

GUEST EDITORIAL

Coming of age: reflections on old age psychiatry as a specialty in the National Health Service, 1989–2010

The further back you look the further forward you can see.

Winston Churchill

Those who do not learn from history are doomed to repeat it.

George Santayana

Mental illness in old age is one of the most important healthcare issues of our times: if dementia were a country, it would be the world's 18th largest economy (Alzheimer's Disease International, 2010). In 1989, the UK Department of Health formally recognized old age psychiatry as a specialty in its own right, and by 2010 it had come of age. This anniversary was commemorated with a special edition of *Old Age Psychiatrist*, the newsletter of the Royal College of Psychiatrists, Faculty of Old Age Psychiatry (2011). To produce this, we called for "Janus" articles drawing on past experiences and giving thought to the future. Thirty-seven authors, ranging from students to retired colleagues, responded. Most contributors were UK-based but five worked elsewhere and provided an international perspective. The majority were psychiatrists who had devoted many years to the specialty, but their thoughts were set in context by representatives from other disciplines closely aligned to specialist healthcare services for mentally ill older people.

By 1989 a great deal had already been achieved to create better services for older people in the UK. Old age psychiatry developed within a social psychiatry model, which drew on the best practices of psychiatry in association with geriatric medicine and social care. Mental hospitals were closing, units in general hospitals became the norm, and recruitment grew despite the Cinderella status of the specialty (Hilton *et al.*, 2010). Specialty status was aimed to make it possible for best practice to become available equably throughout the UK by facilitating service development, monitoring services, and enabling recruitment and adequate training of staff. Contributors to *Old Age Psychiatrist* reflected on the widespread international interests, adoption, and interpretation of the UK model.

The newsletter was stamped with the enthusiasm and devotion of contributors. They have become involved in, or seen at close hand, the flourishing of a specialty which is relevant to the world's demographic and epidemiological needs, now and for the foreseeable future. There was much pride and satisfaction that despite social, economic, political, and professional challenges, something good has evolved, through innovation, dedication, and creativity, which will benefit future generations. But confidence was muted with recent frustration; influence and control is so often falling into the hands of policy-makers and managers who have not had the benefit of direct learning in the realities of this exacting and complex area of human need.

The dangers of a lack of institutional memory

The National Dementia Strategy for England was published in 2009 (Department of Health, 2009). Other countries have also produced strategic documents, often available on the websites of dedicated Alzheimer's disease support organizations. There are also international statements outlining best practices in dementia care (WHO, 2011). However, it is dangerous when new ideas prevent a balanced appraisal of earlier initiatives and learning from past experiences, both success and failure (Cohen, 2009). Disregarding past achievements has been associated with the abolition of effective, locally relevant services, at times against the wishes of experienced clinicians. Examples of dismantled services include integrated social and healthcare community teams, joint geriatric and psychiatric units, home treatment teams, special services for ethnic minority populations, and memory clinics set up to facilitate early referral and high quality assessment and treatment. Examples of good services, which had been created, lost, and sometimes reinvented, were manifold. Staff morale and confidence are eroded when trusted and effective service components, created and progressively improved over many years, are lost. Fashion, economy, and templates derived from political or management ideology and imposed top-down were identified as culprits of wanton damage.

Innovation, uniformity, and money

Front-line clinicians working with patients, families, and other agencies have been thoughtful and creative in finding solutions to individual and shared conundrums. Alternatives have been explored – community clinics, travelling day hospitals in rural areas, caregiver groups, lecithin cakes, and many more. Services have been developed and varied to suit local needs, strengths, and preferences. Maintaining flexibility at the frontline is essential for the best use of resources, albeit within a budget that is reasonably adequate as well as affordable. Ingenuity has been perhaps a logical response to chronic under-funding.

Current pressures for uniformity are good in one respect, since it means that everyone can be assured access to an agreed range of services irrespective of location. On the other hand, blanket uniformity imposed in the name of equity can suffocate the very spirit that gives new life to services. Service innovation may be discouraged by day-to-day clinical pressures, endless documentation, and management, which is sometimes remote and authoritarian. Bidding competitions for an extra share – with one winner and many losers – are demoralizing and counterproductive.

Collaboration

The key to success lies in working with others in the care of older people or younger ones who share the difficulties and characteristics identified with age. Historically, in the UK the first and the strongest links were with geriatricians (Hilton, 2005). These and links with social services remain important here and internationally, but things are changing as the balance of commitments and expectations change. As the provision of specialist services increases, activities shift from desirable to essential: wider public knowledge about dementia and other conditions and the expectation that they be identified, investigated, and treated mean a greater demand for services, with the number of people presenting for help multiplying and likely to increase further. This calls for work with colleagues in Primary Care as co-workers, not simply referrers. General hospitals are beginning to acknowledge the impact of delirium, dementia, and other mental disorders on their own work (Royal College of Psychiatrists, 2005). This requires restructuring of their functioning and the help they require from specialists. The appeal of special wards with shared staff and responsibility is being rediscovered, valued by experts within living memory, but lost

from institutional memory and now undergoing academic review (George *et al.*, 2011).

There was, and remains, much to change. There is still much fear, ignorance, and prejudice. The work is far from complete. Long-stay National Health Service hospital wards have become a rarity, not because the people with characteristics previously served by them have gone, but because they are now distributed across a lattice of private sector homes. In these homes, specialist healthcare teams are still asked to advise. However, they have often lost the competence which comes from the direct experience of caring for the most dependent, disturbed, and disabled patients. We heard of deaths associated with poorly conceived and enacted hospital closures. We know of ongoing struggles to obtain justice in providing adequate long-term care with appropriate health service sponsorship for very ill older people. Yet there are new collaborative schemes creating hope, such as work with hospices through outreach programs and a closer appreciation of the end-of-life needs of people with dementia, their families, and professional caregivers (National Council for Palliative Care, 2011). Advocacy to provide adequate humane treatment and care, boldly demonstrated by pioneers, remains essential in what is perhaps a less receptive, less kindly environment.

Collaboration can improve patient care, engender respect for colleagues, and may optimize use of resources. However, with scarce resources there is also the risk that sharing becomes an anathema to those preoccupied with their own needs and the survival of their professional discipline. Achieving well-integrated and collaborative services therefore needs adequate funding. Integration is not a panacea for proper resources.

The medical–psychosocial balance

There can be no doubt that the most powerful interventions for many mental disorders of late life, particularly dementia, rest within the psychosocial part of the therapeutic spectrum. These are often given unreasonably low status and, consequently, low funding. This needs to be addressed. The popularity of memory clinics with emphasis on technological investigation and the prescription of medication, which is of modest benefit to only a minority of people with dementia, is regarded by some as a misguided wish to put many eggs into the medical model basket of illness and cure, to the neglect of the psychosocial aspect. We may have become too medicalized and less compassionate in our approach, perhaps reflecting the perceived wishes of society and our desire to be seen as “real doctors.”

A balance needs to be achieved which reflects real potentials rather than imagined potency.

Teaching

Stories of inspiration came from enthusiastic and insightful leaders in the field from around the world. Both formal teaching and clinical experience of the specialty for students, doctors, and other professionals in training have been vital to inspire them to take on this rewarding, though unglamorous, field of work. The opportunity to teach is the life-blood of the specialty.

Conclusions

Producing a reflective newsletter taught us much about the history of our specialty, and highlighted strengths to build upon and weaknesses to avoid in the future. It was an informative and thought-provoking exercise, and one that may be interesting to undertake in other countries.

Inspired clinical collaboration, teaching, and innovation, and striking a balance between various aspects of clinical practice, especially medication, psychological, and social, have characterized the development of old age psychiatry. With the difficult economic climate currently affecting many countries, and the move to a more commission-led, top-down, and financially driven model of service provision, as is happening in the UK, the opinion of expert practitioners may have become less valued. Often, practical experience of developing clinical services is not considered valuable evidence if it has not been reported in peer reviewed journals. Nevertheless, experience over decades needs to be carefully integrated into new models of healthcare. We urge our colleagues internationally to follow the advice of old age psychiatrist Baroness Elaine Murphy (2011) in the House of Lords, for our specialty to be “pushing and shoving its way to the front of the policy debates.”

Conflict of interest

None.

Description of authors' roles

Both authors shared the writing of this guest editorial.

Acknowledgments

We thank all the contributors of *Old Age Psychiatrist*. We also thank Tom Arie for his advice.

CLAIRE HILTON¹ AND DAVID JOLLEY²

¹Consultant Psychiatrist, Older People and Health Ageing Directorate, Central and North West London NHS Foundation Trust, London, UK

Email: claire.hilton@nhs.net

²Consultant Psychiatrist, Honorary Reader, Personal Social Services Research Unit, University of Manchester, Manchester, UK

References

- Alzheimer's Disease International** (2010). *World Alzheimer Report*. Available at: <http://www.alz.co.uk/research/world-report>.
- Cohen, G.** (2009). Historical lessons to watch your assumptions about aging: relevance to the role of *International Psychogeriatrics*. *International Psychogeriatrics*, 21, 425–429. doi: 10.1017/S1041610209008540.
- Department of Health** (2009). *Living Well with Dementia: A National Dementia Strategy*. Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_094058 2009.
- George, J., Adamson, J. and Woodford, H.** (2011). Joint geriatric and psychiatric wards: a review of the literature. *Age and Ageing*, 40, 543–548. doi: 10.1093/ageing/afr049.
- Hilton, C.** (2005). The origins of old age psychiatry in Britain in the 1940s. *History of Psychiatry*, 16, 267–289. doi: 10.1177/0957154x05050075.
- Hilton, C., Arie, T. and Nicolson, M.** (2010). A witness seminar. The development of old age psychiatry in Britain, 1960–1989: themes, lessons and highlights. *International Journal of Geriatric Psychiatry*, 25, 596–603. doi: 10.1002/gps.2380.
- Murphy, E.** (2011). A word from the House of Lords. *Old Age Psychiatrist*, 53, 48–49. Available at: <http://www.rcpsych.ac.uk/specialties/faculties/oldage/aboutthefaculty/newsletters.aspx>.
- National Council for Palliative Care** (2011). *Difficult Conversations for Dementia*. London: NCPC.
- Royal College of Psychiatrists, Faculty of Old Age Psychiatry** (2005). *Who Cares Wins*. London: Royal College of Psychiatrists. Available at: <http://www.rcpsych.ac.uk/PDF/WhoCaresWins.pdf>.
- Royal College of Psychiatrists, Faculty of Old Age Psychiatry** (2011). *Old Age Psychiatrist*, vol. 53. Available at: <http://www.rcpsych.ac.uk/specialties/faculties/oldage/aboutthefaculty/newsletters.aspx>.
- WHO** (2011). *Evidence-Based Recommendations for Management of Dementia in Non-Specialized Health Settings*. Geneva: World Health Organization. Available at: http://www.who.int/mental_health/mhgap/evidence/dementia/en/index.html.