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Meeting

PSYCHIATRIC SERVICES FOR THE ELDERLY

On 6 February, 1978, the Group for the Psychiatry of Old Age, soon to become a full division of the College, held a well attended one-day symposium to discuss what was at present being done for the elderly, how the problems were changing, and what could be hoped and planned for the future.

Dr R. A. Robinson (Edinburgh) emphasized how closely in his hospital geriatrician and psychogeriatrician worked together, in joint assessments and weekly reviews and clinics. An impressive range of remediable physical disorders had been revealed in psychiatric cases. They used three wards, including one for 24 psychiatric cases, and two day hospitals (50 geriatric and 35 psychiatric places), as well as 85 long-stay beds, to provide for all the needs of a population of 25,000 aged over 65. He had about 200 admissions annually (60 per cent dementia, 25 per cent affective), half of whom went home again but 30 per cent went on to long-stay accommodation. The psychiatric day hospital took about 90 new cases a year, one-fifth eventually going home again, a quarter attending for over a year, and a fifth eventually being taken into long-stay care. They owned two minibuses and two ambulances for these day attenders. His ideal was on call consultation, with home visits for initial screening, but one-third of their referrals came from general hospital or geriatric services.

For **Dr P. M. Jeffreys** (Harrow, London) the psychogeriatrician had two major tasks, the mobilization and maintenance of enough beds, personnel and equipment in the face of administrators' reluctance, and the establishment of constructive links with all the other services, social or voluntary, which existed for old people. Clinically, the patient's care and support over years was his task, since only a minority of illnesses remitted completely. At present about 2½ million U.K. residents were aged 75 or more, and 43 per cent of the women in this age group lived alone. In the next 15 years there would be a 50 per cent increase in people aged 85 and over, which was bound to increase the demand for care dramatically. The Newcastle prevalence study showed that 5 per cent of the elderly at home had a severe organic psychosis, and another 15 per cent had a major functional disorder. They were cared for by neighbours, voluntary societies, various divisions of Social Services and by the general practitioner and his nursing colleagues. Nearly 10 per cent of people aged 75 or over were in institutions, half of them in residential homes mostly run by local authorities, a quarter in geriatric beds, and less than one-sixth under psychiatric care. For every elderly confused person in a psychiatric bed, there were two in a residential home and nearly one-and-a-half in a geriatric bed. Therefore one big part of the psychogeriatrician's job was to go out and meet the hundred or so general practitioners in his area, teach, consult over the telephone, and hold joint clinics. Another big part was to go out with offers of help to social workers, including regular visits to residential homes run by them.

Dr C. Godber (Southampton) also emphasized the support to residential homes, and to Community (G.P.) hospitals where they existed. The problem was how with inadequate resources to spread help most widely. Four years ago his unit consisted of 100 long-stay patients, so that from an elderly population of 28,000 his predecessor had only managed 50 admissions a year direct from the community for assessment or holiday relief. He had introduced a very firm clear admissions policy, in which very few new long-stay patients were accepted initially, and as the residents died off many of the beds were converted to acute short-stay use—there were now 50 of them accepting nearly 600 patients a year. This was backed up by work in the community by psychogeriatric nurses and by regular medical visits to residential homes. Day centre care was handicapped by lack of enough transport. He criticized government planning for its basis on faulty data. With dementia, a disorder predominantly of the over 75s, the expanding section of the elderly population, bed norms based on the over 65s as a whole would lag further and further behind actual requirements. Manpower needs derived from existing national averages were self confusing. They should be based on the actual staff operating a good service. This applied particularly to nursing staffing where 'bed productivity' is high. It was astonishing how much variation there was up and down the country, with different models for the provision of services.

Professor Tom Arie (Nottingham) said the elderly were society's biggest problem, not just a medical problem, but a problem which would never be completely solved. It had been proposed that we needed one psychogeriatrician to every three general psychiatrists, which meant there were about 200 specialist vacancies, and not more than six senior registrars in training. We needed to look on the care of the elderly as a political emergency, establish some university departments so that all medical students got some training, arrange general practitioner vocational training and rotating registrar schemes, and take good people wherever we found them. Part-timers and married women could be fitted in if there was administrative flexibility over ranks and sessions and the use of money. Some said it was no use appointing an extra consultant if the post had no beds or supporting staff. On the other hand one did not get resources allocated until there was someone there to fight for them. However meagre the existing resources the consultants already in post should be expected to share them with a newcomer.

Professor S. Brandon (Leicester) described his city as very backward, with no day places at all, only three community psychogeriatric nurses, inability to fill his senior lecturer post, and a fragmentation of services. Another speaker had the money but could not recruit the professionals: Professor Arie reiterated 'flexibility' and suggested advertising for housewives. Discussion roamed over whether health visitors could do community psychogeriatrics, whether general practitioners should control more staff, and how their work should be co-ordinated with other services. Areas differed greatly.

Professor B. Isaacs (Birmingham) said geriatrics and psychogeriatrics were specialities born out of the need to use multiple services economically, not from specialist knowledge or technology. Argument waged over whether a general psychiatrist could fulfil the role, or whether because of the amount of organic medicine and liaison and political work, there had to be a specialist for it. Newcastle's urban solution would not necessarily work in the rural Isle of Wight where **Dr I. Thomson** integrated his elderly patients with his general psychiatric service. Other general psychiatrists doubted the need for specialization though it was less clear whether they were themselves meeting the psychogeriatric need. Speaker after speaker illustrated the extent to which the service failed because people could not work together, because political and administrative skills were lacking.

Dr Pamela Mason (D.H.S.S., London) said this was a transition period and a White Paper was in preparation, but she failed to spell out the extent to which the Government can recommend but not compel, and the gap between the planner at the centre and the specialist who meets the crises of despair and anger at the periphery remained unbridged.

Other invited speakers included **Dr K. Bergmann** (Newcastle), **Professor E. Wilkes** (Sheffield) and there was vigorous discussion from the floor.