

WHAT'S WRONG WITH PSYCHOGERIATRICS?

by Dr D. M. D. White, *Consultant Psychiatrist, Hereford General Hospital*

For some months I have been toying with the idea of writing some notes under this title. The recent article by the Sub-Dean, (*Bulletin*, January 1979 p. 7) analysing the reports of Assessors on Advisory Appointment Committees seems to make comment necessary, confirming as it does what many of us working in the field have felt for some time—that something is very wrong with the opportunities available in the psychiatry of old age.

Six posts were unfilled because of deficiencies in the post. Anyone who has been on an Advisory Appointments Committee and tried to persuade the appointing authority on the shortcomings of the post will know that, this being very difficult, the figure is likely to be an underestimate. However, even so, it means that 19 per cent of the advertised posts were unsatisfactory, compared with 3.5 per cent and 0.6 per cent of posts in subnormality and general psychiatry respectively. That this happens is, I believe, because of the complete failure of most authorities to consult in the planning stages with anyone who has a working knowledge of the psychiatry of old age. 'Psychogeriatrics' is the non-specialty of our time, and time and again it just does not seem to occur to administrators, whether at Local, Area or Regional levels—to doubt their own abilities to 'knock up' a post that 'will do'.

Sometimes this can be wilful, when one suspects that 'psychogeriatrics' has been made the excuse to create an extra post onto which is laden all the rubbish and chores of a District's psychiatric service; I have personally come across at least one post, called 'psychogeriatric' where only three sessions were allocated to the elderly, the remainder going to a ragbag of tasks including, if I remember aright, one session seeing candidates for abortions on psychiatric grounds. Usually, I believe, a post is not bad deliberately but because there is no clear model in the minds of those planning it. As they honestly believe that psychogeriatrics is a dead-end job for which no psychiatrist in his right mind applies, the necessity of seeking advice just does not occur to anyone. Often it is obvious that the College Assessor is the first 'psychogeriatrician' to have set eyes on the job description. Sad to say, rarely is there evidence that geriatric physicians have been consulted either; indeed, despite a College recommendation to that effect, I only know of one Region where it is regular practice for a geriatrician to be a member of the Advisory Appointments Committee, whilst in most places the omission, if brought to the notice of the

Authority, is usually greeted with looks of blank amazement which pass to frank incredulity when it is suggested that the psychogeriatrician and geriatrician may actually want to work together.

Obviously, a job that is poorly conceived will be poorly planned and lack any mention of potential for development when it is advertised (in the broadest sense). A good potential candidate may well apply for a third-rate post if he sees clear possibilities of improving things, of developing a service the way he wants. This means a certain freedom for a 'new boy' coming into the existing scheme of things, and it also means a revenue sum for such items as a community nursing service, day care—even a secretary. Much of psychogeriatrics is organizational rather than clinical, and to expect a knowledgeable candidate to apply for a post where he will have half an office and a third of a secretary—on the grounds that it is adequate for everyone else—is foolish.

A poor post with no prospects will only attract poor candidates, who have no idea what they are doing but just want any consultancy.

Despite the College's training requirements, young psychiatrists are still being produced to senior registrar level without any idea that there is more to the psychiatry of old age than the back wards of an old mental hospital filled with bedridden demented; often this is how candidates view the work, and one can only wonder at the motivation of people who apply for work as deadly dull as they conceive it. Meanwhile, the few—the pitifully few—trainees who have worked in a decent psychogeriatric department and have a genuine interest in the work can select the worthwhile—or potentially worthwhile—posts for which to apply; despite the efforts of the College Assessor they may not always get the job, but perhaps in that case they are well out of it. I recall one most interesting discussion with the representative of an employing authority that it was not for me, as the College Assessor, to comment on a candidate's positive suitability for a post, merely to rule out those who were unacceptable in the strict terms of the College's criteria, and the fact that one candidate had wide experience in both geriatric medicine and the psychiatry of old age was immaterial.

Perhaps the problem is, again, in the local attitudes; I know one young man who, on arriving to take up his post as 'psychogeriatrician', was summoned to the physician-superintendent's office and asked what he really wanted to do, as, of course it was clearly under-

stood by all his colleagues that his successful candidature for the psychiatry of old age post was merely a backdoor method of becoming a consultant.

As Dr Brook says in his article, not only are there 'a large number of applicants who seem to lack experience in geriatrics' but also 'the number of posts which were recorded by the College Assessors as having too large a commitment is alarmingly high, and there are indications that unsuitable posts are still being advertised'. They are. Yet the psychiatry of old age, in terms of sheer numbers of patients, is on the increase, and failure to tackle the problems of unsuitable jobs and poor candidates can only lower standards throughout psychiatry.

As it is easy to criticize, I would like to end with some thoughts on the basic requirements to make a post attractive.

It should have the majority of its time devoted to the elderly, and any other work allocated sessions should not be likely to grow to such an extent that it impinging on the services for the elderly.

There should be a reasonable share of the available beds, and some of these should be close to—or within—a department of geriatric medicine, and

preferably in a general hospital.

Day care facilities should exist—and not just buildings but staff and transport for patients.

A revenue sum should be available for the development of a community nursing service for the elderly.

There should be a base available, with an office for the person appointed and a revenue sum for the successful candidate to appoint a secretary of his own choosing who should also have an office next door to his; a telephone is a necessity, though often forgotten.

It should be clear, from the material sent to potential candidates, that an established psychogeriatrician had been involved with the planning—brought in from outside the Region if none existed inside. It should also be seen that a local geriatric physician was involved and was on the Advisory Appointments Committee.

The candidate, for his part, should be able to demonstrate, apart from general psychiatric competence, that he really is interested in old people, has worked for at least a short time in an established department for the psychiatry of old age, and knows of the existence of—and preferably has visited—a few other such departments in the country.

CORRESPONDENCE

THE FUTURE OF THE MENTAL HOSPITAL

DEAR SIR,

Several letters and articles published in *The Times* last year deplored the lack of psychiatric facilities. Topics covered the problem of accommodating disturbed patients in a District Hospital unit, the lack of community homes and the number of mentally ill offenders in prison. A note of despair linked the contributions, and with it there were urgent requests for new resources. Those of us struggling with Regional plans encounter similar problems: lip service is paid to the acute units in general hospital, to community treatment and local specialized units, but there is no money for such developments. An added assumption is that the large mental hospitals will gradually diminish and close and release much revenue. It is also so much nonsense. Money will not become available for expensive community facilities and only slowly for acute units. But buildings and resources do already exist in our mental hospitals to provide a comprehensive psychiatric service. To do so will require a change in viewpoint by our planners.

The invidious aspects of large psychiatric hospitals have been well publicized over the past 30 years, stemming from research work, descriptive accounts

and public inquiries. All have highlighted the dangers of a 'bad' institution. (The support for Regional secure units is all the more curious: that concept appears to embody all that is characteristic of a 'bad' institution, and it is unlikely to provide a solution to the problem of the mentally ill offender). Concurrently it became fashionable to discharge chronic patients to the community. A high discharge rate was seen as a therapeutic advance, but at times added nothing to the quality of a person's life. A further stage has been the preoccupation with therapeutic communities and, as a corollary, to have open wards. Some hospitals have made it a matter of policy to have no locked doors under any circumstances and have restricted their admissions. This occurs especially with mentally ill offenders. Another factor has been the development of psychiatric units in District General Hospitals and the difficulty of providing a service to a broad range of patients in these units. Inevitably, distinctions between such units and large psychiatric hospitals become emphasized, with at times an elitist view by patients and staff of the former. These various threads, woven together with, at times, emotive views, have produced a limited psychiatric service, one which reflects poorly on the profession.