Light into the darkness

Bringing old age psychiatry to unfashionable places

David Jolley

A recent postmark declared Wolverhampton to be 'ON YOUR WAY', perhaps suggesting that many would pass through, but few would choose to stay. Yet to those who live there and have grown to love it over generations, it is a fine industrial town, capital of the Black Country, centre of a unique culture and home of Wolverhampton Wanderers. Of the 254 000 residents, 16% are elderly (≥65 years) and 18% are non-white.

There are areas of considerable affluence, particularly to the west of the town which gives way to the countryside of Shropshire and Staffordshire, source of the wool which was the original wealth of the town. Central and South Eastern wards have high Townsend scores, high morbidity and mortality rates (Townsend *et al* 1988; Kelleher 1994).

Wolverhampton has a place of honour in the history of medicine of older people as it provided the site for the first epidemiological survey of the health of old people. This survey was undertaken by John Sheldon (1948) who practised as a physician at the Royal Hospital and conducted the research in addition to his clinical responsibilities. The mental state assessment included in his standardised examination was designed with the advice of Professor Aubrey Lewis (Sheldon, 1948).

But from the perspective of old age psychiatry, Wolverhampton has remained bottom of every league table: the town has yet to attract and retain its first consultant, though it has been advertising two posts once or twice each year for the best part of a decade. It is one of 24 Districts unable to name one specialist in old age psychiatry (Benbow & Jolley, 1995). It is one of the three Districts providing no long-stay beds for patients suffering from severe dementia or other conditions (Alzheimer's Disease Society, 1993).

What does the present service offer?

From the perspective of a concerned outsider, the impression is that the service is short on resources of all kinds, lacks the leadership and confidence that should be associated with competent medical skills, but does include good staff in nursing and some other disciplines (it is notable that all four established posts for occupational therapists in psychiatry, including old age, are empty).

Thirty acute beds are insufficient for the predictable needs of a population of 40 000 old people, even when there is an adequate spectrum of other facilities (Royal College of Psychiatrists, 1993). Thus, these beds operate under pressure and have developed a culture of admission by crisis, real or engineered, assessment and discharge within two weeks. Readmissions and complaints are not uncommon though tempered with praise for the dedication, skill and compassion of nursing staff.

Thirty day hospital places, all in one unit on the main hospital site, are insufficient in number, not easy to access from some parts of the town and are expected to do too much. There is a waiting list of 18 patients. Families, general practitioners (GPs) and social workers are all grateful for the help provided when it can be made available but staff are stressed beyond the limits of tolerance. They know that more could be done and they want to be able to do it.

There are no respite beds, no long-stay beds. An arrangement whereby long-stay wards were closed with transfer of patients and monies to newly built nursing homes operated by a housing association has proved a disastrous venture. The new accommodation is good and well sited. The staffing is good in number and quality. Patient-residents are well cared for, though there is no specialist medical input other than by consultation (which has often been unavailable and not always valued). But these units do not function as components of the specialist old age psychiatry service: though the housing association receives sponsorship from the health authority, placements are means tested and most patient-residents have become a charge on social service funding. Admissions to these beds are determined by the officers in charge and there is no reference to the specialist team. These units have

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no role in the support or training of staff in other Homes within the town.

Dedicated community psychiatric nurses (CPNs) work the town in four sector teams, coterminus with social services, relating well to GPs. They are loved by everyone and represent the available face of specialist old age psychiatry. They cannot escape from learning of problems but often find they cannot provide adequate responses to the obvious needs of patients, carers, and colleagues. This means that they too are severely stressed, though quite properly proud of their role and the high standing in which they are held.

How did it get to be so bad?

Psychiatry's problems are not limited to old age: there have been only two established consultants in general psychiatry for most of the past decade (total population 250 000). All other posts have been occupied by a changing population of locums.

Situated halfway between Birmingham and Keele, the two centres of excellence and training in the West Midlands, Wolverhampton has been on the periphery of vision and interest of both: nobody's favourite child.

Geriatric medicine, which might be looked to as a helpful sister speciality with interest in old people and the welfare of services for them, is certainly stronger than psychiatry. Yet it has had its own difficulties and preoccupations. In recent months it has contrived to become divided in its management allegiances between the 'acute' trust (Royal Wolverhampton Hospitals) and the 'community' trust (Wolverhampton Health Care) which includes the whole of psychiatry, learning disability, physical disability and some other specialities. The geriatricians have been associated with a denial of the need for longer-term care and the threatened closure of a popular community hospital. This has fanned anxiety and suspicion within the population and boundary disputes between health and social service agencies.

Within these discussions concern for the needs of mentally ill old people has been expressed by social services, the voluntary organisations and the Community Health Council, but not by geriatricians nor other health authority lobbyists. A series of changes in the management structure of the health authority, each bringing with it threats to existing staff and an influx of ambitious 'new brooms' determined to make their names through 'radical reorganisation', has led to asset-stripping of this and other related services. The community trust, especially in its psychiatric directorate, is grossly underfunded in contrast to the much better resourced acute trust which continues to attract additional monies through an aggressive contracting policy. Old age psychiatry is a loser in an association of losers.

Are there any saving graces?

Even in the darkest corners, there are often glimmers to encourage hope. This is certainly the case in Wolverhampton: social services are superbly led and utterly committed to playing their part in developing good practice, good service and in encouraging the health authority to redirect its resources to the benefit of people who are suffering from mental illness and the less fashionable illnesses of late life. Voluntary agencies are active and effective and the local branch of the Alzheimer's Disease Society has been influential in helping sufferers and carers where no other help was to hand, and in keeping the debate alive which seeks to see appropriate responses from the statutory bodies.

GPs, though frequently pilloried for lack of knowledge, lack of interest and downright obstruction, have declared that the situation is unacceptable and 'something must be done'. Health purchasers are aware of the deficiencies, though they can be said to have been contributors to their generation. New personnel bring the possibility of improvements and it is encouraging that the medical officer of health lists mental health promotion with prevention of coronary heart disease as his highest priorities (Kelleher, 1994).

Wolverhampton now boasts a University (developing from a Polytechnical College which had a good reputation) and the potential for collaborative ventures in mental health are yet to be explored but could be rewarding.

Wolverhampton health care is a newly established Trust, and though starting with a legacy of difficulties, seeks through good and fearless leadership to earn a reputation for innovative good practice. There are almost certainly other sources of potential help and support which are currently not identified but will be revealed if a start can be made on making some effective and relevant first moves.

What can be done in a situation like this and how can a start be made?

We have a great deal of experience in South Manchester in developing and supporting old age psychiatry services, starting within our own District in 1975: the first service was established in the North West, declaring one of our responsibilities to be the encouragement and training of staff to create similar services elsewhere (Jolley & Jolley, 1991). Most of this 'seeding' activity has been achieved through the training of senior registrars who have gone

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on to pioneer developments in the North West or further afield. In the early 1980s we took on responsibility for the population and service in our sister teaching district of Central Manchester, using our own manpower and senior trainees to work with facilities and other staff of the home district until an appropriately trained consultant became available. More recently, our Trust has created two additional posts with academic sessions, to begin the development of the service in neighbouring Stockport where it had proved impossible to attract candidates over a number of years. The advantages of this arrangement include the certainty that the new consultants are not alone but part of an established group of colleagues who can help each other out, share an 'on-call' rota, and discuss strategies and potential difficulties. In addition, when colleagues in Salford were unable to identify a satisfactory locum to cover a period of extended maternity leave, we have been able to help by offering consultant sessions to work within the established team, thereby protecting the remaining consultant from absolute overwork.

On occasion, other authorities have sought help or advice and my own activities as Chairman of the old age section of the College have made me acutely aware of the need to develop the speciality on the two fronts: better and more comprehensive services in established settings, supporting research and evaluation as well as teaching and training; but also helping the poorest districts to get started and begin to reap the benefits of approaches which have been available for 20 years in other parts of the country. Through the initiative of their local Alzheimer's Disease Society and an invitation to join a local care planning team, Wolverhampton made an approach to me in South Manchester, asking for help and advice. It became clear that all the good advice in the world was going to achieve nothing unless we could get consultants into post to demonstrate what can and should be done. Repeated advertisements yielded no takers. This has led us to explore a new method of 'seeding' by secondment of an established consultant (myself) to work within the distant Trust (Wolverhampton) for part of each week for a determined period (two years in the first instance).

Initial plans are: 1) to tidy up and understand what is available; 2) to confirm a shared vision of what should and can be done with other clinicians, management, purchasers, GPs, social services, voluntary and independent sectors; 3) to involve trainees in the development and evaluation of the new venture; 4) to develop sector teams, each with its own consultant and community-hospital/resource centre with long-stay respite beds, day hospital places and outreach, integrated with other agencies; 5) to undertake and publish audit and operational research; 6) to seek to undertake sponsored research which will include joining with colleagues from Keele University to repeat Sheldon's classic survey; 7) to consider the prospects for a centre for mental health within the Black Country modelled on the Stirling Dementia Centre; and 8) to review progress as we go and revise the action plan accordingly.

Sponsorship received for this work in Wolverhampton will be used to employ additional staff in Manchester on short-term contracts, which we hope to make attractive and worthwhile by including time and training in research along with clinical experience within the service. With luck, all parties can consider themselves to be 'winners' in this scenario. If the project is successful it might be replicated elsewhere with other established 'donor' services helping others to get started when all usual approaches have failed.

The essence of old age psychiatry has always been to bring good practice to the most in need. This is an interpretation of this philosophy in the current state of inequality within the National Health Service.

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