Care of older people with mental illness

Progress in the implementation of recommendations 1989–1998

D. J. Jolley

Older people comprise an increasingly significant proportion of the population of the UK and other developed countries. Most remain fit and able to make continuing contributions to their families and society, but they are at risks of periods of ill health and other stresses. Dementia, especially Alzheimer's disease, is one of the major health problems of our times and particularly affects older people. Mental ill health, physical ill health and social difficulties are often intertwined, calling for close working between health and social services to provide appropriate help for patients and their carers.

The Royal College of Physicians and the Royal College of Psychiatrists cooperate in discussions and reports which reflect their joint concern for patients with both medical and psychiatric problems (Royal College of Physicians and Royal College of Psychiatrists, 1995*a*,*b*). In 1989 the two Colleges published a report entitled *Care of Elderly People with Mental Illness. Specialist Services and Medical Training* (Royal College of Physicians and Royal College of Psychiatrists, 1989). The report drew upon the work of pioneers in the fields of medicine and psychiatry of later life and presented a joint statement of views from the two Colleges which had previously produced separate reports. It concluded with a list of recommendations aimed at accelerating the spread of good practice. This paper reviews progress made in response to these recommendations and provides a background to *The Care of Older People with Mental Illness*, to be published by the Colleges in 1999.

Care of Elderly People with Mental Illness (Royal College of Physicians and Royal College of Psychiatrists, 1989) contains much that is still relevant. Chapter 2 provided a review of developments up to that time and the report concluded with 14 recommendations for immediate progress.

1. Old age psychiatry should be officially recognised as a speciality within psychiatry. This status will facilitate many of the recommendations which follow, and is justified by the number of consultants now working in this field, the specific service patterns, the training requirements and the body of knowledge and research.

Progress Old age psychiatry became a speciality within the National Health Service (NHS) in the autumn of 1989.

2. Every health district should include a specialised service for the psychiatry of old age based on the model outlined in this report and backed by at least the minimum resources set out in the Royal College of Psychiatrists Guidelines.

Progress Provision of specialist services has increased but is still patchy. The Royal College of Psychiatrists Old Age Section identified 405 consultants specialising in old age psychiatry in 1993 compared with 362 in 1991 (further details available from the author upon request). A few NHS trusts now provide establishments of consultants equivalent to one whole-time equivalent (wte) per 10 000 elderly people or better, while others have still not made any consultant appointments in the speciality. Some trusts offer a deficient range and capacity of facilities or an unacceptable style of service.

3. An effective old age psychiatry service requires specialist consultant cover of one session per 2000 people aged over 65 (with enhancement in teaching districts). Achievement nationally of such cover (which already exists in many districts) would entail the present annual recruitment of an additional 25–30 (wte) consultants to this field being maintained for the next 10 years.

Progress The Royal College of Psychiatrists encourages the expansion of consultant manpower to one wte per 10 000 people aged 65 years and above (Royal College of Psychiatrists, 1993). This is in keeping with similar increases in consultant staffing in all other specialities and is necessary because of rising expectations of the

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volume and quality of services and changing patterns of work. The trends are towards greater availability of specialist services in the community, more liaison work in hospitals and increased involvement with multi-disciplinary and multi-agency teams. The need for trained and dedicated consultants remains ahead of supply. Well-resourced centres are better able to attract additional staff so that inequalities between services may increase.

4. Resources, workload, manpower and training facilities relating to old age psychiatry should be clearly and easily identified and the data used by the Department of Health and Social Security and the regions to ensure that policies are effectively implemented in what has long been recognised as a priority area.

Progress It was envisaged that the establishment of the speciality would facilitate the systematic routine collection of data on resources and their use, but the yield has been erratic and unreliable. Policy and priorities have become harder to identify as a consequence of the successive changes in the NHS. 'Planning' has been superseded by 'purchasing' and, more recently, by 'commissioning'. National guidelines have been eschewed and local bargaining championed as the means of determining priorities. Within this poorly defined framework health authorities and other purchasers have not always given priority to the needs of older people with mental illness. Many health authorities have failed to make an appropriate contribution to long-term care of the severely mentally ill and incapacitated. Rather, they have chosen to spend their revenue on other groups of patients. Those older people suffering from mental illnesses who would previously have received care in hospital have been thrown into the means-tested and inadequately regulated environment of social provision. Reports in the media indicate that this is producing alarming and damaging effects; patients and their relatives are dismayed, opportunities for treatment and rehabilitation are being lost, and there are fears that death rates among those recently discharged from hospital to nursing homes are unnecessarily high. The morale of trained and dedicated staff is being undermined and social services departments find their budgets insufficient to meet demand.

5. Improved collaboration between geriatric medicine and old age psychiatry should be constantly pursued since this is essential for good patient care, efficient use of resources and effective planning and liaison with other services. Joint departments should be more widely considered.

Progress Collaboration between psychiatrists and geriatricians is a feature of good practice (Royal College of Psychiatrists, 1992) but can be made difficult by divisions between NHS trusts. Joint departments have not been widely adopted, and geriatric medical services have acquired increasing responsibilities within the acute medical sector. The need for collaboration is not confined to the two disciplines of old age psychiatry and geriatric medicine, but relates also to other hospital specialities and to general practice. Collaboration must also involve other professions and agencies, particularly social services. The aim is to ensure that patients can achieve access to a full range of services regardless of their point of initial contact with the health and social services systems.

6. Members of psychogeriatric teams should be actively involved in supporting, observing and training staff engaged in providing alternative forms of domiciliary and residential care. However, skilled long-term hospital care must remain available for patients with severe behavioural problems.

Progress The responsibilities of specialists for training, supporting, monitoring and working with staff in the full range of services for elderly people, as well as for providing high-quality investigation, treatment and care in their own facilities, are being recognised, but there is still far to go. Work in hospitals, primary care, social services, and the voluntary and private sectors needs to be increased, monitored and evaluated. The 40% decrease in NHS long-stay beds in geriatric medical units, and a similar reduction in beds in psychiatric units and hospitals means that support and training for alternative providers of long-term care is a growing duty of specialist teams. The NHS long-stay units of the future will care for the most severely impaired and disturbed patients from a locality. They will need to provide training and support for staff working with similar patients in residential and nursing homes, as well as for informal carers.

7. Each medical school should have an adequately supported senior academic post in old age psychiatry to develop and evaluate teaching for medical students and allied professions and to promote research in this field.

Progress There are now chairs or readerships at a number of university undergraduate and postgraduate schools of medicine, but gaps remain (Faire & Katona, 1993). At the time of writing there are no senior academic posts in old age psychiatry in any of the Scottish medical schools, Wales or Northern Ireland. In England, the medical schools of Birmingham, Bristol, Cambridge, Charing Cross and Westminster, Royal Free and Sheffield are similarly deficient although some have lecturer posts and most

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have NHS consultants with honorary lectureships.

The increasing preoccupation of universities with performance in raising grants for research has added to problems. There is a need for more good-quality research in old age psychiatry, but the major immediate priorities are for better training, recruitment, service development and evaluation. These are not always best met by researchers primarily interested in the basic science of mental disorder and it is to this area that most research money is attracted. Old age psychiatry is at the beginning of its academic growth and lacks a research infrastructure. An additional problem has been the privileged claim on research and other monies bestowed on younger groups of mentally disturbed patients whose behaviour in the context of inadequate services has alarmed the public and created political embarrassment.

8. All medical students should receive training in old age psychiatry in approved specialised departments with clinical exposure in both hospital and community. Consideration should be given to integrating such teaching with that in geriatric medicine.

Progress Issues relating to mental disorders in late life are among the 'core concepts' of the medical curriculum. Some progress has been achieved in most medical schools though there is a great deal of variation. Faire & Katona (1993) found that 25 of 27 medical schools provided formal lectures in old age psychiatry; 18 involved old age psychiatrists in the planning of teaching and nine included some joint teaching with geriatric medicine. The proportion of psychiatry teaching time devoted to old age varied from 2.5 to 25%. Gregory & Dening (1995) reported that old age psychiatry is taught within psychiatry except at Nottingham, where it is within a department of health care of the elderly. Forty per cent of departments include liaison teaching with geriatric medicine. Most teaching is undertaken by enthusiastic but busy clinicians, and although 60% of teachers felt students were receiving a sensible balance of teaching between old age psychiatry and general psychiatry, they plead for more teachers to do the work.

9. Posts in old age psychiatry (in conjunction with geriatric medicine or general psychiatry) should be included among the options for the general professional level of postgraduate medical training for doctors aiming at a career in hospital medicine, as well as for those training for general practice. Those intending to practise general psychiatry should be encouraged to spend a period at some stage of their training in approved departments of old age psychiatry. The clinical experience should reflect the full range of the service and should be geared to training as opposed to service needs.

Progress All training schemes approved by the Royal College of Psychiatrists include options for a six-month placement with a specialist old age psychiatry service. Implementation of the Calman (1993) proposals should not detract from this. Experience in psychiatry is neither required nor actively encouraged in general professional training for doctors planning careers in hospital medicine, but is likely to be viewed with approval by appointments committees for senior posts. Vocational training schemes for general practice may include placements in psychiatry or old age psychiatry as options. It is unlikely that these will become compulsory, but experience in this area will be relevant to all general practitioners (GPs) and should be encouraged. The Diploma in Geriatric Medicine of the Royal College of Physicians sets a desirable standard for GPs who expect to work with older people. We hope that more GPs will prepare themselves for this qualification. Possession of the Diploma by attending general practices should be used as an indicator of the quality of medical expertise provided in residential and nursing homes.

10. Those intending to practise general psychiatry should be encouraged to spend a period at some stage in their training in approved departments of old age psychiatry. The clinical experience should reflect the full range of the service and should be geared to training as opposed to service needs.

Progress All training schemes are required to offer a sufficient number of placements with approved trainers in old age psychiatry if they are to gain/retain approval for training from the Royal College of Psychiatrists.

11. Higher professional training for specialisation in the psychiatry of old age should include: two years in old age psychiatry; at least two months' experience in geriatric medicine; and further experience in general psychiatry.

Progress Achieved. Clear guidance on the content of specialist training, in keeping with this recommendation are well established (Joint Committee on Higher Psychiatric Training, 1995).

12. Where higher training for the psychiatry of old age is incorporated in regional general psychiatry senior registrar rotations, such schemes should be monitored to ensure that the appropriate output of psychogeriatricians is achieved. This applies particularly to the posts recently allocated by the Joint Planning Advisory Committee on Manpower to enhance training opportunities in this field (the uptake and targeting of which has been in some doubt).

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Progress Old age psychiatry has remained linked with general psychiatry in the Speciality Advisory Committee of the Joint Committee on Higher Psychiatric Training. Trainees in old age psychiatry need some experience in general psychiatry and general psychiatry trainees may seek a placement in old age psychiatry. Nevertheless, it is important that separate manpower allocations for the two specialities has now been achieved.

By 1996, 134 senior registrars were enrolled in training schemes for old age psychiatry in England and Wales. Manpower arrangements are different in Scotland and Northern Ireland but roughly one-third of psychiatry specialist training posts are devoted to old age psychiatry. This should achieve an output equal to the current annual demand for 30 to 40 new consultants. There has been encouraging recruitment to training posts, but some consultant posts remain difficult to fill. Premature retirement is a new factor to be considered in manpower planning. Figures collected by the Royal College of Psychiatrists indicate that there has been an exodus from psychiatry as senior practitioners take early retirement in preference to working in unacceptable conditions. This has affected both general and old age psychiatry.

13. Guidelines should be agreed between the respective higher training committees as to the experience and training required in each other's specialities by senior registrars in geriatric medicine and old age psychiatry. They should also uphold the supernumerary concept of the senior registrar grade in respect of the workload implications of such secondment. Mutual exchanges and linked training in joint departments should be encouraged.

Progress Achieved to a limited extent. It is common for old age psychiatry trainees to spend time in geriatric medicine and experience in old age psychiatry is a requirement of higher medical training in geriatric medicine. There is a need for the specialities to establish more explicit standards for training (British Geriatrics Society/ Royal College of Psychiatrists Liaison Committee, 1990; Forsyth, 1992).

14. There is a need for continuing evaluative research in the psychiatry of old age (including models of collaboration with geriatric medicine and other services).

Progress Little such research has been undertaken. The need for it remains.

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D. J. Jolley, *Medical Director, Mental Health Directorate, Penn Hospital, Penn Road, Wolverhampton, West Midlands WV4 5HN*

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