ways in which people can experience either additive or cumulative discrimination. Different organisations identify sectors of the community or mental health conditions where they see

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[348] *All things being equal – Age equality in mental health care for older people in England,* Mental Health Foundation, April 2009
[349] *Age Discrimination in mental health services: making equality a reality*, Royal College of Psychiatrists' position statement and compendium of evidence, 2009
[350] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

a gap or not enough attention. There are issues of concern for black and minority, ethnic (BME) communities, as well as issues about discrimination relating to gender, sexuality and disability.[351]

While there is an extensive literature about race and health, including mental health, many studies do not distinguish between older and younger BME people so it can be difficult to establish differences. However, it is likely that the issues that pertain to BME people with mental health problems of all ages are at least as relevant to older people, with the possibility that language and cultural issues may be of even greater significance to older age groups. It is also suggested that BME groups report age-related changes at an earlier age and that health differences by ethnicity are actually greatest among older people. [352]

Also Asian and black Caribbean families may have differing ideas about changes that can be attributed to 'ageing' and those that may be attributed to dementia and so may be less likely to ask for help at an early stage. The existence of stigma about mental health problems in old age can be higher in some communities than others.[353]

Older people are more likely than younger age groups to experience mental health problems alongside physical disabilities, with the possibility of experiencing discrimination related to both.

Living in a rural area can also be associated with geographical and social isolation for older people. *New Horizons* points out that in rural areas, the proportion of people over 75 is already at the level that we expect to see in the rest of the country in 20 years or more. This creates extra challenges for rural communities and those planning health and social care.

Demographics and prevalence

Prevalence of mental health problems in older people

Mental health problems are present in 40 per cent of older people who attend their GP, in 50 per cent of older adult inpatients in general hospitals, and in 60 per cent of residents in care homes. Just over a quarter of admissions to mental health inpatient services involve people over the age of 65.[354]

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[351] *New Horizons – A shared vision for mental health*, Department of Health, 7 December 2009
[352] *The health and social care experiences of black and minority ethnic older people,* Moriarty J, Race Equality Foundation, 2008
[353] *The health and social care experiences of black and minority ethnic older people,* Moriarty J, Race Equality Foundation, 2008
[354] *Equality in Later Life - A national study of older people's mental health services*, Healthcare Commission, 2009

Recent figures show that the rate to admitted care for people aged 75 and over was 425 per 100,000 population, which was 71.4 per cent higher than the overall rate of access to admitted care:[355]

Roughly one third of all mental health service activity in England is concerned with the care and treatment of people over the age of 65, but services tend to be geared towards the needs of younger adults.[356] Dementia affects about 570,000 people in England. At the current rate the number of people with dementia will double in the next 30 years and the cost to the country will rise from £15.9 billion this year to £34.8 billion by 2026.[357] Dementia is the most strikingly age-related medical diagnosis with 2.2 per cent developing before age 65, 1.3 per cent at age 65-69, but 32 per cent over 90.[358]

A recent report from the Alzheimer's Society stated that people with dementia over 65 years of age are currently using up to one quarter of hospital beds at any one time.[359] Another recent article showed that in medical admissions to hospital in people over 70, 42.4 per cent of these had dementia, and 50 per cent of those had not been previously diagnosed. The authors concluded that the rising prevalence of dementia will have an impact on acute hospitals and extra resources will be required for intermediate and palliative care and mental health liaison services. [360]

Even more recently, it has been suggested that the number of people with dementia, and the costs associated with it, are higher than previously estimated.[361]

Delirium (acute confusion) is predominantly a condition of later life and affects up to 50 per cent of older people admitted to hospital. It is significantly more common in people over age 65 and people with dementia. The risk of

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[355] *Mental Health Bulletin - Third report from Mental Health Minimum Dataset (MHMDS) annual returns, 2004-2009,* The Health and Social Care Information Centre, 2009 www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services/mental-health-bulletin--third-report-from-mental-health-minimum-dataset-mhmds-annual-returns-2004-2009

[356] *New Horizons – Towards a shared vision for mental health*, Consultation, Department of Health, 23 July 2009

[357] *Improving dementia services in England - an interim report* by the Comptroller and Auditor General, National Audit Office, HC 82 Session 2009–2010.14, January 2010

[358] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[359] *Counting the cost – caring for people with dementia on hospital wards,* Alzheimer's Society, 2009

[360] *Dementia in the acute hospital: prospective cohort study of prevalence and mortality,* Sampson E L, et al, The British Journal of Psychiatry (2009) 195: 61-66. doi: 10.1192/bjp.bp.108.055335

[361] *Dementia 2010, The economic burden of dementia and associated research funding in the United Kingdom*, Alzheimer's Research Trust, University of Oxford, 2010 www.dementia2010.org/reports/Dementia2010Full.pdf

developing delirium after age 65 is 3 times higher and rises rapidly with increasing age thereafter.[362]

Depression in older people is both very common and often goes unrecognised although depression in later life is strongly linked to ill-health and disability. While dementia has been the highlighted age-related condition, the number of people over age 75 with depression will increase by 30 per cent and those over 85 by 80 per cent by 2026. The prevalence of depression in people aged over 64, averaged across Europe, is 13.5 per cent, being almost three times more common than dementia and increasing with age after 65, especially in those living alone with poor material circumstances.[363]

The Royal College of Psychiatrists reports that while the rate of suicide at all ages in the population declined between 1997-2006, the proportion over age 65 has not changed, while that in younger people has reduced. Depression is by far the most common associated mental illness and present in 80 per cent of people over the age of 74 who commit suicide.[364]

However, recent figures on suicide in the UK show a decrease in suicides amongst both males and females over the age of 75, with the rates for men now being the lowest rate across the three male age bands.[365]

Psychosis is much more common in older people than younger adults, with 20 per cent of people over age 65 developing psychotic symptoms by age 85 and most are not a precursor to dementia. These high rates of hallucinations and paranoid thoughts remain high in people of 95 years of age without dementia.[366]

Neuroses and personality disorder, conversely, are less common with increasing age. 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.[367]

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[362] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[363] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[364] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[365] *Suicide rates in the United Kingdom 1991-2008,* ONS Statistical Bulletin, January 2010 www.statistics.gov.uk/pdfdir/sui0110.pdf

[366] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[367] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

Substance misuse, particularly alcohol misuse, has been identified as a cause of dementia in 10 per cent of younger patients. As a potentially preventable, and in some cases treatable, form of dementia, alcohol-related brain impairment represents an area of considerable concern.[368]

Co-morbidity occurs more frequently in older people

Physical co-morbidity is much more common in later life and has implications for the treatment of some mental health conditions. There are many links between physical and mental health conditions in older people. A 2003 survey reported that the highest primary diagnosis, relating to dementia as co-morbidity, was for fracture of the femur. This indicates a need to develop links between mental health services and the falls strategy.[369]

Also see Chapter 12 Falls.

When coronary heart disease (CHD) and depression co-exist, the conditions interact, resulting in worse outcomes. Patients with CHD and depression have an approximate two-fold increase in morbidity and mortality.[370] [371] [372]

In one study, older patients with depression following a myocardial infarction were much more likely to die in the first four months after the event.[373] Depression in late life was an independent risk factor for heart failure among elderly women in another study.[374] Review evidence suggests that depression increases mortality and morbidity in ischaemic heart disease.[375]

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[368] *Services for younger people with Alzheimer's disease and other dementias, Royal College of Psychiatrists*, Council Report CR135, 2006
[369] *A Pilot Survey - The Mental Health Needs of People Aged 65 years of Age and Over in an Acute Medical Setting*, Hopkin C, Kaiser P, Scholes J, Boaler S, 2003
[370] *Depression as a Risk Factor for Mortality in Patients with Coronary Heart Disease: A Meta-analysis,* Barth J, Schumacher M, Herrmann-Lingen C, Psychosomatic Medicine 2004: 66:802-813
[371] *Depression as an aetiologic and prognostic factor in coronary heart disease: a meta-analysis of 6,362 events among 146,538 participants in 54 observational studies*, Nicholson A, Kuper H, Hemingway H, Eur Heart J 2006, 27(23):2763-2774
[372] *Prognostic association of depression following myocardial infarction with mortality and cardiovascular events: a meta-analysis*, van Melle J P, d Jonge P, Spijkerman T A et al, Psychosomatic medicine 2004: 66:814-822
[373] *The significance of depression in older patients after myocardial infarction,* Romanelli J, Fauerbach J, Buch D, Ziegelstein R, Journal of American Geriatric Society, 50, 817-822, 2002
[374] *Depression and risk of heart failure among the elderly: a prospective community-based study*, Williams S, Kasl S, Heiat A, Abramson J, Krumholz H and Vaccarino V, Psychosomatic Medicine, 64, 6-12, 2002
[375] *Relationship between depression and other medical illnesses*, Roose, S P, Glassman A H and Seidman S N, JAMA, 286, 1687-1690, 2001

Mental health problems, particularly depression and dementia, are more common and have a worse outcome in the 60 per cent of older people who suffer from a long-term illness.[376]

Lack of awareness of the mental health needs of older people and poor access to services

Poor mental health is not an inevitable part of old age

Neither depression nor dementia, or any other mental health problem, is a natural or normal part of ageing.[377] [378]

Lack of awareness of the mental health needs of older people

Particular challenges include lack of awareness of the mental health needs of older people and proper diagnosis in primary care and in acute hospitals, as well as variable quality and availability of the full range of services.[379]

There are also concerns about the low level of awareness of and training about dementia and other mental health problems in non-specialist staff.[380]

Poor data on older people's mental health

The Healthcare Commission found that there was limited availability of good quality national or local data in relation to the quality of specialist older people's mental health services. Nationally available data did not provide a robust basis on which to compare the performance of different areas in meeting older people's mental health needs, or to provide the boards of trusts with sufficient information to be confident about the extent to which they are providing good quality non-discriminatory care.[381]

Untreated depression

Unrecognised and untreated depression is a key issue and a lack of awareness of depression in older people has also been noted for some time now, for example in the *National Service Framework for Older People*[382] and *Forget me Not.*[383] A recent report refers to the high rates of depression and low rates of its identification in primary care in both older people who are living

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[376] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[377] *New Horizons – Towards a shared vision for mental health*, Consultation, Department of Health, 23 July 2009
[378] *Living Well with Dementia: A National Dementia Strategy,* Department of Health, 2009
[379] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[380] *Better prepared to care – The training needs of non-specialist staff working with older people with mental ill-health,* Levenson R, Joule N, Mental Health Foundation, February 2007
[381] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009
[382] *National Service Framework for Older People*, Department of Health, 2001
[383] *Forget Me Not: Mental Health Services for Older People*, Audit Commission London, 2000

at home and those in residential care.[384] The Department of Health is working with the Royal Colleges of Psychiatrists, General Practice and Nursing and the British Psychological Society to develop appropriate training initiatives to improve the rate of identification and treatment of depression in older people living both in the community and in residential care.

Care homes

Access to good mental health care in care homes would be an enormous benefit and immediate attention to this area would reach some of those older people with the greatest level of need. A recent paper stated that delivering older people's mental health services to care homes improves quality of life and reduces prescribing of antipsychotic drugs, use of GP time and days spent in hospital.[385]

Access to a range of treatments

There is evidence that psychological therapies are effective with older people and their carers in the management of a wide range of mental and physical conditions.[386] However, older people may be disadvantaged in terms of access to the whole range of treatment options from which they could benefit. There has tended to be an unwarranted reliance on pharmacological treatments, while access to talking therapies and crisis services has not always been available to older people who need it. For more information on psychological therapies for older people, see the website of the Improving Access to Psychological Therapies programme.[387]

Under-diagnosis of dementia

There are long-standing concerns about dementia services for people of all ages, and this has been recognised by the *National Dementia Strategy*, which includes as one of its aims "*to ensure early diagnosis, support and treatment*".[388]

In 2007, a report from the National Audit Office stated that only 31 per cent of GPs felt they had enough training to diagnose and manage dementia.[389]

A recent report from the Alzheimer's Society[390] noted that dementia is still greatly under-diagnosed. It is estimated that only a third of people with any form of dementia actually get a formal diagnosis. In some cases GPs did not

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[384] *New Horizons – Towards a shared vision for mental health,* Consultation, Department of Health, 23 July 2009
[385] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009
[386] *Effectiveness of psychological interventions with older people,* Woods B et al. In (eds) A. Roth and P. Fonagy, What works for whom? A Critical Review of Psychotherapy Research, NY Guilford Press, 2004
[387] www.iapt.nhs.uk/special-interests/older-people/
[388] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009
[389] *Improving services and support for people with dementia*, National Audit Office, 2007
[390] *Dementia out of the Shadows,* Alzheimer's Society, 2008

take symptoms seriously or told people that it was just a natural sign of ageing; or conversely, a diagnosis was not made where younger people were showing symptoms because it was believed that dementia is an illness only associated with old age. There was also evidence of doctors being reluctant to diagnose a condition where it is difficult to do so with absolute certainty and, in some cases, GPs did not have the necessary skills to identify the symptoms in order to make a referral to a specialist for a full assessment and possible diagnosis.

The need for age-appropriate, non-discriminatory services

Older people often have different treatment and care needs

Because of differences in the nature of treatment and care needs of older people with mental health problems, and differences in what having mental health problems can mean to different age groups, older people often have different care and treatment needs from younger people with mental health problems. Meeting the complex needs of older people requires specific professional skills. In addition, services have to be structured in such a way that they can respond to this complex mix of social, psychological, physical and biological factors.[391]

Inequitable services for dementia for different age groups

Dementia services are usually part of older people's mental health services, although there are specialist services for people with early onset dementia in some parts of the country. Younger people with dementia undoubtedly face particular issues that older people may be less likely to face (such as employment, responsibilities for a young family etc) but many of the issues facing people with dementia and their carers are similar for all ages. Services for people with dementia need to be person-centred and responsive to people whatever their age.

Concerns about the quality of dementia care

In 2007, two years before the publication of the National Dementia Strategy, the National Audit Office (NAO) produced a report.[392] The NAO report was critical about the quality of care received by people with dementia and their families. It found that the size and availability of specialist community mental health teams was extremely variable, and that confidence of GPs in spotting the symptoms of dementia was poor and lower than it had been in 2000. They also commented on deficiencies in carer support. The report concluded that overall services are not currently delivering value for money; that spending is late – too few people are being diagnosed or being diagnosed early enough; and that early intervention is needed to improve quality of life. Finally it concluded that services in the community, care homes and at the end of life

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[391] *New Horizons – Towards a shared vision for mental health*, Consultation, Department of Health, 23 July 2009

[392] *Improving services and support for people with dementia,* National Audit Office (NAO), 2007

are not delivering consistently or cost effectively against the objective of supporting people to live independently as long as possible in the place of their choosing.

The Alzheimer's Society has pointed out that there is unacceptable variation in the quality of dementia care in an acute hospital setting and that people with dementia stay in hospital longer than other people who go in for the same procedure. As well as the cost to the person with dementia, increased length of stay is placing financial pressure on the NHS. For all these reasons, they point to the need for better awareness of the needs of people with dementia in acute hospitals, and better care in the acute setting.[393]

Specialist services

Older adults, like younger adults, are likely to benefit from specialist community mental health approaches, such as assertive outreach, out of hours support, crisis care, rehabilitation and home treatment, and access to psychological therapies. Achieving equity of access and a range of services tailored to the needs of older people may require the development of different approaches and not simple duplication of services.[394]

Older people whose primary need is for specialist services, such as substance misuse services or forensic mental health care, should not be denied access to and care from these services on the basis of age.

Transitions

While it is increasingly recognised that the mental health needs of older people do not suddenly become different from those of younger adults, it is also widely acknowledged that different phases of life may be accompanied by different mental health issues, and be best addressed in different ways at different stages.

Generally, people who grow old with enduring mental health problems should remain under the care of the working age adult service with which they are familiar unless their needs would be better met by the older people's service, in which case good transition becomes important.[395]

People who experience their first episode of mental health problems after the age of 65 are usually seen in the first instance by the older people's service and, unless an early onset dementia service is available, people of any age

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[393] *Counting the cost – caring for people with dementia on hospital wards,* Alzheimer's Society, 2009

[394] *New Horizons – Towards a shared vision for mental health*, Consultation, Department of Health, 23 July 2009

[395] *Links not boundaries: service transitions for people growing older with enduring or relapsing mental illness*, Royal College of Psychiatrists, College Report CR135, 2009

with dementia will usually be seen by the older people's service. However, the needs of the individuals should be carefully considered in all cases.[396]

The Mental Health Foundation suggests that it may be necessary to develop entirely new specialist services e.g. for transition from one phase of life to next or employment to unemployment/retirement etc.[397]

Liaison psychiatry

Up to 70 per cent of acute hospital beds are currently occupied by older people and up to half of these may be people with cognitive impairment, including dementia and delirium. Levels of depression in general hospital wards are also high (around 30 per cent). Both depression and dementia may hinder recovery and rehabilitation. The majority of these patients are not known to specialist mental health services, and their problems are not diagnosed. General hospitals are particularly challenging environments for people with memory and communication problems. People with dementia and depression in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation.[398]

However, the needs of older people with a mental disorder in the general hospital are often poorly met and liaison psychiatry is most often a service available only to adults of working age. The Royal College of Psychiatrists points out that liaison psychiatry for working age adults is a developed speciality which has an established multidisciplinary model of service delivery with recommended staffing levels and training programmes, but none of these standards exist for older people. They state that failure to deliver this quality of service for older people represents an ageist policy.[399]

Liaison psychiatry for older people is also commended as a "*high impact change*" under the broader heading of '*Manage variation in service users' discharge processes*'.[400]

→ www.mentalhealthequalities.org.uk/silo/files/10hics-supplementary-guidance.pdf

Also, see Objective 8 of the National Dementia Strategy:

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[396] *Services for younger people with Alzheimer's disease and other dementias*, Royal College of Psychiatrists, Council Report CR135, 2006
[397] *All things being equal – Age equality in mental health care for older people in England,* Mental Health Foundation, April 2009
[398] *New Horizons – Towards a shared vision for mental health*, Consultation, Department of Health, 23 July 2009
[399] *Who cares wins: Improving the outcome for older people admitted to the general hospital: guidelines for the development of liaison mental health services for older people*, Royal College of Psychiatrists, 2005
[400] *10 high impact changes for mental health services. Supplementary guidance for Older People Mental Health Services*, CSIP, 2007

"Objective 8: Improved quality of care for people with dementia in general hospitals. Identifying leadership for dementia in general hospitals, defining the care pathway for dementia there and the commissioning of specialist liaison older people's mental health teams to work in general hospitals." [401]

14.4 Drivers and policy imperatives

The most significant recent policy framework in mental health services is *New Horizons.*[402] This effectively replaces the *National Service Framework (NSF) for Mental Health*.[403] The *NSF for Older People*[404] has also largely run its course and the dates for the milestones have passed. However, the NSFs were key documents that shaped thinking in their time and information about these and other documents is presented here as context for the more recent drivers.

National Service Framework for Mental Health: modern standards and service models[405]

This NSF addressed the mental health needs of working age adults up to 65. It set out national standards, national service models, local action and national underpinning programmes for implementation, and a series of national milestones to assure progress, with performance indicators to support effective performance. However, since it applied only to adults of working age, it had no impact on standards and service models in relation to the mental health of older people, and some would argue that it therefore perpetuated age discrimination in mental health.

It should be noted that in 2005 the National Directors for Older People's Services and for Mental Health supported the start of an initiative to combine forces across mental health and older people's services to ensure that older people with mental illness do not miss out on the improved services that younger adults or those without mental illness had seen.[406]

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[401] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009

[402] *New Horizons – A shared vision for mental health*, Department of Health, 7 December 2009

[403] *National Service Framework for Mental Health,* Department of Health, 1999

[404] *National Service Framework for Older People* Department of Health, 2001

[405] *National Service Framework for Mental Health: modern standards and service models* Department of Health, 1999

[406] *Securing better mental health for older adults,* Department of Health, 2005 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4114989

As the Healthcare Commission noted in 2009,[407] despite the significant achievements of the NSFs for Mental Health and for Older People there has been less emphasis on mental health services for older people than on those for younger adults. The Healthcare Commission also noted that the mental health standard from the *NSF for Older People* has yet to be delivered, yet the framework comes to the end of its 10-year lifespan in 2011.

The Healthcare Commission (HCC) further noted at the time that the *New Horizons* project, led by the Department of Health, was working on the successor to the existing *NSF for Mental Health*, which expires in 2009. The HCC recommended that this project should steer the strategic direction for mental health services towards including adults of all ages and tackling age discrimination in mental health services. Also see *New Horizons* in this chapter.

National Service Framework for Older People (NSFOP)[408]

In addition to Standard One on rooting out age discrimination, Standard Seven of the NSFOP specifically aimed to promote good mental health in older people and to treat and support those older people with dementia and depression.

Standard Seven states:

> *"Older people who have mental health problems have access to integrated mental health services, provided by the NHS and councils to ensure effective diagnosis, treatment and support, for them and for their carers."*

NHS Next Stage Review – High Quality Care for All[409]

Lord Darzi's Review, with its emphasis on personalisation, is as relevant to mental health services as to all other health services. Lord Darzi's proposal to pilot personalised health budgets may be of particular importance for people with long-term mental health conditions.

Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own[410]

The carers' strategy sets out the Government's short-term agenda and long-term vision for the future care and support of carers and it included a commitment to funding several aspects of carer support. It also promised a

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[407] *Equality in Later Life - A national study of older people's mental health services*, Healthcare Commission, 2009

[408] *National Service Framework for Older People,* Department of Health, 2001
[409] *NHS Next Stage Review – High Quality Care for All*, Department of Health, 2008
[410] *Carers at the heart of 21st century families and communities: a caring system on your side, a life of your own*, Department of Health, 2008

more integrated and personalised support service for carers through easily accessible information, targeted training for key professionals to support carers, and pilots to examine how the NHS can better support carers. Given the importance of carers to older people with mental health problems (and the fact that many carers are, themselves, older people), this strategy is of considerable importance.

NHS Constitution[411]

The NHS Constitution was published on 21 January 2009. It was one of a number of recommendations in Lord Darzi's report *High Quality Care for All*. The core purpose and values of the NHS are reinforced by placing a duty on providers and commissioners of NHS services to have regard to the new NHS Constitution. All providers and commissioners of NHS care are under a new legal obligation to have regard to the NHS Constitution in all their decisions and actions. The Constitution brings together a number of rights, pledges and responsibilities for staff and patients. It states:

> *"You have the right not to be unlawfully discriminated against in the provision of NHS services including on grounds of gender, race, religion or belief, sexual orientation, disability (including learning disability or mental illness) or age."*

New Horizons

New Horizons – Towards a shared vision for mental health[412] was a consultation on future directions for mental health, which ended in October 2009 and resulted in a report in December 2009. Key themes emerged during the consultation about improving the mental wellbeing and mental health care of older adults, including the need for:

- action to challenge ageist attitudes in society and to promote positive mental health in older age
- well informed commissioning to ensure that the complexity of needs of older adults is met by all sectors working together
- tailored, specialist approaches and a workforce with specialist skills – one size does not fit all
- action to eliminate discrimination and inequalities in service provision and quality of care for older adults.

The latest report[413] covers a lifetime – from laying down the foundations of good mental health in childhood, through to maintaining resilience into older

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[411] *NHS Constitution*, Department of Health, 2009

[412] *New Horizons – Towards a shared vision for mental health,* Consultation, Department of Health, 23 July 2009

[413] *New Horizons – A shared vision for mental health*, Department of Health, 7 December 2009

age. It also emphasises the importance of prevention through to effective treatment and recovery.

Living Well with Dementia: A National Dementia Strategy[414]

This is a five year plan with three aims:

1. To ensure better knowledge about dementia and remove stigma.
2. To ensure early diagnosis, support and treatment.
3. To develop services to better meet changing needs.

The implementation of the dementia strategy will address some of the issues about age discrimination in relation to dementia care. The Department's goal is for people with dementia and their carers to be helped to live well with dementia, no matter what stage of their illness, or where they are in the health and care system. The strategy is age-inclusive.

Improving dementia services in England - an interim report, 2010

In January 2010, the National Audit Office (NAO) published a report[415] that asserted that despite the Department of Health stating, since 2007, that dementia is now a national priority, it has not been given the levers or urgency normally expected for such a priority and there is a risk that value for money will remain poor unless these weaknesses are addressed urgently.

The report points out that the timing of the National Dementia Strategy prevented the inclusion of dementia in the Department's tier 1 Vital Signs indicators for the NHS, through which it monitors performance, and other levers built into the NHS's devolved management arrangements, such as joined-up commissioning and comprehensive performance information, are not yet fully developed. Changes at a local level are taking place slowly because local leadership on the issue has still to be developed and there is no formal performance monitoring of progress built into the system. The NAO also expresses concerns that the strategy is likely to cost much more than the estimated £1.9 billion over ten years.

14.5 What good age-equal practice might look like

There have been many recent attempts to set out what good practice in older people's mental health services would look like. Since these usually focus on personalised services and an equitable approach, they tend to set out the key components of age-equal practice as part of their vision, even if only implicitly.

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[414] *Living Well with Dementia: A National Dementia Strategy*, Department of Health, 2009

[415] *Improving dementia services in England - an interim report*, NAO, 2010

In 2005, *Everybody's Business*[416] asked what might an older person's mental health service that is fit for purpose look like. It concluded that it would be a service which:

- recognises the dignity of individual service users. It respects and values their diversity as well as acknowledging their major role in the process of planning and developing services.
- is grounded in respect for all those people who engage with these services, not only those using them but also their supporters and carers.
- provides the practical advice and information service users and their carers need as well as developing a consistently high quality, comprehensive package of care and support which minimises bureaucracy.
- makes sure that the best and most effective treatments are widely and consistently available.
- is open to everyone. It responds to people on the basis of need not age and ensures that wherever older people with mental health problems are in the system they are not discriminated against and have their mental health needs met.

Annex A to *New Horizons*[417] sets out the characteristics or descriptors of non-discriminatory services for older people. These are:

Prevention and public health interventions

1. *Older People, i.e. those over 65, have equal access to an appropriate range of health promotion, prevention and early intervention programmes and services, including programmes such as physical activity, healthy eating, smoking cessation etc.*

2. *Local suicide prevention plans will address the needs of people over 65. The refreshed National Suicide Prevention Strategy will underline this.*

Primary care

1. *The mental health needs of people over 65 will be recognised equally within primary care as those of younger people, for example with the same rates of recognition and treatment of depression, including psychological therapies, and, where necessary, referral to secondary*

[416] *Everybody's Business: Integrated Mental Health services for Older Adults: a service development guide*, Department of Health, 2005
[417] *New Horizons – Towards a shared vision for mental health,* Consultation, Department of Health, 23 July 2009

care services. Although 20 per cent to 40 per cent of older people in the community show symptoms of depression only 4 per cent to 8 per cent will consult their GP about this problem. This is particularly true for older men. However, GPs are often seeing these individuals for physical health problems. Even when depression is identified, studies show lower levels of treatment and referral to secondary care services than for younger adults.

2. *The mental health needs of older people in residential care will be recognised and treated to an equal extent as those of younger adults living in the community.*

Mental health services

1. *All older people have the same access in relation to assessed need services as younger adults, that is range, quality, choice and timeliness, to culturally-appropriate mental health services. This includes general and specialist services or approaches, for example community mental health teams, crisis resolution and home treatment services, assertive outreach services, Improving Access to Psychological Therapies (IAPT) and psychological services, inpatient care and intensive care services, alcohol and drug treatment services and intermediate care and continuing services.*

2. *Older people have access to services which meet their needs not only for mental health problems, including dementia, but also for communication problems, physical illness and physical frailty. Services are provided within an appropriate environment, by appropriately-trained staff offering a comprehensive and appropriate range of interventions.*

3. *People of all ages with dementia have equal access to appropriate services.*

4. *Older people are equally involved in the planning of their own individual care, service planning, foundation trust membership etc, for example Putting People First.*

5. *Carers of older people have equal access to assessment, information, advocacy, services and support.*

6. *Older people with learning disabilities have equal access to services (see Valuing People Now).*

7. *Older people in the criminal justice system have equal access to appropriate services.*

8. *Older people have equal access to social support, such as individual budgets, range of accommodation, domestic support etc.*

9. *Mental health services have clear protocols for the transfer of individuals from adult to specialist older people's services. These make it clear that age may be a guide but not an absolute marker for determining which service is most appropriate (see the New Horizons consultation document for common features of these protocols).*

Physical health problems, primary care and general hospital care

1. *Mental health needs of older people with long-term physical conditions are equally identified and treated in primary care and acute medical services.*

2. *Older people with mental health problems have their individual physical health needs identified, assessed and treated as speedily, frequently and effectively as younger adults in primary care and acute medical services.*

Organisations

1. *Provider policies are all impact assessed to ensure that they are non-ageist.*

2. *All statutory, independent and voluntary sector services dealing with older people include in their strategy documents and operational plans the statement that decisions about treatment and care should always be made on the basis of each individual's need, not their age.*

3. *Provider management arrangements should ensure that the needs of older people are represented throughout the structure at board, director, governor and membership level. Research, audit and evaluation grant-giving bodies, academic institutions, commissioners and provider organisations should ensure equal levels of research, evaluation and audit of services for older people as for younger adults.*

Research, audit and evaluation

Grant-giving bodies, academic institutions, commissioners and provider organisations should ensure equal levels of research, evaluation and audit of services for older people as for younger adults.

A Royal College of Psychiatrists position statement sets out an approach based on needs, not age; routine access to specialist older people's services;

equal access to services that are not part of older people's services where that is more appropriate; and personal choice.[418]

Other key features, essential to good age-equal practice, highlighted from New Horizons and from other sources are as follows:

Leadership

Also see Chapter 3 Leadership and motivation.

Good leadership is important in all aspects of healthcare, and particularly in the commissioning and provision of mental health services. In their recent study, the Healthcare Commission found that the trusts that appeared to have a more robust and cohesive development plan for their older people's mental health service, and evidence of progress, were characterised by two aspects. Firstly, they had senior clinical leadership with both internal and external stakeholder involvement and, secondly, they had strong central governance structures.[419]

Similar sentiments had been expressed in 2005. *Everybody's Business* [420] identified the need for strong leadership across health, social services, local authorities and voluntary organisations to co-ordinate and direct improvements in health and care services for older people with mental health problems.

Whole systems working and commissioning

Five factors have been identified as being important to the mental health of older people, whether they are living in the community or in residential care:

- stigma and discrimination
- participation in meaningful activity
- relationships
- physical health, including the ability to carry out everyday tasks
- poverty.

These factors can only be addressed by multi-agency interventions at multiple levels.[421]

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[418] *Age discrimination in mental health services: making equality a reality*. Royal College of Psychiatrists' position statement, PS2/2009 www.rcpsych.ac.uk/PDF/PS2_2009_for%20websitex.pdf

[419] *Equality in Later Life - A national study of older people's mental health services,* Healthcare Commission, 2009

[420] *Everybody's Business: Integrated Mental Health Services for Older Adults: a service development guide,* Department of Health, 2005

[421] *New Horizons – Towards a shared vision for mental health,* Consultation, Department of Health, 23 July 2009

A whole-systems approach to dementia care

The National Dementia Strategy recommends three ways to improve the care of older people with mental health problems in general hospitals, all of which relate to care across the whole system:

- a senior clinician in the general hospital to take the lead for quality improvement in dementia care in the hospital
- the development of an explicit care pathway for the management and care of people with dementia in hospital, led by that senior clinician
- commissioning specialist liaison older people's mental health teams to work in general hospitals.

These principles would apply equally to the other mental health problems commonly experienced by older adults in hospital.

Personalisation and responsiveness

Mental health services for older people need to respond to the needs of the person and not just the age of the person. There is considerable experience from mental health trusts who have developed formal agreements between working age adult and older adult mental health services. These make it clear that age should be used as a guide, not an absolute marker, when decisions are made about which service would be most appropriate.[422]

Personalisation and supporting older people to exercise choice and control can lead to greater independence and an increased sense of wellbeing.

The Royal College of Psychiatrists has set out key principles to define the specialist expertise that is required and the needs that are best met by older people's mental health services. These principles set out the need for a personalised approach, where age does not define needs and wherein an older person could have some choice about where their needs might best be met (i.e. within older people's mental health services, or elsewhere). Similarly, these principles highlight that there may be younger people for whom older people's mental health services would be most appropriate.[423]

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[422] *New Horizons – Towards a shared vision for mental health,* Consultation, Department of Health, 23 July 2009

[423] *Age Discrimination in mental health services: making equality a reality. Royal College of Psychiatrists' position statement and compendium of evidence,* 2009

Good age-equal practice in the treatment and care of people with dementia

Early diagnosis and treatment of dementia

Given that currently only about one third of people with dementia receive a formal diagnosis at any time in their illness, good, age-equal practice in dementia services would ensure that appropriate mechanisms are in place, with a suitably trained workforce, to diagnose dementia and provide prompt support and care at the earliest possible stage for people with dementia and their families and carers.

Configuration of services for people with dementia

Commissioners need to consider carefully how best to configure services for both younger and older people with dementia, paying due heed to whether age-related services are a proportionate means of achieving a legitimate aim. However, there can be no justification for the services that are offered to one age group to be more extensive or more comprehensive than those offered to another age group with comparable levels of need.

Investing in services for people with dementia

The NAO advocated a 'spend to save' approach, with upfront investment in services for early diagnosis and intervention, and improved specialist services, community services and care in general hospitals resulting in long-term cost savings from prevention of transition into care homes and decreased hospital stay length.[424]

Also see section above, *A whole-systems approach*

14.6 Case studies of illustrative / good practice

Increasing Access to Psychological Therapies (IAPT)

The IAPT Pathfinder sites, Buckinghamshire PCT, Stoke PCT, East Riding and Hertfordshire, have demonstrated that older people can and will access psychological treatments provided that appropriate, proactive approaches are used to raise their awareness of the service and engage them with it, and to ensure staff have the correct training.

→ www.iapt.nhs.uk/special-interests/older-people

[424] *Improving services and support for people with dementia,* NAO, 2007

Mental health leaflets for older people in Luton

Local research and evidence funded by Partnerships for Older People Projects found that people with mental health challenges wanted to make more informed choices about their lives and care. The leaflet provides information to residents with dementia, and delivers specific care pathways Luton-wide. This activity links with supporting people to live independently and improving mental health services. Three thousand leaflets were produced, as a one-off project. Areas where leaflets were distributed will be monitored to gauge the level of uptake.

(Source: *Communities for Health: Unlocking the energy within communities to improve health.* Department of Health, 2009)

Depression in Later Life project – Yorkshire & Humber

The Depression in Later Life project was developed through a partnership between YHIP (Yorkshire and Humber Improvement Partnership) and Age Concern (Yorkshire and Humber). The aim of the project was to create a greater awareness and understanding of depression in later life amongst GPs, service providers and older people in the region. The evidence base for the project was developed through an extensive questionnaire exercise, which included all of the above stakeholder groups, and for which a high return rate was achieved. The findings of the questionnaires were used to shape a training and information sharing programme and resulted in the development of a training course for staff working with older people, a referral protocol, and wide dissemination of information materials.

A key finding of the project was that older people from black and minority, ethnic (BME) communities were particularly disadvantaged in accessing support to recognise and deal effectively with depression. The project therefore developed a DVD film for community development workers to use with Urdu- speaking BME elders to encourage discussion of the issue and highlight some simple steps that could be taken to alleviate depression. The research evidence also demonstrated that simple low level preventative services, often provided by local voluntary organisations, provided the most effective ways of supporting older people to deal with depression. The project has documented case studies to demonstrate the value of these preventative services, and how investing in them will provide effective results for older people and directly respond to the recommendations within *New Horizons*.

Further information
Heather Stephenson, Regional Manager - Yorkshire & Humber Age Concern and Help the Aged
heather.stephenson@ace.org.uk

Making connections, not assumptions

This ground-breaking project was set up to address service difficulties in meeting the needs of older south Asian women suffering mental health problems, including dementia. It was formally launched on 12 October 2009.

The project is of particular importance due to the increased suicide rates of south Asian women over 65 and the fact that minority ethnic groups are (largely) unaware of dementia/associated symptoms.

A stakeholder event was held in November 2007, where South Asian women identified that they wanted partnership working, increased awareness about mental health, activities and emotional support.

The project has made connections and challenged assumptions that it would be challenging to engage with older south Asian women. Key relationships have been made with partners across health, social care and the third sector. In particular, in-depth relationships were established with two women's luncheon groups – Kushamdid in Ashton and Oldham Pakistani Centre.

For example:
With Kushamdid an artist was engaged to work with the women to co-produce a culturally appropriate information poster – which was piloted in some GP practices in Oldham/Tameside. The posters were produced in major south Asian languages.

At the Oldham Pakistani Centre, part of the engagement focused on a pilot of an Urdu life story template and the use of culturally-appropriate information in the Oldham life story training.

As a result of the project:

- Closer partnership working has been established with the community mental health development workers in local NHS organisations.
- Better links/communications across care pathways are being established with different partner organisations.
- Mental health awareness training has been carried out around depression and dementia and the women report being more confident about accessing services.
- All key stakeholders have signposting sheets with appropriate information/telephone numbers.
- Access to translated self-help materials (written and audio format) is available on the project's website.
- The women from Kushamdid are now involved in other Trust initiatives.
- A DVD has been produced to extend the learning about the project, especially around engagement issues.
- There are plans for future sustainability.

The project was initially funded by the Care Services Improvement Partnership (CSIP), a collaboration between Pennine Care, NHS Tameside and Glossop, Tameside Metropolitan Borough Council, Oldham Community Health Services, Oldham Partnership, NHS North West and Khushamdid.

Further information
Polly Kaiser
polly.kaiser@nhs.net or polly.kaiser@nmhdu.org.uk
0161 909 8200

→ www.penninecare.nhs.uk/services/making-connections

Mr R – a man with Alzheimer's disease

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 three 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 for three weeks.

The liaison team social worker was able to get access to immediate specialist domiciliary help for Mr and Mrs R and to link with the community mental health team, enabling Mr R to return 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 (despite national guidance) to have a specialist older people's liaison mental health team. 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.

(Source: *The need to tackle age discrimination in mental health. A compendium of evidence.*[425])

Other case studies

Dementia Information Portal (users need to register)

→ www.dementia.dh.gov.uk/userLoginRequired/?pageID=1&referer=%2F&invalidUser=1&restricted

New Horizons

→ www.newhorizons.dh.gov.uk/index.aspx

Department of Health Care Networks

→ www.dhcarenetworks.org.uk/

National Equalities in Mental Health Programme

→ www.mentalhealthequalities.org.uk/

14.7 Suggestions for quick wins / what you can do now

- Commissioners and providers will need to give priority to Recommendation 2 in the recent review of age equality by Sir Ian Carruthers and Jan Ormondroyd, which stated that every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age-appropriate services.[426]
- Ensure teams working on local implementation of *New Horizons* and the National Dementia Strategy are in explicit agreement about how the local approach to implementation both ends age discrimination and promotes age equality.
- Review the Joint Strategic Needs Assessment (JSNA) and ensure that it is clear on a realistic model for future local needs for mental health services for both dementia and functional mental health services.

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[425] *The need to tackle age discrimination in mental health. A compendium of evidence,* prepared by Anderson D, Banerjee S, Barker A, Connelly P, Junaid O, Series H and Seymour J, on behalf of the Faculty of Old Age Psychiatry, Royal College of Psychiatrists, 2009

[426] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, Department of Health, 2009

- Link in with Quality and Productivity challenge work which looks at length of stay in acute hospitals (given the large number of older people with mental health problems who can be discharged earlier) to ensure it helps reduce discrimination and unfavourable treatment of older people. Sources of advice include the Department of Health's work on a cost-benefit analysis of increasing the rate of identification and treatment of depression by GPs. The analysis assumes initially longer GP consultations, treatment costs (both medication and psychological) and additional training for GPs. The costs are potentially considerably outweighed by the health benefits including reduced morbidity from long-term physical conditions (the full economic case will be available on the website www.dh.gov.uk/newhorizons). Primary care organisations will wish to examine how this work can be applied at a local level.
- It has been suggested that some older people would welcome contact with staff who are closer to their own age than is usually the case, as older staff may be better able to understand the issues and experiences of older people.[427] Service managers may wish to review whether this option is open to older people at a local level.

14.8 Useful resources

Dementia Services Guide, NHS London, October 2009

Designed to support commissioners in London to commission dementia services, but has national relevance. See:

→ www.healthcareforlondon.nhs.uk/assets/Mental-health/HealthcareforLondon_Dementia-services-guide.pdf

For up-to-date and detailed information about the mental health needs of black and minority ethnic, older people and the psychiatric services offered to this group, see *Psychiatric Services for Black and Minority Ethnic Older People*.[428]

Age Discrimination in Mental Health Services: Making equality a reality, Royal College of Psychiatrists, October 2009

This report states that access to services must be based on need. It outlines a number of guiding principles and recommendations for action. These include the development of a toolkit that allows self-assessment of services based on need, not age.

→ www.rcpsych.ac.uk/PDF/PS2_2009_for%20websitex.pdf

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[427] *All things being equal – Age equality in mental health care for older people in England,* Mental Health Foundation, 2009

[428] Royal College of Psychiatrists, CR 156, 2009

NICE guidance on various mental health conditions

For example:

Depression in Adults (updated 2009)

→ http://guidance.nice.org.uk/CG90

Depression with a chronic physical health problem, CG91, 2009

→ http://guidance.nice.org.uk/CG91

Forthcoming NICE guidance on delirium is due in June 2010.