

Ageism and age discrimination in mental health care in the United Kingdom

A review from the literature

commissioned by the
Department of Health

carried out by the
Centre for Policy on Ageing

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Principal author: Nat Lievesley

Review team: Ruth Hayes
Kate Jones
Angela Clark

Director: Gillian Crosby

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Contents

1	Context and Scope	5
	1.1 Context	5
	1.2 About the review	6
	1.3 Evidence of age discrimination	6
2	Introduction	8
3	Ageism and types of age discrimination	12
4	A decade of reports reviews and policy documents	14
5	Stigma stereotypes and ageist attitudes	17
6	Mental health services for older people in the United Kingdom	20
	6.1 Age based organisation of services	20
	6.2 Specialist mental health services for older people	24
	6.3 Under-provision of mental health services for older people	29
	6.4 Variation in the provision of mental health services for older people	29
	6.5 Community mental health teams	39
	6.6 Psychological therapies	39
	6.7 GPs and primary care	41
	6.8 General hospital care	44
	6.9 Residential and nursing home care	46
	6.10 Under-use of mental health services by older people	49

7	Age discrimination in the treatment of particular conditions	51
	7.1 Common mental disorders, neurotic disorders, anxiety and depression	51
	7.2 Dementia	56
	7.3 Less common conditions	60
	7.4 Comorbidity	62
8	Prevention and public health interventions	64
9	NICE guidelines and the use of the QALY	65
10	Education and training	68
11	Conclusion	69
12	Recommendations for further study	70
	References	72
	Appendix 1 – Methods	
	Appendix 2 - Bibliography	

This review is one of four reviews of ageism and age discrimination in health and social care available from <http://www.cpa.org.uk/reviews>

1. Context and introduction

1.1. Context

- 1.1.1. The Department of Health has commissioned this review of ageism and age discrimination in the provision of mental health services for older people in the context of the European Commission Draft Directive (July 2008) – COM (2008) 426 and the passage through the United Kingdom parliament during 2009-10 of the Equality Bill and related secondary legislation that will outlaw age discrimination in the provision of goods and services, including health and social care.
- 1.1.2. In its ageing strategy *Building a Society for All Ages* (July 2009) the government has said ‘We have introduced the Equality Bill, which will ban unjustifiable age discrimination from April 2012. We are currently consulting on the detail, especially in difficult areas such as financial services and health and care. The Equality Bill includes the new public sector Equality Duty. This places a requirement on all public bodies from 2010 to have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, advance equality of opportunities and encourage good relations between different groups of people, including people of different ages. This duty makes it a legal requirement to consider the needs of people of all ages when planning and delivering services.’ (Department for Work and Pensions, 2009, Policy document)

‘The Equality Bill is an important step towards changing the culture around ageing and addressing stereotyping of older people, but legislation alone is not enough. Real cultural change to help us all benefit from the advantages of living longer needs action from all sections of society to start to change attitudes and behaviours.’ (Department for Work and Pensions, 2009, Policy document)
- 1.1.3. This review should be seen alongside other government initiatives to reduce inequalities in mental health care provision for older people in the England including the continuing implementation of the National Service Framework for Older People (2001), the National Dementia Strategy (2009) and the New Horizons consultation (2009). This review from the literature will also inform the 2009 review of how the NHS and local authorities in England can ‘tackle’ age discrimination, being carried out by Sir Ian Carruthers and Jan Ormondroyd, reporting in October 2009 (Carruthers and Ormondroyd, 2009, Review).

1.2. *About the review*

- 1.2.1. This review from the literature will look at possible evidence of age discrimination in the provision of mental health care services for older people in the United Kingdom. Companion reviews from the Centre for Policy on Ageing, published contemporaneously, will look at ageism and age discrimination in primary and community health care, secondary health care and social care services.
- 1.2.2. This review is a rapid semi-systematic literature based review. It is not a formal 'systematic review' although it is systematic in its approach. A full methodology and related bibliography can be found in the appendices to this report. The review was carried out between August and October 2009.
- 1.2.3. A literature based review can only reflect ageism and age discrimination that has been documented in the period covered by the review and that has been located by the reviewers. No review can be totally exhaustive so evidence identified in this review may be indicative of a more widely evidenced problem. We have tried to keep the information and evidence presented in this report as up-to-date as possible but it should be recognised that, in research studies, there is often a time lag between the collection of data and the publication of results.
- 1.2.4. Ageism and age discrimination in the provision of mental health services for older people is very likely to reflect ageism and age discrimination in society at large. It is, however, beyond the scope of this report to look at issues of ageism and age discrimination in society as a whole.

1.3. *Evidence of age discrimination*

1.3.1. *Quantitative data*

A 2009 national study of older people's mental health services, carried out by the Healthcare Commission, confirmed what we have found in carrying out this review, that there is 'limited availability of good quality national data in relation to the quality of specialist older people's mental health services'. 'Nationally available data does 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 trust with sufficient information to be confident about the extent to which they are providing good quality non-discriminatory care'.

(Healthcare Commission, 2009, Review)

There is little data on differences in experiences and treatment of mental health patients by age. The Picker institute has carried out a national survey of users of community mental

health services, annually in recent years to 2008. Although service users aged 16 years and above were included in the survey, only those aged 16 to 65 years are included in the report and the information was not broken down by age. Data from the surveys lodged with the UK Data Archive does not include an Age or Age group variable so secondary analysis of this data by age is not possible.

National data is not readily available on the breakdown of cases within older people's mental health services or, since 1998, for mental health treatment within general practice.

1.3.2. *Anecdotes and case studies*

The bulk of the evidence of age discrimination in mental health services for older people comes from the experiences of professionals administering mental health services for older people, case studies and individual stories from older people themselves. For mental health services for older people these anecdotes form not just a trickle but a flood that is augmented by evidence of continued explicit direct age discrimination written into local policies. It has been said 'how many anecdotes does it take to constitute evidence?' but it is generally agreed that there is a substantial body of evidence to support the assertion of age discrimination in mental health services for older people.

1.3.3. *Classification of evidence*

To make it easier to assess the nature and weight of the evidence presented in this report we have, split the sources of the evidence into a small number of simple categories.

Large survey	Sample survey of 800+ from a large population
Survey	Sample survey of 120-800 from a large population or 50%+ from a small population. We will use the generic term <i>survey</i> to include retrospective case audits.
Small survey	Sample survey of less than 120 from a large population or less than 50% of a small population
Group study	Focus group, panel or equivalent study
Study	Individual research project, observational study or analysis not carried out as a group study or survey
Opinion	Opinion of a respected authority, editorial etc.
Systematic review	Systematic review, with or without meta analysis
Review	Literature and other reviews not structured as a 'systematic review'
Policy document	Government or professional overview
Campaign document	Document to promote a particular point of view
Guide	Guide, Information pack or toolkit

Category labels have been added to the reference citations in the body of the text to provide an at-a-glance first indication of the weight of the evidence.

2. Introduction

2.1. Mental health services form a substantial part of National Health Service (NHS) provision. In 2007-8, Primary Care Trusts (PCTs) within the NHS in England spent over £10¼ billion on mental health service provision, over 11% of their total budget. (Department of Health, programme budgeting data, 2007-8)

2.2. There is a general agreement that mental health services should be provided on the basis of need rather than age but there are many locations in which this has not been achieved in practice.

The National Service Framework for Older People (Department of Health, 2001) affirmed that 'NHS services will be provided, regardless of age, on the basis of clinical need alone.

Social care services will not use age in their eligibility criteria or policies, to restrict access to available services.' Standard seven of the NSF (Older people) affirmed '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.' (Department of Health, 2001, Policy document)

The 2005 Department of Health good practice guide *Everybody's Business: Integrated mental health services for older adults* confirmed the principles of the NSF(Older People) that:

- mental health and care services should be available on the basis of need, not age
- older people's health and care services should address mental as well as

(Department of Health, 2005, Policy document)

'The main criticisms of the NSFOP are the lack of any ring-fenced funding for service development and the absence of performance indicators requiring Primary Care Trusts (PCTs) to make further investment in old age psychiatric services. This has meant that, while well intentioned, it has achieved very little for older people's mental health'

(Banerjee and Chan, 2008)

'Since the National Service Framework for Older People, there has been little move from

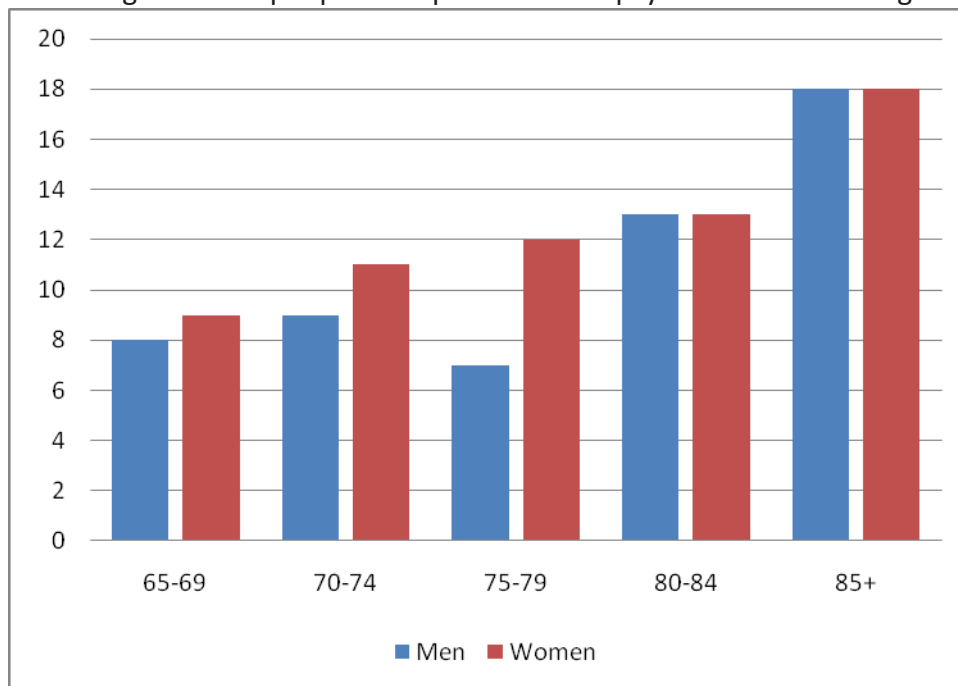
rhetoric to responsibility or from ideas to implementation in older people's mental health services' (Hilton, 2009, Opinion)

'Access to services must be based on need not age. ...A needs based service will still require the development of comprehensive specialist-based mental health services for older people.' (Royal College of Psychiatrists, 2009, Campaign document)

2.3. Older people, (aged 65+) form a substantial proportion of people with mental health conditions in the United Kingdom and a substantial proportion of older people have mental health problems. Thirty percent of mental health inpatients are aged 65+ (Healthcare Commission, 2008, Large survey) and 18% of people aged 85+ have poor psychosocial wellbeing.

(ONS - Health Survey for England, 2005, Large survey)

Percentage of older people with poor levels of psychosocial wellbeing

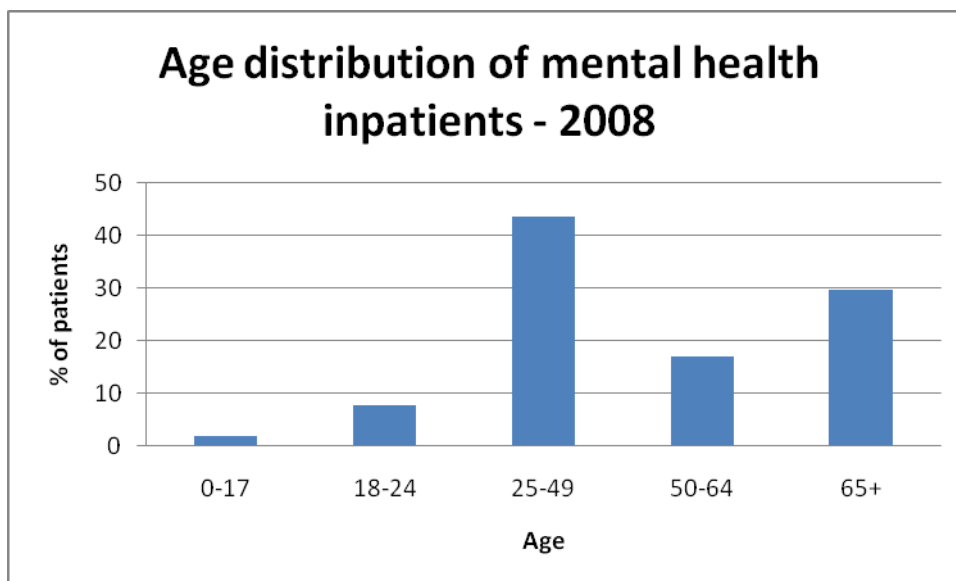


n=1,695 (men) n=2,045 (women)

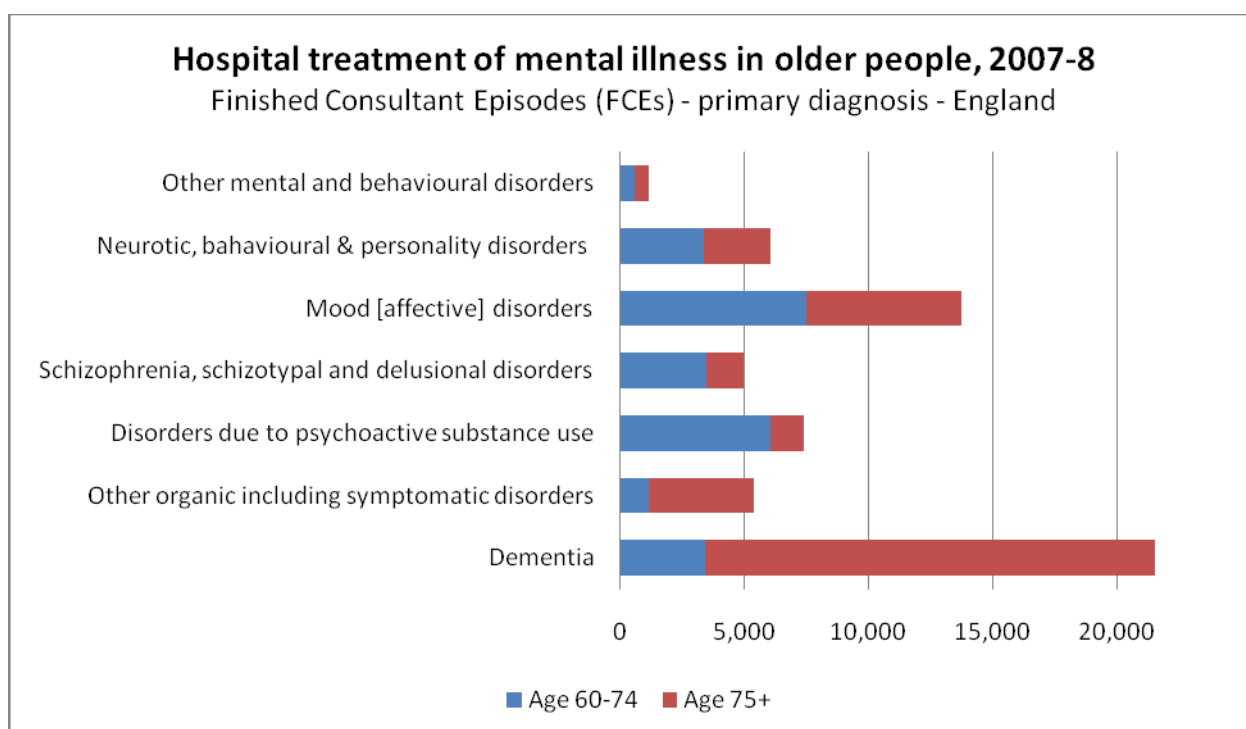
ONS - Health Survey for England, 2005

Note: The GHQ12 questionnaire measures psychosocial wellbeing and is based on twelve items measuring general levels of happiness; depression and anxiety; sleep disturbance; and ability to cope over the last few weeks. A score of four or more is referred to as a high GHQ12 score, indicating probable psychological disturbance or mental ill health.

Women were more likely to have a high GHQ12 score than men (12% and 9% respectively) and high GHQ12 scores were also associated with age. Women aged 85 and over were more likely to score highly on the GHQ12 than women aged 65-69 (18% and 9% respectively). A similar pattern was observed for men (18% and 8% respectively). (ONS - Health Survey for England, 2005)



Source: Healthcare Commission - Count Me In Census - 2008



The NHS Information Centre, Hospital Episode Statistics for England. 2007-08.

2.4. Patterns of mental disorder vary substantially with age. The prevalence of schizophrenia and other psychotic disorders declines substantially in older age (see section 7.3) but the prevalence of anxiety, depression and other neurotic disorders remains high (see section 7.1). Although not exclusively so, dementia is essentially a condition of older age (see section 7.2).

Community based estimates of the prevalence of mental disorders among older people exclude people in hospitals and care homes and therefore tend to under-estimate the overall level of morbidity.

A breakdown of mental health cases being treated by older people's mental health services and by GPs in primary care is difficult to obtain but a breakdown of hospital treated cases is readily available.

Dementia is the largest single primary diagnosis forming just over one third (35%) of all hospital mental health patients aged 60+ and one half (51%) of mental health patients aged 75 and over.

2.5. In its *New Horizons* consultation document (July 2009) the Department of Health recognises the issues of discrimination and inequity faced by older people with mental health problems but affirms that mental ill health is not inevitable in old age and recognises the benefit to older people and society of improving the mental health of older people.

'There is evidence that older people can experience discrimination and inequity in access to and availability of mental health services, and can experience poorer quality of care than working age adults. Older people also typically present with more complex needs.

They are more likely to have:

- multiple care needs for a range of co-existing problems
- physical and mental health and social care needs
- different patterns of social care and family support
- specific problems such as dementia. '

'Poor mental well-being is not an inevitable feature of older age. Neither depression nor dementia, or any other mental health problem, is a natural or normal part of ageing – as with younger adults, there are effective treatments and preventive interventions. Improvements to the physical environment, opportunities for social involvement and activity, good peer and neighbourhood relationships, and a sense of being valued and making a meaningful contribution to society all have a role in maintaining good mental health in old age.'

'Better mental health for older people has enormous benefits not only for individuals but for the whole of society as well, with the potential to reduce the demand on health and social care services. Many of the problems experienced by older people are to do with social attitudes and values; social exclusion can be a cause of as well as result of mental health problems in older age.'

(Department of Health, 2009, Policy document)

- 2.6. Mental health problems have been shown to be associated with levels of deprivation including poverty, unemployment, housing problems, debt and levels of social and financial exclusion. (Payne, 1999, Large survey) Many older people suffer similar forms of deprivation and it may be that deprivation is a contributory factor in the poor mental health of older people, particularly in cases of depression.
- 2.7. Improved mental health has been shown to be associated with ongoing participation in learning activities. Older age depression, in particular, may be reduced by participation in mentally stimulating activity. (Feinstein et al, 2008, Review)

Summary

Mental health services for older people are an important and substantial part of health service provision. Although there is general agreement that older people's mental health services should be provided on the basis of need rather than age this is often not happening. Older people have different mental healthcare needs from younger adults with a decline in psychoses and a predominance of dementia. Depression and neurotic disorders continue and may increase in old age. Mental illness may be associated with deprivation in older age.

3. **Ageism and types of age discrimination**

- 3.1. The terms *ageism* and *age discrimination* are often used interchangeably. Although they are different in nature, the difference is not always observed. *Ageism*, a term first used by Robert Butler in 1969, is an attitude of mind which may lead to age discrimination. *Age discrimination*, on the other hand, is a set of actions with outcomes that may be observed. 'Ageism is inherent in the human condition and transcends national boundaries...' (Butler, 2009, Opinion)
- 3.2. '...ageism is used to describe stereotypes and prejudices held about older people on the grounds of their age. Age discrimination is used to describe behaviour where older people are treated unequally (directly or indirectly) on grounds of their age.' (Ray, Sharp and Abrams, 2006) Ageism is broader than age discrimination. It refers to deeply rooted negative beliefs about older people and the ageing process, which may then give rise to age

discrimination. (McGlone and Fitzgerald, 2005)

- 3.3. Some people distinguish ageism from age-differentiated behaviour. They consider ageism to be based on stereotypes and prejudice whereas age-differentiated behaviour is based on a well-developed understanding of age differences.

‘Ageist behaviour grows out of stereotypes, prejudices and stigmatization. Age-differentiated behaviours are, however, an appropriate function of the age of the target person, based on an understanding of development and thoughtful recognition of age differences’ (Hagestad and Uhlenberg, 2005)

- 3.4. *Age discrimination* is an unjustifiable difference in treatment based solely on age. Age discrimination may be *direct* or *indirect* in form.

Direct age discrimination occurs when a direct difference in treatment based on age cannot be justified. An older person with bi-polar disorder who is excluded from a day centre at age 65 because ‘it’s not for pensioners’, would be an example of direct age discrimination.

Indirect discrimination occurs when a seemingly neutral provision, measure or practice has harmful repercussions on a person. (Belgium - Discrimination Act of February 25, 2003; Ireland - Equal Status Act 2000-2004) For example, poor quality dementia services, equally applied to the whole community will indirectly discriminate against older people who are the predominant users of these services.

Direct age discrimination will occur if people with comparable needs are treated differently, purely on the basis of their age. Indirect age discrimination will occur if people from different age groups, with different needs, are treated in the same way, with the result that the needs of the older person are not fully met.

- 3.5. The 2002 National Service Framework (Older People) interim report on age discrimination, looking at written policies within the NHS with age-related criteria identified in audits by service area, identified Mental health (service organisation), Liaison psychiatry, Rehabilitation, Clinical psychology and Alcohol dependency services as areas of continuing direct and explicit age discrimination.

‘...further work is needed to ensure that the services for older people were at least as good as those for working-age adults (this is seen as a particular problem in terms of mental health services)’ (Department of Health, 2002, Policy document)

Summary

Ageism is an unjustified and prejudicial attitude of mind towards older people that leads to *age discrimination*, observable discriminatory actions. *Direct* age discrimination treats people with similar needs differently purely on the basis of age, *Indirect* age discrimination treats people of different ages with different needs the same so that the person with greater needs is disadvantaged. *Institutional* age discrimination is written into policy and practice. *Overt* age discrimination is open and visible whereas *covert* age discrimination is hidden. Mental health services in the NHS provide one of the few remaining examples, in many localities, of overt, institutional direct age discrimination.

4. **A decade of reports, reviews and policy documents**

The ten years from 1999 to 2009 has seen a greatly increased focus on older people's issues, including the publication of the first strategy on ageing, *Opportunity Age* (Department for Work and Pensions, 2005, Policy document). This has been reflected in the publication of a large number of reports and policy documents looking at mental health and mental health services for older people in the United Kingdom.

- 4.1. The *National Service Framework for Mental Health*, published in 1999 excluded mental health services for older people which were, instead, included in the *National Service Framework for Older People* published in 2001. An audit of age discriminatory policies in the NHS, following publication of the NSF (older people) has been effective in reducing direct age discrimination in healthcare, except in the case of older people's mental health services which often remain separately organised and under-resourced. (Commission for Healthcare, Audit and Inspection, 2006)
- 4.2. The Audit Commission's reports, '*Forget me not*' (2000) and '*Forget me not 2002*' provided a comprehensive analysis and follow-up audit of mental health services for older people in England and Wales.
- 4.3. The Department of Health 2004 document '*Securing better mental health for older adults*' recognised that 'age discrimination in mental health services needs further attention, so that

services developed for working [age] adults are available to older adults on the basis of need, not age...'

- 4.4. The Care Services Improvement Partnership's 2005 service development guide '*Everybody's Business*' aimed to set out, in practical and applicable terms, all the key components of a modern older people's mental health (OPMH) service based on dignity and respect.
- 4.5. In 2004 *The National Service framework for mental Health – Five Years On* was published reviewing progress on the NSF (mental health) and, in 2006, *Living Well in Later life*, a Commission for Social Care Inspection, Audit Commission and Healthcare Commission review of progress against the 2001 NSF (older people) which found that '...the exception to [the] decline in explicit discrimination is mental health services where the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups.'
- 4.6. Key reports have also been published for mental health services for older people in Scotland, Wales and Northern Ireland including *Raising the Standard – the Revised Adult Mental Health National Service Framework in Wales* (2005), *Living Fuller Lives* (2007), part of the Bamford review of mental health and learning disability in Northern Ireland, and *Towards a mentally flourishing Scotland* (2009) – policy and action plan 2009-11.
- 4.7. *The UK Inquiry into Mental Health and Well-being in Later Life* produced two major reports, in 2006 and 2007 highlighting issues of stigma and age discrimination and making recommendations for service improvement and prevention.
- 4.8. During the decade the Royal College of Psychiatrists, in collaboration with others, has produced a number of key reports including CR110 (2002) and CR153 (2009) - looking at service transition for people growing older with enduring or relapsing mental illness, *Who Cares Wins* (2005) - providing guidelines for the development of liaison mental health services for older people in hospital and *Raising the Standard* (2006) - identifying age discrimination and making recommendations for the specialist mental health care of older adults.

- 4.9. For dementia, the 2007 report *Dementia UK*, produced by the London School of Economics, Kings College and the Alzheimer's Society, provided a definitive overview of the prevalence of, and service provision for, dementia in the United Kingdom. This report and the 2007 National Audit Office's key report *Improving services and support for people with dementia* were followed in 2009 by *Living well with dementia – the National Dementia Strategy*, coupled with the Department of Health's joint commissioning framework for dementia provision by local health and care organisations.
- 4.10. *Age Discrimination in Mental Health Services*, published in 2008 by the Personal Social Services Research Unit, provided a review and mathematical models of inequalities between adult and older people's mental health services together with cost estimates for upwards equalisation.
- 4.11. *Equality in Later Life*, a key 2009 report from the Healthcare Commission, looked in detail at older people's mental health services in 6 trusts, monitoring for age discrimination and quality of care.
- 4.12. In 2009 the Mental Health Foundation produced a summary report *All things being equal* highlighting the key issues, including ageism and age discrimination, around age equality in mental health care for older people in England.
- 4.13. Also in 2009, the Government Equalities Office produced a consultation document *Equality Bill: Making it work*. This general consultation included a specific reference to evidence of discrimination in older people's mental health services.
- 4.14. The year 2009 also saw the publication of *New Horizons*, the Department of Health's consultation on mental health services, ten years on from the mental health NSF. This document included mental health care for older adults and emphasised equality of treatment and the need for high-quality, non-discriminatory mental well-being and mental health care services for older people.
- 4.15. *Building a society for all ages*, the cross-government ageing strategy also published in 2009, highlighted the *National Dementia Strategy*, *Everybody's Business* and *New*

Horizons as levers for improving the mental health of older people and mental health services for older people and their carers.

Summary

The ten years from 1999 to 2009 has seen an increased focus on older people's issues. Concern at the state of mental health services for older people in the United Kingdom has been reflected in the publication of a large number of key reports relating to older people's mental health services, identifying the need to address age discrimination and to bring about significant improvements in service provision. Over the decade these reports have reflected a shift in emphasis from viewing older people in society as dependent, passive recipients of services to being more active participants in shaping services around individual needs.

5. Stigma, stereotypes and ageist attitudes

- 5.1. 'The issue of stigma ...is far worse for older people than for any other group with mental ill health. ...ageist attitudes can still have negative attitudes on the kind of thinking in terms of planning and recognising needs...that's a reason why it's been such a neglected area ... even GPs can express attitudes such as "well it's just because you're old, of course you're depressed" towards clients experiencing depression in old age' (Glassman, 2004, Opinion)
- 5.2. 'Older people with mental health problems can be among the most socially excluded in society. The stigma of old age is amplified by the stigma of having a mental health problem, and may be further compounded by physical health problems and disabilities.'
(Department of Health, 2009, Policy document)
- 5.3. 'There is a powerfully negative set of associations with mental illness and dementias both for and by older people. These associations – or stigma - have a profound impact on older people's mental and emotional health and wellbeing; and their families and close personal networks. We believe this not only affects people at an individual level, but also influences how we view mental health in later life as a society, as a community of interest in this area, and as professionals and others involved in the care and support provided to older people and their families.'

These included

- fear - for instance of 'losing your mind' or not being in control or being a burden or being unwell - which breeds anxiety, which possibly leads to people not accessing or asking for help
- ignorance and/or misunderstanding, coupled with a lack of good information and openness in talking about mental health issues for and with older people
- guilt and shame – for example, in being emotionally or mentally vulnerable or unwell; or stressed and emotionally worn out as a result of caring for someone with little or no help over a long period of time.

(Bowers et al, 2006, Group study)

- 5.4. A 2002 study based in the USA reviewed earlier studies in which therapists, psychiatrists and clinical psychologists had been offered 'vignettes', case studies which were identical except that the age of the patient was changed. Younger patients received a more favourable prognosis. The researchers concluded that 'the most probable explanation for younger patients receiving a more favourable prognosis was that the attitude towards the prognosis was reflective of prejudicial attitudes (ageism) towards the older patients.' with 'the older "client" eliciting significantly more negative impressions from the psychologists, as well as receiving more "psychotic" diagnoses than a comparable middle-aged "client".'
- The review suggested that professionals may be 'children of their own culture', reacting with a fear of ageing that coincides with the general populace and concluded that 'innovations in delivery of psychological services, such as collaborative medical/psychological care in primary care settings, may ultimately prove more useful in improving access to mental health services than efforts to combat ageism' (Robb, Chen and Haley, 2002, Review)
- 5.5. A United Kingdom survey of 371 trainee clinical psychologists found that 45% felt that clinical psychology has less to offer older people. The responses contained evidence of both ageism and the fear of ageing and death. The predominant recommendation for improvement of recruitment to the speciality was 'good quality placements and teaching during training'. (Lee, Volans and Gregory, 2003, Survey)
- 5.6. In addition to stigma and ageism, older people with mental health problems run the risk of abuse. A 2007-8 survey of family carers of older people with dementia in London and Essex

found some abusive behaviour occurring in half (52%) of cases with 'important' abuse occurring in one third (34%) of cases. (Cooper, 2009, Survey)

5.7. A growing body of research has shown that people with Alzheimer's disease are affected not only by brain neuropathology but also by their reactions to its effects, by the environments in which they live, and by how they are treated by others. Numerous studies indicate that negative self-stereotypes at conscious and unconscious levels can have adverse effects on the performance of healthy older people on tasks demanding explicit memory (recall in particular) and the mere threat of being stereotyped negatively can have adverse effects on the performance of healthy older people on tasks including those involving memory. There is evidence to suggest that these influences may have significant effects on people with Alzheimer's disease. (Scholl and Sabat, 2008, Review)

5.8. The second (2007) report from the UK Inquiry into mental health and well-being in later life provided quotations from a number of professionals and older people with mental health problems highlighting ageist attitudes and stigma.

'I was told by a doctor, "What can you expect anyone to do? Dementia is not a treatable disease."'

'I had a client who was 84 and had made three suicide attempts. When I spoke to her psychiatrist he said, "Well, she's old, what do you expect?" And he was a mental health professional! If she had been 48 she would have received immediate help!'

'I feel I am treated differently because of my age. It feels like I'm invisible now and I think sometimes I don't get offered services because I'm old.'

'Mum drinks a lot. I think it's abuse. It's interesting when I tell people as they say things like, "If that helps her then let her". I wonder if it would be the same reaction to someone younger?'

'Mental illness is still stigmatised whether you are young or old but older people have a double whammy!'

'The thing is if you've got a broken arm you've got people wanting to help – "Let me cook you a meal". But if you've got a broken heart and a broken head they just don't want to know.'

'There is something secret about dementia, people don't want to know and I find it embarrassing to tell them, so I don't.'

'[When] they know you have Alzheimer's, they just kind of ignore you. You can go to a family affair and everybody is kind of gabbing, gabbing. But they leave you alone because they figure you don't know what is going on... They are frightened, they think you have lost your

mind... You are just there and that's it.'

(Crown, 2007, Review)

Summary

Older people with mental health problems suffer not only from ageist attitudes experienced as older people but also from the stigma associated with mental health problems. Self-stigmatisation can also affect the ability to cope with mental illness and ageism by others can lead to social isolation and abuse.

6. Mental health services for older people in the United Kingdom

6.1. Age based organisation of services

6.1.1. Explicit (direct) age discrimination in the National Health Service has been on the decline since the introduction of the National Service Framework for Older People in 2001. Mental health services for older people have been identified as one of the few areas where direct age discrimination continues.

'The exception to this decline in explicit discrimination is mental health services where the organisational division between mental health services for adults of working age and older people has resulted in the development of an unfair system, as the range of services available differs for each of these groups. For example out-of-hours services for psychiatric advice and crisis management for older people are not as developed as those for adults of working age. Older people who have made the transition between these services when they reached 65 have said that there were noticeable differences in the quality and range of services available.' (Healthcare Commission et al,2006, Review]

6.1.2. There is widespread variation in the way in which mental health services for older people are organised throughout the United Kingdom. In most areas, mental health services for older people are organised and funded separately from mental health services for working age adults. In some areas older people's mental health services may be organised as a speciality within adult mental health services while in a minority of areas, adult and older people's services may be totally integrated.

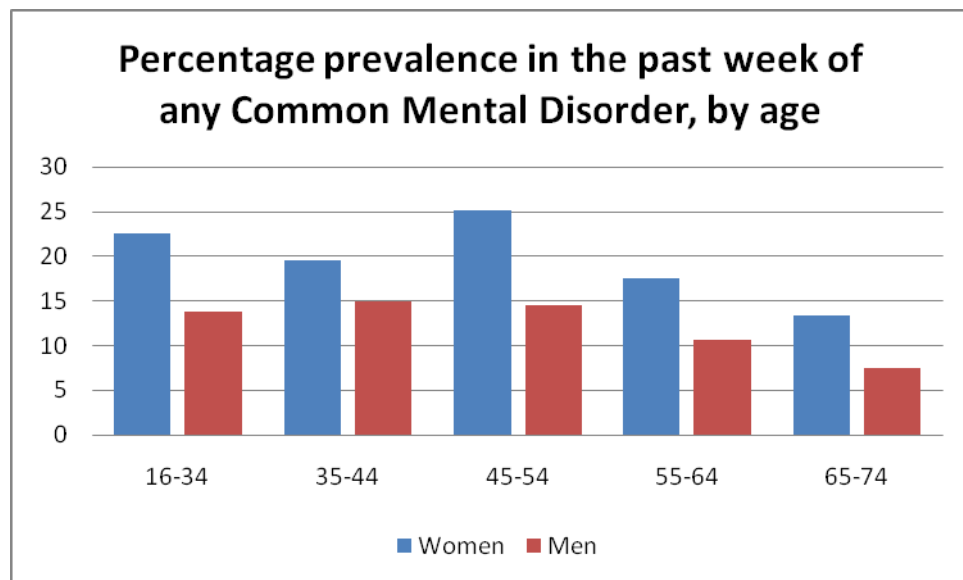
6.1.3. 'The definition of "adult" varies across the United Kingdom. In England, Wales and Northern Ireland it refers to "working age adults" meaning those aged 18 to 65. This definition excludes people aged 65 and over, who are considered "older people" rather than adults.

This has led to age discrimination becoming entrenched in mental health services, with numerous inspectorate reports noting the persistence of this problem. In Scotland however, “adult” refers to all adults aged 18 and over.’ (Crown, 2007, Review)

- 6.1.4. For areas where adult and older people’s mental health services are organised as separate services, ‘transition protocols’ should be in place for ‘graduates’, older people with mental health problems who are making the transition from being cared for by adults service to being cared for by older people’s services, but this is not always the case.
- 6.1.5. A 2007 study of 40 mental health care providers to examine the existence or otherwise of protocols for transition between general and old age psychiatry services in England and Wales found that 66% said they had a protocol in place for this transition. The study reported that ‘With the recent focus on person-centred care, psychiatric services have begun to investigate the advantages and disadvantages of specialist services and the movement of patients between them. Services for older people are sometimes stigmatised as “ageist”, perhaps because are less well resourced, or because neither patients nor professionals choose to be identified with older people’. (Bawn et al, 2007, Survey)
- 6.1.6. A Royal College of Psychiatrists council report CR110 (2002) recommended that for people with an enduring or relapsing mental illness, under the care of working-age adult mental health services, person’s 65th birthday should act as a trigger for reassessing their needs rather than triggering automatic transfer to older adult mental health services.
(Royal College of Psychiatrists, 2002, Policy document)
- 6.1.7. The Bawn (2007) survey found that ‘...as clients’ needs do not necessarily change at 65 years, the 65 year cut-off may serve to reinforce age discrimination; indeed it was recognised as a mechanism for transferring clients inappropriately. Ageism and age discrimination were frequently referred to by participants, one individual observing: *“One of the key challenges is [the attitude of some] professionals who still believe that upon reaching that age of 65 you should move into older people’s services”*. ‘
The survey concluded that ‘the impact of [the Royal College of Psychiatrists council report] CR110 on mental health professionals was limited’ (Bawn et al, 2007, Survey) and the advice has recently been updated in council report CR153. (Royal College of Psychiatrists, 2009, Policy document)
- 6.1.8. One respondent, representative of the whole sample, said:
‘Adult mental health teams have better access to occupational therapy, occupational therapy assistants, day centres in the community, psychotherapy services... So when patients are

transferred over to us they will sometimes get a reduced level of care. For example... a patient with chronic schizophrenia... transferring to use from the adult services... was getting an OT assistant visiting once or twice a week, a CPN visiting weekly and a consultant visiting every two weeks. Once transferred the consultant and CPN would visit every month if you are lucky.' (Bawn et al, 2007, Survey)

6.1.9. Further evidence of the arbitrariness of a break in service provision at age 65 is provided by the adult psychiatric morbidity survey in England, 2007. The survey aimed to collect data for adults up to age 74 and does not usually report results for respondents aged 75 and over. Despite this omission, it can be seen that, although there is a decline in the prevalence of common mental disorders for adults aged 65+ there is still a substantial body of older adults (7.5% of men and 13.4% of women) experiencing one or other of these common conditions in the past week.



n= 3,335 (men) n=3,412 (women) (Adult psychiatric morbidity in England, 2007)

This community based survey is thought to under-estimate the prevalence of depression in older people (see section 7.1).

6.1.10. Writing about Northern Ireland, the Bamford review of mental health services found that older people with mental health problems have not historically been clearly identified as a service user group by commissioners (Finch, 2004). Commissioning arrangements have consequently tended to be unco-ordinated and fragmented, leading to poor outcomes for older people with mental health issues. A number of inspections by the Social Services Inspectorate between 2002–2003 found that there was also a frequent lack of clear

transitional arrangements and of organisational coherence between mental health and older people's services. (Bamford, 2007, Review)

- 6.1.11. The Bamford review (Northern Ireland)'s recommendation for the organisation of mental health services for older people was 'While services for older people with mental health issues may be located within either a mental health or older persons' programme of care, they should be provided as a discrete sub-speciality, with a ring-fenced budget and clear protocols for accessing other programmes of care.' (Bamford, 2007, Review)
- 6.1.12. The Government Equalities Office provide further evidence of the inappropriate transfer of patients between mental health services based solely on age. '...there is also evidence from individual testimony and more systematic research, of age being used in an inappropriate, discriminatory manner in some health and social care services. For example, a recent report by the Healthcare Commission highlighted variations in older people's mental health services, with some mental health trusts proactively addressing age discrimination while others performed less well – in some trusts, older people were denied access to the full range of mental health services that are available to younger adults, and those services which were open to older people were not always sensitive to their age-related need.' (Government Equalities Office, 2009, Policy document)
- 6.1.13. Patients may be transferred between services to offload difficult cases. *'Public expectation, a real rise in the prevalence of some non-psychotic disorders, changing referral patterns and technological advances mean that we are busier than ever before. Politically driven initiatives which lack clinical merit and a thriving blame culture have led to cynicism, exhaustion and defensive clinical practice in all of us at some time, and some of us almost all the time. When burdened, the natural desire is to shed some of the load. There can be a sense of relief when a patient crosses the threshold criterion for transfer to another service. We must, however, try to see matters through the eyes of the patient and their carers and keep them at the centre of all we do. Sixty-five is a good time to step back, reconsider and decide what will best meet their needs for the future.'* Consultant psychiatrist quoted in Jolley, Kosky and Holloway, 2004.
- 6.1.14. The second (2007) report from the UK Inquiry into mental health and well-being in later life provided quotations from a number of older people with mental health problems who had found their services withdrawn when they reached 65.
'[What makes things worse is] being kicked out of my drop-in centre because of my age. Mental illness does not go away at 65!'

'The thing was I went to this service for several years, on and off, and then to my horror I discovered that at 65, they no longer take people because "it's not for pensioners".'

'Going to a group and mixing with others who had similar problems as me was good. And having someone to talk to – I liked my support worker. But I can't get that now because of my age... I feel alone and isolated. I feel as if there's no reason to get up. I feel terrible... I feel suicidal. I was going to harm myself recently.'

(Crown, 2007, Review)

Summary

There is widespread variation in the way in which mental health services for older people are organised but, in most areas there are separate adult and older people's services with, in many areas, transfer between the services at age 65. One third of providers do not have transition protocols in place and levels of provision are less good in older people's mental health services for 'graduates' who transfer between services with a continuing mental health problem.

6.2. *Specialised mental health services for older people*

6.2.1. One question facing mental health policy makers and commissioners in the National Health Service is whether the needs of older people with mental health problems are so different from those of adults of working age that older people benefit from organising older people's mental health services as a separately funded speciality or whether the result of having separately organised services is poorer provision for older adults, particularly those with long standing mental health conditions 'graduating' from adult to older people's services.

6.2.2. Within the timescale of the provision of medical services, and even within the sixty years of the NHS, old age psychiatry as a specialist service is relatively young. According to Jolley (1999) 'Old age psychiatry became a speciality within the National Health Service in the autumn of 1989'

6.2.3. The first comprehensive old age psychiatric service to be established was probably that working from Goodmayes Hospital in east London. The underpinning principles on which this service was based included:

- ease of accessibility
- flexibility
- assessments being made at the patient's home
- management of the patient in close co-operation with general practitioners and other interested parties

(Banerjee and Chan, 2008, Review)

- 6.2.4. 'In the United Kingdom, old age psychiatry services have developed in response to the specialist needs of older people. They aim to be comprehensive, and the closure of large psychiatric institutions has led in many cases to the expansion of community-based services such as mental health teams, clinics and day hospitals. This has been facilitated by a drive towards providing care as near to where the patient lives as is feasible, and by an expectation that community referrals will, at some stage, be assessed at home by a mental health professional in order to provide a more complete assessment. These factors could explain the relative lack of provision for older people in general hospital wards.'
- (Holmes, Bentley and Cameron, 2003, Survey)
- 6.2.5. 'The most widely accepted model for old age psychiatry service delivery has requirements that include being multidisciplinary, comprehensive, integrated, accessible, available, responsive, able to liaise with other services and general practitioners and having a defined catchment area. The model was not based on formal evaluation, but a priori beliefs from the experiences of geriatric medicine, pragmatism, advocacy and available resources in the UK'
- (Draper, 2000, Review)
- 6.2.6. Given this ad hoc development have older age psychiatric services been effective? An evaluative review of studies of old age psychiatry services in 2000 found that, for acute psychiatric inpatients, over 80% of patients improved at discharge. Acute old age psychiatric inpatient services were effective in the treatment of depression (38-69% full recovery, 51-96% partial recovery) but less effective in the reduction of behavioural complications of dementia. For old age psychiatric service delivery on general medical wards...
- '...the exclusion of older people from consideration within the NSF for Mental Health (Department of Health 1999), which focuses exclusively on people of working age, has disadvantaged some patients and made differentials of service quality based on age (ageism) difficult to avoid. This is most apparent for people who survive to become old despite their experience of mental disorder from an earlier age, the so-called "graduates" of the mental health system.'
- (Jolley, Kosky and Holloway, 2004)
- 6.2.7. There is a widespread feeling that older peoples' mental health services are under-provisioned relative to those for adults. This is explored further in section 6.3.
- 'Policy and priorities have become harder to identify as a consequence of the successive changes in the NHS. "Planning" has been superseded by "purchasing" and, more recently, by "commissioning". National guidelines have been eschewed and local bargaining championed as the means of determining priorities. Within this poorly defined framework health authorities and other purchasers have not always given priority to the needs of older people

with mental illness. Many health authorities have failed to make an appropriate contribution to long-term care of the severely mentally ill and incapacitated. Rather, they have chosen to spend their revenue on other groups of patients. Those older people suffering from mental illnesses who would previously have received care in hospital have been thrown into the means-tested and inadequately regulated environment of social provision. ' (Jolley, 1999) 'While there has been improvement in access to services for older people, there is further work to do to provide equal access to the full range of mental health services that are available for adults of working age.

There are poorer and less integrated services for older people with mental health needs compared to those people with mental health needs aged under 65. The out-of-hours services for psychiatric advice and crisis management for older people were much less developed, and older people who had made the transition between these services when they reached age 65 said there were noticeable differences such as poorer quality, fewer services and less support.

Although there were agreed protocols for treating dementia and depression and for managing people with dementia in acute hospitals in all the communities we inspected, their impact and the awareness of them by staff were limited. Older people with dementia frequently had unacceptably long waits for the provision of specialist long term care and the care they received when in hospital revealed a lack of understanding of their needs. We also found that older people with cognitive impairment did not have access to intermediate care and therefore were unable to benefit from rehabilitation to regain physical ability.'

'All aspects of mental health services for older people need to improve including person-centred care, age equality in access to the range of services available, treating people with dignity and respect, holistic care in mainstream services and a whole systems approach to the commissioning of integrated mental health services for older people.'

(Healthcare commission et al, 2006, Review)

- 6.2.8. 'Older people who experience mental health problems for the first time may also be disadvantaged by current service structures. Their problems may not be recognised within primary and secondary care or, if they are, may be considered to be just a normal part of ageing, not requiring a targeted intervention'.

(Mental Health Foundation, 2009, Opinion)

If there has been no contact with services prior to the age of 65, most people will be referred to older people's services straight away. In a survey of senior and middle managers of eight mental health organisations, in every instance those aged 65 and over were routinely

referred to the older people's mental health team for assessment (Mental Health Foundation, 2009, Opinion - referencing Beecham et al, 2008, Survey)

- 6.2.9. Mind and the Mental Health Foundation confirm the view that older people's mental health services are under-provisioned.

'Older people with mental health problems in England do not receive the same level or quality of care as younger people. Despite policies and guidelines setting out the importance of age equality in mental health care, both direct and indirect discrimination has continued to occur within the services. This has been due in part to the way in which divisions have traditionally been created in services between care for working age adults and older people within mental health and social care.' (Mental Health Foundation, 2009, Opinion)

'It is very important not to be transferred to OAP services. The mental health problem does not go away because you are an OAP.' 'The local mental health team do not allow people over 65 to use their facilities. You are told your service is terminated and that you should attend the day centre for older people, despite the fact that you may have attended the mental health day centre for many years and know many others who attend. Having to go to an old person's day centre deprives you of the company of younger people, and is very upsetting.' (Mind, 2005, Campaign document)

- 6.2.10. 'I've watched services for younger adults develop. But older people's services have either stagnated or declined. They keep going to the bottom of the list of priorities' – Glenys Jones, ADSS quoted in *Gross neglect* (Glassman, 2004, Opinion)

- 6.2.11. In its 2009 study the Healthcare Commission made a detailed review of six mental health trusts, finding that only two of the six had made 'concerted efforts to address the age discrimination encountered by older people when accessing services and who were delivering services based on need, not age'. '...both had required strong senior clinical and managerial leadership ... both continued to provide specialist old age psychiatry services for those who required them, and staff were proud of the services they delivered.'

Of the remaining four trusts, three had a transition protocol in place for transfer from adult to older people's services that were 'generally thought to work fairly well' but in one trust 'the services for people under 65 were said to be so much better resourced than those for older patients that the older people's community mental health team would sometimes not accept a transfer on the basis that the patient would be disadvantaged and lose services on transfer'.

'Out-of-hours services and crisis services were often not open to older people and these took referrals only for people under the age of 65, or for conditions other than dementia.'

‘Even when there was no explicit policy about discrimination on the basis of age, staff often reported that, although the rules did not prevent referring older people, in actual practice accessing the full range of services for older people was often not possible.’ There were ‘difficulties in gaining access to services for alcohol and substance misuse’ and ‘one service particularly poorly provided for was psychological therapies.’ ‘One trust reported a waiting list of 6 months for an assessment’ and ‘another reported that, in an audit of 1,300 referrals to psychological therapies from GPs, only 49 were for people over the age of 65.’ ‘Carers expressed general dissatisfaction with the care their relatives received on the general wards in acute hospitals. In particular, they referred to staff in hospitals not being trained or equipped to deal with patients with mental health problems, especially dementia.’

(Healthcare Commission, 2009, Review)

- 6.2.12. While there are still concerns about the level and quality of service in specialist mental health services for older people, the 2009 Department of Health New Horizons consultation confirmed its support for the continuance of specialist older people’s mental health services. ‘...age equality guidance published by the Department of Health recommends: “An ageing population has particular needs... The mental health needs of older people are often multi-factorial and frequently complicated by failing physical health. This complexity requires the skills of specialist practitioners... Specialist mental health services for this group should be the bedrock on which other services can rely for clinical advice, support and practical help.” The aim of the age equality agenda is for services to be of equivalent good quality for people of all ages.’

(Department of Health, 2009, Policy document)

- 6.2.13. The consultation document however recognises the need for a more flexible approach to the organisation of specialist mental health services for older people based on patient need rather than rigidly structured around age.

‘Undoubtedly some older people with severe mental illness have needs that are indistinguishable from those of adults of working age and these older people may well be best served by specialist working age adult services. However, adult mental health services have mostly been designed and developed to meet the needs of working age adults with severe mental health problems. This can result in indirect age discrimination, whereby “apparently neutral practice... disadvantages people of a certain age”.

Specialist older people services should be available to people who would benefit from them. Services should be designed around the needs of older adults with mental illness, with appropriately skilled staff and run in appropriate safe and therapeutic environments.

Many mental health trusts 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. Older people have particular needs and older people's mental health teams, staffed by professionals with training and expertise in the care of older people, are needed. Common features in these agreements include:

- people who grow old with enduring mental health problems 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
 - people who experience their first episode of mental health problems after the age of 65 will be seen in the first instance by the older people's service
 - people of any age with dementia will be seen by the older people's service
 - older people whose primary need is for specialist services such as substance misuse services or forensic mental health care will not be denied access and care from these services on the basis of age
 - joint working between services where patients would benefit from collaboration.'
- (Department of Health, 2009, Policy document)

Summary

The mental health needs of older people may be sufficiently different from those of adults to justify the provision of specialist older people's mental health services but, while there is some evidence of the success of these services, they have frequently not, in the past, achieved the necessary level of commissioning priority or service provision to provide a non age discriminatory service.

6.3. *Under provision of mental health services for older people*

6.3.1. Mental health services for older people are characterised both by under-detection and diagnosis of illness and under provision of services.

'Under-detection of mental illness in older people is widespread, due to the nature of the symptoms and the fact that many older people live alone. Depression in people aged 65 and over is especially under-diagnosed and this is particularly true of residents in care homes.'

(Department of Health, 2001, Policy document)

- 6.3.2. As outlined above in section 6.2, there is widespread reported evidence from professionals and older people of individual cases and services where provision for older people is poorer than that for working age adults. It is worth repeating the quotation by a participant in Bawn's 2007 survey
- 'Adult mental health teams have better access to occupational therapy, occupational therapy assistants, day centres in the community, psychotherapy services... So when patients are transferred over to us they will sometimes get a reduced level of care. For example... a patient with chronic schizophrenia... transferring to use from the adult services... was getting an OT assistant visiting once or twice a week, a CPN visiting weekly and a consultant visiting every two weeks. Once transferred the consultant and CPN would visit every month if you are lucky.'*
- (Bawn et al, 2007, Survey)
- 6.3.3. A 2008 report on Managing Urgent Mental Health Needs in the Acute Trust, prepared for the Royal Colleges of Psychiatrists, Nursing and Physicians and the College of Emergency Medicine noted that crisis team and liaison teams may not see older people and that older peoples' services are 'usually not available 24/7, response times are very variable [and] demand for services can out strip supply.'
- (Academy of Medical Royal Colleges, 2008, Policy document)
- 6.3.4. '[Our] visits also emphasised the lack of implementation of a standard model of care and how older people's mental health services are falling behind services for younger adults in terms of priority.'
- (Healthcare Commission, 2009, Review)
- 6.3.5. 'The *National Service Framework for Mental Health* was explicitly targeted at working age adults, and specialist older people's mental health services by the *National Service Framework for Older People*. There is evidence that the investment in quality improvement of inpatient and community mental health services for working age adults during the period of the National Service Framework may not have been matched consistently by similar development or investment in older people's mental health services.'
- (Department of Health, 2009, Policy document)
- 6.3.6. Despite the large number of observations and assertions that mental health services for older people are under-provisioned, reliable quantitative evidence is hard to come by. A 1999 survey of all 25 consultants in old age psychiatry in Wales found that the average population over 65 being served by each full time equivalent consultant was 22,995, more

than double that recommended by the Royal College of Psychiatrists and Royal College of Physicians. (Napier, 2002, Survey)

Mental health services in England, 2009

2009 Strategic Health Authority data for all service types (Older Adults)

SHA Name	No. Services	Total Caseload	Bed Numbers	Total Staff	Staff / 1000 cases
East Midlands SHA	432	21,290	7,710	3,740	176
Yorkshire and The Humber SHA	637	25,089	11,402	5,361	214
East Of England SHA	435	19,876	6,544	2,892	145
London SHA	636	48,652	8,226	7,176	147
North East SHA	379	22,676	7,250	9,066	400
North West SHA	604	39,506	8,584	7,403	187
South Central SHA	322	26,887	9,638	3,859	144
South East Coast SHA	271	26,454	2,136	1,955	74
South West SHA	448	24,919	2,187	3,548	142
West Midlands SHA	542	25,870	7,815	3,963	153
<i>All England Total</i>	<i>4,707</i>	<i>281,219</i>	<i>71,492</i>	<i>48,963</i>	<i>174</i>

2009 Strategic Health Authority data for all service types (Adult)

SHA Name	No. Services	Total Caseload	Bed Numbers	Total Staff	Staff / 1000 cases
East Midlands SHA	646	57,855	3,263	7,515	130
Yorkshire and The Humber SHA	969	70,364	4,718	10,665	152
East Of England SHA	898	62,211	3,894	8,593	138
London SHA	2,260	130,085	12,024	21,544	166
North East SHA	617	42,638	2,616	6,121	144
North West SHA	1,590	109,440	8,213	18,754	171
South Central SHA	698	48,867	2,912	6,454	132
South East Coast SHA	518	54,475	2,330	5,560	102
South West SHA	800	44,037	3,263	7,395	168
West Midlands SHA	1,157	78,489	4,989	10,662	136
<i>All England Total</i>	<i>10,154</i>	<i>698,460</i>	<i>48,220</i>	<i>103,263</i>	<i>148</i>

Source: Department of Health, CSIP – Combined Mapping Framework, 2009

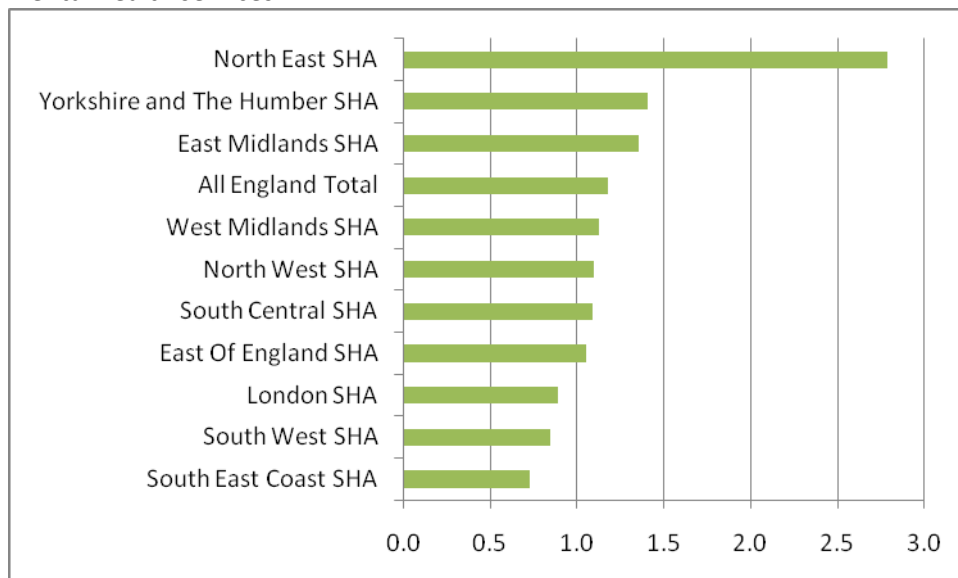
6.3.7. Data from the Care Services Improvement Partnership Combined Mapping Framework for 2009 gives an overall picture of the provision of mental health services for adults and older people in England. Overall the number of staff per case is higher for older adult services than for adult services which would not, in itself, indicate an under resourcing of

older adults mental health services. The type of staffing is very different (see section 6.3.9) and because the case mix is also very different it is difficult to make judgments on age discrimination when comparing adult and older people’s mental health services.

6.3.8. The ratio of staff per case for older adult mental health services to staff per case for adult mental health services can be used to see if some Strategic Health Authorities are more age discriminatory than others. A ratio near 1 would indicate the services were being resourced much the same. A ratio much less than 1 indicates that older adult services are less well resourced in terms of staff numbers per case, which might be considered age discriminatory, while a ratio greater than 1 indicates that that older adult services have a better staffing ratio than adult services. Most SHAs have a ratio greater than 1 indicating that, on average, older adult mental health services are more generously staffed per case than adult mental health services. The exceptions are, South East Coast SHA, South West SHA and London SHA.

North East SHA stands out from the rest as having far more staff per case in older people’s mental health services than in adult mental health services but with more than half of the 9,800 whole time equivalent older adult mental health service staff being carer support and support care workers.

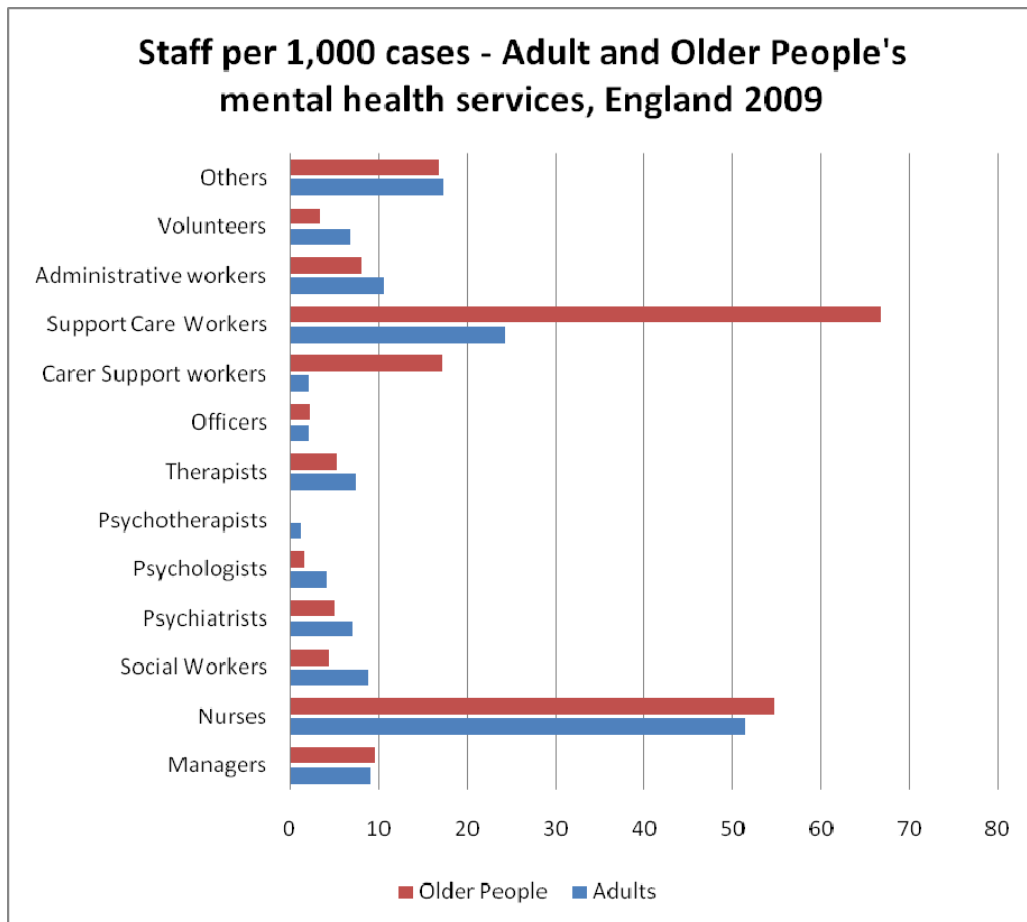
Ratio of staff per case in older adult mental health services to that in adult mental health services



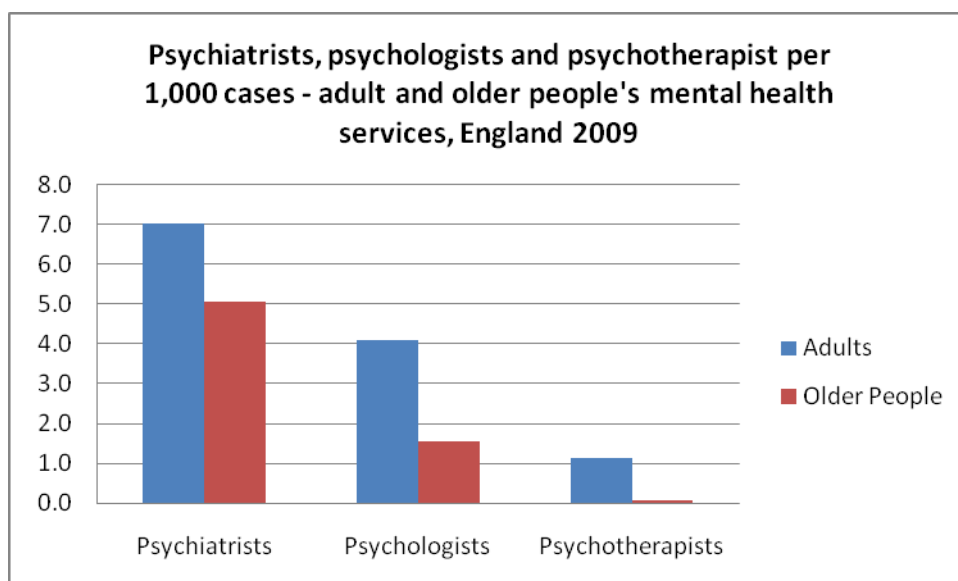
Source: Department of Health, CSIP – Combined Mapping Framework, 2009

6.3.9. A closer examination of staffing arrangements for adult and older people’s mental health services in England reveals that while older people’s mental health services employ fewer psychiatrists and only about half as many psychologists and social workers per case as adult

mental health services they employ many more care support and carer support workers.



Source: Department of Health, CSIP – Combined Mapping Framework, 2009

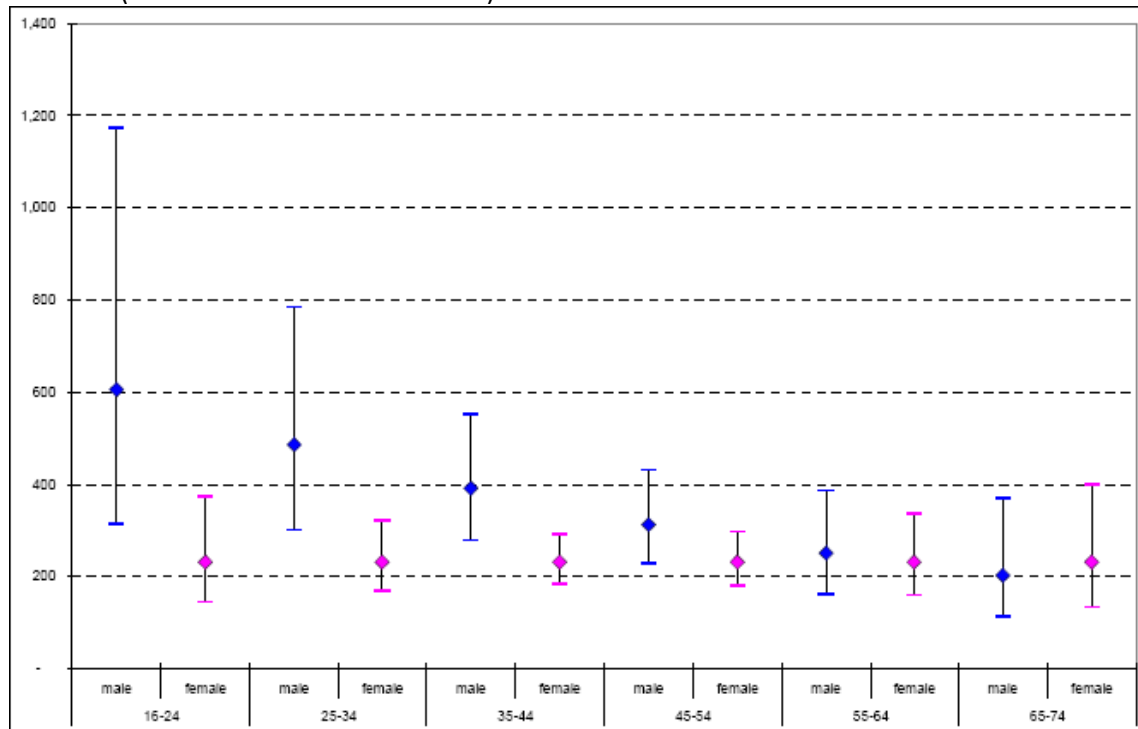


Source: Department of Health, CSIP – Combined Mapping Framework, 2009

Because of the very different mix of mental illnesses treated in adult and older people’s mental health services it is not certain that these differences in provision are evidence of age discrimination, although the reduced availability of key professionals, psychologists, psychiatrists and psychotherapists may be a warning sign.

6.3.10. In a 2008 study of age discrimination in mental health care carried out on behalf of the Department of Health, the Personal Social Services Research Unit (PSSRU), used statistical modelling to try to isolate the various factors feeding into the cost of mental health care. They found that, when all other factors are accounted for, including the nature and severity of mental health conditions, the amount of money spent on individual patients, declines with age for men but appears to hold steady for women.

Predicted total annual mental healthcare costs (£) (if not zero), holding all other factors constant (with 95% confidence intervals)



N=1,330

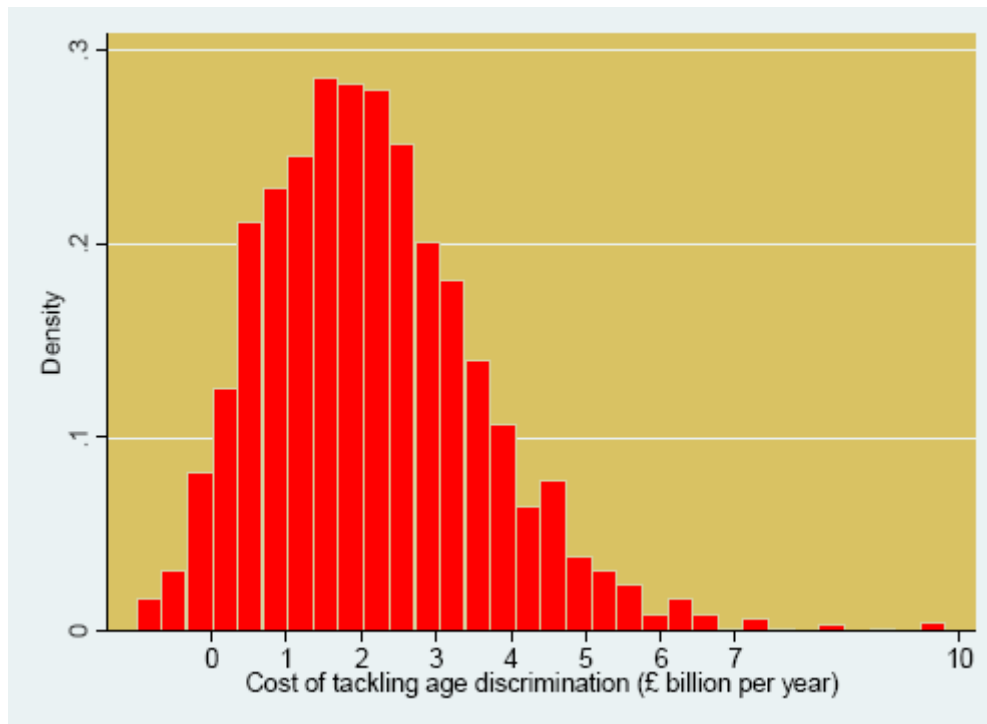
Beecham et al, 2008

PSSRU calculate ‘At the central (point) estimate, increasing service provision among adults aged over 55 to the level received by middle-aged individuals (35-54) with a mental health condition would cost an additional £2.0 billion per annum (2006/7 prices). This equates to an increase of almost 24% on current levels of expenditure.’

(Beecham et al, 2008, Review)

6.3.11. PSSRU also found 'The proportional increase in total costs necessary to increase the supply of services to the benchmark level is significantly higher among adults with "common mental disorders" such as anxiety and depression than among those with psychoses, due to the diversity in the extent of age discrimination between these groups.'

Histogram of expected cost of tackling age discrimination in mental health services (annual)



Beecham et al, 2008

Summary

There is widespread anecdotal and review evidence of the under-provision of mental health services for older people. Older people's mental health services have fewer psychiatrists, psychologists, psychotherapists, therapists and social workers per case than adult mental health services. Less money is spent on older individuals after taking all other factors into account.

6.4. *Variation in the provision of mental health services for older people*

6.4.1. There is widespread geographical variation in the level and quality of mental health services for older people. Staffing provision for older people’s mental health services in comparison to adult services varies greatly between strategic health authorities. One authority provides 179% more staff per case compared with adult mental health services but, for the rest, some provide up to 41% more staff per case whereas others provide up to 28% fewer (see section 6.3.8). This may reflect local preferences and markets or may be indicative of indirect age discrimination in those areas that are providing well below the average.

6.4.2. The Audit Commission found that spending on services for older people with mental illness varied between £300,000 and £2.5 million per 10,000 ‘elderly population’. (Napier, 2002 referencing Audit Commission, 2000)

The table below shows the widespread variation in the number of old age psychiatry places available in different parts of Wales

Places available for old age psychiatry in Wales

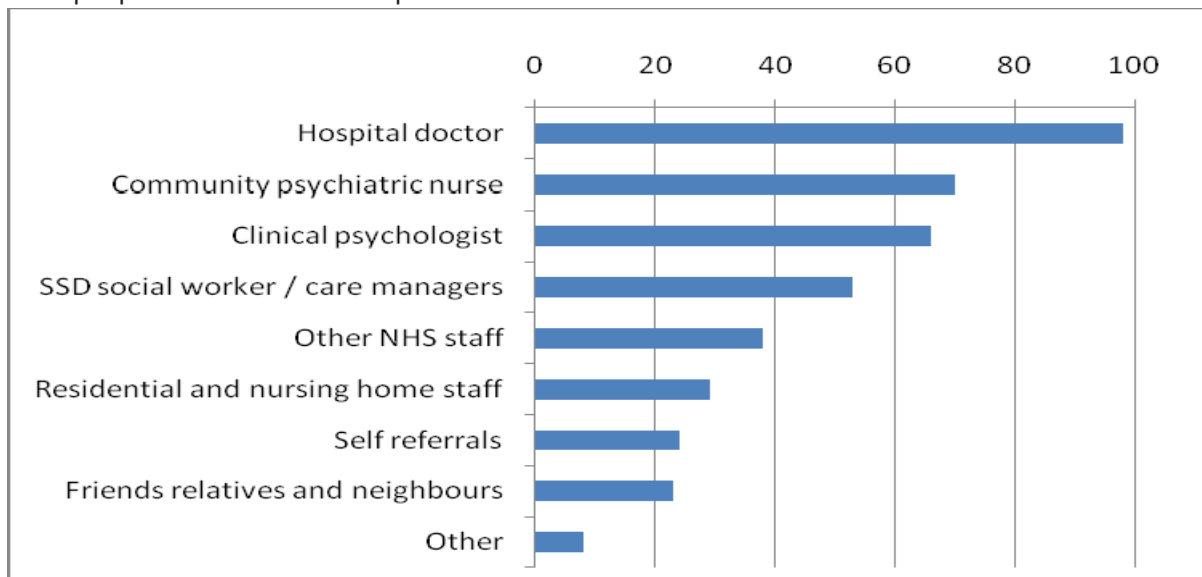
	Total number of places in Wales	Royal Colleges’ recommended range for the stated population	Average number per 10 000 over 65 years	Variations in place numbers between services (per 10 000 over 65years)
Acute assessment beds	477	513-1027	10	4-24
Day places	641	962-1437	15	5-29
Respite and continuing care places	827	718-1436	19	0-59

Napier, 2002

6.4.3. A 1999-2000 survey of 438 old age psychiatrists in England also found ‘marked variations in the provision of services to older people with mental health problems’. Although there was consistency in allowing referrals from hospital doctors there was widespread variation in whether referrals were allowed from other sources.

Eighty percent or above, or 20% and below of services offering a particular option shows some consistency in the provision of that option. A values between 20% and 80% is indicative of less consistency and a degree of variation in service provision.

Service variation - referral procedures: percentage of services or teams allowing direct referral of older people with mental health problems from this source

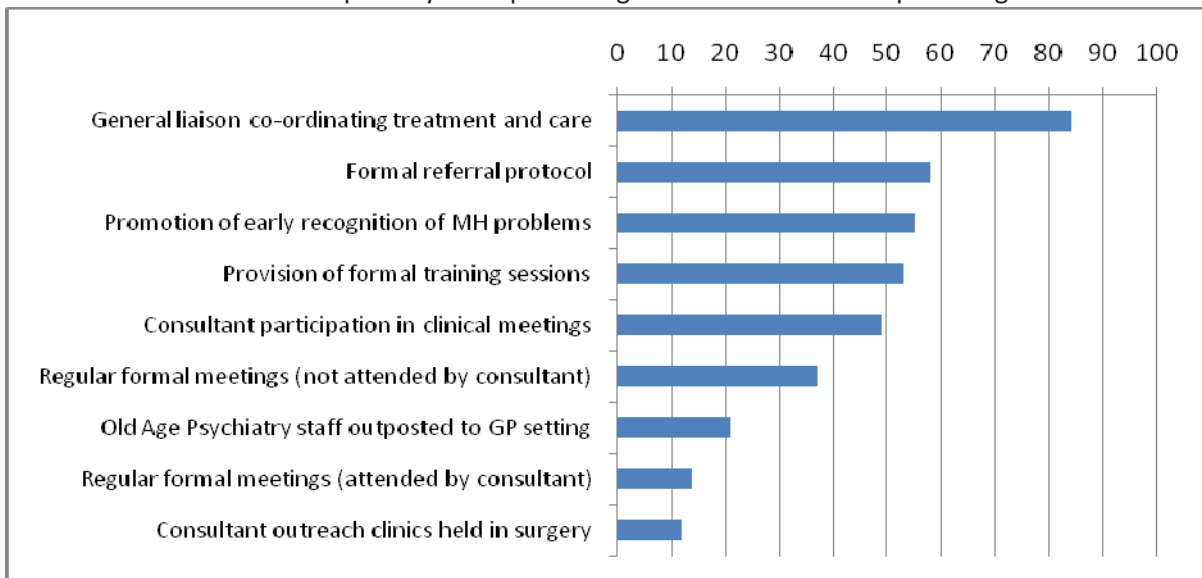


n=317

Challis et al, 2002

There is even more marked variation in how teams and services link with primary care with between 20% and 80% of services not providing most links.

Service variation - links with primary care: percentage of teams or services providing each link



n=317

Challis et al, 2002

6.4.4. Even within Northern Ireland there is marked geographical variation in the provision of services.

‘There is no agreed management structure for the planning and delivery of services to older people with mental health issues. The Dementia Policy Scrutiny 1994 recommended that

responsibility for dementia services should be in Elderly Care Programmes. Subsequently, Boards and Trusts have organised services in a variety of ways. Some have developed integrated Mental Health Services for Older People teams, some located in elderly care and some in mental health. Other services have developed separate teams for dementia and functional mental illness (FMI), sometimes located in one programme of care (POC) and sometimes split between these POCs, both at Trust and Board level. As a consequence of different recoding systems being in place or even none in place, there has not been a comprehensive picture of the needs of these client groups. In addition, there has not been an overall mapping of many instances of best practice which do exist around Northern Ireland. Funding for dementia comes through the Elderly POC and for FMI through Mental Health, together with funding for General Adult Mental Health Services. There is no separate planning or funding for FMI in older people.’ (Bamford, 2007, Review)

- 6.4.5. A 2004 survey of 318 consultant old age psychiatrists (72% of the number identified by DH as practicing in June 2004) to assess progress in older adult mental health services since the 2001 National Service Framework for Older People found that ‘Whilst more than half of psychiatrists believed that services had improved, and a few areas offered comprehensive services in keeping with the government’s aspirations, patchy, inconsistent services appeared to be the norm.’ (Tucker et al, 2007, Survey)

Old Age Psychiatrists perceptions of the provision of older age mental health services

	%
Mental health services have improved in the last two years	55.3
Inpatient mental health services are adequate	44.9
Community mental health services are adequate	23.9
The implementation of the NSF has improved mental health services	17.0

n=304 – n=312

Tucker et al, 2007

- 6.4.6. Widespread variation also occurs in the provision for Community Mental Health Teams and liaison teams in general hospital care (see sections 6.5 and 6.8 below).

Summary

There is widespread regional variation, not only in the level of provision of older people’s mental health services but also in the way in which these services are organised. This variation in provision leaves room for age discrimination at the local level.

6.5. *Community mental health teams*

6.5.1. 'Community teams vary from those consisting of only community psychiatric nurses (CPNs) with other professional input by internal referral, to those including the full-time involvement of other professionals, including social workers, occupational therapists, physiotherapists, case managers and speech therapists' (Banerjee and Chan, 2008)

6.5.2. One relatively recent innovation has been the introduction of crisis resolution and home treatment teams.

The introduction of crisis resolution and home treatment teams for older people with mental illness in West Suffolk is indicative of the priority traditionally given to mental health service for working age adults and the changes in that balance currently taking place in favour of greater equality.

The CRHTT in West Suffolk was launched in June 2005 to cover working age adults (aged 17-65 years old) and was extended to cover older people in March 2006, 'in line with the West Suffolk Hospital National Health Service Trust policy to provide equitable services for all age groups'. When the CRHTT was extended to cover service users over the age of 65, there were a number of other service changes, including the closure of a dementia care ward and two day hospitals, and the introduction of an old age intermediate care team. Since the introduction of the crisis team in older people's mental health there has been a 31% reduction in admissions and service users and carers have been, in general satisfied with the service.

(Dibben et al, 2008, Small survey)

Summary

As with other aspects of older people's mental health services, community teams vary widely in their organisation and structure. The introduction of crisis resolution and home treatment teams in West Suffolk provides an example of a commonly seen feature, namely service improvements being prioritised initially for adult rather than older people's services with older people's services following on.

6.6. *Psychological therapies*

6.6.1. Another example of a programme potentially beneficial to adults of all ages being focussed on working age adults is the rolling out of the IAPT programme in 2009.

The £173m Improving Access to Psychological Therapies (IAPT) programme meets NICE

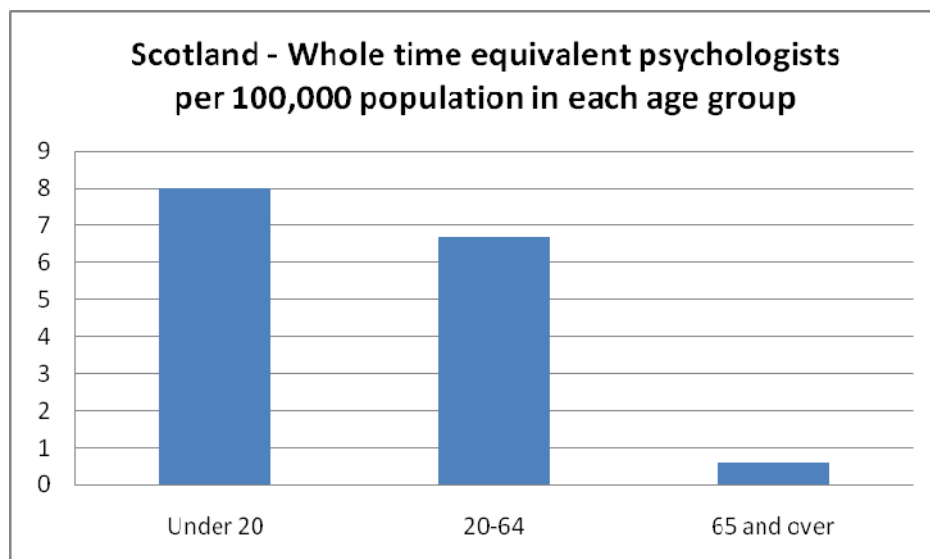
guidelines in providing cognitive behavioural therapy and other evidence based therapies and is available in 35 primary care trusts. ‘A strength of IAPT is that local areas can develop their own priorities according to local requirements. In Telford and Wrekin the IAPT programme will include a focus on older people and people with long-term conditions – in this area, we know that only 4% of over 65s are referred to primary care mental health services’. Despite this, the way that IAPT is being rolled out, focussing on people of working age, with side projects targeting difficult-to-reach communities – means that some groups will have to wait longer to access these therapies.

(Mickel, 2009, Opinion)

6.6.2. Cognitive Behavioural Therapy (CBT) has been shown to be effective with older people in the treatment of mild to moderate late life depression (Laidlaw et al, 2008, Small survey) and a 2009 systematic review of several small studies of the use of CBT with older people concluded that its findings, read in conjunction with larger meta-analyses that include broader age ranges suggest that CBT may be of potential benefit. (Wilson, Mottram and Vassilas, 2009, Systematic review)

6.6.3. Variations in the provision of psychological services, depending on the age of the patient, are reported in Audit Scotland’s 2009 overview of mental health services.

‘There are differences in staffing levels depending on the age of the service user. Across Scotland as a whole the staffing ratio of mental health psychologists for specific age groups varies:’



Audit Scotland, 2009

- 6.6.4. In some areas of Wales there is limited or no access to psychological therapies via mental health services for older people. A survey of consultant old age psychiatrists found that 45% of community mental health teams for older people had team members providing psychological therapy while 17% of teams had no access of any kind to psychological therapies. (Evans and Reynolds, 2006, Survey)
- 6.6.5. It is also questioned whether, as well as being age discriminatory, not introducing psychological therapies for adults of all ages may be in breach of the Human Rights Act 1998. (Hilton, 2009, Opinion)

Summary

The talking therapies are under-provisioned for older people with mental health problems. There are far fewer psychologists per case in older people's mental health services than in adult services. The 2009 roll-out of IAPT services provides a further example of a mental health service, potentially beneficial to patients of all ages, being initially prioritised for working age adults with older people following on.

- 6.7. *GPs and primary care*
 [See also *Ageism and age discrimination in primary and community health care in the United Kingdom* (Centre for Policy on Ageing, 2009, Review)]
- 6.7.1. First contact with mental health services for most older people is through a GP. Early diagnosis of mental illness is important for treatment, where this is possible, to alleviate symptoms and to plan care. While most GPs agree that early diagnosis of depression is important, far fewer recognise the benefits of early diagnosis of dementia.
- 6.7.2. 'Most types of dementia can't be cured, but if it's detected early, there are ways you can slow it down and maintain mental function. Early diagnosis is therefore a crucial part of coping with dementia. It is crucial to get a diagnosis. It's a really important first step in getting treatment and care. Diagnosis can rule out other conditions that might be treatable, such as depression, brain tumours, and other causes of confusion. A diagnosis can also help a person access information, advice and support and enable them and their family to plan for the future.'
 (Evers, NHS Choices, 2009, Opinion)
- 6.7.3. A survey of GPs in 12 areas, carried out by the Audit Commission prior to their 2000 'forget me not' report, found that only 54% felt that it was important to look actively for early signs of dementia. Many of the others saw no point in looking for an incurable condition, even

though carers could be helped by early advice.

Audit Commission survey of GPs

Statement	Percentage of GPs who agree with the statement in relation to:	
	Dementia	Depression
It is important to look actively for early signs of...	54	88
It is beneficial to make an early diagnosis of...	52	92
I use specific tests and/or protocols to help me diagnose and manage...	44	35
I have ready access, when required, to specialist advice to help me diagnose and manage...	75	69
There are satisfactory specialised services for older people and/or their families in my area to meet the needs of people with...	50	51
I have received sufficient basic and post-qualifying training to help me diagnose and manage...	48	70

n=1000+

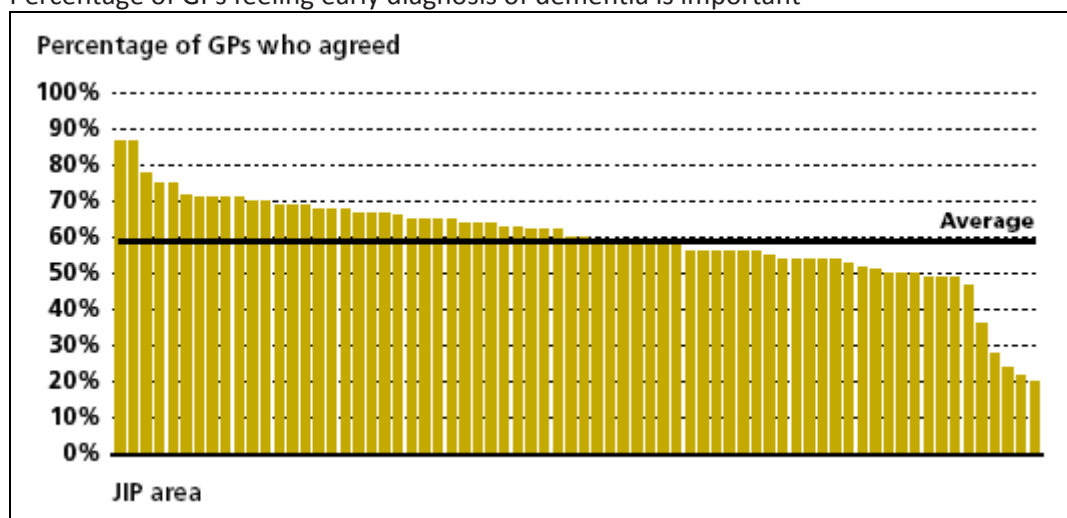
Audit Commission, 2000

Comments included 'What is the point in looking for an untreatable illness?'; 'Dementia is untreatable so why diagnose it?'; 'Diagnosing dementia can be difficult, uncertain and create unnecessary anxiety.'

Less than one half (48%) of GPs felt they had received sufficient training to help them diagnose and manage dementia. (Audit Commission, 2000, Survey)

See also *Ageism and age discrimination in primary and community health care in the United Kingdom* (Centre for Policy on Ageing, 2009, Review).

Percentage of GPs feeling early diagnosis of dementia is important

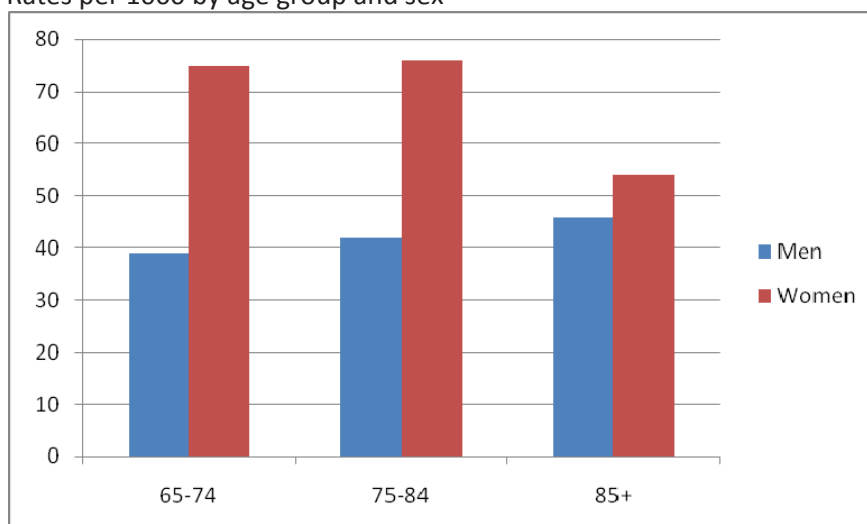


n=8,051 (in 73 Joint Investment Plan areas)

Audit Commission, 2002

- 6.7.4. A second, larger, survey of over 8,000 GPs carried out for the Audit Commission ‘forget me not’ 2002 report found that attitudes had changed but while 60% of GPs now felt early diagnosis of dementia was important, there was much regional variation in attitude with, in some areas, only 20% of GPs feeling early diagnosis was important.
- 6.7.5. Ninety percent of GPs felt that early diagnosis of depression was important but only 40% of GPs use a recognised specific test or protocol to test for either depression or dementia. (Audit Commission, 2002, Large survey)
- 6.7.6. ‘It is worrying that one in ten GPs did not agree with the importance of early diagnosis, since depression is common and disabling but highly treatable. However, many GPs acknowledged that they needed more training in the diagnosis and management of depression’ (Orrell et al, 2000, Large survey)
- 6.7.7. While 20-40% of older people in the community show strong symptoms of depression (see section 7.1) only 4-8% will consult a GP. This is particularly noticeable for older men aged 85+ where around 40% show strong symptoms of depression but only just over one tenth of that number, around 4.5%, consult a GP. The under use of mental health services by older people is discussed further in section 6.10.

Older adults - GP Consultation rates for depression, England and Wales:
Rates per 1000 by age group and sex



n=502,493

(Shah, McNeice and Majeed, 2001)

- 6.7.8. Timely diagnosis and treatment of depression is important and a delay in diagnosis can adversely affect treatment (see section 7.1.5 p55).
- 6.7.9. A follow-up assessment of 315 general practice patients using a range of standard mental health assessment tools supported research ‘...suggesting that older adults may suffer a range of mental health problems, not restricted to depression and organic problems and may be reluctant to mention psychological distress to GP staff. This study also raises concerns about the validity of simple screening at a single point in time as a method of identifying individuals in need of mental health treatment and emphasises the complexity of diagnosis in the context of a brief surgery consultation with a GP or practice nurse.’ (Watts et al, 2002, Survey)
- 6.7.10. A survey of south London social workers in the context of older clients with depression found ‘...older people receive a raw deal from primary care.’ Views on care provided by psychiatric services were generally positive. The main problem was gaining access, which was blamed on ‘reluctance and delays by GPs in making a referral’. The gate-keeping process frequently caused frustration. Delays meant that ‘often clients were severely depressed by the time they got referred’. (McCrae, 2005, Small survey)

Summary

There is evidence that General Practitioners (GPs) have been reluctant to diagnose dementia and are tardy in the diagnosis of both dementia and depression. GP training and the screening tools commonly used in general practice may be insufficient to meet older people’s mental health needs.

6.8. *General hospital care*

- 6.8.1. There is continuing concern over the nature and level of provision of mental health care for older patients who form the majority on many general hospital wards. Inadequate or inappropriate provision of mental health care for older patients may be a form of indirect age discrimination.

According to the Royal College of Psychiatrists, in a 500-bed district general hospital, on an average day, 330 beds are occupied by older people and, of these, 220 will have a mental disorder, 102 will have dementia, 96 will have depression, 66 will have delirium and 23 will have other diagnosable disorders. (Royal College of Psychiatrists, 2009, Policy document)

- 6.8.2. '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.' (Department of Health, 2009, Policy document)
- 6.8.3. 'Carers expressed general dissatisfaction with the care their relatives received on the general wards in acute hospitals, In particular, they referred to staff in hospitals not being trained or equipped to deal with patients with mental health problems, especially dementia.' (Healthcare Commission, 2009, Review)
- 6.8.4. In a 2002 survey of 436 consultant old age psychiatrists most were unhappy with their service to general hospital wards with 71% describing it as poor or needing improvement and only 1% describing it as excellent. Reasons cited included the separate managerial arrangements of acute and mental health trusts (50%), a general lack of support from mental health trust managers (61%), travelling time (44%) and parking difficulties (40%). More than six out of ten (61%) provided a service to more than one general hospital and 18% provided a service to four or more hospitals.
- Nearly three quarters (73%) of services were provide through a traditional, generic, sector based consultation psychiatric model which was 'significantly slower responding to referrals' and for which 89% of respondents were unhappy with their service to older people in general hospital wards and would prefer one or other of a range of liaison psychiatric models based in the general hospital. (Holmes, Bentley and Cameron, 2003, Survey)
- 6.8.5. Further evidence of the advantages of the liaison model of psychiatric care of older people in general hospital wards over the traditional consultancy model was offered by a 2004 comparative study at Kings College hospital. Referring teams were more satisfied with the speed of response, while the new service maintained the salience and clarity of advice. (Mujic et al, 2004, Survey)
- 6.8.6. 'People with dementia and depression in general hospitals have worse outcomes in terms of length of stay, mortality and institutionalisation. This impact creates a strong incentive for clinicians, managers and commissioners to improve liaison psychiatry services.
- General hospital staff have few skills and little training in working with people with mental

health problems. The National Dementia Strategy recommends three ways to improve the care of older people with mental health problems in general hospitals:

- 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 exhibited by older adults in hospital.

The commissioning of such teams would be of benefit to those older people with mental health problems other than dementia as well as to those with dementia.'

(Department of Health, 2009, Policy document)

Summary

It is generally accepted that the provision of mental health services for older people in general hospital wards is inadequate in relation to need. *Liaison* models of service provision, based in the general hospital, are preferred to *consultation* models and have been shown to be more effective.

6.9. Residential and nursing home care

6.9.1. 'Many thousands of older people live in residential and nursing care homes. They are in many ways society's most excluded group. Up to 50 per cent of older people in residential care have clinically severe depression, yet only between 10 and 15 per cent receive any active treatment. Much of the distress and disability resulting from this depression could be relieved by early identification, intervention and treatment.'

'An issue of particular concern is the over-use of antipsychotic medication in care homes for the management of behavioural and psychological symptoms in people with dementia. Antipsychotic medications are known to cause increased risk of mortality and stroke in people with dementia. Behavioural and psychological problems in older people can be managed by changes to their environment and psychosocial interventions.'

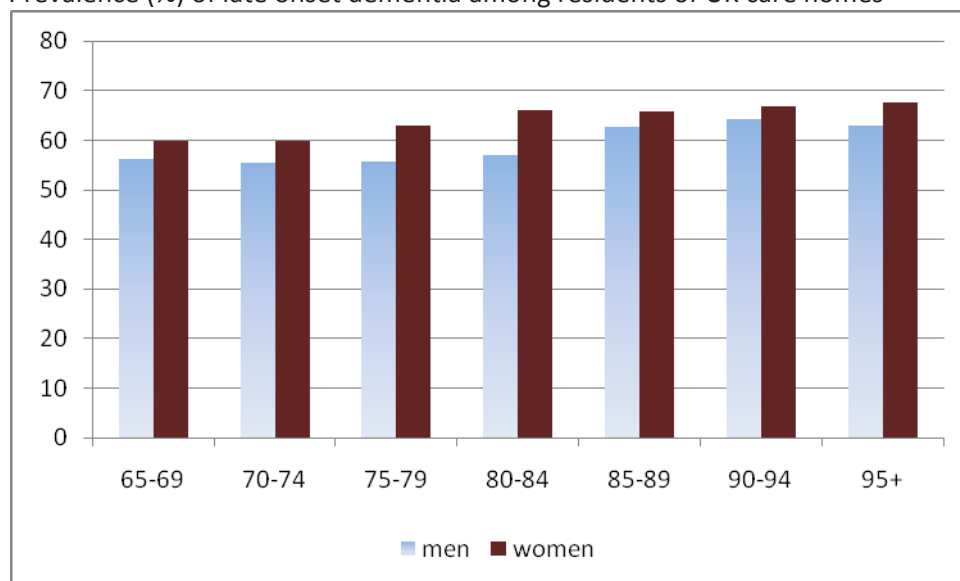
'The high rates of mental health problems among care home residents may be addressed by better liaison between homes and their local older people's mental health services.' (Department of Health, 2009, Policy document)

6.9.2. Depression is much more common for older people living in institutions than for those living in the community. A 2007 stratified random sub-sample of 2,640 individuals from the Medical Research Council Cognitive Function and Ageing Study, 340 of whom lived in institutions, were administered the Geriatric Mental State examination in order to test for depression. The prevalence of depression for those living in institutions was found to be 27.1% compared with only 9.3% for those living at home. Younger residents with severe functional disability were found to be at the highest risk. (McDougall et al, 2007, Large survey)

6.9.3. A 2004 survey of staff and newly admitted residents in 40 care homes in the North West of England found that although rates of depression in care homes are high, recognition of depression by care home staff is low (20-27% of cases recognised). There was no significant difference in recognition rates between nurses and other care staff. Just under 8% of the 332 staff questioned had received any training in “psychological or psychiatric” care and less than 2% had recognisable training in depression. (Mozley et al, 2004, Survey)

With increased emphasis on care at home, care in the residential setting has become, for many older people an option of last resort when they can no longer cope outside. The average stay in a care home is less than two years. The overall result of this is that an increased proportion of care home residents have moderate to very severe cognitive impairment and a high proportion have dementia.

Prevalence (%) of late onset dementia among residents of UK care homes



(Dementia UK, Knapp et al, 2007)

- 6.9.4. Access to mental health care services for residents of care homes can be difficult with only 12% of homes having direct access to a psycho-geriatrician, most access being through referral by a GP but 8% having no access. (Glendinning et al, 2002, Survey)

Percentage of care home residents with different levels of cognitive impairment

MDS Cognitive Performance Scale	1995	2005
Intact	20.2	14.8
Borderline intact	12.7	8.3
Mild impairment	11.2	10.9
Moderate impairment	21.1	21.1
Moderately severe impairment	8.4	13.2
Severe impairment	24.4	27.2
Very severe impairment	2.1	4.6

n=2,287 (1995) n=682 (2005)

(Darton, Forder, Bebbington et al, 2006)

- 6.9.5. A 2008 survey of 772 care home managers for the Alzheimer's Society found that while many had excellent links and support from the local older people's mental health team, one third of care home managers had very little, limited or no support. 'There needs to be a recognition that the responsibility of the local old age psychiatry team for the specialist care and treatment of people with dementia remains once a person enters a care home.'
- 'Before my wife was assessed as requiring NHS Continuing Care and admitted to the care home and I was caring for her at home, her condition was reviewed by a consultant psychiatrist, we were visited by a psychiatric nurse at regular intervals and she attended two day centres each week where she was observed by trained staff. Her GP was someone who had known her as a patient for many years. All this came to an end when she entered the care home. All the qualified medical attention she has now is a registered mental health nurse (the Unit manager) five days a week, general nurses on other days and the local GP.'*
- (Alzheimer's Society, 2008, Review)

- 6.9.6. There is firm evidence to support the long held suspicion of the widespread inappropriate use, in care homes, of anti-psychotic drugs to sedate older people with dementia. It is estimated that this results in 1,800 excess deaths per year. This is a further example of inappropriate and poor treatment directed predominantly at older people and therefore indirectly age discriminatory. (All-party parliamentary group on dementia, 2008, Review; Allred, Petty and Bowie, 2007, Survey; Banerjee, 2009, Review)

Summary

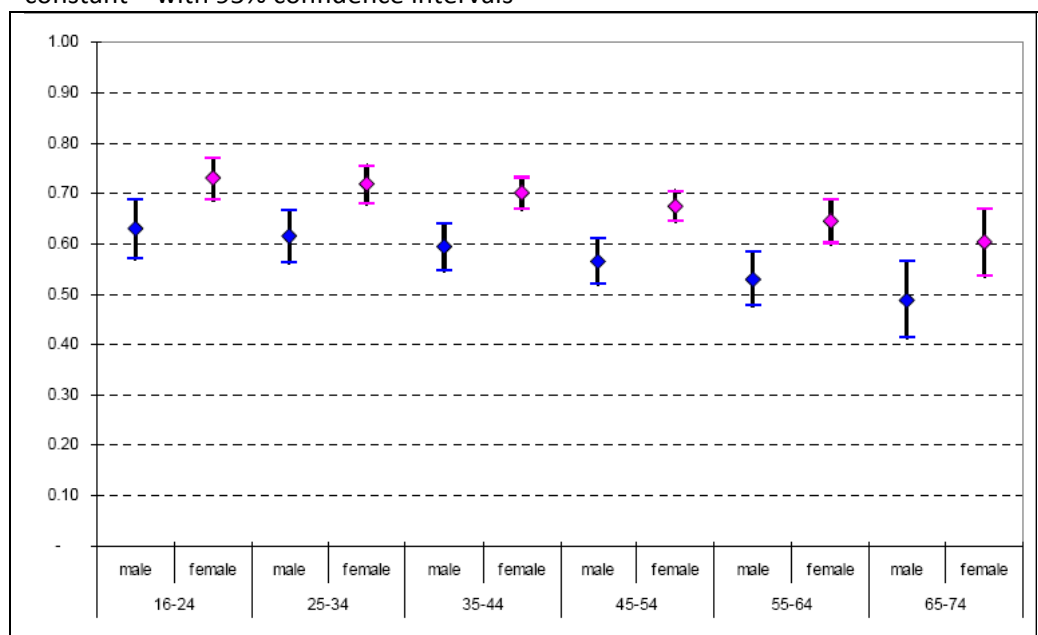
The mental health care of older people in residential care leaves room for improvement. About 60% of care home residents suffer from dementia and around 27% suffer from

depression. Despite this only 8% of care home staff have any training in psychological or psychiatric care and only 12% of care homes have direct access to psychiatric services. There is evidence of the widespread inappropriate use, in care homes, of anti-psychotic drugs to sedate older people with dementia.

6.10. *Under use of mental health services by older people*

6.10.1. In 2008, PSSRU were commissioned by the Department of Health to look at Age Discrimination in Mental Health services. In a secondary analysis of data from the Psychiatric Morbidity Survey, 2000 (Singleton, 2001, large survey) PSSRU identified that, when all other factors including levels of mental and physical health, employment, living alone, and ethnicity have been taken into account, then, as an individual gets older, there is a decline in the likelihood of using mental health services.

Predicted likelihood of mental health service use by age, holding all other factors constant – with 95% confidence intervals



N=2,145

Beecham et al, 2008

This is true for both men and women although the researchers found only the results for women to be statistically significant. This finding may indicate an inherent disinclination on the part of older people to use mental health services or may be an indicator of the presence of age discrimination that is in some way discouraging older people from using those services. (Beecham et al, 2008, large survey)

6.10.2. 'Ageism by providers has been widely used as a possible explanation for the underutilisation of mental health services by older adults' (Robb, Chen and Haley, 2002,)

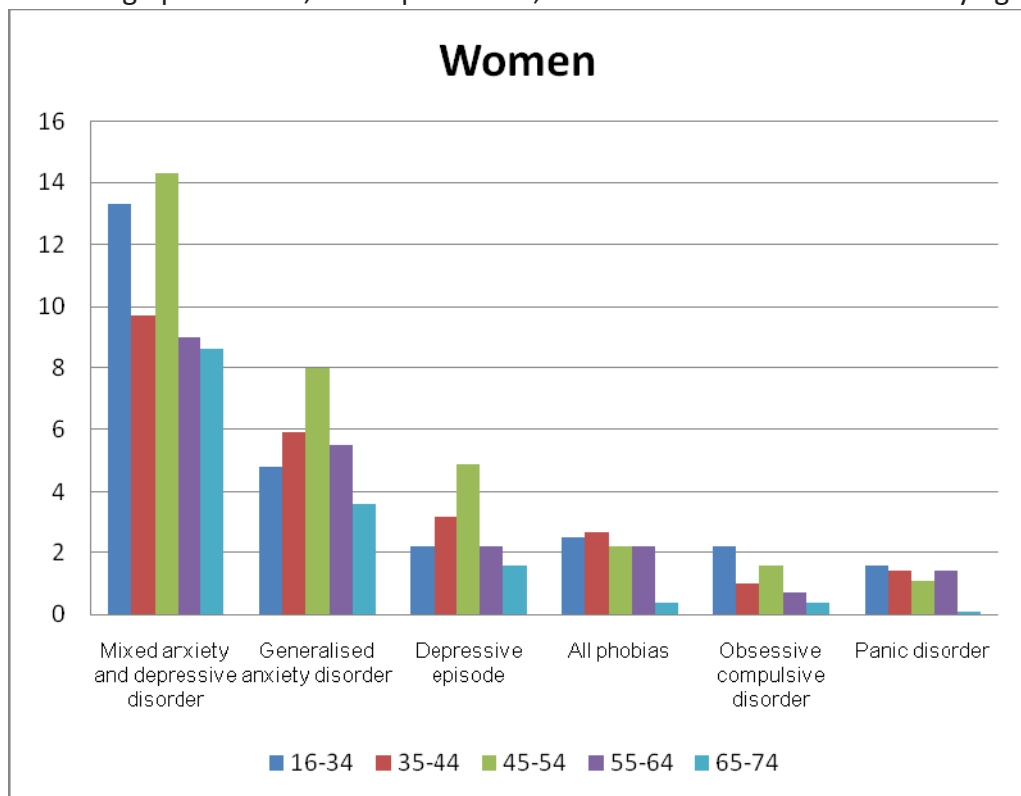
6.10.3. Under utilisation of mental health care services by older people with a mental illness is by no means a purely UK phenomenon. A survey of over 59,000 adults using data from the Canadian Community Health Survey found that, 'compared with middle-aged adults with depression, individuals aged 65 and over with depression were less likely to report any mental health consultation in the past year and especially unlikely to report consulting with professionals other than a family physician. Age remained a significant predictor of mental health service utilisation even after accounting for other relevant variables such as gender, marital status, years of education, "depression caseness" and number of chronic medical conditions.'

(Crabb and Hunsley, 2006, Large survey)

Summary

There is clear evidence of the under-use of mental health services by older people. It is not clear however what the reasons are and to what extent this results from denial of being ill, personal choice, fear of the stigma of mental illness or from age discrimination in the application of services.

Percentage prevalence, in the past week, of Common Mental Disorders by age



n=3,412

(Adult psychiatric morbidity in England, 2007)

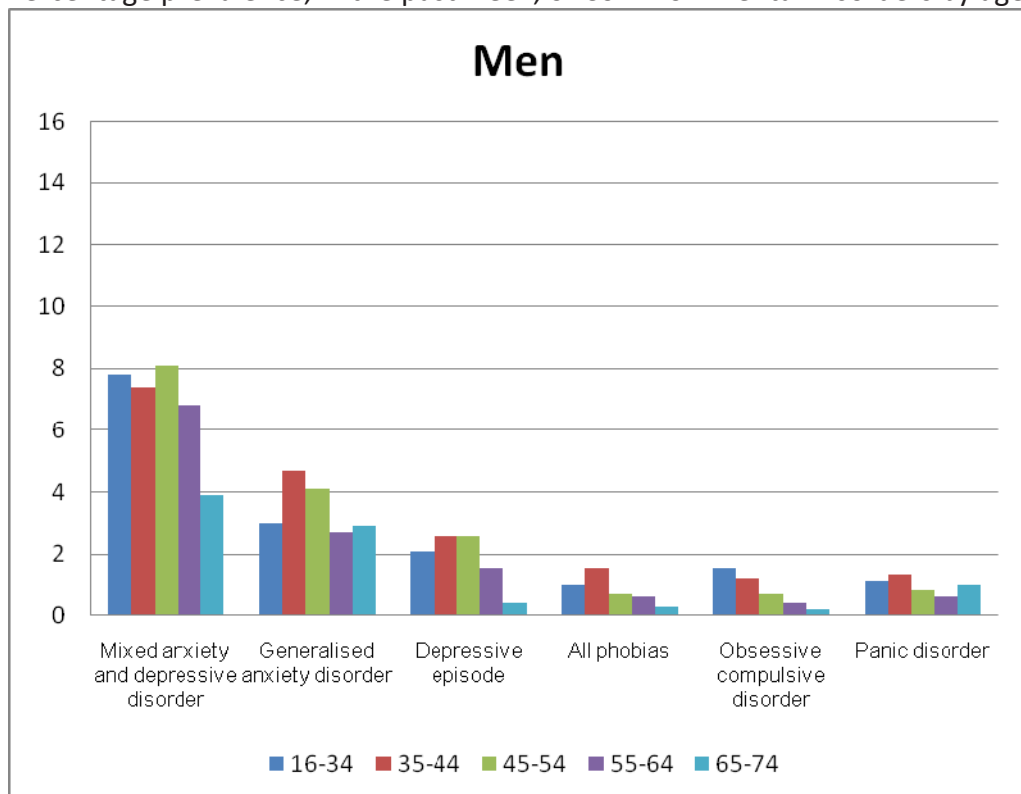
7. Age discrimination in the treatment of particular conditions

7.1. Common mental disorders - neurotic disorders, anxiety and depression

7.1.1. The 2000 Psychiatric Morbidity Survey in England, Wales and Scotland and the 2007 survey of adult psychiatric morbidity in England confirm that, although the prevalence of neurotic disorders declines in older age, there is still a substantial body of older people with mental health disorders of this type.

GP consultation rates indicate that neurotic disorders are particularly prevalent in older women aged 65-74 (see page 52).

Percentage prevalence, in the past week, of Common Mental Disorders by age



n= 3,335

(Adult psychiatric morbidity in England, 2007)

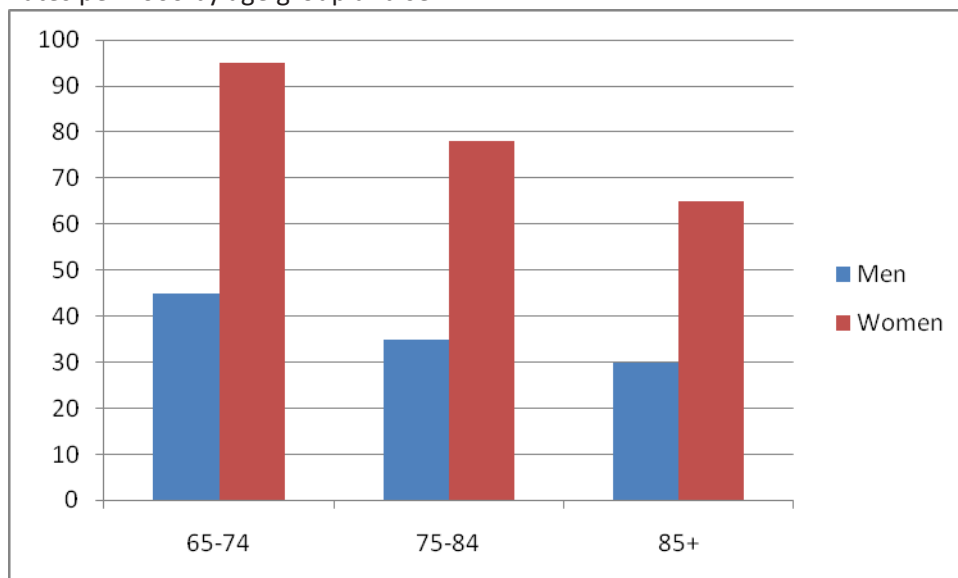
Prevalence of Neurotic disorders, England, Wales and Scotland:



n=8,800

(Singleton et al, 2001)

Older adults - GP Consultation rates for neurotic disorders, England and Wales:
Rates per 1000 by age group and sex



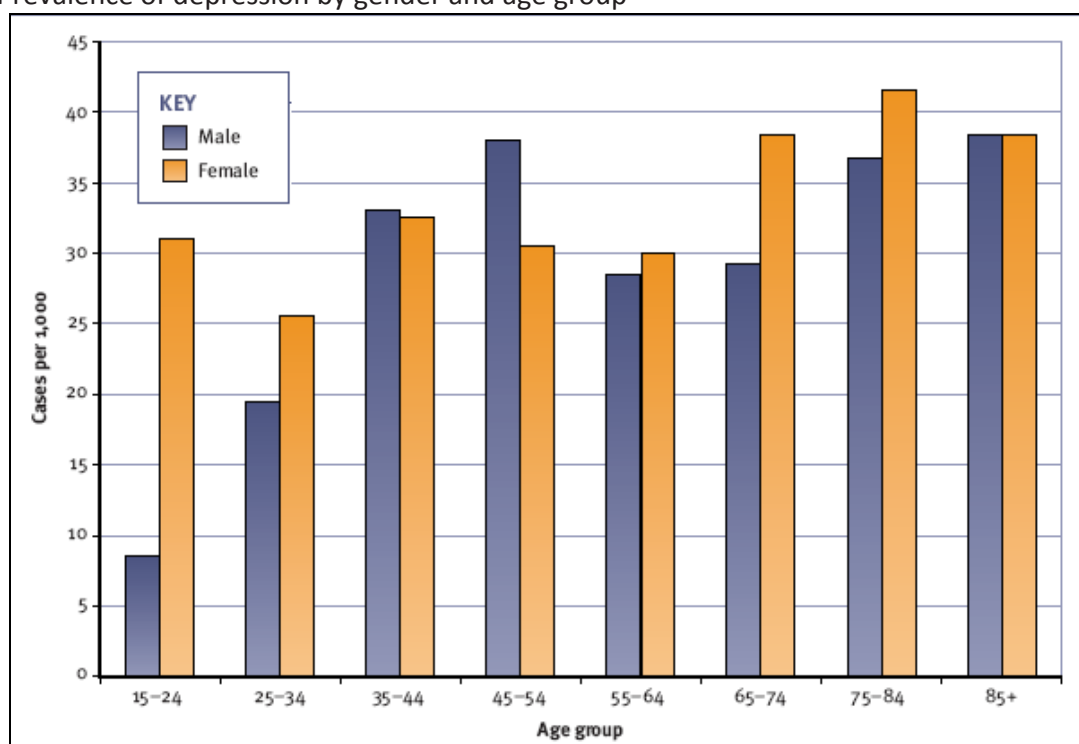
n=502,493

(Shah, McNeice and Majeed, 2001)

A 2008 Kings Fund report (McCrone et al, 2008) suggests that Psychiatric Morbidity Survey (PMS) estimates of depression in older people may be too low because of the relative insensitivity of the diagnostic tools used. The report generates revised estimates

combining PMS data with data drawn from General Practice.

Prevalence of depression by gender and age group



(McCrone et al, 2008)

7.1.2. 'Depression is the most common mental disorder in later life. Between 13 and 16 per cent of older people will have depression that is sufficiently severe to require treatment. Older people with physical health problems have higher rates of depression. Older people in residential care are at particularly high risk. Yet depression in older people often goes undiagnosed and untreated by primary care services, in care homes and in acute general hospital services.' (Department of Health, 2009, Policy document)

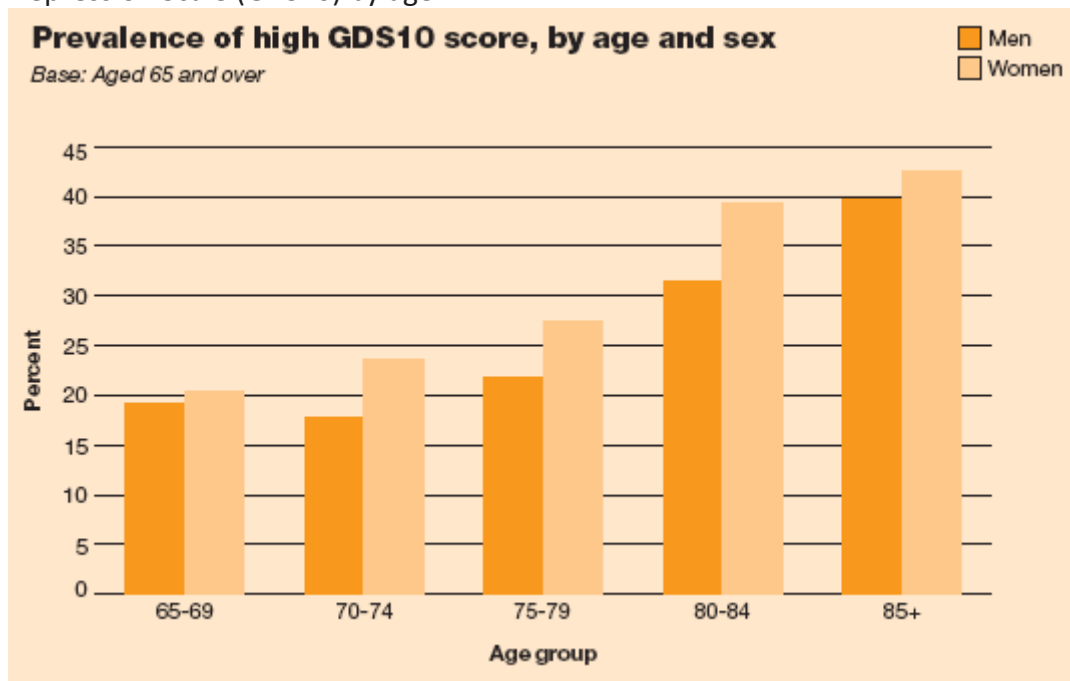
7.1.3. 'Evidence has accumulated since the 1980s that late life depression is significantly undertreated in primary care, yet recent studies suggest that this continues to be a problem' (Watts et al, 2002, Review)

'...the depression paradox: depression is under-recognised in individuals and yet old age is widely seen as a depressing time if life.'

'Perhaps this is emerging as the real problem of depression: as it becomes better recognised, so the lack of options open to older people become more exposed. People with the skills and confidence to recognise depression need to have also the skills and confidence to provide support or treatment, or to make sure that older people with

depression get the help they need. And these networks of support are known to be in short supply for many older people.’ (Manthorpe and Iliffe, 2005, Opinion)

Prevalence of Depression: Percentage of respondents scoring 3+ on the Geriatric Depression Scale (GDS10) by age

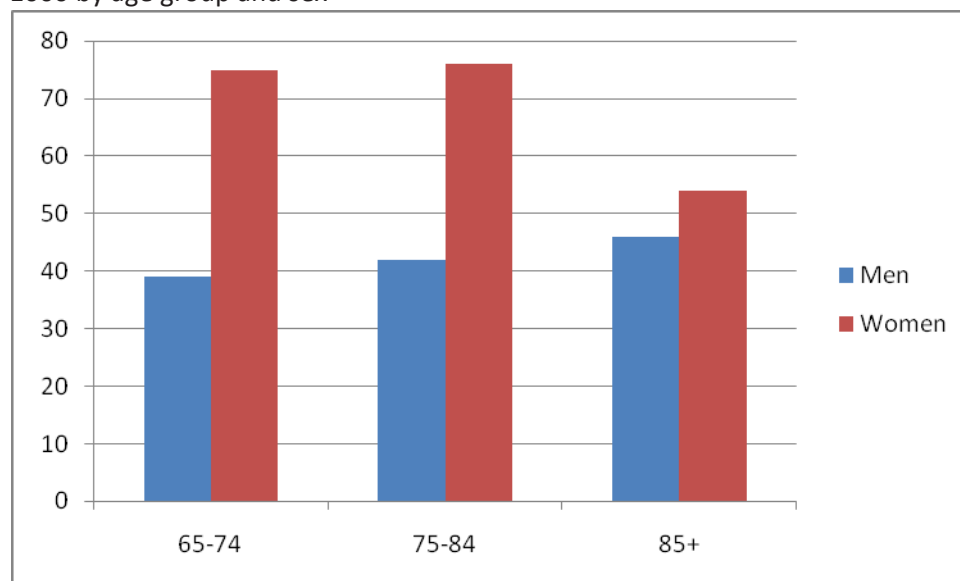


n=3,607

(Health Survey for England, 2005)

7.1.4. ‘A perception that depression is a “natural” part of old age, means many older people are not getting the help they need’ (George, 2005, Opinion)

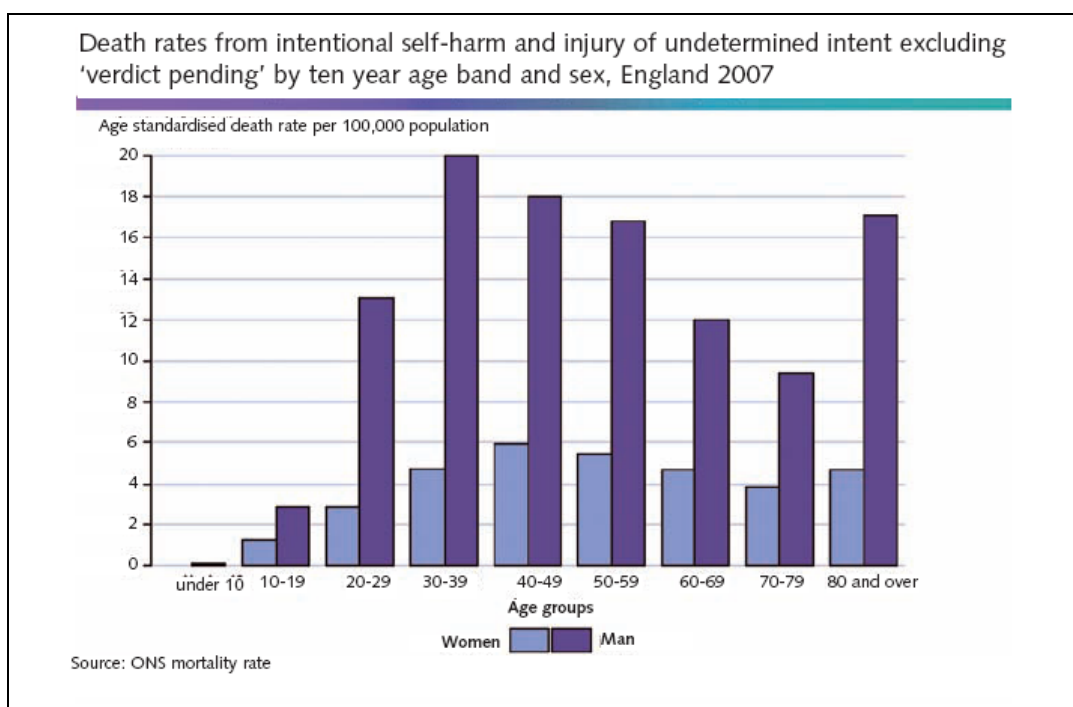
Older adults - GP Consultation rates for depression, England and Wales: Rates per 1000 by age group and sex



n=502,493

(Shah, McNeice and Majeed, 2001)

- 7.1.5. As discussed earlier in section 6.7 on page 41, although 20-40% of older people in the community show strong symptoms of depression only 4-8% will consult a GP. Depression is also seriously under-recognised in the care home setting (see section 6.9 on page 46).
- 7.1.6. Early diagnosis and treatment of depression is important but this is not always achieved. Depression is commonly under-diagnosed or receives a late diagnosis in GP practices and in care homes (see sections 6.7 and 6.9). Early diagnosis is efficacious...
 'Although around 50% of older adults with major depressive disorder (MDD) will recover spontaneously, this is usually only after long periods of morbidity. With standard treatment 75-80% of patients with MDD will recover but with heightened rates of mortality at 4 year follow-up, not attributable to suicide or ill-health.' (Watts et al, 2002, referencing Cole et al, 1999,Review and Baldwin and Jolley, 1986, Survey)
- 7.1.7. The treatment of depression is a particular issue for older men age 80+ because, although only around one tenth of those with depression consult a GP (see section 6.7.6) there is a greatly increased risk of suicide among this group.



National mental health development unit, 2008

A cross-national study of suicide rates among older people has shown that these are closely related to the overall level of mental health care provision.

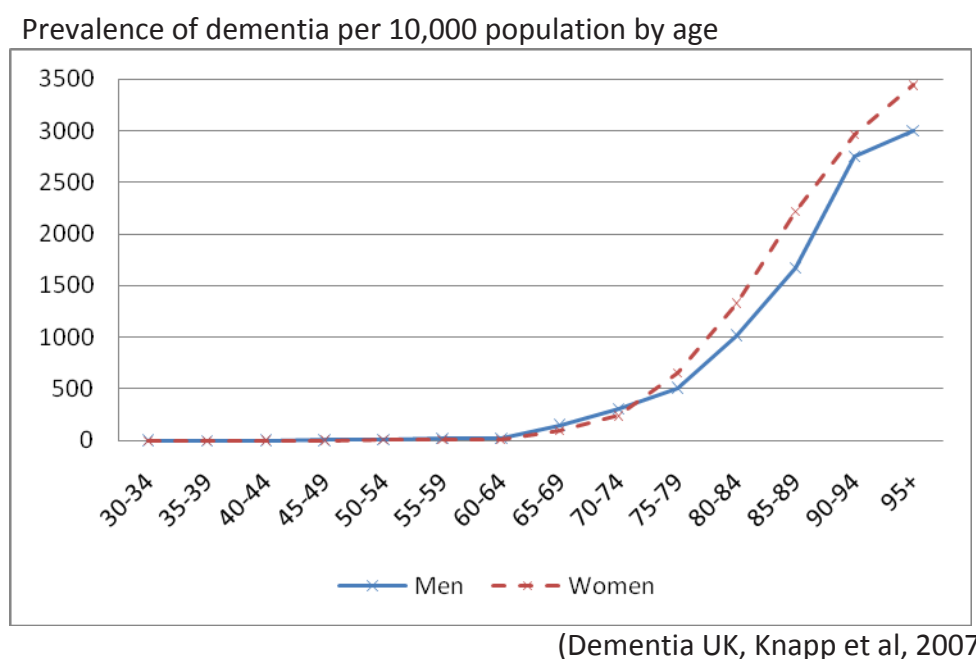
(Shah and Bhat, 2008, Study)

Summary

Neurotic disorders and depression are common features of later life but depression is under-recognised and under-treated both in primary care and care homes. Although 20-40% of older people in the community show signs of depression meriting treatment, only 4-8% will consult a GP. Older men aged 80 and over are at increased risk of suicide.

7.2. Dementia

7.2.1. Dementia is essentially (though not exclusively) a condition of older age. The current best estimates of the prevalence and numbers of people with dementia in the United Kingdom are contained in the 2007 study *Dementia UK* (Knapp et al, 2007, Review)



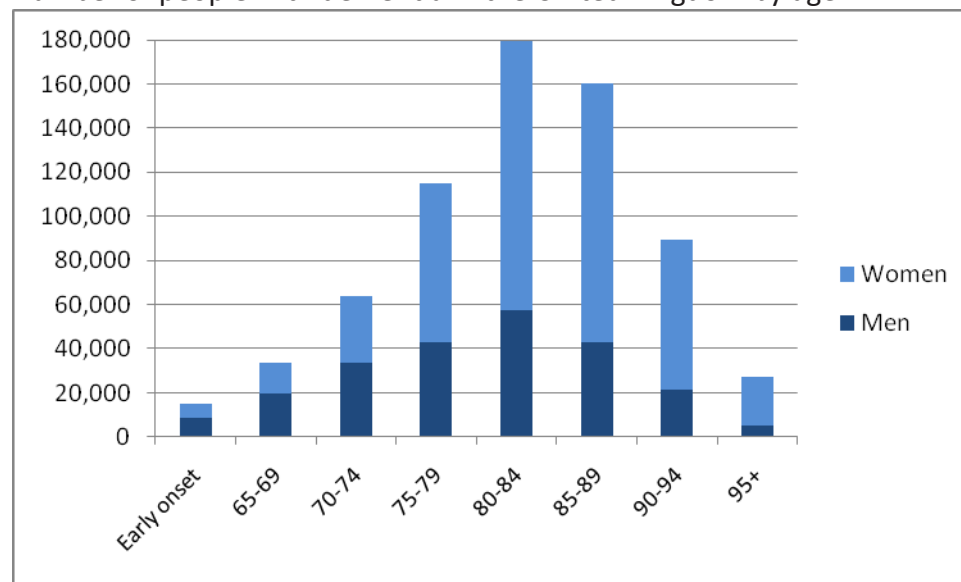
7.2.2. 'Early onset dementia is comparatively rare, accounting for 2.2% of all people with dementia in the UK. We estimate that there are now at least 15,034 people with early onset dementia (onset before the age of 65 years) in the UK and 668,563 people with late onset dementia (onset after the age of 65 years). However, given that data on the numbers of early onset cases are based on referrals to services, this number is likely to be an underestimate. The true figure may be up to three times higher.' (Knapp et al, 2007, Review)

7.2.3. 'Dementia currently affects 700,000 people in the UK and this is projected to double to 1.4 million in the next 30 years. Dementia costs the UK economy £17 billion a year, and in the

next 30 years the costs will treble to over £50 billion a year.'

(*Building a society for all ages*, Department for Work and Pensions, 2009, Policy document referencing Department of Health (2009) *Living Well with Dementia: A National Dementia Strategy*.)

Number of people with dementia in the United Kingdom by age



Early onset = aged under 65

(Dementia UK, Knapp et al, 2007)

- 7.2.4. 'Dementia presents a significant and urgent challenge to health and social care in terms of both numbers of people affected and cost. It is also a major personal challenge to anyone experiencing early symptoms and seeking diagnosis, which merits the seriousness accorded to, say, cancer. Parallels can be drawn between dementia now and cancer in the 1950s, when there were few treatments and patients were commonly not told the diagnosis for fear of distress.' (National Audit Office, 2007, Review)
- 7.2.5. 'Until 2005 the Department [of Health], and therefore local commissioners, attached little priority to dementia, partly because of the focus on other major diseases such as cancer and heart disease. At the same time, progress was hampered by a lack of good quality data, by stigma, and by the low level of political and national focus on older people's mental health. This was exacerbated by a lack of effective joint working across health and social care. As a result, people with dementia have not benefited from the developments in mental health services seen for working age adults.' (National Audit Office, 2007, Review)
- 7.2.6. Early diagnosis and provision of support for people with dementia can help planning and delay institutionalisation but GPs do not always recognise this (see section 6.7 page 41)

‘Currently only one-third of people with dementia receive a formal diagnosis at any time in their illness. When diagnoses are made, it is often too late for those suffering from the illness to make choices. Alternatively, diagnoses are made at a time of crisis; a crisis that could have been avoided if diagnosis had been made earlier.’ (Banerjee and Chan, 2008)

‘...early provision of in-home support can decrease institutionalisation by 22% ‘ (Banerjee and Chan, 2008 referencing Gaugler et al, 2005)

‘Behavioural disturbance, hallucinations and depression in dementia are three of the four most important factors in predicting institutionalisation, and older people’s mental health services are designed to treat these symptoms. ...Contrary to social misconceptions there is a great deal that can be done to help people with dementia and their carers and while there are undoubtedly potential negative reactions to diagnosis as well as positive outcomes, the balance is very much in favour of early diagnosis, and the earlier such intervention is available in the illness the better’ (Banerjee and Chan, 2008)

7.2.7. It is however possible, as a crude indicator, to make comparisons with other chronic conditions with a wider age range or with services in other countries to see if under-provision and therefore indirect discrimination is taking place.

Relative impact of Dementia and Cancer in England

	Dementia	Cancer
No of people with the disease (Cancer=2004, Dementia=2006)	560,000	230,000
Healthcare spend by Department of Health (2005-6) in £ billions	1.17	4.3

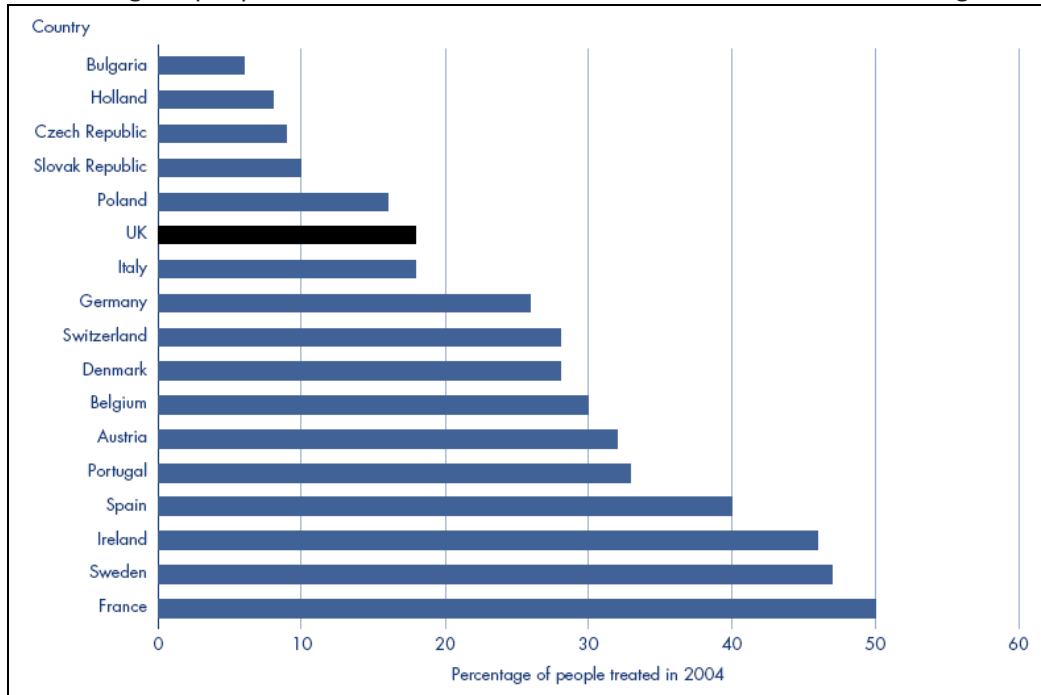
(National Audit Office, 2007, Review)

Although expenditure per patient on cancer is clearly much greater than for dementia we are not really comparing like with like. For cancer a number of expensive treatments with the possibility of cure are already available whereas, for dementia, only care and limited treatment to slow the progress of the condition are possible.

7.2.8. A better indicator might be comparison with treatment in other countries.

The United Kingdom compares poorly with most EU countries in the percentage of people with Alzheimer’s disease treated with anti-dementia drugs (National Audit Office, 2007, Review)

Percentage of people with Alzheimer's disease treated with anti-dementia drugs



(National Audit Office, 2007 from Waldemar et al, 2007)

7.2.9. Dementia is predominantly a condition of older age so it is not generally possible to make comparisons between the treatment of older and younger people.

The 2007 Dementia UK review stated 'There is very little information on care received by people with early onset dementia and therefore the costs here relate only to late onset dementia.' (Knapp et al. 2007, Review)

There is no clear published evidence that younger people with early onset dementia are treated better or worse than older people with late onset dementia so there is no evidence of direct age discrimination in dementia care.

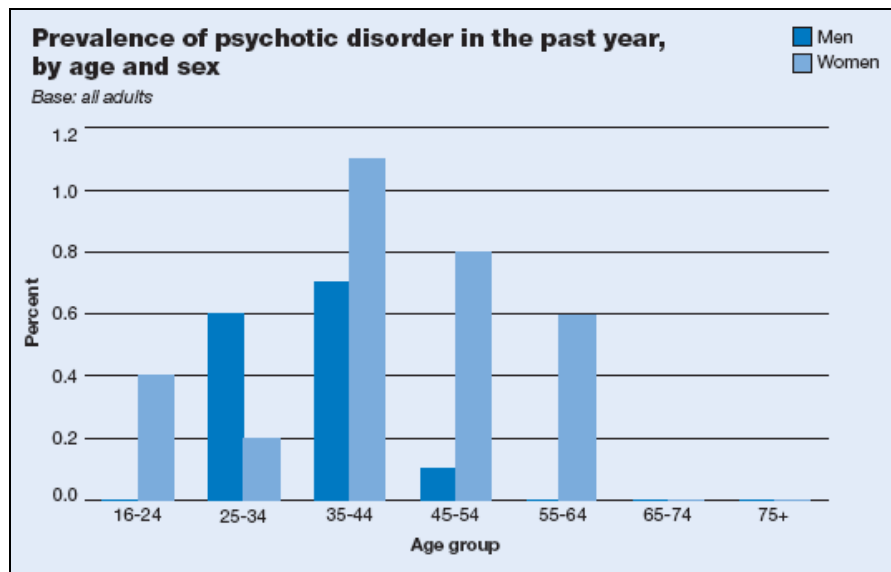
Summary

Dementia is almost exclusively a condition of older age so the under-provision of appropriate treatment may be indirect age discrimination. Dementia is not directly comparable with any other condition but there are indications of inadequate treatment. Only one third of dementia sufferers are formally diagnosed at any time in their illness and late diagnosis is common. The United Kingdom compares badly with most other European countries in the percentage of people with Alzheimer's disease treated with anti-dementia drugs.

7.3. *Less common conditions*

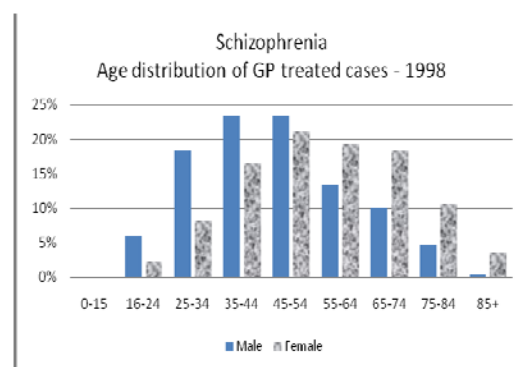
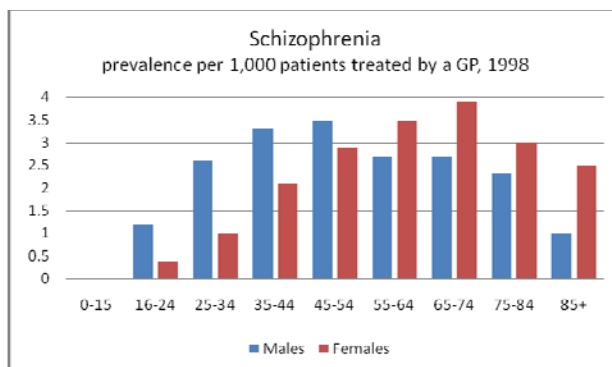
7.3.1. Older people with schizophrenia and other psychotic disorders, older people with alcohol and drug misuse problems and younger people with early onset dementia form minority groups who may find it difficult to obtain treatment appropriate to their age and condition.

7.3.2. Early onset dementia occurs in only 2.2% of people with dementia in the United Kingdom. Provision for this minority group may need to be sensitive to the age of the person with dementia but should not be better or worse than for an older person.



n=7,278

Adult psychiatric morbidity in England, 2007



Source: Office for National Statistics (ONS)- Key Statistics from General Practice (1998)

7.3.3. Although, according to the large *Adult psychiatric morbidity in England* survey, 2007, the prevalence of people aged 65 and over with psychotic disorders in the community is small, a smaller Swedish study has predicted that up to one fifth of non-demented older people who survive up to age 85 will develop first-onset psychotic symptoms. (Ostling, Palsson and Skoog, 2007, Survey) The prevalence of schizophrenia among older GP treated patients is higher than in the community and around 15% of male patients being treated by GPs for

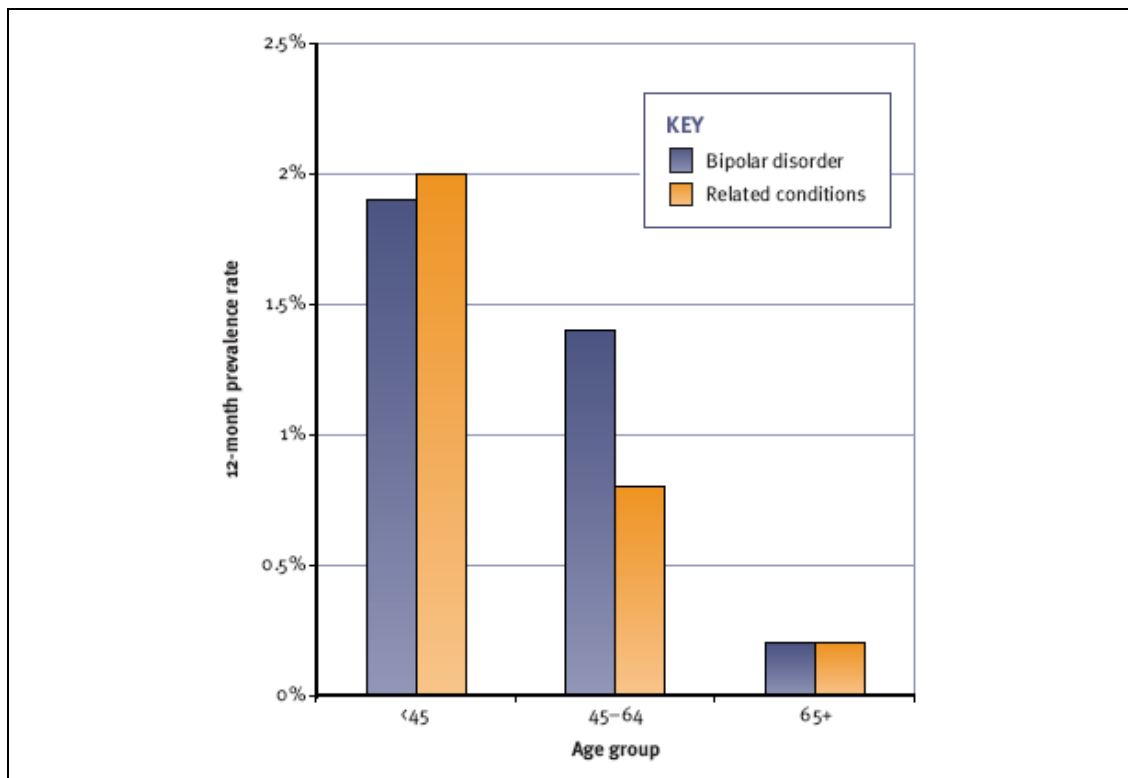
schizophrenia, and just under one third of female patients are aged 65 and over.

Similar issues arise around the age appropriate treatment of a less common condition arise with bipolar disorder.

‘Allowing for attrition due to age, the prevalence [of bipolar disorder] is probably the same as it is in younger age groups. Overall between 0.5 and 1% of the general population have the condition. ...the [NICE] guidance should emphasise that bipolar disorder affects all age groups. Although people can develop bipolar disorder at any age, most patients start to show symptoms of mania in early adulthood. Those who are older than 40 years when they present for the first time probably have something organically wrong with their brain rather than primary bipolar disorder. Such patients are identified as having a secondary mania. Regardless of age, people with mania do not want to talk about their symptoms because they do not think they are ill. ... Just because a person reaches 65 that does not mean they should be transferred to a different service’ (Salter, 2009, Opinion)

Contrary to Salter’s view, USA prevalence estimates from the National Comorbidity Replication, a very large community survey of mental health problems showed a marked decline in the prevalence of bi-polar and related conditions among older adults. (McCrone et al, 2008, Review)

Twelve month prevalence of bipolar disorder and related conditions by age group



Source: National Comorbidity Survey Replication

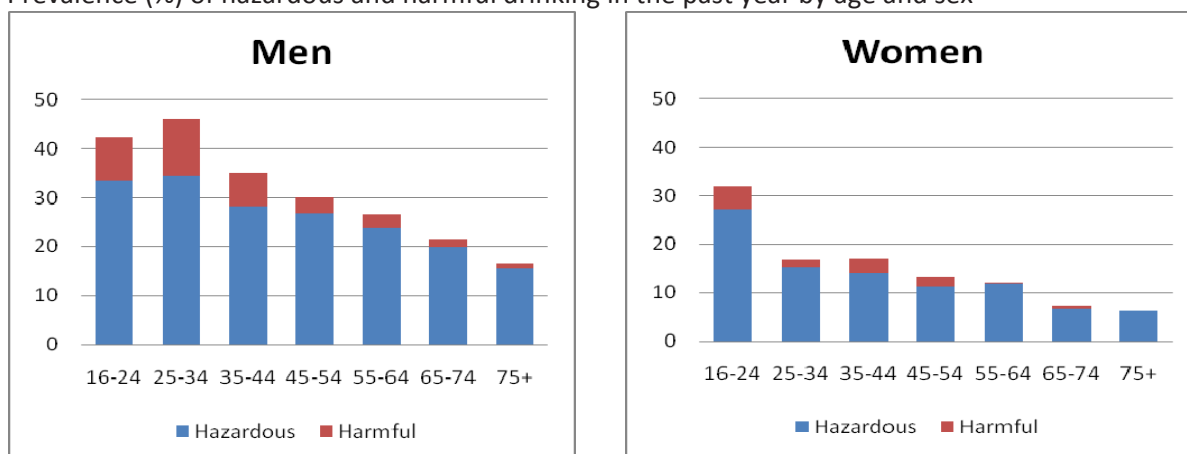
(McCrone et al, 2008, Review)

7.3.4. The prevalence of alcohol and drug misuse declines in older age.

The 2002 National Service Framework (Older People) interim report on age discrimination identified alcohol dependency services as one of the service areas within the NHS where written policies still had age-related criteria. (Department of Health, 2002, Review)

Possibly because older people form a minority group within those with alcohol related problems, there is evidence that older people have 'difficulties in gaining access to services for alcohol and substance misuse' (Healthcare Commission, 2009, Review)

Prevalence (%) of hazardous and harmful drinking in the past year by age and sex



n=7,384

Adult psychiatric morbidity in England, 2007, McManus et al

Summary

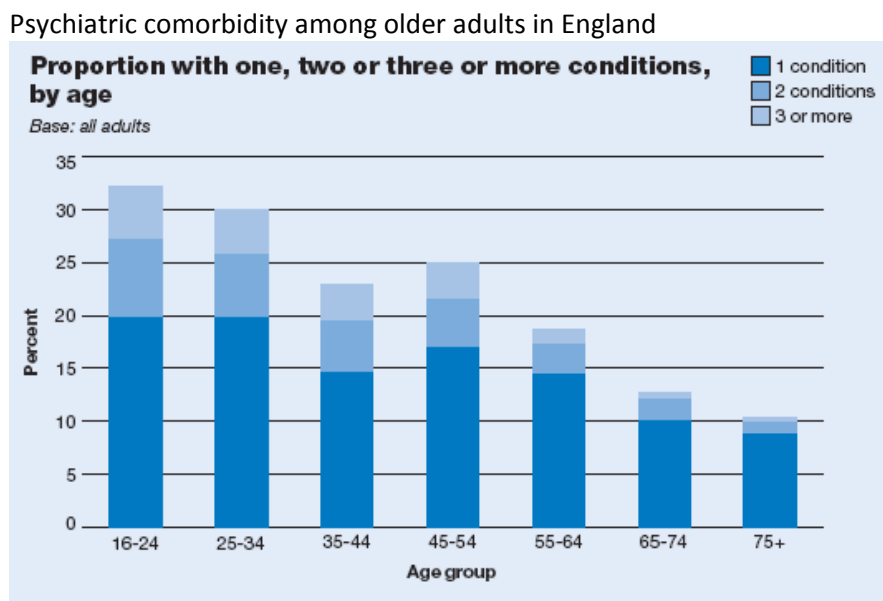
Older people with less common conditions have particular difficulty in gaining access to age appropriate service treatment for their condition. This is particularly true for specialist services such as those for alcohol and substance misuse.

7.4. *Comorbidity*

7.4.1. A complicating factor in the assessment of appropriate general healthcare for older people is comorbidity - the presence of more than one health condition. Older people commonly suffer from more than one physical condition which may lead to a more conservative approach in the treatment of any of the individual conditions suffered and to polypharmacy, the prescribing of a cocktail of drugs.

7.4.2. Anecdotal evidence indicates problems in the hospital treatment of older people who have both a physical and mental healthcare problem because these are typically treated by different teams in different locations. Liaison teams may well be able to help with the mental health care needs of older people in general hospital wards, but what is less obvious is that psychiatric ward nurses, may not have the necessary training to deal with a frail older mental health patient's physical health problems where application of the standard psychiatric ward protocols may be inappropriate. Older psychiatric ward patients may also have difficulty in gaining access to general hospital services such as physiotherapy.

7.4.3. Psychiatric comorbidity presents a less clear picture.



Source: Adult psychiatric morbidity survey in England, 2007

The 2007 Adult psychiatric morbidity survey of households in England (PMS) reported that psychiatric comorbidity declines with age with only 2.4% of adults aged 65-74 having two or more mental health conditions with the proportion falling to 1.5% at age 75 and over. This large community based survey excludes the 4% of older people in hospitals and care homes and may therefore tend to under-estimate overall morbidity. The PMS estimates that just 12% of older people have a psychiatric condition of any kind whereas the 2005 Health Survey for England (HSE), using different tests, reports that 20-40% of older people show strong symptoms of depression.

International studies have shown that older people with depression (Luchsinger et al, 2008, Survey) parkinson's disease (Aarsland et al, 2003, Survey), psychosis (Ostling, 2007, Survey)

and late and very late onset schizophrenia (Korner et al, 2009, Large survey) are more likely to develop dementia later in life.

- 7.4.4. Mental health and general levels of physical health in older people are closely related (see section 8.3). Depression and cerebrovascular accident are strongly correlated. Stroke is a risk factor for depression and, conversely, depression predicts a poor outcome after stroke. (Charney et al, 2003, Review)

Summary

Physical and mental health conditions are closely inter-related in older age and mental ill health may mark a predisposition towards later dementia but, except in conjunction with dementia, and unlike with the physical health of older people, psychiatric comorbidity is not a major problem.

8. Prevention and public health interventions

- 8.1. '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. '

(Department of Health, 2009, Policy document)

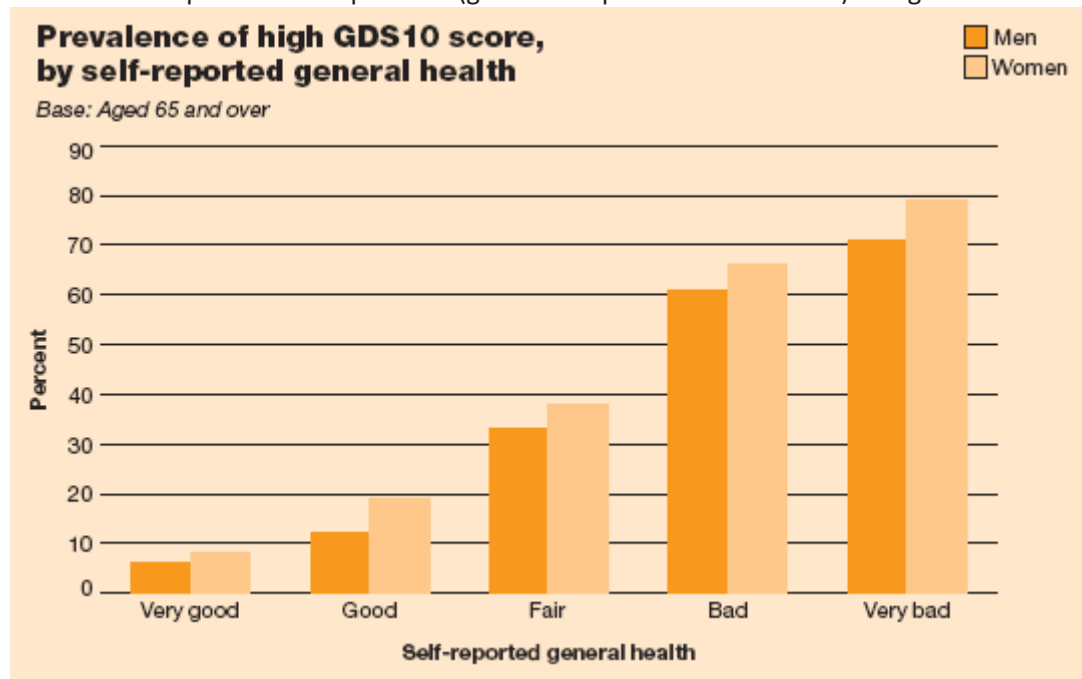
- 8.2. A systematic review of the effectiveness and cost-effectiveness of public health interventions to promote mental well-being in people aged 65 and over found evidence of the effectiveness of various exercise programmes (mixed exercise, aerobic exercise, walking interventions, and Tai Chi) in improving the mental health of older people. The review also reported strong evidence of the effectiveness of psychological interventions including cognitive training, control-enhancing interventions, psycho-education, relaxation and supportive interventions. The review also identified a two hours per week group session with an occupational therapist and twice-weekly exercise classes led by a qualified instructor as probably cost effective. (Windle et al, 2008, Systematic Review)

- 8.3. The Health Survey for England, 2005 demonstrated very clearly the strong relationship for older people, between mental health, as exemplified by a geriatric depression score of 3+, and self reported general health.

Summary

Physical and mental good health in older age are closely related. There is evidence that preventative exercise programmes are a cost-effective way of reducing the risk of mental illness. The absence of such programmes may be an example of indirect age discrimination.

The relationship between depression (geriatric depression score of 3+) and general health



n=3,606

(Health Survey for England, 2005)

9. **NICE guidelines and the use of the QALY**

- 9.1. In an attempt to standardise and rationalise the use of health care resources, the National Institute for Health and Clinical Excellence (NICE) uses Quality Adjusted Life Years (QALYs) and Incremental Cost-Effectiveness Ratios (ICERs) to assess the relative cost effectiveness of treatments as part of its Health Technology Assessment programme. The possible age discriminatory nature of the use of ICERs and the QALY are examined in more detail in the CPA companion review 'Ageism and age discrimination in secondary health care'.

- 9.2. It is generally accepted that because of lower life expectancy and higher levels of comorbidity, treatments and interventions for older people are less able to generate QALYs. 'Life expectancy is correlated with both age and the ability for a treatment to produce QALYs. Other things being equal, those who are older have lower life expectancy; and those with lower life expectancy are able to produce fewer QALYs.' 'Other things being equal the treatment of a patient with significant comorbidities will produce fewer QALYs than treating a patient in otherwise perfect health. Since older people suffer from more comorbidities than the young, their health gains will be lower on average.' (Edlin et al, 2008, Review)
 '...if the effects of treatment are expected to last for life, patients with a short life expectancy cannot expect to come out as favourably as those with long to live.' (Taylor, 2007, Study)
- 9.3. It has been argued that, because older people with lower life expectancy and higher levels of comorbidity are less able to generate QALYs, the QALY is inherently age discriminatory. 'It is the fact that younger people usually (though not always), have more life expectancy to gain from treatment that makes the QALY "inherently ageist".' (Harris, 2005 quoted in Taylor, 2007)
- 9.4. Others argue that because of averaging, the effect of age on QALY league tables is reduced. 'The influence of age on QALY league table estimates is normally quite small because the estimates derive from averaging results from patients of different ages. Where a treatment is predominantly for older patients, the estimate would be affected by the lower life expectancy of the elderly...' (Dey and Fraser, 2000, Study)
 'While the macro level use of CEA [cost-effectiveness analysis] greatly reduces the scope for age discrimination, it does not entirely remove it. The benefits to older people will still be lower and so treatments that mostly impact on an older population will still be affected by a generally lower ability to produce QALYs.' (Edlin, 2008, Review)

It is also argued that where a treatment is provided on a pay-as-you-go basis the marginal costs effectiveness will be the same at any age.
 '...provided costs and the health gains are the same, the incremental cost per QALY will be no different for a three year old than for an 83 year old. The QALY is not therefore inherently ageist...'
 '...the elderly might in theory be disadvantaged in the evaluation of an exceptionally

expensive procedure, device, or drug (given as a single dose or a short course) whose health gain persists over a long period. A child aged three years would then be likely to enjoy more than 70 years of benefit compared to the additional five years that an 80 year old could expect. We cannot, though, think of a single example...' (Rawlins and Dillon, 2005, Opinion)

- 9.5. There would appear to be no age related ethical problems in the use of QALYs to assess the cost effectiveness of treatments applicable across all ages or to assess the relative cost effectiveness of a range of treatment options for patients of a particular age. The issue is whether the QALY is an ethically valid tool to assess the relative cost-effectiveness of a treatment only or mainly of value to older people against treatments for other conditions applicable to younger people or across all age ranges.

In mental health, controversy has arisen over NICE's use of the QALY to assess the cost effectiveness of treatments for Alzheimer's disease. In addition to questions about the ethical justification of the use of the QALY in assessing a treatment for older people, this assessment raises issues of whether and how QALYs can be calculated for someone with cognitive impairment and whether carers are good proxies.

(Taylor, 2007, Study)

NICE recommends the use of the EuroQol 5-dimensional measure EQ-5D to assess changes in quality of life. (NICE, 2008, guide) Drawing together earlier studies on chronic schizophrenia, Knapp and Mangalore highlight the unreliability of EQ-5D in assessing quality of life in mental health '...the use of EQ-5D as the core measure of health state evaluation in the field of psychiatry seems less than fully convincing or appropriate.' In assessing patients with dementia 'results from proxy ratings raised further questions as to whom the appropriate proxy should be as different groups provide different ratings' (Knapp and Mangalore, 2007, review)

- 9.6. It has also been argued philosophically that the QALY is a utilitarian measure being used in a National Health Service that is and should be organised on egalitarian principles. 'NICE openly works to a utilitarian model, but this is not to say it endorses discrimination. The discretion applied after the application of the QALY and the other stages of appraisal are intended to account for this. ... NICE is applying utilitarian principles and then adapting them to conform to the egalitarian restrictions placed upon them by the NHS. ... adaptation and

even weighting of the QALY, can never fully reflect the principles supported by the NHS due to the differing ethical basis, and as such NICE should be cautious in applying the results of such a model in situations such as the current Alzheimer's controversy.'

(Taylor, 2007, Study)

Summary

While there appears to be no ethical problems in the use of the QALY to compare the relative cost effectiveness of treatments applicable to all ages, or to compare the relative cost-effectiveness of alternative treatments of the same condition at any particular age, there may be problems of age discrimination in the use of QALYs to compare the costs effectiveness of the treatment of a condition such as Alzheimer's disease, which only or predominantly occurs in older age, against treatments of other conditions that occur in younger people or at all ages. In addition, the EQ-5D measure of quality of life may not be sufficiently sensitive to accurately reflect changes in mental health status.

10. **Education and training**

10.1. A UK survey of trainee clinical psychologists to determine why few were attracted to working with older people found that the predominant recommendation for improvement of recruitment to the speciality was 'good quality placements and teaching during training'.

(Lee, Volans and Gregory, 2003, Survey)

10.2. A European wide study of older age psychiatric training identified the small proportion of total time in general psychiatric training spent on the older age speciality. Although in England in 2009, older adults made up 29% of the combined caseload of adult and older people's mental health services, the European wide study found that the average proportion of time allocated to old age psychiatry in European psychiatric residency programmes is 10% (de Mendonca Lima, 2003)

Summary

Old age psychiatry is under represented in general psychiatric training. Good quality placements and teaching during training have been identified as key factors in attracting

clinical psychologists to work with older people.

11. Conclusion

- 11.1. Bodies campaigning to end age discrimination in mental health services for older people are, in many ways, knocking at an open door. Although quantitative evidence is thin, and there is widespread variation in service provision, in evidence from professionals there is general agreement that mental health services for older people are under-provisioned in comparison to those for working age adults. Bodies such as Age Concern / Help the Aged and the Royal College of Psychiatrists have long argued that services should be provided on the basis of need rather than age, and the government, in a range of policy documents from the 2001 National Service Framework for Older People to New Horizons (2009), has agreed.
- 11.2. The issue is that mental health services for older people are locally organised and locally provisioned to reflect local variations in need. This seems to have resulted in regional variation in the level and quality of service with some areas discriminating directly by age in continuing to operate a 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.
- 11.3. Mental health services for older people provide one of the few remaining examples, within the NHS, of the continued existence, in some localities, of explicit institutional 'direct' age discrimination. This direct age discrimination results from the age based division into mental health services for adults and older people's mental health services (OPMHS). It is particularly noticeable for 'graduates', older people with continuing mental health conditions who transfer from adult to older people's services and find they can no longer access the same facilities or quality of service as before.
- 11.4. 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. Organisation as a separate service, if under-provisioned, may be inherently age discriminatory or, if properly provisioned, may be a case of reasonable age

based differentiation and therefore a proportionate means of achieving a legitimate aim.

11.5. The model of a primary care based physician should enable a holistic approach to the care of older people but expertise in identifying and treating mental illness in this group is variable among General Practitioners. There is widespread evidence of the under-recognition and late diagnosis of both dementia and depression. Depression is often seen as just a part of ageing and the value of early recognition of dementia is often questioned.

This is compounded by the reluctance of older people with mental health problems to seek help from mental health services. The net result is that a large proportion of mental health cases in older people remain undiagnosed and untreated.

11.6. It is not clear whether the under use of mental health services by older people results from the perceived social stigma of having a mental health condition, a denial of being unwell , or ageism and age discrimination in the application of mental health services. It is possible that older people with a mental health problem face double discrimination from the combination of ageism and the stigma of mental illness.

11.7. Many residents of care homes have mental health problems but access from care homes to psychiatric services is insufficient and care home staff have very little training in dealing with residents with mental health problems. There is evidence of the inappropriate use of medication for psychosis on care home residents with dementia.

11.8. It is likely that the levels of mental illness in older people could be improved by the wider availability of adult education classes and other forms of appropriate mentally stimulating activity, by programmes of suitable physical exercise and by a reduction in pensioner poverty and other forms of deprivation.

12. **Recommendations for further study**

12.1. It is recommended that steps be taken to improve the availability of quantitative information about the provision of mental health services to older people throughout the United Kingdom. Where surveys do take place it is recommended that published results give

a breakdown by age.

- 12.2. More work is needed to find the reasons for the low levels of diagnosis and treatment of mental health conditions in older people and why older people are reluctant to use mental health services.
- 12.3. Further research is needed to determine the relationships between mental illness, particularly depression, and levels of deprivation in older age.

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