'A HAPPIER OLD AGE'*

The College's Comments

Health and Personal Social Services

If Social Work with the elderly is to be effective, it will require, in addition to the basic skills used with any client group, specialized experience and abilities. The need will range from highly skilled and experienced workers, who may give advisory and supervisory services to other trained social workers, through people with natural ability or experience in working with the elderly down to less skilled and untrained staff.

Certainly there is much work that is capable of being done by assistants or trainees under supervision, especially in the practical 'fixing' of services; but the often complex and subtle case-work required with elderly mentally disturbed clients and their families can call for high levels of competence. The College urges the Department to encourage Local Authority Social Services Departments both to foster a degree of specialization of trained staff in work with the elderly and to create and seek opportunities for developing the skills of other social workers. It is important that Local Authorities should be encouraged to regard the secondment of staff to courses providing training in this field as a matter of priority. There is also scope for some trained social workers to develop special expereince in old age psychiatry.

Community psychiatric nursing is providing a vital arm of the psychiatric services for the elderly. It has so far arisen chiefly as an out-reach from the hospital, but extra-murally based community psychiatric nursing for the elderly is also developing. In either case, the closest links are necessary with both the local psychiatric service for the elderly and the geriatric service. It is still a question of debate as to how far the community psychiatric nurse should operate only, or mainly, as part of the hospital team and whether he or she should take referrals direct from general practitioners. But the College is aware of the danger that referral to hospital-based community psychiatric nurses direct from family doctors may cause the patient to fall between the two stools of general practitioner care and care by a consultant psychiatrist, the general practitioner perhaps feeling that by contacting the hospital community nursing team he has in some sense secured a psychiatric consultation and thus shared responsibility with the hospital psychiatric service.

While these developments are still at an early stage, and further monitoring is necessary, it is the College's view that community nurses should work as part of the hospital team with referral by general practitioner to the psychiatrist, so that there is no ambiguity about responsibility. It sees virtue also in the further development of extra-murally-based community psychiatric nursing as a part of the primary care team. It is essential that in either case responsibility should be clearly in medical hands.

While the spread of community psychiatric nursing is recommended, the need for a public health nurse advising on health education, nutrition and hygiene within the primary care team is most strongly recommended for the elderly and their families. The necessary educational training and staff orientation is recommended as a matter of urgency. The possible shrinkage of the health visitor role in the care of the elderly is viewed with concern.

Accommodation—Residential Homes

It is doubtful whether the type of special housing schemes currently available can provide an effective alternative to the facilities of a residential home. People with established chronic brain syndromes are rarely adequately cared for even in the best purpose-built dwellings. They may need fairly constant supervision and care. However, recent experience has shown that warden-supervised dwellings with sufficient staff to provide a continuity of support can successfully manage such problems. This type of experiment should be urged in the future. It is likely to succeed only if people in need can be placed quickly and where there is close liaison with the established psychiatric service.

Some recently bereaved and depressed elderly people may seek residential care, only to regret this later. There is scope for a scheme to help such people re-establish themselves in more appropriate types of sheltered living. At the moment endless delays in allocating a place in a desired location, together with the problems in finding furniture and other living essentials, often makes rehabilitation into the community difficult or impossible.

Real choice of placement demands an adequate provision of a wide spectrum of types of residential

* A discussion Document issued by the Department of Health and Social Security. The comments were prepared by a Working Party of the Section for the Psychiatry of Old Age and have been approved by the Executive and Finance Committee and endorsed by Council. They are abbreviated for publication.

and sheltered care. Many elderly people need patient guidance in the selection of appropriate living styles. There is not always a free choice between warden-supervised accommodation managed by the Housing Departments and the residential home managed by Social Services. If specialist housing is to make a real impact on the care of the more frail elderly then Social Services must be given a bigger voice in the development of modifications of this type of accommodation and in its allocation.

Whilst it is appreciated that under some circumstances residential homes could have a rehabilitiative function, it is considered that the hospital service should provide short-term preliminary assessment and rehabilitation. There is a danger in second-rank developments but here there is scope for collaborative ventures (jointly financed) between Local Authorities and Health Authorities. An important rehabilitative function of the Home is that of maintaining skills and interests and so preventing deterioration in morale and the need for hospital treatment.

Short-term places and day places in Part III Homes and Day Centres are most desirable. Day attendance at the former can be a vital prelude or alternative to admission and can offer support to the frail client, relief for relatives and ease the pressure on hospital based day treatment facilities which can then concentrate upon observation, assessment and treatment.

Day provisions will require:

1. A reliable and adequate transport system.
2. Expanded day facilities in the Home, including the provision of activities rooms, dining facilities and additional staffing.

The College, of course, supports the principle that the old person should live as normal a life as possible. However, the concept that residents should have complete freedom of choice may be difficult in practice. Freedom to keep and take one's own medication may involve freedom to lose dangerous tablets or have them stolen by others. Freedom to retain one's own general practitioner may involve a dozen or more doctors visiting a Home without learning the practicalities of managing a given illness by the staff of a given Home at a given time. Communal living freely entered into by frail persons may involve some sacrifice of personal freedom which would be unacceptable to a fit person able to live alone. There should be as few restrictions as possible, but this will demand higher staffing levels than at present.

The training of all staff is an essential requirement. The Social Services Department should hold induction courses and encourage senior staff to have in-service training. There should also be opportunities for some experience in local geriatric and psychiatric departments. The training of those in charge should include: the emotional needs of frail elderly people and their relatives; the nursing needs of frail elderly people; and hotel management and catering. When trained, staff should be appropriately financially rewarded.

Hospital Care—Psychiatric Provision

The College welcomes the insistence on the need for improvement in the services for the mentally ill and infirm and the recognition of the low priority which has frequently been given to the elderly in the development of psychiatric units in general hospitals. In this respect we strongly endorse the Discussion Document and wish to affirm that the general hospital psychiatric service for the elderly will need more beds than are required for 'joint assessment' with the geriatric physician—a development which has had major emphasis in DHSS plans for this field in the past.

We have already commented on the improvement in services to the elderly which may result from specialization by psychiatrists in this field. We have recommended that one in every four consultant psychiatrists providing a community service should specialize in the care of the elderly with an appropriate proportion of medical, nursing, remedial and secretarial staff, secondment of social workers and availability of psychologists and psychotherapists. The College has recognized the specialty by according it the status of a Section, and plans to provide suitable training for senior registrars to fill the remaining consultant posts still needed must be implemented with urgency. A more positive approach to therapy, to the allocation of resources and to teamwork within the service and with others involved with the elderly has often generated effective services from even quite limited provision. Future guidelines on the pattern of 'psychogeriatric' services should be derived from the experience of such departments, as should norms for beds and staffing rather than reliance on national averages and arbitrary guesses, as has tended to be the case in the past. Short-stay bed requirements are certainly higher than those estimated in HM 72/71.

Although earlier intervention and the effective use of short-stay beds may considerably postpone long-stay admission, there is no indication from the more active services that we should drop below the long-stay bed norms set out in HM 72/71; even with the more rigorous selection for long stay, there is never a shortage of suitable candidates. We must also remember that norms based on the over-65 population are year by year falling behind the expansion of the case load of dementia consequent on the increase in the

population over 75. We suggest that in future the norms for any service relating to the mentally frail should be related to the over-75 rather than the over-65 population. Some figures illustrating the prevalence of mental problems in the very elderly, though not pleasant, should be quoted. For example, handicapping memory defects have been found in more than 50 per cent of people over 85 years; that at least 20 per cent of persons over 80 years suffer from incapacitating mental deterioration; that by the age of 90 years self-care has been found to be severely jeopardized by mental changes in one third of subjects.

More active and effective services generate extra requirements for medical, nursing and remedial staff. In particular the more careful selection by severity of disability of patients for long-stay wards puts increasing strain on nursing staff. We have suggested minimum nurse-patient ratios of 1:1.2 for short-stay and 1:1.5 for long-stay wards; the ultimate target should be 1:1.

Education and Research

These important topics require more attention and emphasis. Without knowledgeable and well-trained workers even a well designed and well funded service is of little value. Education in the welfare and health problems of aged persons is important at all levels.

Operational research should be encouraged and supported to determine which of the present methods of therapy and support for the physically and mentally impaired elderly are the most effective in clinical, social and financial terms. Fundamental research may within the next few years demonstrate that the more severe forms of senile mental decline are due to pathological processes which can be halted or retarded by appropriate remedies. As a result there could be considerable changes in future services with a shift from caring towards early ascertainment of dementia and its active treatment. There is particular need for financial support to be given to longer-term research programmes such as might be mounted by a M.R.C. research unit devoted to these problems.

COLLEGE ANNOUNCEMENTS

ELECTION OF FELLOWS

The following Members have been elected to the Fellowship:

P. Abraham, J. V. Ananth, R. N. Antebi, M. W. Atkinson, M. G. Barker, R. J. Belas, Ann Dora Black, J. Blackburn, A. Boroffka, P. K. Bridges, R. S. Britton, Joan Bruce, P. Bruggen, G. D. Burrows, I. A. Cameron, Isobel Card, J. R. Christie Brown, C-M. Chung, Mary Coghlan, J. G. Cooney, A. J. Cooper, B. D. Cooper, A. D. Cox, C. Dare, R. Davidson, B. M. Davies, H. Eaton, H. Ellett-Brown, J. Evans, N. D. Farnan, M. Faulk, P. G. Fawcett, W. L. Flanagan, N. G. Fraser, W. I. Fraser, A. G. Fullerton, A. M. Gordon, B. Gordon, J-Y. Gosselin, A. J. Graham, L. A. Guile, J. D. Hailstone, M. A. Harper, P. Harper, F. S. Hashmi, J. A. Hatrick, J. R. Hawkings, B. E. Heine, S. R. Hirsch, L. Honigsberger, J. S. Hughes, L. C. Hurst, Lai Hung Im, R. C. Ingrey-Senn, F. E. James, D. A. W. Johnson, G. F. S. Johnson, D. A. Jones, E. J. E. Jones, I. H. Jones, G. C. Kanjilal, R. L. Kapur, R. E. Kendell, T. A. Kerr, G. E. Langley, N. B. Le Couteur, J. P. Leff, Shirley Leslie, Janet Lindsay, Mary Lindsay, S. K. Littmann, I. M. Lowit, C. McCance, Elizabeth MacDougall, W. R. McKibben, S. C. Macmillan, P. E. McQuaid, J. B. McWhinnie, G. E. Mahy, I. C. A. Martin, K. R. Masani, R. A. Mayou, P. J. Meehan, G. Milner, J. Moffat, R. Neville, P. J. Noble, Irene Ovenstone, W. L. Parry-Jones, J. R. Pedder, D. C. Pitcher, B. M. N. Pitt, G. Pollitt, J. S. Price, R. A. W. Ratcliff, D. N. Ratnavale, Freda Reed, F. J. Roberts, Irene Rowlands, C. Roy, M. Segal, Susanne Shafar, S. Sharma, D. M. Shaw, G. M. Simpson, A. C. P. Sims, Margaret Smith, L. Sohn, D. Steinberg, J. L. Swift, Mary Tannahill, T. G. Tennent, H. B. G. Thomas, N. A. Todd, P. J. Tyrer, A. Wakeling, J. J. Waldron, N. R. Walsh, W. P. Walsh, P. G. Wells, P. B. Whatmore, J. M. White, B. F. Whitehead, P. C. Whybrow, C. E. Williams, S. N. Wolkind, P. G. Woolf, G. Woolfson, N. J. Yorkston, A. A. Zabow, A. K. Zealley.