National Mental Health Development Unit

National Development Team for inclusion

A Long Time Coming

Part 2 - Achieving age equality in local mental health services

older people and ageing

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It's been a long, a long time coming
But I know a change gonna come, oh yes it will

Sam Cooke, 1964

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Overview

This report shares the findings, lessons and recommended actions arising from a National Learning Network established to inform the development of age equal mental health services in the Midlands. It is the second of two Papers produced to share the key messages and conclusions from this work, including national and local priorities for developing mental health services that improve the life chances of older people whilst meeting the requirements of the Equality Act 2010.

The Achieving Age Equality in Mental Health Network was a four month project that worked with two diverse localities from neighbouring regions of England, to help them assess their readiness for age equality in line with the Equality Act 2010[1] and the aims of the Equality Delivery System described in *Equity and excellence: liberating the NHS*[2].

The Network helped local partners to establish whether and where age discrimination exists in mental health services; and agree local priorities for developing cost effective and inclusive mental health systems for all ages, as outlined in *No Health without Mental Health*[3]. It used and tested key elements of an online Resource Pack for Achieving Age Equality in Health and Social Care, produced in response to the findings of the Department of Health's review of age discrimination in health and social care (The Age Review[4]). The Resource Pack is accessible at www.southwest.nhs.uk/age-equality.html.

The Network focused on age equality within the broader context of the Equality Act, i.e. the eight protected characteristics of age; gender; disability; race, religion or belief; sexual orientation; gender assignment; marriage and civil partnership; and pregnancy and maternity. It also addressed the seven types of discrimination set out in the legislation (direct and indirect discrimination, associative discrimination, harassment, harassment by a third party, victimisation and discrimination by perception) as well as actions taken to promote equality. The project was funded by the National Mental Health Development Unit (NMHDU) and delivered by the National Development Team for Inclusion (NDTi) with the support of a National Reference Group and East and West Midlands Strategic Health Authorities.

[1] *Equality Act 2010.* Government Equalities Office. http://www.equalities.gov.uk/equality_act_2010.aspx
[2] *Equity and excellence: liberating the NHS.* (2010). Department of Health
[3] *No health without mental health* (2011) Department of Health
[4] *Achieving age equality in health and social care* (2009) Sir Ian Carruthers and Jan Ormondroyd for the Department of Health

The findings and lessons from this project have been written up in two separate but connected reports. This report – Part 2 – shares the experiences and lessons from auditing mental health services in the two localities involved in the Network, including the process of agreeing local actions in order to address age discrimination identified. Part 1, which accompanies this report [available on http://www.ndti.org.uk/publications/ndti-publications/] focuses on the national implications and strategies for achieving age equality in the light of key findings and outcomes of the Network sites and other elements of the project.

Summary of findings

As a result of this work, four key factors which define successful age equality in mental health were identified, which can be used to guide the development of local services and inform future policy and practice in this area. These four factors include:

- A shared vision of age equality in mental health
- Better outcomes for and experiences of older people
- Responsive, personalised services and support
- Positive attitudes and mindsets.

In addition, four specific challenges to achieving age equality in mental health were also found which need to be addressed as part of the key strategies for achieving equality in mental health services at a national and local level. The four challenges are:

- Lack of familiarity and confidence with 'age equality
- Persistent age discrimination in mental health services
- Lack of guidance on how to tackle age discrimination
- Lack of relevant data and outcome measures.

Finally, the following priorities for action were identified to address the issues faced in developing age equal mental health services in all areas:

- Ongoing work to demonstrate "what works" (in combating age discrimination and delivering age equality in mental health) and supporting local partners to achieve age equality across the country
- Building the capacity, skills and confidence of older people, including mental health service users growing older
- Strong leadership in order to develop and adopt a shared vision about "age equality" in respect of mental health / mental health services
- Development of an outcomes and data framework on age equality in mental health.

These findings and recommendations have implications for the way in which local services

seek to meet the needs of their local communities, and respond to the particular requirements and circumstances of older people with mental health support needs. They also have implications for public agencies as they prepare for the requirements of the Equality Act 2010, and specifically the need to promote age equality as one of the eight protected characteristics set out in the legislation.

About this report

Chapter 1 provides the background to this work, and introduces the aims and activities of the Network.

Chapter 2 introduces the two Network sites and shares their experiences, findings and priorities for achieving age equality in local mental health services.

Chapter 3 summarises the key findings and messages arising from looking across all elements of the work.

Chapter 4 sets out four key priorities that need to be addressed to ensure achieving age equality in mental health services is taken forward at a local and national level.

Six appendices provide supporting information and data relevant to the work in the Network sites and age equality in mental health more widely.

Chapter 1: Introduction and background

This chapter provides the background to and rationale for this work, including the main aims and objectives associated with different aspects of the Network.

1.1 Achieving Age Equality – why it matters

Age discrimination is one of the least discussed but most often encountered forms of social injustice in the UK. Providing high quality care to people of all ages is at the heart of the principles of the health and social care system; and in the White Paper *Equity and excellence, liberating the NHS*, the Government committed to end age discrimination in health and social care by 2012.

This commitment was based on the conclusions of the national review of age discrimination led by Sir Ian Carruthers, OBE, Chief Executive of NHS South West, and Jan Ormondroyd, Chief Executive of Bristol City Council. In their report *Achieving age equality in health and social care*[5] (also referred to as the Age Review), Carruthers and Ormondroyd advised on how the health and social care sector could end age discrimination and promote age equality in the light of the provisions in the Equality Act 2010.

Mental health was one of the three key areas[6] highlighted for particular attention in the Age Review, where evidence of age discrimination was most widespread. The review states that:

> *"Every provider and commissioner of mental health services will need to consider how to achieve non-discriminatory, age-appropriate services, drawing on insights from reports such as Equality in Later Life[7] and other sources of good practice."*

[5] *Achieving age equality in health and social care*, Sir Ian Carruthers and Jan Ormondroyd, 2009
[6] The other two areas were acute care, and primary and community based health and social care.
[7] *Equality in Later Life: a national study of older people's mental health services*. Healthcare Commission. March 2009. Commission for Healthcare Audit and Inspection

As a response to the critical findings set out in this report, the NHS Operating Framework for 2010-11 highlighted the need for the NHS to take account of the recommendations made, and the Association of Directors of Adult Social Services advised local authorities to use them in their work to prepare for the new public sector equality duty introduced in the Equality Act 2010.

> The Equality Act 2010 places new duties on organisations and individuals to treat individuals fairly through ending discrimination and promoting equality. Alongside the other "protected characteristics", such as race, gender, disability etc, the Act for the first time bans age discrimination in the provision of services and introduces a duty on public bodies to promote equality, including age equality.

Work on age equality therefore should inform existing work programmes to address inequalities and improve local service delivery and efficiency. In particular, it will help local organisations developed a clear, local focus in preparing for the requirements of Equality Act as set out in the White Paper *Equity and excellence; liberating the NHS*.

The Age Review also highlighted the need for local authorities, NHS organisations, voluntary and independent sector providers, community groups, older people's forums and networks to work together to undertake a joint audit of age discrimination and age equality across all services, systems and processes in health and social care. A resource pack and audit tool was developed to assist local partners to undertake this task, and to develop locally agreed action plans for eliminating age discrimination and achieving age equality. The audit tool can be accessed on http://age-equality.southwest.nhs.uk. NHS Chief Executives and Director of Adult Social Care were encouraged to adopt this process and mandate a small local Area Audit Group to deliver this work (see also section 1.3).

1.2 A Regional Network on Age Equality in Mental Health Services

The Mental Health Equalities Programme of the National Mental Health Development Unit (NMHDU) commissioned NDTi to design, facilitate and support a Learning Network to promote age equality in mental health in designated sites in one English region. The network was open to NHS organisations and local authorities' adult social care departments, and their third sector, community and private sector partners involved in the planning, commissioning and delivery of mental health services.

Following extensive discussions at the design and planning stages, it was agreed to target the work in the East and West Midlands, working through the two Strategic Health

Authorities and local Inclusion and Equality networks to engage interested health and social care communities.

Expressions of interest were received from a number of authorities and their partners across the Midlands, and a decision was made to provide in-depth development support to two local partnerships who would also participate in cross site, region wide learning events. The two local partnerships (or Network sites) were from Coventry & Warwickshire, and Leicester, Leicestershire and Rutland.

The aims of the Network were to:

- Provide an environment that enabled the Network sites to: establish an Area Audit Group and get started on their local audits; share what's working and not working in delivering age equal mental health services; and identify steps to combat age discrimination and achieve age equality
- Use (and therefore test and refine) the mental health criteria in the AAE audit tool, to assess local readiness for meeting the requirements of the Equality Act 2010 in mental health and associated services
- Capture examples of best practice through a national 'call for information' to identify examples of age equality in mental health services
- Analyse national and site specific, publically available data highlighting key trends and recommendations for future outcome/data analysis
- Make the links with and build on concurrent developments to transform health and social care services, including the personalisation of services/support.

Each site was asked to set up a small, representative Area Audit Group (AAG) that would be coordinated by a nominated 'local lead' from the respective PCT/Local Authority/Partnership Trust.

A National Reference Group (NRG) was established by NMHDU to help guide and oversee the work, consisting of representatives from relevant teams within the Department of Health, the Care Quality Commission, Royal Colleges and key organisations involved in promoting equality for and of older people. NRG members are listed in Appendix 6.

1.3 The Achieving Age Equality Toolkit and Audit Process

The Achieving Age Equality audit tool comprises 54 criteria of age discrimination and/ or age equality within and across health and social care services. These criteria are organised into four main categories, reflecting the key priorities identified in the Achieving Age Equality report where further work is required to eradicate and ban age discrimination.

These are:

1. Organisational and system readiness (for age equality in health and social care)
2. Acute care and treatment
3. Primary and community based health and social care
4. Mental health.

Each of the 54 criteria is presented in the form of three statements:

- A 'RED' statement describes a situation in urgent need of significant improvement.
- An 'AMBER' statement describes a situation that is not critically poor but where there is still room for significant improvement.
- A 'GREEN' statement describes a situation in which local services reflect current best practice, where age discrimination is almost or completely eradicated.

The web based Resource Pack which houses this audit tool also describes an “ideal process”, whereby local Area Audit Group members work together to collect data that will enable them to assess the local situation in relation to these criteria - forming a judgement as to whether local services and practices reflect a red, amber or green situation. The process enables partners to undertake a joint self-assessment and gap analysis, the results of which can be used to identify priorities for action. The process is therefore of practical and strategic value in informing local decision making regarding critical investments and the allocation of scarce resources across the health and social care system.

This Learning Network focused primarily on using the mental health criteria, whilst also taking account of the organisational and system readiness criteria in order to steer local developments designed to achieve age equality in mental health. See Appendix 1 for a summary of the mental health criteria.

1.4 Wider national context for the work

The Achieving Age Equality in Mental Health Network ran between November 2010 and March 2011 – an extremely condensed timeframe during which the scale and pace of change within NHS and social care organisations increased in both intensity and reach. This section outlines some of the most pertinent and challenging contemporary issues impacting on local services and decision makers.

No health without mental health[8] - the strategy framework for mental health - was published by the Department of Health in January 2011, halfway through the lifetime of this short programme. It is a package of 8 documents and associated resources written to inform the development of comprehensive and holistic services and support to promote better mental health and wellbeing in England. It takes a life course approach to mental health, spanning children and young people's mental health issues through to very old age. Placing older people's mental health and wellbeing within a clear public health framework is an important shift from current provision.

At the same time, the scale and nature of public services cuts and reforms within and across health and social care systems have proved to be wide ranging and cross cutting. No service or 'client group' is unaffected and it will be increasingly important for different public bodies to work together to map and allocate scarce resources, identify and assess local needs and priorities, develop and deliver cost effective, personalised services that improve health and wellbeing whilst demonstrating value for money. The need for high quality, easily accessible data and outcome measures cannot be under-estimated, and is a key focus of the new mental health strategy framework.

The coalition government is committed to a vision of a 'Big Society' whereby local communities have a much greater voice and influence over local decision making and are expected to contribute as active, engaged citizens[9]. Local authorities and NHS organisations have a role to play in supporting service users, carers and staff to work together in order to better understand the key determinants of good and poor mental health and wellbeing locally – and to coproduce services that meet the needs and aspirations of local people across all ages. Ensuring this happens and is inclusive of older people whose voices are continually not well heard[10] is a key challenge and priority in the future development of age equal mental health services.

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[8] *No health without mental health: a cross Government mental health outcomes strategy for people of all ages* (2011) Department of Health

[9] http://www.cabinetoffice.gov.uk/big-society

[10] *Moving Out of The Shadows* (2004); *Disregarded and Overlooked: a report on the Learning From Experience research into the needs, experiences, aspirations and voices of older people with mental health needs, and carers, across the UK.* Bowers, H et al. (2006). A report to the National

The supporting evidence which informed the Age Review included a detailed analysis of age discrimination in mental health services[11]. This review and the best practice guides which form part of the Achieving Age Equality Resource Pack[12] point to the decade or more of studies, reports and concerns about the low profile and expectations, and poor quality and outcomes associated with older people's mental health services. For example:

- The Royal College of Psychiatrists' report on Age *discrimination in mental health services: making equality a reality (*October 2009) states that access to services must be based on need and that "a needs-based service will still require the development of comprehensive specialist-based mental health services for older people". It outlines a number of guiding principles and recommendations for action. These include the development of a toolkit that allows self-assessment of services based on need, not age.

- The Healthcare Commission report, *Equality in later life: a national study of older peoples' mental health services (March 2009),* the Mental Health Foundation report All *Things Being Equal: Age Equality in Mental Health Care for Older people (April 2009),* and *Everybody's Business (Department of Health/Care Services Improvement Partnership, 2005)* all identify aspects of a good mental health service for older people and aspects of a non- discriminatory service. None of these reports includes clear indicators or measures of a non-discriminatory service, although the first two documents make clear that non-discrimination does not mean providing an identical service to people of all ages; and they also highlight the paucity of data available which can be used to identify progress on key themes including age discrimination.

A number of critical challenges and recurring messages can be discerned from looking across these important and influential reports and policy frameworks, all of which are relevant to the findings and subsequent conclusions drawn from this Learning Network on achieving age equality in mental health. These somewhat negative messages, summarised below, reinforce the need for coordinated and urgent action to improve older people's access to and experiences of high quality, evidence based mental health services and support. They also form the backdrop to the work of the Network sites, providing the context for their work and explaining results of their age equality audits.

Inquiry on Mental Health and Wellbeing in Later Life which informed the final Inquiry report published Summer 2007; *Improving Services and Support for Older People with Mental Health Problems (2006).* Age Concern England; *Older people with high support needs: how can we empower them?* (2010) Blood, I. Joseph Rowntree Foundation's Better Life Programme; *Older people's vision for long term care* (2009) Bowers, H. et al. Joseph Rowntree Foundation.

[11] *Ageism and age discrimination in mental health care in the United Kingdom* (2009) Centre for Policy on Ageing

[12] http://age-equality.southwest.nhs.uk/downloads/guides/age-equality-nhs-practice-guide-chapter14.pdf; http://www.scie.org.uk/publications/guides/guide35/index.asp

1. There is a tendency for national mental health strategies to either avoid, ignore or downplay the prevalence of mental ill health among the older population and effective strategies for preventing, treating and reducing these patterns and trends in order to improve the outcomes and experiences of older people in relation to mental health services and the broader determinants of their mental health and wellbeing;

2. As a result, there is a lack of a strategic, whole system, whole life approach to mental health needs and services. This is reflected in how services are commissioned, configured and delivered at a local level. For example, there is an ongoing debate and tension between those who view “age related” services as a specialism to be protected and those who view this model as discriminatory;

3. There is a wealth of evidence that older people experience restricted access to services and support in respect of their mental health and wellbeing than people under the age of 65. This inequity is reflected in how resources are allocated between and to different service and client group areas – particularly in relation to commissioning budgets, professional /workforce profiles, individual budget allocations and the range of services / supports promoted for younger and older adults

4. There is an absence of high quality and easily accessible information and data (especially relating to outcomes) relating to mental health in general and older people’s mental health in particular;

5. The involvement and influence of older people in designing and delivering responsive mental health services and support is variable and in most places woefully inadequate. Older people continually identify age discrimination as one of the key concerns they have about health and social care services, and about mental health services in particular.

6. There is an ongoing focus on dementia at the expense of a profile of and understanding about the prevalence and experiences/outcomes associated with the far more common mental health difficulties that older people experience such as depression, anxiety, low mood, psychoses, drug and alcohol problems, eating disorders, and suicide.

1.5 Searching and Learning from Innovation

NDTi issued a call for information designed to source practical examples and approaches that are shown to be effective in tackling age discrimination in mental health services, and in relation to broader aspects of older people's mental health and wellbeing. The aim was not to gather more evidence of problems or examples of discrimination; those are well documented and acknowledged[13]. This call was designed to find out how different areas and partners/stakeholders address age discrimination or prevent it from happening in the first place.

It focused on four key areas:

- Commissioning and resourcing local services
- Delivery and provision
- Enabling the voices of older people and those of carers to be heard
- Guidance, advice and information on multiple discrimination/equality issues including tools adopted or used to achieve age equality in mental health.

See Appendix 2 for the template provided to guide respondents in providing information on these four topics.

From all the responses received, eleven local examples were selected as meeting the Network's criteria of demonstrating current or recently initiated developments to achieve age equality in mental health services. Detailed information relating to each example was logged using an "evidence grid", summaries of which are shared throughout this report. Contact details are provided for most of these examples, if further information about the detailed, local practicalities is required.

From looking across these examples, a number of specific issues become apparent, which resonate with the findings and experiences of the Network sites and data analysis:

[13] *Ageism and age discrimination in mental health care in the United Kingdom* (2009). Centre for Policy on Ageing; *Achieving age equality in health and social care* (2009) Sir Ian Carruthers and Jan Ormondroyd, Department of Health

- Professionals seem to equate ‘age equality’ with “age neutral” specialist services and teams or contracts (i.e. where age is not specified as an inclusion or exclusion criterion for a particular service). This is a seductive idea, especially when examples of age discrimination are provided that illuminate the negative impacts of people not being able to access services because they are over 65 years. However, within age neutral services, it remains important that the needs, aspirations, circumstances and outcomes for individuals can be determined and monitored by age – to ensure that equity of access, opportunity and outcome can be assessed and assured. It was most often the case that those providing this information about “age neutral” services either did know or could not provide this information.

- There are widespread and strongly held assumptions and beliefs that older people do not benefit from certain interventions (such as psychological therapies) despite the lack of evidence that this is the case. In fact the evidence base gathered together through this work indicates that the opposite is true. These assumptions and beliefs influence the expectations of/for older people, their access to services, and the outcomes they experience from the services they do access;

- There are equally strong concerns about fairness and ensuring a ‘fair deal’ in relation to what range and type of services/supports are on offer to people of different ages. These concerns were most commonly raised or instigated by older people and third sector organisations.

- There was a striking absence of information and/or examples relating to primary care and adult social care, which is particularly relevant given the concerns raised about the responsiveness of primary health and social care services within the Network sites (and the lack of data readily available to ratify or evidence those concerns);

- There is a growing understanding of the need to and potential benefits from adopting a life course approach in commissioning and providing mental health services – but little apparent or consistent understanding about what this means including the implications for how services will be resourced, organised and delivered in the future.

1.6 Developing an Outcomes and Data Framework

This feature was added to the programme following discussions and early work with sites, as a result of problems experienced in accessing and using data in order to populate the audit tool. This element of the work was carried out in three stages.

1. The critical "data issues" experienced by the sites were examined to distil common concerns or areas where targeted, independent analysis would be helpful – both to the sites but also for wider learning;

2. A "data grid" was drawn up to capture these concerns, and a desk based search of relevant data sources and published literature/studies was undertaken. The results of this search and subsequent analysis were used to populate the grid and identify key national trends and features in one "composite" table.

3. A review of each site's JSNA was carried out, including a process of applying the national trends from the second stage to local demographic and service/system information.

Figure 2 summarises these key issues and the kinds of data sourced and analysed to identify national trends and issues, i.e. the data grid produced in stage 2.

Key areas to focus on as part of this work	Look for **age-specific** data around rates and types of:				
	Prevalence	Diagnosis	Referral[14]	Treatment / access to therapies[15]	Outcomes
Dementia					
Depression and other "common MH problems"					
Suicide					
Access to drug and alcohol services					
Co-morbidity (e.g. m & phys illness)					

Figure 2: Measuring age equality in mental health – data grid

[14] Including GP referrals to CMHTs, specialist mental health services and psychological therapies
[15] 'Access to psychological therapies' also a key focus area in its own right

Chapter 2: Local Findings and Priorities

This chapter shares the background to and activities undertaken by the two Network sites, and their experiences of working in partnership to audit their services, explore issues of discrimination and equality in mental health services, and identify priority actions.

2.1 Introducing the sites

Each of the participating sites comprised a minimum of two statutory agencies working in partnership with voluntary and community sector organisations, independent/private providers, support groups, user and carer participation arrangements, and user led/peer networks. For Coventry and Warwickshire, the lead agencies were Coventry City Council and Coventry and Warwickshire Mental Health Partnership Trust; for Leicester, Leicestershire and Rutland the lead agencies were Leicester City Council, Leicestershire County Council, Rutland Borough Council and Leicestershire Partnership NHS Trust. .

This list of local partners reflects the complexity of most health and social care communities and interest groups that have a stake in developing age equal mental health services. This complexity is set to further increase with the commitment to stimulate market developments aimed at increasing choice and personalising services and options for support e.g. through greater diversification of provision such as the development of social enterprises and civil society organisations as well as developments associated with shifting power to individuals, families and 'capable communities'.

Through this Network, and previous work to develop age aware and age equal services, we have emphasised the importance of understanding local communities' demographic profiles and characteristics. This essential starting point in enshrined within the guidance on developing local Joint Strategic Needs Assessments[16]; however, all too often those with the greatest responsibility for commissioning and providing mental health services to and for older people have the least direct knowledge and understanding of local communities and individuals using or needing their services[17].

[16] *Guidance on Joint Strategic Needs Assessment* (2007) Department of Health/Department of Communities and Local Government
[17] *Don't Stop Me Now: preparing for an ageing population* (2008) Audit Commission

Discussions with participating sites revealed some frustrations in using the information contained within their JSNA's in order to better understand the individual and community characteristics of older people needing and/or using local mental health services.

The following summary provides an outline of the profile of each Network site.

Leicester, Leicestershire and Rutland

Leicester is one of the most diverse and disadvantaged urban areas in the country. The Office for National Statistics (ONS) estimate thst the mid-2009 population is 304,700. The number of people over 60 in Leicester is declining as older residents move to the neighbouring areas in the county. Approximately 40% of Leicester's population has an ethnic minority background and nearly a quarter of older people in Leicester are from black and ethnic minority communities.

Leicestershire is a large county in the East Midlands which includes market towns, villages and more remote rural areas. Leicestershire has an estimated mid-2009 population of 644,700. The population is slightly older than the average for England as a whole, and the number of older people is expected to increase at a faster rate than nationally over the next twenty years.

Rutland is a sparsely populated, mainly rural county in the East Midlands with numerous villages and hamlets. The population is just over 38,000. There is a higher proportion of older people in the population compared to nationally. The future population is expected to increase at an above average rate. The population consists mostly of people from white ethnic groups, with very low numbers of other black and minority ethnic groups.

Leicestershire Partnership NHS Trust provides mental health and learning disability services for people living in the city of Leicester and the neighbouring counties of Leicestershire and Rutland.

Coventry and Warwickshire

It is estimated that 309,800 people live in Coventry (the 11th largest city in the UK). The proportion of younger people aged 15 – 39 is higher than the UK average, partly due to the large student population of the 2 Universities. The numbers of older people are increasing but at a slower rate than the country as a whole. Over a 100 languages are spoken in Coventry and a quarter of the population come from minority ethnic backgrounds. The health of the people of

Coventry is poorer than the England average and there are major health inequalities. Coventry Partnership is the city's Local Strategic Partnership with representation from organisations from the community, private, public and voluntary sector[18]

Coventry and Warwickshire NHS Partnership Trust serves a population of some 850,000 people in a mix of urban and rural settings, providing mental health, learning disability and substance misuse services, with a range of out-patient, in-patient, specialist, day hospital and Community Mental Health Teams based in over 70 locations[19].

2.2 Establishing the area audit groups

The audit tool sets out an "ideal process" for formulating an area audit group and undertaking the review of age equality/discrimination within and across local services (see http://age-equality.southwest.nhs.uk/implementing-your-approach.php). Time constraints of this Network meant that the participating sites 'collapsed' these key stages as illustrated in Figure 3.

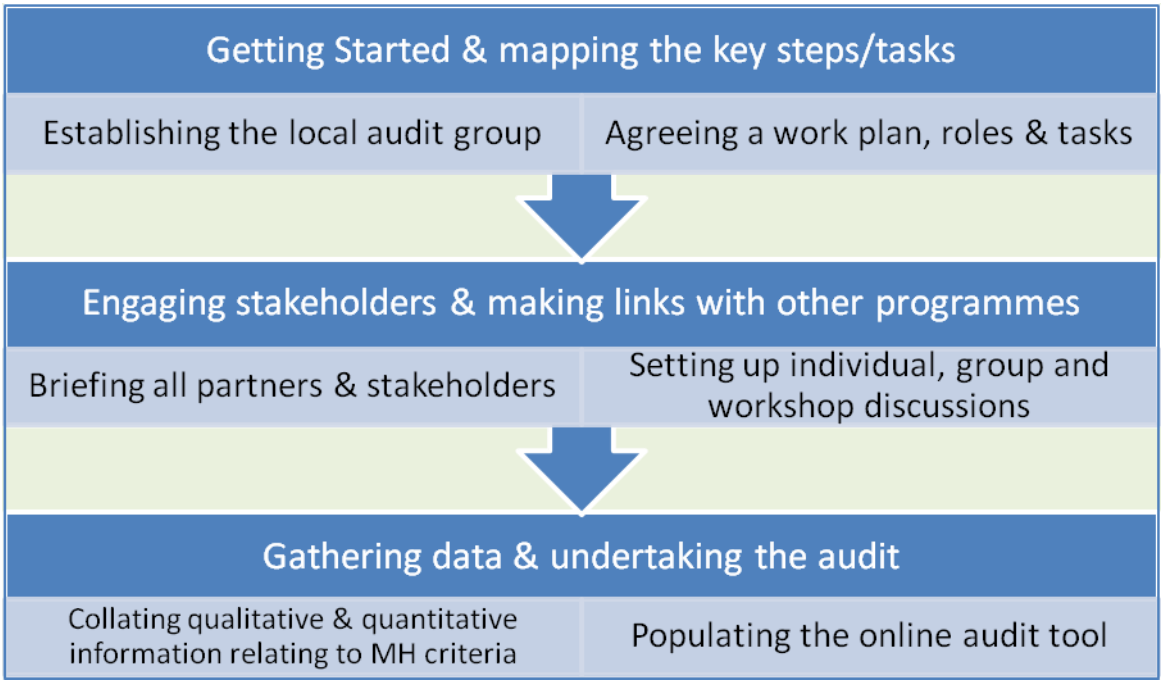

Figure 3: Key steps undertaken by sites

[18] Audit Commission, Comprehensive Area Assessment June 2010.
[19] Coventry and Warwickshire Partnership Trust website www.covwarkpt.nhs.uk

Each site took a slightly different approach to implementing the audit process from the nature and members of local area audit groups, and sourcing and collating information to undertaking the audit itself including populating the audit tool. Sections 2.2.1 and 2.2.2 summarise each site's approach, and the emerging findings, priorities and lessons at the time of writing this report.

It is important to emphasise that each site is very clear that being involved in the Network has enabled them to make a really important start in this work, which they are continuing to progress now that this short term project has completed.

> *Coventry City Council felt that, despite the time pressures and a rapidly changing public environment, the agenda for age-equality and tackling age-discrimination was of paramount importance. This project enabled us to practically consider how we might start to address this in reality, both in terms of our partnership working and our local mental health services. Coventry's Older People's Partnership has been an active voice in leading the work on behalf of older people, and has campaigned for age-equality in mental health services for some time. In addition the keen involvement of Coventry & Warwickshire Partnership Trust has enabled us to consider how we can practically implement the audit to create real change*
>
> Rachel Upton - Head of Citizen Involvement, Carers and Partnerships, Adult Social Care, Coventry City Council

The three remaining and crucial steps which the sites are progressing involve:

- Drafting an action plan, using the template provided in Appendix 3
- Agreeing emerging priorities and actions for addressing these at a local level
- Reporting back on the audits findings and agreed actions to Directors and Chief Executives of the partner agencies (Director of Adult Social Care, Chief Executive of the Primary Care Trust and Mental Health Partnership Trust, and Equality and Inclusion Leads in each Region).

2.2.1 Leicester, Leicestershire and Rutland (LLR)

Following sign up from LLR in late December 2010, an Area Audit Group was established comprising a small but diverse membership of representatives from local agencies, organisations and support groups.

This Group met on a regular basis over 2-3 months during which time they worked together to audit local mental health services and organisational / system readiness for

age equality across LLR, using the criteria and other tools from the Achieving Age Equality Resource Pack.

The first session was important for bringing different stakeholders together to address the following key areas: -

- Developing a shared understanding of age equality/discrimination more generally and what that 'looked' like in MH/services.
- Agreeing the local approach to be taken, including designing and implementing a local approach; engaging stakeholders; linking with other work programmes and collecting data.
- Agreeing how the audit will be undertaken; when and how often the audit group would meet; and mutual roles and responsibilities
- Ensuring that the right mix of people and perspectives was reflected in the membership of the AAG, and steps taken to address any gaps (e.g. it was at this stage that older people with experience of local mental health services were engaged).
- Using the Partnership Readiness Framework (one of the tools from the AAE resource pack) to determine how and where to begin the audit process (i.e. as a 'whole system' or within specific services)[20].

Subsequent sessions focused on understanding and applying the mental health criteria to local services including gathering, collating and analysing different sources of data. A final session was held at the end of March to work through key priorities and actions, including undertaking the audit around organisational/system readiness.

> *The audit has given the Authority the opportunity to collate real evidence to either support or discount anecdotal information and to see what needs to be done to achieve age equality in mental health services. This work has been prioritised as there is a lot of evidence that older people do not do as well as they should in terms of support, and this is particularly pertinent with the changing pattern of commissioning services and the use of personal budgets.*
>
> Jane Forte, Planning & Service Development Officer,
> Planning and Commissioning, Leicester City Council

[20] http://age-equality.southwest.nhs.uk/downloads/age-equality-partnership-readiness-check.pdf

2.2.2 Coventry and Warwickshire

Following attendance at the first Network Learning Event in December 2010, Coventry City Council and Coventry and Warwickshire Partnership Trust decided to join the Network to facilitate a joint approach to reviewing the local situation for older people and mental health services in relation to age equality.

Following a meeting involving the County's Older People's Steering Group in late January, (including representatives from the County's Older People's Partnership, City Council and health and social care providers from voluntary and statutory sectors), it was agreed to adopt a different approach in this Network site; the tight timetable for this work meant that local partners were not able to secure the level of engagement ideally required in convening an Area Audit Group and following the ideal process described in the toolkit. Instead, the development lead from NDTi conducted a series of 1:1 interviews with representatives from a wide range of voluntary and statutory sector organisations, service users and carers' networks. At the same time, the Head of Citizen Involvement, Carers and Partnerships, and the Head of Equality and Diversity for Coventry and Warwickshire Partnership Trust met to determine the key elements from the mental health criteria that they felt the work should focus on – in order to target specific data required from different teams, organisations and sectors.

A set of survey questions was devised based on the criteria, and shared with a wide range of partners, service user and carer groups and other local networks – as a time efficient way of obtaining feedback from a variety of perspectives and backgrounds. This also served to raise awareness about the work and age equality in respect of mental health and mental health services. These questions are provided in Appendix 4, as an example of the different ways in which the audit can be undertaken and the tools within the resource pack used.

> *Coventry and Warwickshire Partnership Trust see the work around Age Equality and Mental health as an essential part of good health. Older people are the fastest growing population and the Trust is aware that services have to meet the needs of this diverse population. The toolkit itself is helpful in ascertaining how the Trust is monitoring Age Equality in service delivery i.e. services should be responsive, the emphasis being on need not age. It encouraged staff to collate data in a systematic way, so the Trust can see where the gaps are and put in some actions. The process also encourages joint working with partner organisations. I myself felt the toolkit was clear to understand and work with to ensure meaningful data was collated that would really make a difference to Age Equality for service users and staff.*
>
> Rano Bains, Head of Equality and Diversity,
> Coventry & Warwickshire Partnership Trust

2.3 Emerging findings and priority actions

This section summarises the emerging findings identified as a result of the sites' audits of local mental health services. It also shares some of the views and experiences of those involved in this work at a local level. Each sub section ends with a summary of priority actions identified by partners and decision makers in local agencies.

The format for each site follows the 3 key headings used to organise the mental health criteria in the audit tool (see Appendix 1).

2.3.1 Leicester, Leicestershire and Rutland

The AAG adopted a systematic approach to gathering data, experiences, views and results of previous surveys relating to the three headings used to categorise the mental health criteria. The following points summarise the main areas of focus within the time available, and the emerging issues and lessons identified to date. The online audit tool was used to generate the traffic light ratings used within the resource pack – which proved to be a useful exercise in highlighting key concerns as well as areas where services are clearly taking steps to address discrimination and achieve age equality.

> *The audit has focussed our attention on a really important area and has highlighted areas where improvements are needed which otherwise may have gone unnoticed*
>
> Ian Redfern, Quality & Performance Manager,
> Leicestershire Partnership Trust

i. Public Mental Health and Prevention

Assessment/diagnosis of common mental health problems

Including a focus on: to what extent do older people, including those with physical health conditions, get their mental health problems assessed and addressed? Do they get the right support and referrals to/for specialist support?

The AAG found it difficult to locate specific information / data about GP assessments, diagnostic rates and onward referrals to CMHT's, social care and to third sector organisations providing advocacy/counselling support. This gap was noticeable across the range and severity of mental health problems experienced by older people. This lack of data meant it was difficult to assess whether appropriate information, advice and support exists and is provided / accessible to older people.

Discussions among the group and their respective networks also revealed doubts and uncertainty about the extent to which GPs are aware of and skilled in assessing /treating

common mental health issues affecting older people; and the extent of training and expertise relating to older people's mental health and wellbeing within primary care generally. It was felt that the GP leaflet on depression recently produced by NMHDU[21] should help to raise awareness. The need to target the new cohort of GP and NHS Commissioners[22] was also raised.

A shared protocol for assessing and diagnosing dementias is currently being developed for use within primary and community based settings, and the role of early identification and advice/information for people living with dementia is also being explored locally. Anecdotally, it was felt that some GPs may wait or postpone a diagnosis of dementia in order to avoid the perceived stigma associated with dementia which could prevent the person from being able to access wider services (e.g. some services and housing options still have exclusion criteria based on a diagnosis of dementia). Such practice may be compounding these situations, is detrimental to the people concerned, and is counter to the evidence on early intervention and anti-stigma/anti-discrimination work more generally.

The First Contact Scheme in Leicestershire aims to provide a single point of access to a wide range of low level preventative services to and for people aged over 60. This is widely known and used across the county. However, a question was raised as to whether the single 'checklist' that voluntary and statutory sector agencies complete contains any prompts or questions about people who are experiencing mental distress, or are at risk of experiencing mental ill health, and who to refer them to.

ii. Primary mental health care

Including a focus on whether younger and older adults have the same access to CMHTs, talking therapies, alcohol/drug treatment, and intermediate care and continuing care, (including people living in residential care).

Evidence around rates of diagnosis, prescribing versus other treatments and interventions, appropriate referrals and early intervention was found to be lacking, which made it difficult to make a judgement about the extent to which different aspects of primary mental health care are age equal/discriminatory.

There was however, a great deal of opinion, experience and anecdotal evidence that GPs tend to refer older people onto specialist services and for treatment/support relating to memory and concerns regarding dementia, when the problems are in fact to do with other mental health issues such as depression or anxiety/low mood. Further work is needed to

[21] http://www.nmhdu.org.uk/silo/files/management-of-depression-in-older-people.pdf
[22] The functions of GP commissioning consortia: a working document. (2011) Department of Health

clarify whether this is due to a lack of awareness and understanding on the part of GPs, or there are other systemic issues which need to be addressed locally.

Intermediate care does not cater for/address issues around some of the more common mental health problems in later life. It would appear that unless diagnosed by GP, it is difficult for the 'system' to pick up on mental health issues especially when accessing other services related to physical health (i.e. staff tend to focus on the "primary diagnosis" or reason for admission to a service, rather than taking an holistic view of someone's needs and circumstances).

It was agreed that in the absence of more specific data, other locally available sources of information would be useful to collate and inform the overall picture of age discrimination/equality, including: complaints, equality impact assessments, feedback and stories from older people and mental health service user groups/forums and organisations; and examining and applying national trends for some services/needs to local population profiles e.g. for drug/alcohol services and talking therapies.

Information and feedback gathered by the AAG indicated an inconsistent, variable approach to the provision of support for people living in care homes. Some CMHTs and GPs provide in-reach to homes, but others do not.

A more consistent pattern was observed with regard to the very high rates of admission to general hospitals from residential care. Work by Leicestershire Partnership Trust is underway in this area, to pinpoint the underpinning reasons and provide training, awareness raising and more consistent in-reach support from specialist mental health services. The local authorities in the area are also concurrently working on embedding a consistent quality framework for/within residential care settings, so the outcomes of the audit will need to be fed into and inform those developments. The recently published Let's Respect toolkit *Do you see me? w*ould support this development[23],

It was agreed that further local information and data was needed to determine the use of anti-psychotic drugs in residential care.

iii. Mental health services

Access to high quality, specialist mental health services by age

In theory there is a clear gateway/graduate policy in place within the mental health Trust, which states that those people who are receiving help and support in adult mental health services should remain with those services unless there are specific reasons why the

[23] *Do you see me?* Let's respect toolkit for care homes, NMHDU, 2011. http://www.nmhdu.org.uk/silo/files/lets-respect-toolkit-for-care-homes-.pdf

person concerned would be better supported by specialist older people's mental health services. It was found that this protocol is not always followed, such that the specialist older people's inpatient service receive a number of inward referrals for people previously supported by 'adult mental health services', and they cannot identify the age related reasons for these referrals.

It was agreed that quantifiable data was needed to verify this statement and to determine both the number and pattern of referrals between working age adult and older people's services.

A key question was raised about access to specific teams and interventions by older people including assertive outreach and crisis resolutions teams; feedback indicates this rarely happens but data is also needed to quantify/back this up.

Hospital admission rates and experiences

In reviewing the range of services and options available to people who require urgent or emergency respite support (and avoid un-necessary hospital admissions) it was identified that no such provision currently exists for people over 65, but this does exist for people under 65. This means that rates of admission and length of stay in hospital are both higher for older people than people under 65, due to a lack of mental health services /support in the community.

In addition, the data analysis carried out on publically available information relating to hospital and care home admissions reveals that if you are an older adult living in Leicester, Leicestershire or Rutland, and have a mental health need, you're 4-5 times more likely to be placed in residential care than if you are a younger adult (18-65).

Priority actions in Leicester, Leicestershire and Rutland

> *It is absolutely vital that the mental health Trust is providing an equitable service for the increasing population of older people. It makes sense to ensure services are being used efficiently, but more than that it's what people have a right to expect*
>
> Joan Hawkins Equality & Human Rights Lead,
> Leicestershire Partnership Trust

As a result of the findings and emerging issues (to date) the following six priorities have been identified for LLR.

(i) Public mental health and prevention

- GP/primary care diagnosis of common mental health problems including depression
- GP training in mental health across the life course
- Ensuring the First Contact service explicitly cover mental health issues and signposts where further information/advice and support is available and how to access it.

(ii) Primary mental health care

- Promote and encourage GP referrals to multi-disciplinary community mental health teams, talking therapies, alcohol and drug services – for older people living at home and in care homes
- Work with intermediate care, continuing care and inpatient services to ensure they are inclusive of and accessible by people who need them
- Review the profile of talking therapy workforce and explore ways of increasing/widening access

(iii) Mental health services

- Keep a clear focus on monitoring and reviewing access to primary and secondary health and social care services by age –focusing on numbers of older people accessing crisis resolution service, assertive outreach, home treatment services and secondary care psychological therapies
- Review the content and use of protocols relating to age differentiated services
- Ensure personalisation and person centred approaches are embedded within all services

(iv) Building capacity, skills and confidence of older people/mental health service users growing older

- Enable and empower older people to become local change agents by becoming “age aware” and also “mental health aware”?

(v) Raising awareness about age equality/age discrimination in mental health/services

- Identify key drivers for achieving change including Equality Act; Equality Impact Assessments (Equality Analysis from April 2011); Equality Delivery Frameworks
- Raise awareness at all levels including among older people and their families so that they feel confident about where to get information/advice during very distressing times,

and raise issues with services/others providing support.
- Include stories of older people living with mental distress focusing on mental well being, highlighting their journey towards recovery and what keeps them well.

(vi) Supporting local people/partners to use the toolkit:

- Report on audit findings and actions to Director of Adult Social Care and Chief Executives of the PCT and Partnership Trust, making the case for change and highlighting the need to develop a clear vision for achieving age equality locally
- Share audit findings with older people and mental health services
- Use existing mechanisms e.g. Equality Impact Assessments (Equality Analysis from April 2011) to improve mental health services for older people (e.g. for your EIA to be approved you have to have considered the mental health and organisational and system readiness criteria contained within the AAE toolkit
- Highlight the financial, moral and legal costs of getting it wrong – i.e. inequality costs
- Use the organisation/system readiness criteria around commissioning and evidence gathered through this process to influence commissioners.

> *To make sure that people of all ages have a say and use services. [We need to] try to ensure that this is followed up, and that older people are part of that. [we need to] try and ensure that changes happen and that is not another costly exercise that fails to make change.*
>
> Lester Aqil, Service User

2.3.2 Coventry and Warwickshire

The key headlines gained from the data collection and 1:1 interviews are summarised below, under the three main headings used to organise the mental health criteria.

i. Public Mental Health and Prevention

Two key issues have been identified from reviewing all available information and sources of data gathered so far:

- Information: the Guide for Later Life is a good resource that is widely known and used to signpost people to a broad range of information and advice. There is opportunity now to improve statutory sector mental health information to ensure it is relevant, engaging and inclusive of older people
- Access to talking therapies for older people: some evidence was presented to the effect that organisations have stopped referring older people to psychological/talking

therapies, and concerns were highlighted that older people may view 'therapy' as stigmatising (i.e. there is a need to consider the language and information provided through these services/teams).

ii. Primary Mental Health Care:

- Evidence that some GPs are up to date on key mental health needs and experiences of older people, and evidence that some GPs consider poor mental health a "usual part of getting older".
- Evidence that some CMHTs are less 'assertive' in supporting older people with mental health needs.
- Identified issues relating to how the transition between 'working age adult' and older people's services is managed and experienced.
- Concerns about the mental health skills and experiences of staff working within housing with care and residential care settings.

iii. Mental health Services:

- Concerns that older people are excluded from specialist mental health services.
- Concerns that general hospital settings do not support older people with dementia, delirium or depression well (specifically, concerns with hydration, nutrition and restrictive visiting hours), although steps already being taken to address these concerns including the SEE ME passport and specialist dementia nurses.
- Positive feedback received about local Early Onset Dementia services.
- Alcohol and substance misuse issues were not considered to be a significant issue for older people, despite the research evidence to the contrary – indicating that further work may be required in this area.
- There are plans to move from age-specific to needs-led approaches in the design, commission and delivery of local mental health services.

In addition, the following cross cutting issues and concerns were identified:

1. The need to ensure that changes in commissioning arrangements (moving from PCTs to GP Consortia) take account of the findings of this audit and embed age equality in ongoing commissioning arrangements.

2. A possible skills and confidence gap within voluntary and community services as well as local statutory agencies with regard to the delivery of age equal mental health services

3. Ageism, both within the health and social care sector and in society generally.

Priorities for action in Coventry & Warwickshire

Five key priorities were identified by the members of C&W's virtual area audit group. A recent meeting of the Coventry and Warwickshire Older Peoples Partnership examined and endorsed the findings and these priorities. It was agreed that this forum would take on the role of monitoring progress and implementation of the subsequent action plan (currently being developed) as a part of its core business for the year 2011-12.

The five priorities are:

(i) Widening and monitoring **access to Talking Therapies** for older people, including a review of all 'access' issues identified during the audit process.

(ii) Addressing the needs and quality /responsiveness of services within **general hospital settings** – e.g. promoting the work of dementia specialist nurses, educating all staff to ensure that older people with mental health problems in hospital settings are treated with sensitivity, dignity and kindness.

(iii) Raising **awareness around "common mental health problems**" (such as depression) and how these affect older people – for the public, staff and board members within and across all agencies/sectors.

(iv) Using the audit / toolkit as a local improvement tool:

- Considering whether and how use of the AAE audit can be built into contractual process/Section 75 processes
- Securing commitment from people leading at an operational level, as well as strategic leads – for example, Head of Talking Therapies (IAPT) and Head of Dementia services.
- Ensuring that Partnerships (such as the Older People's and Mental Health Partnerships) are representative and diverse, reflecting the key characteristics of local communities and users of services; and that they work together to scrutinise and oversee the implementation of the Action Plan arising from the audit.
- Embedding AAE audit process within local Equality Analyses (as demanded by the 2010 Equality Act).
- Ensuring age equality built into training and learning opportunities and networks.
- Establishing different angles for a local evidence base, for example an age based comparative study of access to Talking Therapies.

2.4 Analysis of Age Equality in Mental Health Data

As the findings and experiences of the Network sites indicate, the process of undertaking these initial audits of age equality in mental health services has identified a number of issues in relation to the access of and gaps in locally available data. These are summarised below:

- A wealth of demographic and service related data exists, but it isn't easy to track it all down nor engage with the volume of material quickly or in a targeted way
- Some data may not, or does not, exist (e.g. most often in relation to outcome information, but also in relation to some specific needs and services, such as drug and alcohol use/support)
- There is also much anecdotal evidence (such as examples and personal stories), which is relevant and would enrich the quantitative data referred to above, but it is not currently collated, documented or presented in a way which enabled it to be shared or discussed
- Nationally available data and studies highlighting key trends are not being used to inform local decision making and service developments beyond widely publicised patterns relating to dementia. For example, the prevalence of common mental health problems including depression is far less publicised and/or addressed either at a local or national level.
- Whilst JSNAs hold some useful data, the collation, analysis and interpretation of data and other sources of information focusing on older people's mental health and wellbeing (including their access to, use of and outcomes achieved through services/support) is undertaken in an inconsistent manner. In particular, mental health and age/older people data sets are not generally linked or cross tabulated.

Appendix 5 provides a summary of the analysis of national data and trends relating to the data grid illustrated in Figure 2, in Chapter 2. In addition, the data grid was also populated for each of the two Network sites to provide them with a targeted analysis of local data, and of national trends relating to local populations of older people.

Key points to note from the results of this analysis of local and national data are highlighted below. These reinforce the findings of the Age Review and the critical messages identified from the review of concurrent strategies / developments focusing on mental health services for older people (referred to in Chapter 1). The reason for including these findings in this report is not to repeat concerns highlighted in numerous previous studies, but to emphasise the need for urgent and radical action to address these concerns. Chapter 3 of this report, and the accompanying report (Part 1: Strategies for

Achieving Age Equality in Mental Health Services) sets out an agenda for change, based on these findings, to help local commissioners and service providers take practical steps for reversing the trends identified.

Key points arising from the analysis of local and national data

- There is much more data and information available on prevalence and on diagnosis (especially relating to dementias and depression) than on referral rates, access to different interventions, use of specific services and forms of support, and most importantly outcomes. At a local level, there is more information about access to and use of different services, but this still tends to be volume based rather than outcome focused
- Data on prevalence and use of services is not generally being connected or interpreted indicating that where data *is* being used to inform local decisions and discussions, this is happening in a very limited and incomplete way
- Understanding the characteristics, preferences and aspirations of local communities and service users is crucial; JSNAs hold vital clues and potential for achieving this understanding but a much greater and detailed focus is needed on establishing and using information to improve outcomes and life chances of older people with respect to their mental health and wellbeing. For example, demographic analyses describe Leicester as a 'young city', yet the JSNA for Leicester City states that 67% of people known to social care services are over 65 years of age
- There are a number of critical trends which reveal serious and worrying inequities and inequalities in mental health and in relation to mental health services, including:
    - Older mental health service users in LLR are 4-5 times more likely to be living in residential care than their younger counter parts, and between 2 and 15 times less likely to access professional support – and this appears to be a worsening trend. We believe these trends to be typical patterns that are not just relevant to one of the Network sites
    - 40% of older people attending GP appointments are estimated to have depression; yet only 6% are referred onto mental health services and 84% receive no treatment or intervention
    - 2-4% of all older people have significant drug and alcohol problems and yet it was not possible to find local or national data relating to their access to specific services and support to either prevent, reduce or help combat these problems
    - Access to personal budgets and other forms of self directed support is lower for

older people with mental health problems than for younger adults with mental health problems

- Suicide rates for older women and older men are higher for people over 65 than for those under 65; twice as many people over 65 commit suicide than those under 25 and yet all the focus of initiatives and suicide reduction strategies is focused on younger people and working age adults.
- Resources for CMHTs focused on working age adults total approximately £696m per year, compared to £227m per year for older adults. This when the prevalence of depression, suicide, dementia and other common mental health problems is higher among older people than any other age group
- The positive benefits and outcomes of treatments, interventions and specific forms of support have been documented over recent years, and yet access to these services remains either low or un-quantified (but anecdotally low) – for example talking therapies especially CBT; home treatment teams, crisis resolution services; targeted instructive advocacy support; hospital liaison services; peer support.

Chapter 3: Strategies for Achieving Age Equality

This chapter shares the key challenges and four solutions for achieving age equality in mental health and preparing for the requirements of the Equality Act 2010. It includes examples from the call for information to illustrate practical strategies taken in different parts of the country to improve the life chances of older people with mental health support needs.

3.1 Defining Age Equality in Mental Health

The central message arising from this work is the need for greater clarity and a shared understanding about age equality in respect of mental health and mental health services.

This initiative has demonstrated that whilst different organisations, agencies and sectors have a similar understanding about and can articulate, and evidence, “age discrimination” in mental health services, they are much less clear about ‘age equality’. This makes it extremely difficult to establish the extent to which local services are discriminatory or ‘age equal’; for the public to have a clear sense of whether or not they are being explicitly or implicitly discriminated against; and for health and social care organisations to agree on priority actions for addressing age discrimination and measuring progress towards age equality in a challenging financial climate.

A working definition of age equality in mental health services was developed as a result of the learning derived from the Network to clarify “what good looks like”. This definition could be used to stimulate a much needed debate about what age equality is and isn’t in relation to promoting good mental health and wellbeing for people of all ages at a national and local level.

It focuses on four inter-related components of age equal mental health services, illustrated in Figure 1.

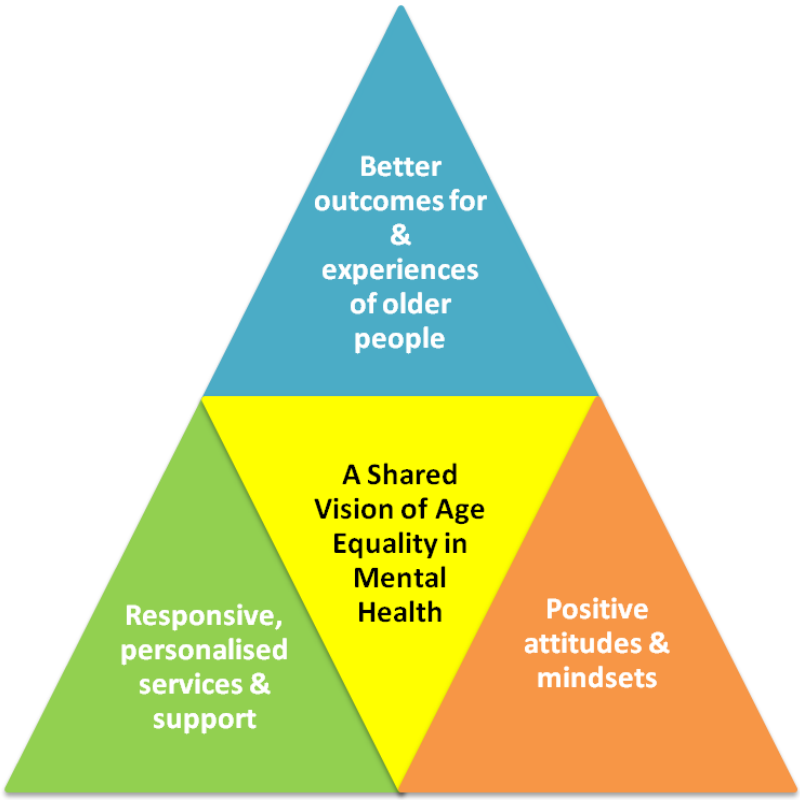

Figure 1: What does age equality look like in mental health?

The first and central component, **a shared vision of age equality in relation to mental health and wellbeing** is essential for establishing the future direction and development of local mental health services; and securing a clear commitment to eradicating age discrimination at all levels of policy and practice development and implementation. The Achieving Age Equality Resource Pack states:

> *We need to be developing and maintaining services which eliminate discrimination, advance equality of opportunity and foster age equality. To do this effectively, it is vital to have a clear understanding of age discrimination and equality.*

At a local level, partner agencies need to work together and with their local communities, including service users and carers, to develop a clear vision about what age equality in relation to mental health, and mental health services, looks like for them. A number of strategic and practical exercises and resources on developing a shared understanding of age equality – both general and specific to mental health – are provided in the audit tool[24].

[24] http://age-equality.southwest.nhs.uk/preparing-for-the-audit.php ; http://age-equality.southwest.nhs.uk/downloads/age-equality-partnership-readiness-check.pdf ; http://age-equality.southwest.nhs.uk/login.php

The following underpinning principles and aims for achieving age equality were found to be a helpful way of enabling local people to work together to develop a shared vision and priority actions for achieving this.

- People are not and do not feel excluded from services or work opportunities because of their age (or any other aspect of themselves – the principles that apply to age equality apply to all other aspects of a person's diversity)
- Services and workplace opportunities ensure that people have no need to feel ashamed of or try to hide their age (or their mental health/ill health) and actively seek to welcome diversity and value difference
- People working in organisations and across partnerships/networks, try not to do anything – however subtle or unintentional – that will make other people feel unhappy or inferior about who they are, or restrict/limit their access to support
- People within organisations/teams/partnerships are given 'a good enough why', if for example there are differences in provision and resource allocation. It is not enough to simply say "we will not discriminate". We have to give people an explanation, a rationale that explains what age discrimination is about, how it affects people, and why it is not only a legal duty but a moral, ethical and economic responsibility to root out discrimination and work towards age equality.

A sense of belonging - a joint strategy for improving the mental health and wellbeing of Lothian's population, 2011-2016

Older people with mental health problems are regarded as a strategic priority in Lothian, as demonstrated by their joint mental health strategy for all ages, the key focus of which is addressing the primary causes of mental ill health such as isolation and physical well being.

Reducing the gap that exists between life expectancy and healthy life expectancy as a result of poor mental health and wellbeing in later life, is a particular focus of this strategy, which is designed to:

- Continue to support programmes and initiatives across Lothian which focus on promoting mental and physical well-being, and reducing social isolation
- Ensure the involvement of older people in the design and development of
- mental health and wellbeing initiatives
- Continue to redesign services to meet the changing needs of older populations within Lothian, including being aware of diversity strands and new technologies which can give people more autonomy within their care

As part of the process of implementing this strategy, the Health Board in Scotland organised a debate –'Why Change at 65?' - for clinicians and service users in order to determine whether there should be separate services for people over 65. One participant shares his views on the key issues involved:

Historically there has been an under investment in 'OPMH' services in the NHS; most people in their 60s and 70s are no different to someone under 65 as far as their needs are concerned. Old age in itself is not the key determinant, rather the complex set of needs that present themselves. 'Age integrated' services still need to acknowledge differences and similarities between older younger adults.

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The second component refers to **better outcomes for and experiences of older people** achieved as a result of equal access to and guaranteed quality of services and support designed to respond to the individual needs and circumstances of the person. Participating sites and members of the National Reference Group identified the following key features relating to this component:

- Older people are fully engaged and involved in the design of and decision making about their own support and in the development of services more broadly through a visible commitment to and adoption of coproduction with older people within mental health services and in promoting better mental health among older people
- Older people are treated with dignity and respect, and their rights are respected and promoted
- The diverse needs and circumstances, hopes and aspirations of older people are recognised, valued and responded to on an individual basis (whilst also highlighting patterns and trends that individuals may share)
- Older people are confident that the staff who support them are competent, confident and effective in their role(s)
- Positive action is taken to promote and harness the many and diverse contributions of older people e.g. through adopting coproduction of services and support; by recruiting and retaining older workers; by ensuring older people are represented and included as members of Trust Boards and advisory groups; as

local champions; and through ensuring a wide variety of user and peer led networks are available, accessible and included in local developments

- Older people are, and feel, empowered and supported to exercise choice and control over all aspects of their own support/treatment and any services/support they use promotes their inclusion
- Older people are fully engaged as active and equal citizens in family, community and civic life.

An All Ages Mental Health Service in Plymouth

This initiative, prompted by feedback received from service users and carers, aims to develop older people's mental health inpatient services to ensure they are equitable with adult mental health services and regarded as one comprehensive service based on one site. A stakeholder event highlighted particular confusion and difficulties around the 'transition' that mental health service users have to make from 'Adult' to 'Older People's' mental health services at the age of 65. Carers in particular could not understand why the people they were supporting are 'transferred' and then not able to access the same services that they could when they were 64.

Older people's mental health inpatient services are currently provided from a separate site to those for adults of working age, and are separated into functional and organic specialisms. Whilst the current provision is believed to be of a satisfactory standard and quality, local commissioners and providers have recognised the advantages of integrating adult and older people's mental health services, or, "mainstreaming" inpatient services for older people, so that they can access the same services/support as adults of working age. This does not mean that the same inpatient facilities are always used (e.g. for older people requiring in-patient mental health support for the first time, care and consideration is given to which environment is suitable and appropriate to their individual needs).

As part of an integrated in-patient service, older people will have greater opportunities to access services such as talking therapies, and adults will have greater opportunities to access services which are traditionally seen as being for older people, e.g. the memory service. This change programme has been running for 18 months and is part of local QIPP developments to improve the efficiencies of secondary care mental health services and address inequity of provision.

Contact details: Julie Wilson, Lead Commissioner for Mental Health/Dementia for NHS Plymouth. Julie.Wilson@plymouth.nhs.uk

Leeds Advocacy for Mental Health and Dementia (A4MHD) is a third sector organisation providing independent mental health advocacy. They aim to promote the inclusion, choice and independence of people with dementia, supporting people along a spectrum of empowerment, risk enablement, protection and safeguarding. One FTE dementia advocate is embedded within the organisation, to ensure that advocacy support is accessible to people with dementia regardless of issues concerning their capacity.

People are typically referred by carers / families, often in relation to concerns regarding standards of care, discrimination, lack of understanding and/or training about dementia in hospitals, care homes and in general community services and support. Issues are also raised by health and social care professionals who feel that the views of carers are often given greater credence than that of the person living with a dementia. Advocacy support is also offered at care planning and Care Programme Approach (CPA) meetings where a person with dementia may find it difficult to have their voice heard effectively.

The service was initially funded through a Mental Illness Specific Grant and provided by Leeds City Council, and has been provided by A4MHD since 1998.

Contact: Diane Edwards, Advocate (Dementia)
T: 0113 247 0449; Diane Edwards <Diane.Edwards@A4MHD.org.uk

The third component, **positive attitudes and mindsets in relation to ageing, older people and mental health** should be evident and actively promoted within and across all services at a local and national level, including:

- A range of opportunities and initiatives that promote healthy, active and inclusive ageing, harnessing the contributions and opportunities of diverse, multi-generational communities
- A whole system, whole community approach is taken to promoting better mental health across and within all ages and stages of life, which is evident at a strategic, commissioning level as well as at an individual, delivery level
- Anti stigma campaigns and educational activities targeting people at different ages and stages of their life about mental health and wellbeing, and in relation

to age, ageing and older people. Such campaigns should seek to engage and educate – raising age and mental health awareness among the general public, service users, families/ carers, and staff working at all levels in public services as well as third sector and private/commercial enterprises involved in service delivery and the provision of information, advice and advocacy services.

All Ages Anti Stigma Campaign in the North East

An older woman living with mental ill health contacted us to tell us about the work she is doing, alongside others, across the NE to raise awareness about mental health, helping to reduce stigma and demonstrate that it is possible to achieve mental well being. She is determined that people understand that the aim of all services and campaigns should be about achieving mental well being for people of all ages and across all stages of your life.

The 'Shift' anti stigma campaign in England was funded by NMHDU and ends in March 2011. It builds on the *mind out for mental health* campaign, which ran from 2001 to April 2004. Whilst not explicitly targeting older people or mental health in later, this woman's own experiences are being shared in the North East to ensure there is a regional and local understanding of age and ageing in relation to mental wellbeing.

The fourth component refers to a comprehensive range of **responsive, personalised services** based on individual needs and circumstances, with particular attention given to the following key features:

- A clear, strategic approach to planning, commissioning and delivering age equal mental health services, based on a shared understanding and underpinning principle that people accessing and using local services are defined by their needs, not their age
- A focus on early intervention and preventative approaches for people of all ages regardless of their condition/diagnosis, their level of support needs, and their eligibility for state funded social care support or other benefits.
- The key aim of all services, interventions and treatment is the promotion of wellbeing, recovery and inclusion so that people of all ages are enabled to lead their lives, exercise choice and control, and contribute to family, community and civic life
- People of all ages can and do access the full range of services, treatment, interventions and therapies available to local communities; and equality of

access is monitored on a regular basis across all equality strands (age, gender, disability, race/ethnicity, sexual orientation etc)

- Contemporary developments aimed at shifting power and control to those using/needing services and support are equally applied and experienced across all ages, with particular attention given to the take up and use of personal budgets, support planning, access to user/peer led support, information, advice, advocacy and brokerage.

2gether NHS Foundation Trust for Gloucestershire has developed a new organisational structure which is designed to deliver services according to needs rather than age.

"We call this Fair Horizons; it is a clinical and service user led pathway service model, which moves away from the traditional model of delivering services in silos for 'working age adults' or 'older people' or 'people with a learning disability'. The aim is to adopt a recovery focus to improve quality of life outcomes and ensure service users and carers' individual needs are very firmly at the heart of our services".

The Fair Horizons principles are: Clinically conceived, driven and maintained; Equitable, person centred and non discriminatory; Prevention of mental ill health and promotion of mental health and emotional wellbeing; Early intervention and recovery; Best practice; Quality, safety, experience and outcomes; Engaging communities proactively.

Fair Horizons has the complete sign-up of the Trust, including sign off by the Trust's Board, as its plan for service delivery over the next two years. Hundreds of members of staff have contributed to these developments through staff engagement events; and service users and carers have been actively engaged and involved in local discussions.

Our First Point of Contact Centre will be an early example of age/discrimination free access to services – due to be operational from May 2011.

We have set up a dedicated research and outcomes measures workstream which has been collecting data in order to demonstrate inclusion and equality within services. Our research also includes a grant-funded academic and practice partnership with Queen Margaret's University Edinburgh to help identify how staff can be supported to deliver new ways of working.

Contact details: Anna Burhouse, Director of Strategic Modernisation

2Gether Foundation Trust for Gloucestershire
T: 01452 894260. Anna.Burhouse@glos.nhs.uk

In terms of how age equality in mental health is measured and assessed, the Mental Health Criteria within the Achieving Age Equality Audit Tool also provide a means to develop a shared, demonstrable vision of age equality which can be quantified and monitored on an ongoing basis. This will help local partners and stakeholders move from a position of being able to articulate and evidence "age discrimination", to demonstrating their commitment to and progress in achieving a more positive and empowering age equal mental health system. The criteria emphasise the importance of doing this across services and sectors, in ways that also achieve cost efficiencies and best value from limited public and other resources. Network members emphasised the practical and strategic benefits of using the Audit Process to facilitate partners and stakeholder groups to work together and stay focused on critical issues of service quality, equality and improvement during challenging economic and uncertain times.

These criteria are summarised in Appendix 1, which highlights the 'age equality' statements against which services can assess their local situation. The full criteria can be accessed via the toolkit, on http://age-equality.southwest.nhs.uk

3.2 Key Challenges and Barriers to Age Equality

Four key challenges or barriers to age equality were identified through a cross cutting analysis of the Network's activities, the sites' experiences in undertaking the local audits, the analysis of local and national data, and the best practice examples obtained through the call for information. These are outlined below.

1. **Lack of familiarity and confidence with "age equality":** the concept of and a focus on age equality, especially in relation to mental health, is very new and unfamiliar to most health and social care systems and third sector organisations. This lack of familiarity is reflected at a national as well as local level:

    - At a local level – as demonstrated through the experiences of the Network sites and from feedback received via the call for information - "equality" is not yet an integral part of the core business of commissioning and delivering mental health and social care services and support. It is, however, increasingly recognised as a driver for change - largely as a result of the Equality Act, positive experiences of using Equality Impact Assessments to improve outcomes, and the current focus on taking action to prepare for the Equality Act. In addition, age equality is an entirely new consideration introduced during an era of unprecedented cuts in public and third sector services and general uncertainty about future investment

in local developments.

- At a national level, there is a tendency for mental health strategies and plans to emphasise evidence, requirements and recommendations for mental health services and outcomes relating to "working age adults". The (unintended) consequence is that evidence, requirements and recommendations relating to mental health in later life and services accessed by older people achieve a lower profile. It is essential that all strategies, frameworks and guidance relating to mental health are both age inclusive and age explicit, to ensure that a clear statement of intent is communicated that 'good mental health for all' means equal attention to the mental health needs and experiences of all ages. We highlight two specific messages relating to this theme: a) mental ill health and the need to promote good mental health does not stop at 64 years of age; and b) "working age adults" is an increasingly outdated term in this era of extending working lives and a move away from a default retirement age.

West London Mental Health Trust (WLMHT)'s Crisis Resolution Team has been operational since 2004, and for the first five years was only accessible to people aged under 65. From November 2009, the Team has operated with no upper age limit – following requests from the local Older People's Mental Health Service to work with their patients.

It was agreed that a clear, two way relationship was vital between these two teams, in order to support older people well. Older people with mental ill health are admitted to the same in-patient unit as people aged 18-65 years, and it was felt that the next logical step was to integrate the crisis resolution services in the same way.

Contact: Nicky Goater
T:020 73861146; nicky.goater@wlmht.nhs.uk

2. **Persistent age discrimination in mental health services:** Four common areas where age discrimination persists in relation to mental health and mental health services were identified across the Network sites, the analysis of national data / trends and the call for information:

- A lack of data about outcomes achieved for people of different ages within primary care services, combined with an absence of readily available best practice in this area, raises questions about the awareness, understanding and commitment of primary care to proactively identify, manage and support older people's mental health and wellbeing across the common mental health

problems that people experience in later life, and the different forms of dementia that people experience at any age

- Persistently poor experiences and inadequate quality of care and support provided to older people with depression, other mental health problems, and dementia in general hospitals. This includes a specific issues about low levels of access to specialist knowledge and skills e.g. via hospital liaison teams.
- Inequity of access to the full range of interventions, treatments and options for support by age, with particular concerns regarding access to home treatment, personal budgets, crisis resolution services and talking therapies and other psychological interventions, by people over the age of 65.
- The need to dispel widespread assumptions and beliefs about the perceived lack of benefits and efficacy of supporting older people's mental health and wellbeing through different interventions and treatment/support. These assumptions and beliefs are held by older people, families, and staff working in mainstream and specialist health and social care services provided in a range of settings. They reflect low expectations for and of older people in relation to their mental health and wellbeing (i.e. as people age); and of the likelihood that older people will benefit from any treatment or intervention (so its not worth the expense or the bother of providing it)

Commissioning for age equality in Gloucestershire

Local agencies in Gloucestershire are using Equality Impact Assessments (Equality Analysis under the Equality Act 2010) to monitor the Gloucestershire National Dementia Local Action Plan. This process has identified issues about access to dementia services across the county for specific individuals and groups - for example, BME communities, younger people with dementia, people with learning disabilities, prisoners, gay men and lesbian women.

The first assessment was carried out in 2009, but was extensively reviewed in 2010 through consultation and discussion with members of the local Dementia Project Management Board, who challenged the validity of the first assessment on the basis that it did not effectively engage all members of local communities and specific groups in relation to their experiences and needs.

The National Dementia Strategy document offers very little in terms of addressing the cultural issues created by dementia. The Local action Plan was revised to respond to the areas identified. For example, a

community engagement workshop with a multi cultural group was set up to explore their needs in supporting people to live well with dementia. This resulted in 7 key actions that are now being addressed. A further meeting has identified 4- 5 individuals who want to become Dementia Champions for their communities, and are working towards setting up a multicultural memory café.

Contact details: Helen Vaughan, Commissioning Development Manager, Dementia, NHS Gloucestershire. T:08454 221947; M: 07933 335903. Helen.vaughan@glos.nhs.uk

3. **The need for guidance on how to tackle age discrimination**: there is alot of information and guidance on what constitutes age discrimination and where it exists. There is far less – both in terms of evidence and guidance - on achieving age equality and/or addressing discrimination (both generally and specifically within mental health services).

   Network members consistently asked for such guidance – and were surprised to find that much of it does exist in the Resource Pack referred to earlier. They discovered that using this resource and focusing on a small number of specific criteria to pool knowledge, data and experiences from a variety of sources and perspectives can help to determine where age discrimination exists, and agree the practical means for achieving age equality in mental health services. Whilst the Resource Pack proved to be effective and practical, it is not well publicised or profiled. Most agencies and authorities, therefore, are not aware of it.

Bassetlaw

The local crisis resolution service for mental health was extended to cover older adults two years ago (previously it stopped at age 65). This change was initiated as a result of feedback from GPs and primary care nursing teams who were seeing people over 65 clearly experiencing mental distress, but who could not refer them to the crisis resolution service.

There is a strategic commitment to improving mental health services for all and to make them as inclusive as possible. A strategic decision has been taken that there will be no upper age limit to any service, and that commitment is built into costings for all services.

Feedback from older people, family members and professionals indicates that being able to refer to/access appropriate services at a time of crisis makes a positive difference to individuals' wellbeing, and providing a speedy response

avoids unnecessary hospital admissions.

Whilst psychological therapies do not operate an age limit it has been identified that they are not easily accessed by older people. One possible explanation currently being explored is the mismatch between older people's life experiences and the young profile of the workforce: it is felt that some therapists themselves may have ageist beliefs, which play themselves out in sessions; and for older people there is a stigma associated with talking about mental distress, particularly with someone who is not your peer.

Contact details: Sue Gill - Head of Partnership Commissioning.
sue.gill@bassetlaw-pct.nhs.uk

4. **Lack of relevant data and outcome measures:** As Chapter 2 (section 2.4) indicated, the Network sites and analysis of local and national data revealed a number of specific challenges associated with accessing relevant information and evidence to support the audits of age equality in mental health services.

   Detailed guidance and information on measuring outcomes and focusing on a small number of key data sets would help local services to establish where discrimination exists and demonstrate their progress in meeting the needs and improving the life chances of their entire communities.

   Practical, targeted information is needed not only on what to measure, and how to gather and monitor this information, but more importantly on how to analyse and use this intelligence to improve local services for local people. This lack of data, particularly the lack of clear, evidence based outcome measures, contributes to the ongoing low profile of and assumptions made about older people's responsiveness to certain treatments and interventions and the benefits experienced as a result of accessing different kinds of support (see also Chapter 1, section 1.4).

Avon and Wiltshire Mental Health Partnership NHS Trust

This is a new development that was initiated by staff in one team in one locality, and first piloted in February 2009. It involves the development of a new CBT, psycho-educational course aimed at older adults to help them manage stress and their wellbeing more effectively.

Historically, these courses have tended to be specialised in terms of the presenting issue rather than age or specific client groups. However, local research highlighted the ages of individuals on the courses were not representative of the local population. Only 5% of individuals who attended a course between April 2008 and April 2009 were 65 years and over. 95% of

individuals who attended a group between April 2008 and April 2009 were under 54 years. Possible reasons for this trend were identified as:

- older adults may not feel comfortable attending a group or may feel that the content covered would not be relevant for them.
- transport difficulties as many of the current psycho-educational groups run in the evening.
- courses are promoted through GP surgeries, the internet and word of mouth, which may not be the best methods of reaching people over 65.

The Primary Care Psychology Team worked with Clinical Psychologists from the older adults Community Mental Health Team (CMHT) in to design and deliver an intervention aimed specifically at older adults, which would aim to teach the individuals some techniques to help manage stress more effectively.

The team contacted a local housing association providing supporting living arrangements for people aged 55 and over, and a collaborative working arrangement was set up. Westlea Housing Association provide the accommodation and the Primary Care Psychology Team run the group free of charge with 2 Assistant Psychologists and support workers from Westlea facilitating the group.

A set of questionnaires are given out at the first and last session of each group, consisting of the Patient Health Questionnaire (PHQ9), Generalised Anxiety and Depression Questionnaire (GAD7), Phobia Scale, Economic Status Questions and the Work and Social Adjustment scale (WASA). This enables before and after evaluations for individuals participating in the group. Analysis and feedback from the group indicates that participants find this approach beneficial in helping them to manage their stress and anxiety more effectively; the group approach has a normalising effect and participants report feeling more confident about sharing things with people in similar situations to themselves.

Contact : Laura Blackhall, Assistant Psychologist, Avon and Wiltshire Mental Health Partnership NHS T: 0117 378 4154. Laura.Blackhall@awp.nhs.uk

3.3 Priority Actions

Four priority actions were identified by the Network for addressing these challenges and taking developments forward at a local and national level. These actions are relevant to local commissioners and providers as well as organisations, bodies and networks concerned with ageing, mental health and wellbeing more generally.

The four priorities are summarised in the following points, and expanded upon in Chapter 4 of Part 1, A Long Time Coming – strategies for achieving age equality [available on http://www.ndti.org.uk/publications/ndti-publications/].

1. **Ongoing work to demonstrate "what works" and support local partners to achieve age equality**

   The experiences of using the AAE toolkit identified a small number of practical changes and updates that are required in order to further enhance its value to local health and social care communities. These changes are being explored by NDTi and the Equality and Inclusion team at the Department of Health.

   Three further, specific areas are highlighted where further work at a national level would help to support local partners and stakeholders to meet their requirements under the Equality Act, in addition to those set out in NHS quality and efficiency programmes and Social Care regulatory frameworks. These are:

   - A practical guide to developing a lifecourse approach to delivering mental health services and promoting mental health and wellbeing.
   - Further work to track and assess the impact of reconfiguring local mental health services to become "age neutral", including the development and testing of the outcomes and data framework referred to below.
   - Targeted work to address the four common areas where age discrimination persists in mental health services (primary care, hospital care, assumptions about ageing and mental health, equity of access to the full range of mental health interventions and support).

   Leicestershire Action for Mental Health Project (LAMP) has developed a targeted advocacy service for older people in mental distress (excluding dementia) covering Leicester, Leicestershire & Rutland. Prior to the introduction of this service older people experiencing mental ill health were excluded from LAMP's existing advocacy service, due to a gap in the then commissioning and funding arrangements. These gaps in advocacy services for older people with common mental health problems had been highlighted by

mental health service user forums and older people.

The new service provides one to one and group advocacy in community and acute inpatient mental health settings. Developing the new services entailed:

- Approaching key people working within health and social care to promote the service.
- Establishing weekly outreach in inpatient facilities within the local NHS Trust hospitals
- Promoting the service within local Community Mental Health Teams
- Networking with other voluntary agencies to spread the work.

The service has provided instructed one to one advocacy for 35 clients since the service began in July 2010. Group advocacy is now provided fortnightly in an inpatient facility, through the introduction of a regular ward forum facilitated by the Older People's Advocate working for LAMP, enabling older inpatients to influence how inpatient services function. The key equality issues here are about older people with common mental health problems being able to access specialist mental health advocacy services in the same way as adults under 65 years, and being supported to express their needs and bring about change in their treatment and those of their peers.

Contact: Janice Lambert, Older People's Advocate, LAMP.
T:0116 255 6286; Janicelambert@lampdirect.org.uk

2. **Building the capacity, skills and confidence of older people, including mental health service users growing older**, so that their voices are heard and are increasingly influential, locally and nationally. This action has two key components and applies at a local as well as national level. The two components are:

   - Reinforcing the need for older people with diverse experiences and expectations of local mental health services to be involved in undertaking local audits of age equality. This will entail some additional work in equipping older people to be conversant themselves with the requirements of the Equality Act 2010, the Achieving Age Equality audit process, and the AAE criteria. It will also require local partners/agencies to co-design and co-deliver the local audit process; and ensure that older mental health service users are fully engaged in ongoing developments designed to achieve age equality and combat discrimination.

   - NDTi will work with members of the National Reference Group, Department of Health, Government Equalities Office, the Care Quality Commission and EHRC to brief and secure the commitment of national and regionally based forums, age

sector, mental health and disability organisations/networks in developing a strand of coaching and mentoring work on older people working as agents of change in achieving age equality in mental health.

Nottinghamshire Healthcare NHS Trust received funding from NMHDU for a 10 week community development project to explore the reasons for the under representation of people with dementia from black and minority ethnic communities within secondary mental health services.

The BME East Midlands and Dementia Project was initiated by staff working in the Trust who realised that their services were not well used by people from diverse communities and backgrounds. The work is focusing on Nottingham with a view to informing developments across the East Midlands, and involves CPNs working with Community Development Workers to reach out and engage diverse communities.

Contact: Maria Dowbenko, BME Living Well With Dementia Project East Midlands
T: 07770 828787; maria.dowbenko@nottshc.nhs.uk

3. **Strong leadership is required to develop and adopt a shared vision about "age equality" in respect of mental health / mental health services** at a local and national level. Nationally, this priority refers to the need for a wide ranging debate about what age equality means and how to achieve it within and across local services, in order to promote better mental health and wellbeing in later life. A vision statement (similar to that adopted for the National Dementia Strategy[25]) could be published to initiate this debate, as part of the range of activities designed to support the adoption of the *No health without mental health* framework.

   We believe there is a need for some ongoing support and assistance at a local level in order develop a shared understanding and direction for achieving age equality, in public services generally and in mental health services in particular. Local agencies and staff working in them have told us that they have benefited from initial external help and a clear steer to get started on their audits, and to keep this work going in uncertain and changing times.

   We also believe there is a need for a small but dedicated national capacity to provide ongoing leadership, coordination and support across Government, sectors and for

[25] *Living Well with Dementia: a National Dementia Strategy. Implementation plan* (2009). Department of Health; http://www.dementiaaction.org.uk/info/3/national_dementia_declaration

people working at a sub national and local level; and to ensure compliance with the legislation and monitor improvements in achieving age equality in services.

4. **An outcomes and data framework on age equality in mental health** is needed to help local partners and national leaders to focus on the key indicators of age equality and improving life chances for older people with mental health support needs.

   We believe there is merit in developing a simple tool for use at a local level which can also inform the synthesis of data at a national level to track important patterns and trends, for example as part of the remit of regional Public Health Observatories.

   There is an opportunity for this work to also inform the planned revisions to the current NHS Outcomes Framework during 2011-12[26], with its focus on reducing inequalities and promoting equality in health and in health care.

In conclusion

Age discrimination in mental health services remains a significant problem that local agencies and national bodies, including Government departments, need to prioritise as a matter of urgency.

This report outlines the practical steps that local health and social care communities can take to audit their services in order to identify where discrimination exists and what needs to happen in order to achieve age equality. Using the Achieving Age Equality Audit Tool [http://age-equality.southwest.nhs.uk/] and the vision for age equality in mental health services developed through this work have been shown to be highly effective and practical means of implementing the recommendations of the Age Review[27] .

This work has confirmed that both local action and national oversight are required in order to improve the quality and effectiveness of mental health services, and to achieve better outcomes and positive life chances for people of all ages.

The accompanying paper (A Long Time Coming, Part 1) sets out the strategic framework within which these actions sit, ensuring that progress can be monitored, improvements assured and the persistent examples of discrimination shared in Chapter 3 eradicated for good.

[26] *The NHS Outcomes Framework 2011/12* (2010). Department of Health
[27] *Achieving age equality in health and social care* (2009) Sir Ian Carruthers and Jan Ormondroyd for the Department of Health

Appendices

Appendix 1: What Age Equality Looks Like In Mental Health Services

AGE EQUAL MENTAL HEALTH CRITERIA	WHAT GOOD LOOKS LIKE
PUBLIC MENTAL HEALTH & PREVENTION	
Assessment and diagnosis of common mental health problems by age	Primary healthcare and community teams are trained in the early detection and diagnosis of common mental health problems experienced by people of all ages. They are using locally agreed and recognised protocols, so that diagnosis triggers access to information, advice and counselling support and referrals to secondary care services where necessary. The JSNA is clear about the prevalence, needs and characteristics of older people with mental health and with physical health problems, and those with co-morbidity.
Access to psychological services: proportion of people over 65 accessing/ receiving psychological therapy compared to people under 65 *Supporting information* *Local data on access to psychological services for different ages. (Note: British Psychological Society recommendation = 1 psychologist per 10,000 pop. for people over 65 years.)*	Community mental health teams work closely with primary health and general community teams to ensure that people over 65 have rates of access to psychological therapies that are equivalent to people under 65. There is training for psychological therapists in age-related ways of working (ie how to adapt cognitive behavioural therapy).
PRIMARY MENTAL HEALTH CARE	
Delivery of primary mental health care by age *Supporting information* *Compare actual referral patterns locally with expected patterns, given advice on prevalence of mental ill health among people over 65. Alzheimer's Society have developed an indicator by PCT on actual compared to expected levels of dementia* *[http://www.alzheimers.org.uk/site/scripts/download_info.php?fileID=531]*	People of different age groups have the same access to primary mental health care, including specialist knowledge and interests among general practitioners and access to multi-disciplinary community mental health teams, psychological therapies/ services, alcohol and drug treatment services, intermediate care and continuing care services.

Levels of support and treatment to older people living in residential care	Liaison services operate between care homes, GP services and community mental health teams, ensuring staff understand the range of mental health problems likely to be prevalent in a residential care home setting.
MENTAL HEALTH SERVICES	
Access to high quality, specialist mental health services by age *Supporting information* *Compare access to a range of specialist services for different ages using local data including returns to the Mental Health Minimum Data Set published by the Health and Social Care Information Centre [http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services] as this includes some age-based analysis. Some data is still being piloted.*	People of different ages have equal access to a comprehensive range of mental health services and support across primary and secondary health and social care services, including crisis resolution, home treatment services and assertive outreach services. Clear protocols are used to facilitate a smooth transfer of individuals from adult to specialist older people's services where age differentiated services exist, and these make it clear that age may be a guide but is not an absolute marker for determining which service is most appropriate.
Hospital admission rates for mental health diagnoses *Supporting information* *The Health and Social Care Information Centre Mental Health Minimum Data Sets report [http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services] contains data on inpatient admission rates to mental health services.* *Association of Public Health Observatories Older People report, Chapter 6 [http://www.wmpho.org.uk/resources/APHO_OP.pdf] is on mental health and presents regional data on age standardised admission rates (p81-86) for all hospitals.* *When looking at length of stay for mental health, the median may provide a more helpful indicator than the mean.*	A range of alternatives to general and specialist hospital admission exist which are accessed by all age groups. There is evidence that admission rates to and lengths of stay in inpatient services are equitable across different age groups and for those experiencing multiple discrimination, with follow up support provided on an individual basis to avoid unplanned readmissions.
Management and support for people with dementia, delirium and depression in general hospitals by age *Supporting information* *The Health and Social Care Information Centre Mental Health Minimum Data Sets report [http://www.ic.nhs.uk/statistics-and-data-collections/mental-health/nhs-specialist-mental-health-services] contains data on inpatient admission rates to mental health services.*	Person-centred approaches underpin the way that all older people are supported in hospitals, including people with diverse mental health problems, and staff are trained, confident and competent in responding to their individual needs. Waiting times for social care assessment do not vary by age and there is good access to rehabilitation services for all age groups.

Association of Public Health Observatories Older People report, Chapter 6 [http://www.wmpho.org.uk/resources/APHO_OP.pdf] is on mental health and presents regional data on age standardised admission rates (p81-86) for all hospitals. *When looking at length of stay for mental health, the median may provide a more helpful indicator than the mean.*	
Percentage of people accessing alcohol and drug services by age *Supporting information* *Local data on access to drug and alcohol services by age [http://www.nta.nhs.uk/areas/facts_and_figures/default.aspx] – national data is for all ages and over 18s only.*	Older people with drug and/or alcohol related support needs are able to access appropriate treatment and support from primary as well as specialist secondary health and social care, including specialist interventions, services and support where necessary.
Organisation, funding and delivery of mental health services for people by age	People of all ages are positive about their experiences of mental health services including initial contact and assessment; responsiveness, knowledge and competence of staff; range and quality of treatment, interventions and support; information, advice and advocacy support and level of choice and control throughout the period of support. Provider organisation's policies are impact assessed to ensure they are non-ageist and local provision is based on an underpinning principle that treatment and care is always provided on the basis of each individual's needs, not their age, in line with the features of non-discriminatory mental health services outlined in *No Health without Mental Health*.

Appendix 2

CALL FOR INFORMATION!
INNOVATIVE PRACTICE FOR ACHIEVING AGE EQUALITY IN MENTAL HEALTH

NDTi (www.ndti.org.uk) and NMHDU are working together to explore different approaches to achieving age equality and address age discrimination in mental health services. As part of this work NDTi are asking for information about local examples and approaches that you are aware of or involved in relating to the following key areas and issues. We would love to hear from you using the attached template which can be returned by email (Sarah.Morris@ndti.org.uk) or post (The Older People and Ageing Programme, NDTi, Magnolia House, 21a Stour Road, Christchurch, Dorset BH23 1PL). If you would prefer to ring us and tell us about your work please contact Sarah on 01202 471423 to arrange a convenient time to do this.

KEY ISSUES AND AREAS WE WANT TO HEAR ABOUT

- **Commissioning and resourcing 'age equal mental health services'**
  - Approaches to population needs assessments/community profiling relating to mental health at different life stages and ages
  - Methods of reviewing existing provision and identifying gaps, including diversity and equality impact assessments ie to determine how well the mental health needs and support needs of older people are met
  - Examples of indicators and outcome measures used to determine whether services are age equal or discriminatory – and how these are used to improve local delivery
  - Examples of standards, guidance & protocols used or developed locally to ensure age equality or address age discrimination in mental health services.

- **Delivery and provision**:
  - Examples of how mental health services are organised, managed and delivered to meet the needs of individuals and communities across all ages
  - Examples of how achieving integration across health and social care, and between adult and older age services has helped to reduce age discrimination and achieve age equality
  - Increasing/enabling access to diagnosis, treatments/interventions, services and support (e.g. talking therapies, assertive outreach, crisis teams, home treatment teams, occupational therapy, drug and alcohol services, hospital liaison)
  - Ensuring the continuity of staff, services and support across ages, especially at times where life events are known to impact on mental health and wellbeing, or where traditional services and models move people on (e.g. transition protocols, person centred support plans)

- **Improving awareness and addressing stigma and misconceptions** regarding mental health and ageing/older people

- **Best practice in enabling the voices of older people and those of carers to be heard in their own support/treatment and in wider mental health service developments**

NAME:	**TITLE:**	**ORGANISATION/AREA:**
EMAIL:	**PHONE:**	**CAN WE CONTACT YOU FOR FURTHER INFORMATION? YES NO**

Area covered (please indicate which – and use one sheet per example) **1. Commissioning** ☐ **2. Delivery** ☐ **3. Voices** ☐ **4. Anti-stigma** ☐	Is this : - Existing local/best practice ☐ - A new development or project ☐ - Initiated by services/staff ☐ - Initiated by service users/carers ☐ - Initiated by community ☐	Is this: - Locally based ie happening in one area/locality/neighbourhood ☐ - Happening in one service/team ☐ - Common practice in all areas/services/teams ☐ - Not known ☐
A simple description about what you want to share with us, and why	How long has this been happening?	How did it begin/start?
Who is involved?	How is it resourced?	How is it measured/monitored? (how do you know it helps combat discrimination/achieve age equality?) Can you provide (e.g. as attachments or over the phone/email) data, stories, other information that demonstrates what works?

Action planning template for age equality in mental health services

This aid to action planning forms part of the toolkit for achieving age equality (www.southwest.nhs.uk/age-equality.html) . It is designed to provide a starting point for pulling together and agreeing your next steps.

Our work suggests that an action plan should consider the following material:

- The quantitative and qualitative data you have gathered to inform your assessment, and the outcomes you wish to achieve in relation to the criteria covered by the audit (in this case mental health).
- What you plan to do locally to move the criteria assessed as Red or Amber towards a Green rating.
- Local priorities for change and the timescales for addressing these. It is suggested that urgent or 'short term' priorities are those that need to be addressed within the next 12 months; 'medium term' priorities are those that can be progressed within the next two years.
- What work is already underway that will affect the changes you need to make, and what will require new work?
- What are the likely resource implications of implementing changes in these areas?
- How and when are you going to share the conclusions of the audit and the action plan with key stakeholders?
- How will you maintain engagement and involvement of these key stakeholders and the wider public?
- When and how will you review progress on these actions?

Once completed, the action plan should be reported back to the people (e.g. the CEO of the PCT and Director of Adult Social Care) who mandated you as a team to undertake the audit).

An action planning template for addressing issues identified from your local AAE in mental health audit

Critical factors requiring action	**Issues raised (including source of information/evidence)**	**Actions required to move closer to a Green status**	**Led by?**	**Priority rating** Short term: within 1 year Medium term: within 2 years
Mental health criteria				
Public mental health and prevention				
Primary mental health care				
Mental health services				

Critical factors requiring action	Issues raised (including source of information/evidence)	Actions required to move closer to a Green status	Led by?	Priority rating Short term: within 1 year Medium term: within 2 years
Organisational and system readiness criteria				
Commissioning and service development				
Leadership and managing change				
Involvement and participation				
Workforce development and human resources				
Quality management and quality assurance systems				

Appendix 4

Key areas for consideration and comment
(Area Audit Group – Coventry and Warwickshire)

To assist the Older Peoples Reference Group and colleagues in completing the first attempt at populating the audit tool (as per information previously circulated) we would be grateful if you could offer your thoughts on the following key questions. Please add any information/evidence that endorses your views and/or relate any particularly powerful stories.

- **Do you feel that there is good local information about common mental health problems for older people?**
- **Who/where would you go to for information about mental health problems and mental health services for older people?**
- **Do you feel that there is good information about psychological therapies (such as Cognitive Behavioural Therapy – CBT) and do you feel that there is equal access to these services for older people?**
- **Where would you/an older person go to find out about psychological therapies?**
- **Do you feel that there is equal access to primary mental health services for older people – do you have any examples?**
- **What do you feel might be the key issues for older people in local housing with care and/or residential services regarding mental health?**
- **What information do we need to know to ensure that older people have access to specialist services that are high quality and age specific only where relevant and appropriate?**
- **What evidence would tell us that older people with dementia, delirium or depression were cared for well within the general hospital setting (data and/or experience)?**
- **What local drug and alcohol services are available for people?**
- **Do we know if theses drug and alcohol services are accessible to older people? What would tell us that they were/were not accessible?**
- **How can we assess organisational design (e.g. effective partnership working, strong leadership and commitment to achieving age equality) and funding (commissioning and procurement) to check if they are providing age equal mental health services?**
- **Any other comments/views?**

Appendix 5: Analysis of Key Data Sets and Trends

Key MH areas to focus on as part of this work	Look for **age-specific** data around rates and types of:				
	Prevalence (estimates)	Diagnosis	Referral[28]	Treatment / access to therapies[29]	Outcomes
Dementia	• 5% people over 64 live with a dementia • This rises to 25% for people over 85 • And 32% people over 90 • 20-25% people with dementia also have depression	• 39% have a formal diagnosis • 67% are undiagnosed	WMPHO give referrals rates for mental health including dementia split by region and 2 age bands (65-74 and 75+)	No specific data on rates of access to different forms of support/treatment in information reviewed A prospective study of older medical admissions in London found 42.4% had dementia, 50% of these were undiagnosed and they were 3 times more likely to die in hospital, yet, 43% suffered medical conditions for which admission is thought to be avoidable or manageable with prompt medical care.	The National Audit Office survey found up to 68% of people with dementia in general hospitals would have their needs better met by other services, and only 41% had evidence of a mental health assessment. Estimate that relocating people with dementia to more suitable forms of care would save local acute hospitals in Lincolnshire £6.5 million per year. Lack of training, access to specialist care and unnecessary delays in discharge are highlighted by the Alzheimer's Society report on general hospitals, which estimates, that better care could save the NHS hundreds of millions of pounds.

[28] Including GP referrals to CMHTs, specialist mental health services and psychological therapies
[29] 'Access to psychological therapies' also a key focus area in its own right

Depression *and other "common MH problems*"	• Nearly 1 fifth of older people report feeling lonely and isolated • 14% people 64+ live with depression • 25% have symptoms which require treatment • 40% people 85+ have depression • 40-60% of people in care homes • 50-60% of people in hospital • 7% people 64+ have "other mental illness" • Delirium affects up to 50% older people in hospital • 20% people 65+ develop psychotic symptoms by the time they are 85 which are not a precursor to dementia • High rates of hallucination and paranoid thoughts remain high in people aged 95+ without dementia • Annual incidence of late onset schizophrenia-like psychosis increases by 11% with each 5 yr increase in age over 60	• 40% of older GP attendances have depression • 17.5% of people 65 have a diagnosis of severe depression • For every 100 people with depression, only 50 seek treatment and only 25 are diagnosed • GPs find it difficult to diagnose and manage mental illness in older people, 70% of the social care workforce have no training or qualifications, detection and treatment in hospitals is poor	• Only 6% of people 65+ with depression are referred to mental health services (compared to 50% of people under 65) • Less than 17% of older people with depression discuss their symptoms with their GP	• 84% people with depression over 64 receive no treatment • 17% receive treatment of some kind • 80% of those with anxiety disorders and 68% with depression opt for psychological therapies • " a study in London shows the needs of older people with persecutory and perceptual symptoms in the community are poorly met"	• Psychological therapies, particularly CBT, are effective with older people • Older people with mental illness are more likely to die, stay in hospital longer, lose independent function and be discharged to a care home Various data re outcomes including: - Crisis Home Treatment leads to reduced hospital & care home admissions, reduced hospital stays, user and carer satisfaction - Hospital Liaison reduces hospital stay & readmission rates - Care Home Liaison reduces drug prescribing, GP time and hospital admission
Suicide	• Suicide rate for people 65+ is double that for people under 25 • People aged 65+ have the highest suicide rate for women and second highest for men • Suicide rate for older inpatients increased from 12%	• Depression in later life is major risk factor for suicide; men living alone at particularly high risk	No data apparent	No data apparent	No data apparent

	in 1997 to 15% in 2006 • Rate of suicide for the general population 1997-2006 declined, but remained static for older people • Sudden unexplained deaths on psychiatric inpatient wards for people aged 65-74 are 8 times higher than for people aged under 54 years.				
Co-morbidity (e.g. m & phys illness)	• Depression is 7 times more common in people with 2 or more chronic physical conditions • 50% of people 65+ have 2 or more long term conditions, and are on 4+ medications • Depression in later life strongly linked to physical ill health and disability, but only 10-12 % are treated for depression • Depression is 3 times more common for people with end stage renal failure, COPD, CVD	No data apparent	No data apparent	• Only 10-15% of co-morbid depression is treated	• Proactive management of people with dementia and hip fracture could save £64-102million, nationally, each year
Drug & alcohol use/ access to services	• 2-4% of all older people	No data apparent	No data apparent	Significant increase in older people needing treatment for substance misuse is predicted	No data apparent

Appendix 6

Members of the National Reference Group (NRG)

Polly Kaiser – NRG Chair; NMDHU Age Equality Lead/Lead on Mental Health in Later Life

Susan O'Connor – Mental Health Strategy Team, Department of Health

Gill Russell – Department of Health, Equalities Team

Sue Waterhouse – NMHDU Mental Health Equalities Team

Professor Dave Anderson - Royal College of Psychiatry

Dr Andy Barker - Royal College of Psychiatry

Dr Caroline Chew-Graham- Royal College of General Practitioners

Catherine Davies – Department of Health Equalities Team

Ruth Ely – Department of Health, Older People & Ageing Division

Helen Bowers – Director, Older People & Ageing, NDTi (Network Lead)

Gilly Crosby – Centre for Policy on Ageing

Rekha Elaswarapu– Care Quality Commission

Maqsood Ahmed – East Midlands Strategic Health Authority

Raj Gil – East Midlands Strategic Health Authority

Caroline Bernard – Counsel and Care

Kieron Murphy – NMHDU, Commissioning Team

Lesley Robertson – Department of Health

Jacqui Ruddock – Department of Health