

OP82



The Equality Act 2010 and adult mental health services: achieving non-discriminatory age-appropriate services

Joint guidance from the Royal College of Psychiatrists' Faculties of Old Age and General and Community Psychiatry

December 2011

OCCASIONAL PAPER

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Occasional Paper OP82
December 2011

Royal College of Psychiatrists
London

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Executive summary

From April 2012, unjustifiable age discrimination will be banned in the UK and health and social care services will be legally required to promote age equality in their adult mental health services.

Of all health and social care services, older people's mental healthcare has been highlighted as one of the worst examples of discrimination. This has been described in a number of high-level national reports.

There is a danger that commissioners and providers of mental health services, in an attempt to meet the need for equality and to save money, might attempt to merge adult and older people's services into 'age-blind' services. This does not recognise age-appropriateness, is against the policies of the government and the Royal College of Psychiatrists, and will result in indirect age discrimination.

As the population is ageing there will need to be more expertise available for older people, and specialist older people's mental health services will be essential to train future generations to acquire that expertise.

This document:

- explains what age discrimination is
- gives examples of age discrimination in action
- describes the requirements under the Equality Act 2010, and
- provides guidance on responding to the equality challenge in a non-discriminatory age-appropriate manner.

Non-discriminatory age-appropriate services

WHAT IS AGE DISCRIMINATION?

Direct age discrimination occurs when a person receives a less favourable service or intervention because of their age alone. Examples of direct discrimination include services developed as part of the National Service Framework for Mental Health (Department of Health, 1999), such as crisis intervention and assertive outreach, which deny access to people 65 and older.

Indirect age discrimination occurs when a service or intervention is provided, often unintentionally, in a manner that puts a person of a particular age group at a disadvantage. This might happen when a service designed for the needs of younger adults is opened up to older people without tailoring the service to the specific needs of many in this age group. Examples include all-age admission wards, and crisis services with staff who have little experience, training and ongoing supervision in old age psychiatry.

WHAT EVIDENCE IS THERE THAT IT IS HAPPENING?

Age discrimination has been recognised as a problem by the Royal College of Psychiatrists (2009a), the Healthcare Commission (2009), the Care Quality Commission (2010) and the Department of Health, which even commissioned a report (Beecham *et al*, 2008) that quantified a £2 billion gap in the funding of mental health services for older and for younger adults.

THE EQUALITY ACT 2010

The Equality Act 2010 created, for the first time, a duty on public sector bodies in the UK to have regard to the need to eliminate age discrimination. From April 2012 there will be a legal requirement to apply this duty to health and social care services.

In some circumstances, however, it may be beneficial to provide services specifically targeting older adults, for example in screening programmes for age-related disorders. Therefore, the Equality Act allows age discrimination if it passes the 'objective justification' test: if it is a

proportionate means of achieving a legitimate aim. It also allows 'positive action' to improve the situation of a group that is discriminated against. In a report on age equality to the Secretary of State, Carruthers & Ormondroyd (2009) cite older people's mental healthcare as an example of a service targeted at older adults that is not discriminatory and could be an example of positive action.

DANGERS OF MERGING

Members of the Royal College of Psychiatrists have raised concerns to their Faculty Executive about how commissioners and mental health providers might respond to the need to demonstrate non-discriminatory services. In an attempt to meet this need while coping with current stringent financial curbs there may be an inclination to cut overheads and merge adult and older people's services into 'age-blind' services. This does not recognise age-appropriateness, is against the policy of the government and the Royal College of Psychiatrists and will result in indirect age discrimination.

WHAT NATIONAL POLICY SAYS

The policy of the government is clear. Its *National Dementia Strategy* (Department of Health, 2009: p. 73) states:

'The nature of risk and need in older people with mental disorders means that, in order to provide services that are of equivalent quality to those available to adults of working age, specific provision needs to be made in terms of specialist community mental health teams and inpatient services for older people with mental disorder. The separation of 'organic' and 'functional' disorders in terms of service provision is essentially a false dichotomy, and one that is likely to disadvantage people with dementia with complex needs and their family carers. Specialist mental health services are needed that can deliver good-quality care that is attuned to the specific needs of older people.'

The government's mental health strategy *No Health without Mental Health* (HM Government & Department of Health, 2011a: p. 16) refers to the 'clear evidence that mental health services do not always meet the needs of certain groups, particularly black and minority ethnic communities and older people'. Its companion document, on delivering the strategy (HM Government & Department of Health, 2011b: p. 68), states that the government 'is fully committed to ending age discrimination in health and social care by 2012, with no exemptions to the Equality Act 2010 requirements'. This document suggests various current and future measures to assess age discrimination, and references an age equality resource pack and audit tool (Department of Health, 2010) that was at that time being piloted.

The Royal College of Psychiatrists set out its position in 2009 in two statements: *Links Not Boundaries: Service Transitions for People Growing Older with Enduring or Relapsing Mental Illness* (Royal College of Psychiatrists, 2009b) and *Age Discrimination in Mental Health Services: Making Equality a Reality* (Royal College of Psychiatrists, 2009a). The College believes that all services should be available to people on the basis of need,

not age, and that comprehensive specialist mental health services for older people are essential to appropriately meet need in later life. For people already receiving mental health services, there is no justifiable reason for transferring them to older people's services simply by virtue of their age, but only if their needs have changed and would be better met by those services.

These principles recognise an individual's different needs, the requirement to address those needs in an equal way and not to treat all people the same when their needs are different. Addressing needs in an unequal way, or treating all people the same when their needs are different, would be discriminatory. Discrimination will also exist when inequitable distribution of resources prevents services meeting needs fairly, when older people are required to attend services not designed to meet their needs, or when older people are denied access to services available to younger people that could meet their needs.

MEETING THE NEEDS OF OLDER ADULTS WITH MENTAL HEALTH PROBLEMS

As people get older, certain needs become more common. This is due not only to the differences in mental health problems that arise in later life, but also to increasing comorbidity with physical ill health and the psychosocial context in which these problems develop. Although not universally true, older people's mental health services will generally be best placed to assess and meet the needs of people who develop mental health problems in later life. Failure to recognise the changing needs of people as they grow older, so that all people attend exactly the same service regardless of need, will serve people badly and amounts to indirect discrimination.

It is informative to consider how old age psychiatry became differentiated from general adult psychiatry. Old age psychiatry became a recognised specialty within the National Health Service in 1989, having emerged from age-inclusive general psychiatry because the needs of older people were being neglected in these services. The fact that older people's mental health services have since been seen to fare worse than services for younger adults does not mean that they have failed. Indeed, where evidence exists, old age psychiatry services produce better outcomes for older people (Anderson *et al*, 2009). What it does mean is that the continuing age discrimination in mental health policy, commissioning and provision has been recognised. Without the differentiation of old age psychiatry, such indirect age discrimination would have been more difficult to establish. A lesson worth remembering for those services considering reverting to an age-blind approach is that it is age-blind, not age-equal.

The Royal College of Psychiatrists' position statement on age discrimination, endorsed by the Royal College of General Practitioners, the Royal College of Nursing, the British Geriatrics Society, Age Concern and Help the Aged, suggests a list of needs that should be the basis for access to specialist older people's services (Royal College of Psychiatrists, 2009a: p. 4):

- mental health problems developing in later life, as these are often of a different nature and require a different approach to treatment than those occurring earlier in life; this applies to a range of conditions, including cognitive disorders, mood disorders and psychoses

- multi-morbidity of both physical and mental health conditions
- cognitive disorder or dementia
- problems related to being at a later point in the life cycle, which include psychological and social difficulties and lifestyle
- frailty
- where other services required are more directed to the needs of older people, for example, particular types of social care needs or care homes.

If older people, regardless of their condition or circumstances, are unable to access specialist older people's mental health services or these services cannot meet the needs of their population because of inequitable distribution of resources, then discrimination will exist.

COMPETENCIES REQUIRED

Competently trained psychiatrists are required to meet the increasing need for psychiatric services for the growing elderly population. The competencies required include not only specialist clinical skills but also knowledge of effective service delivery models. Future trainees will need good-quality specialist old age psychiatry services and well-trained consultant old age psychiatrists from which to gain experience.

The Royal College of Psychiatrists produces competency based curricula for the different psychiatric specialties, based on the General Medical Council's (2009) *Good Medical Practice* and the College's *Good Psychiatric Practice* (Royal College of Psychiatrists, 2009c). The College's curriculum (Royal College of Psychiatrists, 2010) outlines the competencies needed to complete core and specialist training for the award of the certificate of completion of training (CCT) required to become a consultant in old age psychiatry. Maintaining competency will be necessary for relicensing and recertification.

ORGANISING NON-DISCRIMINATORY AGE-APPROPRIATE SERVICES

The Royal College of Psychiatrists believes that specialist older people's mental health services, with unique expertise in meeting a particular set of needs characteristic of later life, should be provided comprehensively in all commissioning areas. This appears to be in agreement with Department of Health policy. Failure to provide these services would deny older people access to services specifically designed to meet their needs.

However, there may be more than one way to structure an organisation and services to meet the age-equality challenge. For example, in the Healthcare Commission's (2009) national study of older people's mental health, *Equality in Later Life*, two of six trusts visited appeared to have good-quality age-equal services. One trust had merged the adult mental health and older people's mental health directorates into one, with a multi-agency mental health strategy covering both younger and older adults. The other had maintained separate directorates for older and younger adults,

although these worked very closely, with a joint commissioning group and management board for mental health across all age groups. Both had restructured and had made a concerted effort to address age inequality, scrutinising all existing and new policies. Critically, however, both had retained specialist older people's mental health services.

No matter how services are organised and managed, they will need to be set up to meet the needs of older adults in an age-appropriate non-discriminatory way. In addition, to maintain the skills necessary for old age psychiatry, there will need to be a sufficient and ongoing core of specialist knowledge, peer support, supervision and training.

DELIVERING NON-DISCRIMINATORY AGE-APPROPRIATE SERVICES

One challenge for the delivery of age-equal services is having a common understanding of what this means. A National Learning Network, established to inform the development of age-equal mental health services, has generated a working definition (National Development Team for Inclusion, 2011: pp. 14–17). This includes four components:

- 1 a shared vision of age equality in relation to mental health and well-being, which is essential for establishing the future direction and development of local mental health services, securing a clear commitment to eradicating age discrimination at all levels of policy and practice development and implementation;
- 2 better outcomes and service experiences for older people, achieved as a result of equal access to and guaranteed quality of services, and support designed to respond to the needs and circumstances of the individual;
- 3 positive attitudes and mindsets in relation to ageing, older people and mental health that are evident and actively promoted within and across all services;
- 4 a comprehensive range of responsive, personalised services based on individual needs and circumstances, with particular attention given to:
 - a a clear, strategic approach to planning, commissioning and delivering age-equal services, based on a shared understanding and underpinning principle that people accessing and using local services are defined by their needs and not by their age;
 - b a focus on early intervention and preventive approaches for people of all ages, regardless of their condition/diagnosis, their level of support needs or their eligibility for state-funded support;
 - c making the promotion of well-being, recovery and inclusion the key aim of all services, interventions and treatment;
 - d ensuring that people of all ages can and do access the full range of services, treatments, interventions and therapies available to local communities, and that equality of access is monitored on a regular basis;
 - e ensuring that developments aimed at shifting power and control to those using/needing services and support are equally applied and experienced across all age groups.

Age, in itself, is clearly unsatisfactory as the single criterion for access to services in later life. No person should be required to attend older people's mental health services by virtue of their age alone. Nor should they be prevented, because of their age, from attending alternative services that better meet their needs.

No one already receiving mental health services should be transferred to older people's services simply because of their age. The only justification for such a transfer is if their needs have changed and would be better met by those services. This principle is already set out in the College's report on service transition as people move into old age (Royal College of Psychiatrists, 2009b).

There may be younger people for whom older people's mental health services would be appropriate. These include people with young-onset dementia, as described in *Services for Younger People with Alzheimer's Disease and Other Dementias* (Royal College of Psychiatrists, 2006).

There will be people whose needs could equally be met by more than one service – a person should be able to choose, with advice from professionals, the service they prefer.

There will be people who have complex needs who require more than one service. In these cases, there must be close collaboration between services and a clear agreement that one service will take the lead role to ensure clear clinical and managerial accountability and properly coordinated care.

It is essential that all mental health services collaborate, whenever necessary, to make decisions based on a person's needs and that accountability remains clear at all times.

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