Care
for
The Elderly Mind

CARE FOR THE ELDERLY MIND

A collection of reports
on a series of five conferences
held at the King's Fund Centre
between September 1972 - January 1973

May 1973

Price 25p

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CARE FOR THE ELDERLY MIND

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Introduction

This publication contains reports on a series of 5 conferences held at the King's Fund Centre between September 1972 and January 1973 on the subject of psychogeriatric services.

In an earlier series of conferences on geriatric care in 1970, there had been mentioned time and again the problems of mental infirmity in the elderly. It was for this reason that in 1972 the Centre decided to concentrate more specifically upon the subject of psychogeriatric services and to arrange this programme of conferences.

The first three of the five conferences were held at the Centre, and one of these three was organised by the Geriatric Care Association. The fourth conference was arranged in co-operation with the Luton and Hitchin Group Hospital Management Committee and the North West Metropolitan Regional Hospital Board and was held at Luton and Dunstable Hospital. The fifth conference was arranged in co-operation with the Kingston Postgraduate Medical Centre and Kingston and Long Grove Hospital Management Committee and was held at the Medical Centre. In these last two conferences, the aim was to relate the discussion to the problems of a particular geographical area and to involve those who would be actively concerned with planning psychogeriatric services in the post-1974 area health authorities and corresponding local authority areas.

These reports have been prepared largely at the request of the conference participants who asked for a record of the conferences to be made available. The detailed programme for each conference has been included for the benefit of those who may wish to consider organising similar conferences in their own region or area. It is hoped that the reports will also be of interest and help to all those who are concerned with introducing or developing good ideas and practices in the care of the elderly in hospital and community.

May 1973

Miles Hardie
Director
King's Fund Centre

PLANNING SERVICES FOR THE ELDERLY

Conference on Thursday, 28 September, 1972

Chairman for morning session:
Professor M R P Hall, Professor of Geriatric Medicine
University of Southampton

10.30 Welcome to the Centre
Mr B Brookes, Assistant Director,
The Hospital Centre

10.35 Introduction by the Chairman

A REGIONAL STRATEGY FOR DEVELOPMENT

10.45
Mr J W Dummer, Principal Assistant Secretary,
Wessex RHB
Mr N L McLellan, Director of Social Services,
Bournemouth County Borough
Dr C J M Clark, Consultant Physician,
Bournemouth & East Dorset HMC
Dr C L Hall, Principal Assistant Senior Medical Officer,
Wessex RHB

11.45 Interval

11.55 Questions and discussion

12.30 Buffet lunch

Chairman for afternoon session:
Dr K O A Vickery, Medical Officer of Health,
County Borough of Eastbourne

2.00 Introduction by the Chairman

PLANNING FOR DISTRICT SERVICES

2.10
Dr John Powles, Research Fellow,
University of Sussex
Dr I M Brown, Consultant Geriatrician,
Eastbourne HMC
Mr J C Matthews, Assistant Director,
Residential and Supporting Services
Social Services Department,
East Sussex County Council

3.10 Questions, discussion and summing up

4.00 Tea

PLANNING SERVICES FOR THE ELDERLY

The planning of services for the elderly at both a regional and a district level was discussed at the Hospital Centre on 28th September, 1972, during the first of a series of conferences on aspects of psychogeriatric care. The chair was taken at the morning session by Professor M R P Hall, professor of geriatric medicine, University of Southampton. He said that the aim of the geriatric service must be to keep health at an optimum so as to keep the help needed by old people at a minimum. The quantity and quality of services depended on their ability to wrest resources for geriatrics from the general pool and they were, as a result, uneven. Three recent reports from the S E Metropolitan R H B, the Hospital Advisory Service and the Royal College of Physicians had drawn attention to the inequalities in hospital provision for elderly and to the need for geriatric medicine to be recognised as an important specialty and to be better represented in hospitals. The number of old people was likely to increase and multi-disciplinary planning was necessary to meet their needs. The problem was, however, so urgent that something had to be done before the results of research into actual needs became available. This was why the Wessex R H B had set up a working party to advise its forward planning unit on geriatric care and they were now producing a flexible strategy which would be open to discussion as to detail in each of the areas of the region and which might be applicable to other regions. This would be described during the morning and would, Prof. Hall hoped, provoke discussion and not just add to the pile of words and paper already circulating on the subject of geriatric care.

A regional strategy - philosophy and planning methodology

The Wessex R H B strategy was introduced by Mr J W Dummer, principal assistant secretary in charge of the Forward Planning Division. He said that the board had started by making a distinction between planning for a building programme and planning a strategy for health care services and had consigned the latter aspects to the Forward Planning Division some two years ago. The Division was to look at all aspects of care in as comprehensive a manner as possible and, in terms of the elderly, this meant an overall plan for the care of all old people in Wessex. It was also necessary for the Division to produce a methodology for this comprehensive approach. They had begun by examining the framework for action which involved:

a) a definition of the needs of the elderly, based on questionnaires, research, literature scanning, etc.

b) an examination of the roles of the providers as they currently existed including the hospital and the community, statutory and voluntary services.

c) a look at the provision of resources of buildings, staff, etc. and at how they were provided and in what quantities, etc.

d) a consideration of the organisation of health care services for the elderly as they existed at present, and particulary the gaps in the complex network of statutory and voluntary provision.

This was followed by the drawing together of a plan for action which was a joint exercise between the Forward Planning Division and an expert working party. This partnership was essential both to provide judgement at all stages on the practical consequences of decisions and to show how priorities were seen outside and within the Board in relation to other services. They had together produced three documents:

i) a stategy or framework within which local plans could be evolved,

ii) documents to explain the basis on which decisions had been made, ie a compendium of information gathered from statutory and voluntary organisations, views and opinions, the results of research, literature scanning, etc.

iii) a series of outline plans for the hospital service. The R H B had no responsibility for community services at the present time but hoped that the local authorities would match this volume with similar documents.

Organisation of a personal and primary care service

Mr N L McLellan, director of social services, Bournemouth County Borough, said that there were four common factors relevant to social service departments at this time, which related to the needs of the elderly. These were:

a) for organisational purposes, social service departments were divided into areas covered by teams: the teams had to reflect and meet needs in their areas.

b) a generic approach, ie an attempt to meet needs by the use of a multi-disciplinary team: he personally did not think the individual generic social worker was ever likely to exist.

c) an increased demand and expectation of services, and at local authority level, an inability to pass the buck.

d) the necessity to examine priorities and to be concerned with research and with the department's interaction and inter-dependence with other agencies.

It was this fourth point which formed the theme of the report.

The collection of data was an essential first stage of a project. There were very different levels of provision in different parts of the region which could not be explained solely in terms of local differences; eg very different rates for the use of incontinence pads. There was a clear need to look into and explain these differences. In examining the provision and utilisation of resources, they had come up against a lack of knowledge of needs and a difference in the utilisation of resources concerned with the assessment of needs, ie at a manpower level. Research reports indicated large areas of unmet need and assessment staff clearly had to encompass many disciplines. The problem was one of management of resources or the management of choices to meet agreed ends. There were choices in which the key factor might be something like the availability of transport rather than the total availability of services such as day care, etc.

The establishment of social service departments and the reorganisation of the N H S offered an opportunity for change which might not occur again. There could be changes at both the A H A/new county level and at district and area team levels. He foresaw the growth of community teams to bring together all concerned with the health and social welfare of old people in an area, and including the voluntary services.

These teams would be concerned with the recognition of consumer views, the provision of services and with the assessment of needs by as small a number of people as possible. They would be flexible to meet local needs and to make rational decisions on local priorities. They might involve the use of 'at risk' registers, a local coordinator who was possibly a coordinator of voluntary services and a community physician in geriatrics, who could be the catalyst for this overall approach, watch demographic trends, etc.

Organisation and the role of the hospital service

A plea that geriatric medicine should be brought into the mainstream of hospital life was made to the meeting by Dr C J M Clark, consultant physician, Bournemouth and East Dorset HMC. This was particularly necessary in medical schools and teaching hospitals so that the student could see expert geriatric care at an early stage in his curriculum. The speciality would gain status from an increased academic element, research, etc. Other university departments could be involved in research, eg a sociology department could look at the health care of the elderly. There should be more post-graduate training in geriatrics, clinical assistantships, etc. Secondly, Dr Clark said that he would like to see the district general hospital being used as the base for geriatric services, rather than an outlying hospital. This would facilitate cooperation with other departments, eg psychiatry, orthopaedics, general medicine, etc. Thirdly, he saw scope for greater cooperation with the community, and with the relatives of the old people in particular. This would allow for a greater flexibility in the use of facilities, eg day hospitals.

Dr Clark went on to say that he would like to see more amenities for the old person in hospital. An admission at over age 65 was a first hospital admission for more than 50% of patients and was an emotionally traumatic experience. He wanted to see as much consideration given to the elderly as was now given to children; an increase in staff understanding and an attempt to shield them from distressing experiences caused by other patients. Fifthly, he hoped to see an acceleration of the transition of the nurse from her passive custodial role to an active rehabilitative role, facilitated by improved education. The Wessex working party report included the syllabus for a 36-week post-registration training course in clinical geriatrics for nurses. This would provide them with the necessary expertise for their job and include training in emotional aspects. They planned to free nurses from housekeeping and clerical duties and increase staffing at nursing auxiliary and remedial aide levels. These grades would receive in-service training and a syllabus for this was also included in the report.

Dr Clark said that he agreed with the Department of Health in that he would like to see 50% of geriatric beds in the district general hospital and an administrative officer in each geriatric department who was concerned with management, research, monitoring and cooperation with the community. Each service should have a defined catchment area and cooperate with defined community teams. He then drew attention, with the help of a number of slides, to the number of non-geriatric beds occupied by patients aged 65 years or over, and particularly to the rapid rise in this occupation by patients aged 75 and over. In their new hospital they were trying to get round this by placing the acute geriatric unit next to an area of 120 acute medical beds. All admissions were to the medical beds, but the physicians worked in cooperation with the geriatric team in the work of diagnosis and assessment and they could decide together whether to move a patient to an acute geriatric, backup medical or backup geriatric bed. The backup geriatric beds should be placed as near to the community as possible, and should be only part of a range of choices (eg in-patient, out-patient, day hospital care) which were available to the doctor. They were also trying experimental units such as pre-discharge, amputee, hemiplegic.

Dr Clark offered his definition of a psychogeriatric patient based on behavioural factors. He suggested that the psychogeriatric department within the district general hospital should be basically diagnostic and concerned with decisions on treatment and assignment. The nurses should include a majority with a psychiatric training and others with geriatric experience. He favoured the inclusion of a psychogeriatric day hospital as a unit within the psychiatric day hospital and an increase in the number of community based psychiatric nurses to do the necessary follow-up.

Implementation

Speaking on the implementation of the Wessex working party proposals, Dr C L Hall, PASMO, Wessex RHB said that he could not tell the meeting how to increase the number of geriatricians or the number of geriatric beds in district general hospitals or how to improve cooperation with the community. He could, however, assert his belief that rehabilitation began at the beginning of all treatment and that implementation had begun at the realisation of the need for a working party. In Wessex they had, in fact, seen a need to look more closely at geriatrics before the decision had been made to give one of the first chairs at Southampton University to geriatric medicine.

The working party could have been made up of hospital consultants who called for evidence, but then its report would have been a hospital report which had to be sold to the community. As it was, all interests took part in the production of the report through small groups at local level. These participants were the nucleus on which change could be built. The report was however, still a RHB report and one which would be presented before the integration of the NHS. The Board's planning committee had set up a subcommittee to examine the report and they had accepted it but decided that implementation was not realistic until 1974. They had therefore decided to use the intervening time for education and persuasion to get support for its recommendations from all those concerned with the care of the elderly. Plans were as follows:

a) There would be talks with groups of people working on the ground, those within the NHS, those working for the local authorities and those in the voluntary services.

b) The capital programme could not be delayed until 1974 so decisions on the additional sums of money being made available by the DHSS were being taken in the light of the report, eg units were being concentrated on DGH sites.

c) Changes were being made in staff training. The syllabi for the training of nurses and rehabilitation aides were being tried out and there was to be increased rotation of junior medical staff to include geriatrics.

d) There was a clear need for more operational research. There were many references to this in the report and there was scope for studies on, for eg the problems of transport, the uneven distribution of home helps, etc.

Finally, Dr Hall emphasised that the thrill of being involved in change, research or working parties, could not be allowed to interfere with the day to day care of the patient, in view of staff shortages. There was only so much that busy people could do and planning activities had to be undertaken in addition to normal duties.

Questions and impications

A period of general discussion followed. Professor Hall assured a questioner that copies of the first two volumes of the working party report were available from the RHB. The third volume was in process of production. A consultant geriatrician expressed concern that the psychogeriatric units, as described by Dr Clark, would be simply a dumping ground for people with progressive dementia and unattractive to staff. Professor Hall said that effective care for this group was a vital alternative to the dumping that went on at present and that consultant appointments to the units would be coupled with a general psychiatric responsibility. He did not envisage the appearance of a specialist psychogeriatrician.

On the question of amenities for geriatric patients, Prof. Hall said that the report included recommendations on the need for more single rooms and a less clinical atmosphere. They hoped to combine a more hotel-like atmosphere with active rehabilitative care. They were considering separate terminal and pre-discharge units; the latter being linked to a day hospital and an assessment flat to facilitate the patient's return to the community. The speakers recognised that it was often difficult to distinguish between the type of patient now in hospital and many in local authority old people's homes and that great difficulties surrounded the running of these homes. There were SRN-trained matrons caring for perhaps 50-100 residents with an entirely untrained staff, who did not even know the basics about how to lift a patient. They felt, however, that hospital services should emphasise treatment and a return to the community and that hospitals could best help the community homes by an interchange of staff, joint training schemes, etc.

Several people drew attention to the problems in coastal areas caused by the large numbers of pensioners who moved away from their families to settle there after retirement. Local authority and voluntary services could play a part in helping them to settle in, and in encouraging the more active newly retired people to help their older neighbours. The increase in old people at the expense of those of working age also had repercussions in the field of nurse recruitment. Answering a further question, Mr McLellan said that the report attempted to set standards and norms for the care of the elderly but that these were pointless without integration and cooperation between the providors and a collective agreement on priorities. Mr Dummer said that volume 3 was concerned with priorities, but the balance would vary from area to area within the given framework. They did not intend to plug gaps in the short run with hospital services where these were not applicable to real needs.

In reply to a question on the proposed community phsyician, Prof. Hall said that a job description for this post was included in volume 2 of the report. Community physicians were likely to work as a team even at district level, and they suggested that one should be concerned entirely with geriatrics to supervise the local geriatric team, monitor requests for geriatric care, advise on standards of care in local authority and voluntary homes, undertake planning, undertake training, monitor services and demand, look at the epidemiology of geriatrics and liaise with hospital and local authority field staff, especially the social service area teams of which there were likely to be about five per health district. Asked about routine medical examinations and screening, he said that this would be part of the role of the community team. They might produce 'at risk' registers based on, for example, a local health centre. The report stressed the importance of the maintenance of good health. A nurse described how a liaison officer from a social service department attended weekly conferences at the geriatric hospital and said that it was important to get general practitioners to realise what services were available and how they could be used to keep patients in the community.

Prof. Hall agreed with a health visitor who said that general practitioners were more aware of services if they had an attached or laision health visitor to advise them. He said that Wessex had a high level of attachment and hoped to get medical students and GP trainees out into the community to help them to understand the role of other field workers. At Southampton, medical students were given a community orientation from the very first year of training.

Planning for district services

The chair at the afternoon session was taken by Dr K O A Vickery, medical officer of health, County Borough of Eastbourne. He said that the south coast towns had the highest concentration of elderly people in Britain; a concentration which was only matched at a 'sunshine city' in the U.S.A. Eastbourne had more residents over 75 years that the national average of over 65's. This was the background to a study of services for the new health district 44 in East Sussex. The district was referred to as the basic operational unit for the new health service and would equal the population served by the community and specialised services of a district general hospital. District boundaries were to be defined by the new area health authorities and ad hoc committees were already making recommendations on this. East Sussex had three DGH's in its three county boroughs and these buildings and their catchment areas were a fact of life. This did not mean, however, that the DGH would be the dominant factor in any new scheme. The district, was to be the foundation for planning in all its three stages: formulation, approval and implementation. The community physican was especially involved at the formulation stage. The changes that would follow 1974 were likely to be painful, especially in the public health services and as with the establishment of the social service departments, might lead to a temporary deterioration of services. It was important to be prepared for this possibility and to work to bridge the gulf between health and social services to the benefit of the community.

Dr Vickery then went on to introduce Dr J Powles, research fellow at the University of Sussex, who had undertaken the planning study of services for area 44. Dr Vickery said that they had been fortunate to receive a grant from the Kings' Fund to pay for the services of a research fellow to look at planning problems, even in advance of the White Paper and the Management Study. Dr Powles said that the project had begun in January 1971 with a baseline study of existing services. They had then set up first stage advisory groups which had been concerned with coordinated services for target populations including the elderly. The advisory group on the care of old people had been chaired by a reader in social administration from the University and had included two geriatricians, one psychologist, a hospital secretary, a geriatric health visitor and an assistant director of social services. These groups had been followed by second stage groups which had looked at management problems in the new structure, at area and district level, support and information services and consumer representation with a view to anticipating the effect of integration in East Sussex and making recommendations on how to handle it. This work had been overtaken by national decisions but the project team still hoped to make useful comments.

Dr Powles stressed that in considering the technical aspects it was important also to keep sight of the fact that planning was essentially a political process and that in the context of the care of the elderly, there was a moral commitment, a feeling that the old somehow received less than their fair share; that they undervalued once they ceased to play the worker/consumer role.

This coloured all sections of the advisory group report. They had pointed to a need to change the professional culture surrounding geriatrics. At present the work was poorly esteemed and this effected recruitment of staff and the provision of accommodation and supporting services. One of the aims of integration was greater rationality. At present, too little thought was given to the allocation of resources because nobody had a comprehensive responsiblity for all the services in an area and could plan and provide rationally. The proposals in the White Paper were significant both for the changes they would effect in the services themselves, and for the changes which would be possible in the future as a result of integrated planning. The technical contribution to change would come in two areas: the structuring of the planning process and the input of information.

The district management team in the new structure would be expected to plan in the short-term and to make outline plans over a ten-year period. They were expected to establish specialised health care teams for special groups, like the elderly, which could be incorporated into the district plan. There would be a yearly planning cycle which would probably work as follows: April-June, assessment of needs; October-December, updating and modification of the forward plan; January-March, budget allocation. The project team had looked at information in relation to planning and the decision-making process and had divided information into the following categories: needs, resources, services and results. They felt that there should be a specialised information function at area level and that this team should collate information received from administrators, treasurers, etc., as well as from the community physicians.

In East Sussex, it had been particularly necessary to relate resource allocation to need, in face of the abnormal age profile of the area because this would help the district to compete at regional level when the DHSS allocated money on the basis of objective criteria. Finance was likely to become less negotiable and an important aim of the study had been to consider how area 44 could strengthen its case. They had examined the expenditure per bed per week in ex-workhouse and ex-voluntary hospitals for the years 1949/50 and 1969/70 to see if there had been any closing of the gap between them. They found that the former workhouses, which were now mainly geriatric hospitals, had slipped back over the 20 year period. It was known that the mean period of widowhood was increasing and now exceeded eight years. Also that number of over 75's in the population was continuing to increase and would be reflected in an increased demand for services. The elderly presented a caring rather than a curing problem and there was a need for norms of good provision based on quantifiable demographic data. There were in fact no national formulae of need based on either demography or districts. Dr Powles and his colleagues had attempted some calculations along these lines and had concluded that area 44, because of its age profile, had a need for resources which was 1.25 in excess of the need for a standard population. He thought that it would be helpful to go on from there to consider whether the rise in the cost of caring for the elderly was due to more medical interventions or to more expensive interventions.

Cooperation in the community

One of the consultant geriatricians on the advisory group to the study, Dr I M Brown of Eastbourne HMC, said that his hospital already welcomed community health service staff to weekly meetings and hoped to include representatives of the social service department as soon as this was possible.

He felt that the role of the community physician had not yet been properly defined but that he had a vital role to play. As a hospital doctor, he looked forward to cooperating with the community physician to provide a better service. Thirty per cent of the people in his hospital's catchment area were of pensionable age and cooperation had already meant that the waiting list was going down and that a better service was being provided to patients through day hospitals, etc. As a result of the project, and of continuous planning in the future, they hoped that the service would improve still further. There had, however, been problems of communication and terminology between those working in the two areas which needed further examination.

Social services representation on the working party had been provided by Mr J C Matthews of the East Sussex County Council Social Service Department. He told the meeting that he too recognised the need for cooperation because health and social problems were usually intertwined but said that he thought it was a pity that the Government had seen a need to legislate for cooperation through the proposed joint consultative committees. The social service representative in the planning process was already part of a team within his own department and this had allowed for a two-way feedback. Planning topics were also included in their staff magazine. The social service departments had been working through the problems which followed the Seebohm report and were now about to tackle the changes arising out of the Maud report, but they hoped to continue with a number of interesting experiments, eg: various kinds of links with general practitioners. The area 44 project had highlighted the need for an interchange of documents between the various services and also shown up the value of meetings to discuss how proposals affected others. A face-to-face confrontation ensured that officials did their homework on documents and led them to feel a greater responsibility towards the other services. It was also an opportunity to learn about each other's services and about the voluntary services and some of which were nearer to health and others to the social services. The participant became a more constructive critic. He was also an enabler in that he took a positive rather than a negative approach to cooperation, and thirdly an ambassador for his own department. The project had helped participants to line up the respective priorities of health and social service projects and to react to their interaction. They had also been concerned to collect feedback from field workers and would monitor plans as they were put into effect.

Statistics and resources

The period of general discussion opened with a number of questions about Dr Powles' statistics. He said that much of this had come from the RHB statistics department. Dr Vickery supported a suggestion that a similar statistical background should be made available by universities to other health areas and said that he and his colleagues had been amazed by the output of Dr Powles' small team. His work had been of great value and was likely to be equally valuable to others. Mr Dummer also favoured university/health service links, but only as a back-up to the statutory planning provision. Prof. Hall agreed that authorities should develope their own information services and said that Wessex was trying to do this at district level. Other speakers said that statutory work of this kind was being undertaken at Leeds and York universities. Professor Williams at York was looking at a number of problems such as the effect of services on the dependency of clients and the cost of residential as against domiciliary care.

In reply to other questioners, Dr Powles said he had not worked in sufficent detail to be able to draw any conclusions about management information statistics, but that there were plans to use a computer for management information in area 44. A doctor pointed out that London had a falling population and a rising percentage of old people. This suggested that many areas would have a claim to extra resources. Dr Powles said that the percentage of old people in the population as a whole was rising because of the low birthrate in the 1930s and would flatten out. He felt that a greater problem was the rise in the number of interventions and their cost.

The discussion moved on to the management of scarce resources. Asked whether there was really a need for more beds or whether existing beds were needlessly overused, Prof. Hall said that the working party on geriatric services had recommended that there should be more collaboration with other specialities to jointly make best use of the resources of a DGH. Dr Powles said that this related to the basic problem, namely that the care section was competing with the cure section, and that because total resources could not increase, the competion between the sectors would lead to hard decisions on allocation and priorities. The fact, Dr Vickery said, that some community resources would continue to come from rate funds would make this allocation even more difficult.

Finally, on the subject of housing for the elderly, Dr Vickery said that current difficulties were likely to be helped by the reduction in the number of district housing authorities and that it would be for the social service departments to liaise with them. Mr Matthews said that East Sussex made grants to the Housing Department for warden supervised dwellings but that they were unsure as to how the Housing Finance Act might effect this. There was some discussion as to whether or not it was cheaper to support old people in their homes and whether more money should be invested to this end. Some people felt that life at home could be very lonely and that the fact that those who could afford it often chose to retire to a hotel, might be taken into consideration. The best solution might be to provide more transport to get old people out to luncheon clubs, etc., while still allowing them to live in their own homes.

Finally, a nurse drew attention to the need to upgrade the status of the geriatric nurse. There was a great need to get more nurses into this field. It was not attractive at present and there was a great loss of staff. She suggested more research into mechanical aids which could help to reduce the back breaking element in the work. Taking this up, another nurse pointed out that throughout the day, nursing had only been mentioned in passing, although nurses formed the largest group of health service staff and were in very close contact with the patient. The nurse should be very closely involved in all planning processes as she had valuable experience to contribute. Dr Vickery said that this was a very suitable note on which to conclude a meeting concerned with the planning of services for the elderly.

GERIATRIC CARE ASSOCIATION OF GREAT BRITAIN

PRIORITIES FOR PSYCHOGERIATRIC CARE

Conference on Wednesday, 18 October, 1972

Chairman: Dr K Hazell, Consultant Physician,
Geriatric Department, St Mary's Hospital,
Colchester, Essex

10.00	Registration and coffee
10.30	Welcome by Mr M C Hardie
10.35	Chairman's opening remarks
10.50	Guest speaker - Dr A A Baker, Director, NHS Hospital Advisory Service
11.20	Discussion
12.00 noon	Dr W Davison, Consultant Geriatric Physician, United Cambridge Hospitals
12.30	Discussion
1.15	Lunch
2.15	Mr W E Boyce, Director of Social Services, Essex County Council
2.45	Discussion
3.15	General discussion on day's proceedings
3.45	Tea

PRIORITIES FOR PSYCHOGERIATRIC CARE

The annual conference of the Geriatric Care Association of Great Britain was held at the Hospital Centre on 18th October, 1972 under the title 'Priorities for Psychogeriatric Care'. It was chaired by Dr K Hazell, consultant geriatrician, St Mary's Hospital, Colchester. He said that the demarkation line between the need for geriatric or for psychogeriatric care was not always clear, but that, with an increasingly elderly population, both problems could be expected to increase. Mental illness with a physical or partly physical cause and depression were both common amongst the elderly, but the extent of the problem was not quantifiable because many never sought medical attention. Some of those who were depressed came to their general practitioners with superficial physical complaints, others neglected themselves and refused help until a real crisis occurred. Exdogenous depression due to environmental stress was the most common form of this illness in old people. The number who could benefit from psychiatric attention was considerable but unknown. About 30% of the patients seen by a geriatrician had some psychiatric disability and it was likely that a similar proportion exsisted among those who were not seen.

These people needed considerable personal care and many were receiving this at home; but supervision could also be provided by hospital day centres and there was a urgent need for more of these. There had been no decrease in the percentage of old people who were being cared for by their relatives at home, but the inadequacies in the support offered to relatives by the community had been reflected in the flood of people coming to the open ended geriatric departments over the past few years. Dr Hazell said that he, personally, was seeing more elderly, confused patients with associated physical conditions and the relief of these associated conditions often indicated that the person had in fact been confused for some years. The problem of achieving the best help for them would continue to fall on the assessment wards.

A higher priority for geriatrics

The case for a higher priority for the geriatric services in general was then put to the meeting by Dr A A Baker, director, NHS Hospital Advisory Service. He said that in stating this case he was expressing his own views rather than those of the service. Geriatrics was a branch of medicine which was of prime importance and increasing rapidly. It needed priority. It was one of the most interesting areas in medicine, in that it allowed doctors to use their skills to the full to make a diagnosis, often with few clues and a poor history to go on. For nurses it offered a chance to work with more freedom and scope for personal initiative and less medical supervision than in most other fields. All staff were called on to make the best use of scarce resources.

Many of the problems in geriatric care were based on ignorance and the inability of some groups to see how their attitudes effected others. There were many people who accepted the promise that geriatrics was a second class service which found it difficult to get staff, and then wondered why elderly patients blocked acute beds. Teaching hospitals had a particular problem in this respect because of their tradition of treating acute patients drawn from a very wide area. They found it difficult to take on an additional commitment to geriatrics, physhiatry and to their local catchment area. Their attitude and priorities influenced other people and other decisions.

If their commitment could be to their local community then other decisions would flow from this. Should teaching hospitals be looking for rare cases or providing a model service for a catchment area? Should their students be learning to assess priorities over the whole range of services and to manage on limited resources? The time had already arrived when we were seeing more progressive services in the provinces than in the London teaching hospitals, where geriatrics were expected to manage with second class facilities, if they were let in at all.

So far as psychogeriatrics went; it had to be decided whether this was a branch of psychiatry, of geriatrics or just a social problem. There were many old people with severe progressive dementia who lived and died at home and who did not differ in clinical state from those who lived and died in hospital. All the psychiatric hospitals had large numbers of elderly patients, many of whom had grown old within the walls. The only age group which had more members in psychiatric hospitals than was the case five years ago was the over 75 year olds; and this prompted him to ask how they could have survived to that age and then become so dangerous as to need hospital admission. These patients created a very heavy nursing load and needed much higher staff ratios than were normal in a psychiatric hospital. They needed more privacy, toilets, aids etc than were usually available. The mental hospitals were having a real problem in carrying this load, in buildings which were not designed to cope with it, and with inadequate staff.

Geriatricians were also reporting an increase in the number of confused patients coming into their departments and there needed to be a good assessment ward for both psychiatric and geriatric patients. We were now being told that a psychogeriatric assessment ward was also necessary. Were three assessment situations really necessary? Was it going to become a separate speciality on its own with psychogeriatricians and a separate training for nurses? These were already the least popular specialities for nurses; would it be possible to recruit for a separate service? Local authorities were already finding it difficult to recruit staff for their hostels for the elderly confused. Could we afford the necessary one to one staff/patient ratio and what were the alternatives?

The problem of the psychogeriatric was in the main the problem of progressive dementia in the elderly. Many psychiatrists were prepared to accept thses patients but others were being cared for by geriatricians. This was chiefly because the work load was three or four times higher in geriatric departments and a general practitioner could get the opinion of a psychiatrist more quickly than that of a geriatrician. If the number of geriatricians increased as planned, was this situation likely to change? Need psychogeriatric care be unrewarding for nursing staff? If the ward was well managed it could offer more job satisfaction because it allowed for more responsibility than in an acute ward.

Elderly patients in hospital tended to get less social work time than younger people. This again was a matter of attitudes. The challenge presented by the elderly and the potential difference in quality of life indicated that this was an area which could offer great job satisfaction. Old people were also in great need of attention from the remedial professions but their skills were often made available to the geriatric department last of all. Patients often came into hospital in a state which had gone too far for the remedial staff to be able to reverse. Should the remedial staff be employed in the community instead to give advice to relatives and others and to catch problems in time. Above all, there had to be a change of attitude amongst the population at large. There was a general feeling that it was somebody else's job to care, and this rejection of old people on all sides added to the problem.

Dr Baker said that he hoped that we would begin to think in terms of a service to a population across a very wide span including housing. Better and more appropriate housing might solve many other problems, and old people should be offered this before deterioration and a crisis made it unsuitable. There was a general need for more provision in the community. Hospitals cared well for the dying but the same provision could often be provided in their own homes and this would make many of them much happier. Gadgets and equipment of the type used in hospital should be equally freely available to patients at home. At present patients were learning to use gadgets and aids in hospital and then found that they could not have them at home. What was needed was a very wide range of facilities from in-patient beds for assessment and limited treatment through day facilities, community provision and out-patient services including therapists. Where therapists were in short supply they should be used to visit wards and homes to pass on their advice and skills to nurses relatives etc rather than in treating a small number of patients. Elementary guidance might make all the difference to the others.

The need for liaison committees after 1974 was obvious but would there, Dr Baker wondered, also be effective coordination between the people who actually dealt with the patient. They had to assess the total human resources and how they could best be involved and organised to work together for the patients. Communication could be improved by getting together to discuss cases to a greater extent than was done at present, and with the patient and or relatives present. These discussions could take place in a health centre or day hospital setting or in the patient's own home. The health centre was a particularly good location for the exchange of ideas, the passing on of skills, the planning of individual care etc. There was a great deal of research at the present time on obscure physical conditions and very little on how to provide continuity of coordinated care by small groups of people known to the patient and his family. 1974 could be the impetus for change of this sort, but integration would not work unless those at fieldwork level could meet together to plan their work and to share their skills.

One of the first problems raised in the discussion period which followed this paper was that of local authorities being obliged to take old people into Part III accommodation after a crisis admission to hospital had led to their home being lost or sold and so leaving them with no possibility of return to the community. These patients did not always need medical care; social support would be adequate in many cases but they became forced into unsuitable long term care because of the lack of alternatives. There was a crucial need for joint assessment of physical, emotional and social problems and for a joint assessment unit shared by the general hospital, the psychiatric hospital and the local authority with joint responsibility, joint admissions and joint provision of beds for the patients to go on to. A geriatrician said that he had helped his local authority with assessment for some time and that this should be done before the old person was dislocated from his background; preferably in his own home. The problem, another speaker said, was that we should be asking local authorities to provide better housing and domiciliary services, more remedial workers and welfare homes, but that they did not have the money available. A director of social services agreed that housing was a priority, and not necessarily the sort that local authorities currently thought it appropriate to provide; but with regard to the social services they had been asked to produce ten-year plans on the basis of a 10% growth rate. This implied an increase in his county from £5-15 million, at current values, over ten years and would allow for a much larger programme if the money actually became available.

A physiotherapist said how much she had appreciated Dr Baker's suggestion that therapists should spend more of their time passing on advice and skills. She felt that they were all fumbling about in face of too much work and too few people to do it and it was important that this should be seen as a proper use of their training. She agreed that old people should receive more therapy in their own homes to prevent them developing the intractable conditions that took up much of the therapists time in hsopitals. There was some discussion of ward design and the difficulties of providing progressive patient care in buildings that were not designed for that purpose. A nurse said that she disliked new designs with a majority of very small units because this reduced her ability to observe the patients and increased the tension caused by personality clashes. It was felt that what was needed was more flexible designs which allowed for a great number of situations. Asked about the role of the Hospital Advisory Service, Dr Baker said that its reports were produced by multi-disciplinary teams and hoped to encourage a multi-disciplinary approach within the hospitals themselves. He was not concerned to tell people what they should do in their hospitals, but a visit from one of his teams was in itself an educative process for the hospital. He went on to reply to the nurses who had raised points and said that too little thought went into the needs and problems of ward sisters. They were key people, especially in the care of elderly patients.

A consultant's view

Dr W Davison, consultant geriatrician, United Cambridge Hospitals, also drew attention to the massive increase in old people needing medical and social care and the logistical problem this posed. He pointed out that there was a particular increase in the number ofelderly women with mental impairment. Many of these people were living at home and at least fifty per cent of them had disabilities similar to elderly patients living in psychiatric hospitals. A further five per cent had limited organic brain damage which would not warrant hospital admission and about twelve per cent had functional disorders. The use of the blanket term 'psychogeriatric' disguised the fact that these disabilities were in fact very different in arrisal, treatment and prognosis. Some old people needed treatment for their underlying physical disorder while others needed psychiatric management. There was also a broad grey band in the middle which led to quibbling and the draft pink circular from the DHSS failed to give clear guidance on this.

Dr Davison said that he had been very impressed by the work of Dr John Powles of Brighton in which he had drawn attention to the difference between the curing, technological element and the caring element in the health service. The gap in allocation of resources between these two sectors was greater now than it had ever been. There was a national faith in salvation through medical technology and a failure to set the costs of this against other alternative ways of treatment and of spending the money. The choices involved in decisions on priorities had not been made clear to the general public. Past medical advances, eg the development of effective treatments for tuberculosis, had freed hospital beds which had then been filled up with old people and hidden the impact of the increase of old people within the community. Psychiatric hospitals and general medical wards were also full of patients aged over 65. There would be a 13% increase in the number of people over 65 and a 20% increase in the number of over 75s over the next decade and the effects of this could no longer be masked. This meant that the health and social services now had a problem on their hands which had been predicted as much as 30 years ago.

In face of this, the defects of both the hospital and local authority services were both multiple and visible. Many local authorities had proved themselves to be willing to build and experiment, perhaps because their buildings could be less complicated, but wherever one looked there were gaping and ragged holes. All services were deficient; there was a lack of information on how to deploy resources. There was a lack of local authority day care schemes, especially for psychogeriatrics, and although the amount of residential accommodation for this group had increased since the 1959 Mental Health Act, the local authority responsibility in this field dated back to 1948. The hospital service had a dreadful image; it offered poor quality care and had too many beds, most of them in the wrong places. It was usually easier to get an old person into hospital than to get him the sort of care which he really needed and there had been no lead from the DHSS on this problem.

Cambridge had a system of geriatric assessment for all elderly patients presenting for the first time, close links with the psychiatric hospital, case conferences at ward and day hospital level, and planned progress and discharge. Prompt assessment was vital, said Dr Davison; the longer it took to get a patient into hospital, the longer it took to get him out again. Assessment should lead to the production of a medical and social prescription for each patient and the main need was often social rather than medical. Many crisis admissions could have been identified weeks before the need occurred, and the increase in attachment of staff to general practitioners might improve this process of identification of patients at risk. In the future, he expected to see district general hospitals handling the acute and technological side of medicine, and having beds to spare on today's reckoning, working alongside community hospitals staffed by general practitioners and caring for other groups of patients. There would also be a vast increase in day care schemes.

GNP represented total national resources and the share of this that went to the health and social services was a political matter, and would only be increased by political pressure. Similarily, the £200 million pa which was budgeted to the health service allowed some room for manoevre and this would only be allocated to geriatrics and psychogeriatrics as a result of polictical pressure. Political pressure could lead to a more rational allocation. If an old person was presented as a crisis hospital admission because her home help was ill, the true need was for another home help, not for hospital admission. We had to halt the technological rush to cure everything, inclusing the incurable, and put resources into caring at the cheapest possible level. We could not wait for earning power to increase after fifty years in the EEC, we had to make more money available to the elderly now. The resources already existed to identify those in need. General practitioners knew the over 65s on their lists because they received an extra capitation fee for them, and this could be the basis for 'at risk' registers. We should concentrate on finding out what the vunerable needed and on meeting those needs at the simplest possible level. We did not need a separate speciality to do this.

Answering questions, Dr Davison pointed out that male life expectancy at age 65 had not increased throughout this century. Medical technology had achieved very little despite wonder drugs etc. This suggested that money had been spent in the wrong directions. The improvements in acute care had increased the chance of people living to age 65 and he would like to think that they would now be better cared for after that. A local government officer said that he did not accept that political pressure was the way to change priorities and the allocation of resources. The public lost interest if their rate demand had to go up, so he thought that the first need was better public relations through the media etc to get a better informed public opinion.

Dr Davison agreed and said that there was considerable public support for better geriatric services. The public had never been shown that there were choices between, say, more kidney machines or more home helps. The costing had never been done in this way and presented to the general public so that they could assess priorities and decide if they were getting value for money.

Several speakers referred to the problem of doctors who admitted elderly patients and encouraged their relatives to think that they would not be returning home and in so doing often made it impossible for them to do so. This problem was particularly common in teaching hospitals and the worst offenders were general practitioners and consultants, other than geriatricians. There was a suggestion that the general public should be educated to understand what caused deterioration in the condition of old people so that they could make a contribution to avoiding this and that it should be understood that the elderly had a right to live on with dignity. The majority were only too willing to accept impositions by society which we had no right to expect of them. Reference was made to the acute shortage of day care and Part III accommodation and Dr Davison pointed out that there would be an outcry if there were no maternity services; why was there no similar outcry about the lack of community services for old people? There was considerable anxiety that 1974 would not be the answer to the problem of community care. The question, Dr Baker said, was not how to get old people out of hospital but how and why did many of them ever get in in the first place? It was a depressing and desperate subject.

A community view

The speaker at the afternoon session was Mr W E Boyce, director of social services, Essex County Council. He said that the social service departments had an enormous role to play in the buildup of comprehensive services for old people and congratulated the Geriatric Care Association on the timing of its conferences, because it came at a time when it was possible to influence events. Local authorities had been asked to prepare their development plans for the next ten years and there was to be a reorganisation of both the health services and local government. If these changes were to make sense, they had to include machinery for closer collaboration between the health and local authorities.

Essex had been doing an across the board study of the needs of psychogeriatric patients with a team from the London School of Tropical Medicine. They had identified three problems: the lack of realistic knowledge as to the extent of the problem and of effective ways of doing something about it, organisational problem and thirdly, the lack of resources in money, manpower of the right kind and appropriate premises. This last problem was mostly the fault of those in the service, who had failed to press their case with sufficient accuracy and strength. They had tackled the lack of knowledge problem through a liaison committee of representatives from the regional hospital board, the local authority and the executive council, and serviced by a working party of chief officers. This committee had been studying various services, and on psychogeriatrics, they had drawn attention to local authority specialist facilities and the family group system in old people's homes. This allowed for one group of mentally infirm people to be housed near others not handicapped in this way but sharing facilities with them. They were then kept in their own home districts and in accommodation which did not have a 'loony bin' conatation. Essex had 130 beds for the mentally infirm and this was about 5% of the total provision. This seemed to be about right in terms of the residents they had and those on the waiting list, but there were no figures for people in the community or for people in the wrong beds provided by other services.

This needed further enquiry. The organisational problems derived from dealing with three branches of the NHS, two levels of local government and a multiplicty of voluntary bodies. Even with the liaison committee for the statutory authorities they could not ensure a common purpose to their endeavours and there was a need for improved communications right down to fieldwork level.

Mr Boyce then identified the priorities in tackling these problems. Firstly there was a need to get involved in research through joint studies between the services. Findings were much more likely to be accepted if all parties were involved in producing them, and if they were not considered to be biased towards one body which had sponsered them. The research process could also help people in the various authorities to get to know one another. It was going to be important to get our facts straight to feed into the brave new world of corporate management which lay ahead. The planned reorganisation was going to produce coterminous authorities at AHA/county level and require the establishment of joint consultative councils made up of authority members and serviced by officers. They would produce joint reports. He was less happy about the situation at district level; this was more dependant on the personalities involved. The health district management team was to call in the social service department and this might not happen if they were not expected to give the answer which was wanted. There might have to be changes in attitudes for people to want to cooperate and so make the machinery effective.

The ten-year plan for Essex would give priority to the services which helped people to stay in their own homes. He did not favour the use of a register because a list, without the resources to keep in touch with the people on it, did not achieve a great deal and could upset some. A survey of the need for such a register in a number of sample areas had indicated that 70% of the old people contacted wanted to keep in touch with their interviewer. They wanted a lifeline - a contact service - and it had been decided that local area social service offices should work with general practitioners to produce a list of people at risk, referred with their knowledge; and offer them a visiting service to be provided largely by voluntary bodies. This had a very high priority. They were also developing the home help service by increasing both the volume and the status of the work. It was a basic support service. They had increased the hours worked by 15% in 1971 and DHSS figures suggested that a two or three-fold increase would be possible during the period of the ten-year plan.

The next priority was the building up of local social work teams. They wanted to improve training facilities and utilise existing resources to the best advantage. This would include employing more occupational therapists to provide aids and do assessments etc and odd job men to fit the aids. This would leave the social workers with more time for contact with other professions such as the general practitioners. There was a possibility of social workers becoming attached to group practices; they were taking over work with young people under 14 from the probation service and there was an increased demand for help from the education services. Housing would remain the responsibility of the district authorities after 1974, but the social service departments could hope to influence their decisions. His department was already holding regular conferences for their 34 district having authorities to discuss areas of common interest, and this had led to a fourfold increase in special housing units over the past six year. They aimed to have 4-5% of pensioners in sheltered housing by 1976 and some areas were already up to 7%. The problem was not altogether one of provision, but of the role of the warden who could become involved in the provision of services. Mr Boyce thought that local authorities should consider how to increase their support to the residents of sheltered housing so that it could be more like family support.

Residential accommodation would continue to be a big element in their total provision. The department had a £17 million capital programme which included £7 million for old people's residential accommodation. This was not the answer on its own and new building had to be accommpanied by new thinking about its pruposes. At present, the hospitals were caring for those who needed full nursing and medical support; Part III accommodation was for those who needed care and attendance and special housing was for thoseswho could cope alone. There should be a blurring of those lines. People needed different degrees of care from intensive care to those who could not cope in sheltered housing but still did not need night and day attendance. The priorities for hospitals had already been indicated, but he hoped that they would concentrate on making quick assessments and on finding ways of dealing with emergencies speedily. Situations should not be allowed to drift on without decisions.

The first questioner at the end of this paper, brought up the plight of matrons in residential homes who were left to cope with up to 60 patients with only one or two untrained care assistants. The homes provided no activities geared to daily living and the old people, who might have been on an active rehabilitation programme while in hospital, were left to vegetate. The matrons were on a pay scale below that of a ward sister and had inadequate support staff. Councillors were out of touch on this and the situation should be changed before new homes were built. Mr Boyce said that he thought that this must be an extreme example. Essex had an average ratio of care staff of one to six, not counting night staff, and 55% of total running costs went on wages. Insufficent activity for residents was not usually due to lack of thought or effort. Many old people did not seem to want to be brought to life and matrons did perhaps need guidance on this. The small family group type of accommodation for 7-11 people probably helped. The residents could then be involved in serving food, day to day household activities etc. There was considerable support for this view from speakers who said that most homes were too large and hotel-like. Residents were not allowed to bring in their own furniture and unable even to make a cup of tea. They were in fact cut off from everything which had been part of their lives. It was suggested that homes should be supported by visiting occupational therapists who could put forward ideas on activities for the residents and that there should be more inservice training for social workers. Students often did not know how to approach old people. An occupational therapist suggested that the old people needed to feel needed and that doing work such as packing for a CSSD might help them to feel that they were contributing to the community. Homes should not become too dependent on scarce occupational therapists but should involve voluntary helpers who could bring particular and individual skills. Dr Boyce replied to the point raised about student social workers and said that in Essex initial assessments were always done by trained staff. It was unfortunate if the upheavals caused by the Seebohm reorganisation meant that trainees were being expected to do them in some areas.

A nurse said that she did not think that geriatric care needed to be the unloved profession. Her hospital had a waiting list for pupil nurses through to 1974 and also for qualified staff. There need not be a shortage. If conditions were right and the nurses were allowed to use their initiative and made to feel part of the team, they would come in to the work. There was some discussion as to whether Part III accommodation, sheltered housing and day care facilities should be brought together on one site and it was felt that this was not desirable if it involved day visitors being brought into the residential home. The residents should instead be linked to activities outside their home if they were able to get out. It was pointed out that if special housing was used properly, and people moved in to it in time, there was very little need for residential accommodation. Old people could manage in sheltered housing with supporting services until they were really ill and needed hospital care.

A doctor said that consultant geriatricians should assert themselves more to put across the needs of their patients. They were usually absorbed into the medical division of a Cogwheel structure where they received insufficent support for the allocation of resources to geriatrics. In the community, he hoped that the new area medical officers would each have the support of a medical officer interested in geriatrics. There were to be health care councils at district level which would make proposals for the improvement of the overall service; but would these councils also bring in the social service department, housing etc? Dr Davison said that geriatricians were willing to stand up and say their piece but they were up against an entrenched medical oligarchy, and that even those other consultants who wanted to help, dared not do so for fear of affecting their own positions. Cogwheel buried the underpriviledged specialist and restricted power to the individual entrepreneur. The emasculation caused by this reorganisation and the succession of other reorganisations which were in the pipelime suggested that things would get worse before they got better.

Psychogeriatrics, another speaker said, was largely a social problem. It was social factors which decided whether an old person was at home or in hospital. An increase in community care seemed to mean putting patients, that would otherwise have been in hospital, back into the community without the necessary contacts or support. What was called 'community care' rarely was that, and 'care' was in any case not a very good word. It implied doing things for and at people rather than with them. If a change was made to providing 'support' then the results might come right. The place to begin was in housing, and this did not always need to be segregated housing. There were other single people who would be glad of accommodation with a portering service and who, if they were working, could help to pay for it. Mr Boyce said that one of the concerns of his department was to try and change the attitude of the housing department towards their job; they saw the provision of housing as a commercial rather than a social service. The reorganisation into larger housing authorities after 1974 might make them more willing to help with social problems and to look more closely at the needs of homeless and problem families, the old and disabled etc. Concluding the meeting, Dr Hazell said that the Associations aim must be to impress on those who held the purse strings that they would all be geriatrics themselves one day and so encourage them to get their priorities right.

THE ORGANISATION OF PSYCHOGERIATRIC CARE

Conference on Wednesday, 25 October, 1972

(repeated on Tuesday, 19 December)

Chairman: Professor W Ferguson Anderson
Professor of Geriatric Medicine, University of Glasgow

10.00 - 10.30		Coffee on arrival
10.30 - 10.35		Welcome to the Centre Mr M C Hardie
10.35 - 10.45		Introduction by the Chairman
		THE ORGANISATION OF PSYCHOGERIATRIC CARE
10.45 - 11.05	i)	A Departmental view Dr J Brothwood Principal Medical Officer, Dept of Health & Social Security
11.05 - 11.25	ii)	A General Practitioner's view Dr D C Kilbride General Practitioner, Nottingham
11.25 - 11.45	iii)	A Consultant Physician's view Dr O H D Portsmouth Department of Geriatric Medicine, East Birmingham Hospital
11.45 - 12.05	iv)	A Consultant Psychiatrist's view Dr T H D Arie Goodmayes Hospital
12.05 - 12.15		Interval
12.15 - 1.00		Questions and discussion
1.00 - 2.15		Buffet lunch
2.15 - 3.30		Syndicate discussion
3.30 - 4.30		Reporting back, discussion and summing up
4.30		Tea

THE ORGANISATION OF PSYCHOGERIATRIC CARE

Doctors, nurses, social workers and others concerned with the care of old people in hospital and in the community attended a conference on the organisation of psychogeriatric care held at the Hospital Centre on 25th October, 1972. The chair was taken by Dr W Ferguson Anderson, professor of geriatric medicine, University of Glasgow, who said that this was not only a topical subject, but also a very necessary subject for their consideration. There were likely to be an increasing number of mentally ill elderly people in the future. They would only exceptionally come under the care of the general physician. The geriatrician would take those who suddenly became confused to look for a physical cause, treat it and return them home. The psychiatrist would see those who had deteriorated gradually, but at present he usually saw them too late, becuase of waiting lists, to take effective action.

The provision for mentally ill old people varied from area to area depending on the degree of consultant interest, local authority provision, the availability of sheltered housing etc but there was no more urgent problem than the coordination of services to this group. The general practitioner could not be expected to cope with this type of patient without knowledge of whom to contact for help and the services that were available to him. These patients could be difficult to manage in an ordinary hospital setting so there was a need for good diagnostic beds, backed up by small units of hospital beds in the community and local authority homes for the mentally frail. While doctors continued to argue about borderlines and the placement of patients, the general public could not understand why physically ill old people were cared for, but the mentally ill were not. He could see no clearer need than for research into the mental disorders of old age. Its increase could be the final straw in the reduction of public respect for old people.

A departmental view

A policy document on the hospital care of mentally ill old people was introduced to the meeting by Dr J Brothwood, a principal medical officer, Department of Health and Social Security. He said that this was complementary to two earlier circulars published in 1965 and 1971 on local authority responsibility and psychogeriatric assessment. The new circular referred to any type of mental illness starting in old age. This excluded schizophrenia which started in middle age and which was the reason why many old people were in psychiatric hospitals at the present time. It was expected that with modern treatment facilities and better community care, there would be fewer of these chronically handicapped schizophrenics in hospitals over the next ten to fifteen years. At present, just under half of the mental hospital resident population was aged 65 or over.

Diagnostic advances had led to the dropping of the old term 'senility' and to the identification of three main types of mental disorder in old age: depression which was often associated with a physical handicap, dementia or irreversible progressive brain damage and confusional states, which often had physical causes. The new DHSS circular advised that cases of depression should be dealt with in the district general hospital (DGH) unit. The cases of dementia would need a number of longer term hospital beds and they envisaged a provision of 2.5 to 3 places per 1,000 together with a similar number of day places.

This was equivalent to what was provided at the present time. They had distinguished between three types of dementia: mild dementia without associated physical disease which could be cared for within the family with local authority support, if necessary; severe dementia without physical disease or handicap which would come within the orbit of the psychiatrist if hospital care was required and, thirdly, severe dementia associated with significant physical disease or disorder which would be the responsibility of the geriatric services.

The organisation of psychogeriatric care started at the primary care level and it was a problem that was mostly coped with in the community. The trend to group practices, health centres and attached staff had helped the community approach and the DHSS welcomed this. Two fifths of the residential care for mentally ill old people was provided by the local authority social service departments and this was roughly equal to the provision of 20 places per 1,000 people aged over 65. It was hoped to increase this provision to 25 places per 1,000 and to define more clearly the type of patients that should go into this sort of accommodation. The setting up of geriatric units under the care of geriatricians within the DGHs was not yet complete, as there were some recuitment difficulties into this speciality. The existance of psychogeriatric assessment units indicated the hospitals' acceptance that a patient needing care should not be passed about or misplaced. There was some discussion on optimum sizes but the collaboration between the geriatrician, the psychiatrist, the general practitioner, the social worker and others was the important element.

Dr Brothwood identified a number of tasks for the future. Firstly prevention; there was a need for studies into 'for example' the value of local authority screening clinics in preventing serious disorders. This could be the concern of the community physician and the epidemiologist. Secondly improved assessment; this might include pre-admission screening, home visiting and the mobilisation of community resources to avoid the need for hospitalisation. Thirdly, there was a need for health and local authority resources to be looked at jointly in terms of the needs of the elderly in an area, and priorities agreed between the two. The new area health authorities and the social service departments were going to be required to plan together after 1974 and the DHSS was going to want evidence of joint planning, as against an exchange of individual plans after they had been produced.

Finally, Dr Brothwood said that he saw a number of hopeful pointers for the future. There was, firstly, the increase in consultant posts for psychiatrists with a special interest in psychogeriatrics, although these were not necessarily full-time posts. Secondly, the Department had identified the number of beds and day places needed for the elderly mentally ill and it was a part of the policy of improving the quality of the psychiatric services, to build these up through an increased provision in the DGHs complex. It was hoped that this would make it easier to get staff and to increase the involvement of relatives and volunteers.

A general practitioner's view

Dr D C Kilbride, a general practitioner from Nottingham, also spoke of the tendency to take up positions behind diagnositc frontiers and to ignore what was happening to the patient, his relatives and general practitioner, while the dialogue was going on. The general practitioner had a right to expect adequate support in terms of community and institutional care, but what were the providers in this field entitiled to expect from him.

Firstly an assessment of total needs; about 10% of the public aged over 65 needed some positive psychiatric care and in his practice this meant 150 in need of help and 50 in acute need of help. This last group might be inccapable of living an independent existance and yet unknown to the general practitioner because they were poorly motivated towards requesting his services. A system of screening and clinics was vital to get to them.

There was no mention of preventive medicine in the general practitioner's contract. He could be concerned to intervene at an early stage, but there were too few crusaders who were prepared to do this. No amount of teamwork, organisation etc would achieve this unless the basic motivation was right. In many cases, health centres had involved a marriage of people who were not properly motivated to make use of the organisational opportunities which had been presented to them. Perhaps the development of bigger centres with hospital care facilities attached would improve this. Many general practitioners were not interested in geriatrics and were content to contain the situation within their practices rather than to discover areas of new need. They did, however, face obstacles. There was a lack of supporting services, and it was ridiculous that doctors should be expected to cope with a list of 3,5000 patients. Doctors needed re-education to take an interest in community care and this would prepare them to take a lead in the community team. Medical schools were only slowly increasing their stress on community care and preparation for general practice.

The general practitioner could not be expected to cope with early detection unless he had fewer patients and better support. Nurse attachment had helped in some areas but it often failed as a result of a lack of enlightenment on both sides. The district nurse was over deployed in areas which did not need her skills, doing chores that did not use her special knowledge. The role of the health visitor in community care was too vague. There was an inordinate emphasis on infant care at the expense of other groups which were at greater risk. An average of less than 3% of the health visitors's time was spent on geriatrics and there should be a radical revision of nurse deployment and training. Did we need two separate goups of nurses at all? Their divided loyalties reduced their commitment to the practice team. Dr Kilbride said that he would like to see a single core of SRNs supported by SENs and auxiliaries and prepared and trained as 'community nurses' to function far beyond the range of traditional local authority nurses duties. His practice employed a full time poly-function nurse. Why were so many local authority health visitors prepared to fill their notebooks but not their syringes? He also hoped to see an enlargement in the spectrum and quantity of domestic services. Seebohm seemed to have made the service less adequate and more remote. The services in some areas were quite insufficient. Home helps were key people in caring for the frail elderly. They offered service and companionship and were often able to build up an excellent rapport with the confused. The great disparity between the demand for and the supply of this service was obvious. Why should it be rationed to five days a week? Why should it not have a more imaginative time schedule?

Well coordinated voluntary service, Dr Kilbride thought, also had a secure place in support of the professionally trained workers, but this should not be expected in excess of voluntary resources. The provision of home meals, for example, should become a mandatory local authority responsibility. There should be a range of residential accommodation including sheltered housing and homes for the mentally frail with trained staff. Hospital admission should never be necessary because of a lack of other alternatives and should be seen as only a stage of care. Day centres and day hospitals were essential if the possibility of movement was to be maintained. A decrease in hospital beds must be matched by an increase in community care facilities.

Dr Kilbridge said that he was neutral about the role of the assessment unit. This could be done in the community if the necessary resources were available. An assessment unit was, in any case, unlikely to function properly if there was nowhere to send patients on afterwards, and it was often this very shortage of alternative residential care which was the reason for admission to a psychogeriatric assessment unit in the first place. Volunteers should be used to monitor services rather than to meet needs. Finally, Dr Kilbride said that he would like to see a national policy for an ambitious service to transcend boundaries and traditions and backed with a massive injection of funds. Nothing less would do.

A consultant physician's view

The third speaker, Dr O H D Portsmouth, Department of Geriatric Medicine, East Birmingham Hospital, reminded the conference that psychogeriatrics was only part of the whole field of medical management of elderly patients and that the separate title suggested a precision in definition which was not always possible in practice. A great deal of mental illness was managed by the geriatrician and the general practitioner without reference to the psychiatrist. There was a tendency to extol family support and assume that it was always to the benefit of old people, but some of the worst cases of neglect lack of stimulation etc occurred among old people living with their families. The conference had to adopt a practical approach in terms of the NHS as it was today.

When mental disability was severe, or there was a mixture of mental an physical illness in an old person this could pose real problems for the GP Services had to be flexible and the cooperation and trust between the various branches had to be good. Yet there was a great diversity of provision from area to area depending on geography, the personalities of the providers etc. His own appointment included sessions at a psychiatric hospital and this enabled geriatric and psychogeriatric services to be closely co-ordinated. The area geriatric service was based on the district general hospital and did not usually have a waiting list for patients from the community. One difficulty was that the 350,000 population catchment area of the DGH did not match that of the psychiatric hospital. This hospital had two acute assessment wards for old people, two continuing care wards for elderly women and one for men, which came to 150 beds and 25% of the hospital's total. The wards were under the care of a geriatric registrar who also saw all elderly patients admitted to the hospital under the care of a psychiatrist. Some patients were admitted to these beds from the long-stay wards if they developed a medical condition and some were admitted by geriatricians for joint assessment or because they were too distressed for general geriatric wards. The hospital also had two designated psychogeriatric wards for ambulant dements which were under the care of a psychiatrist.

Dr Portsmouth identified three categories of psychogeriatric patients: old people with mental and concurrent physical disability, the long-stay chronic schizophrenics already in psychiatric hospitals, and, thirdly, younger patients with organic brain disease who needed more physical care than was usually available on psychiatric wards. Close links between the geriatric and psychiatric services offered the psychiatrist great advantages in handling all these groups of patients. There was ready advice on physical disease for the psychiatrist and vice versa. Criteria for admission and care could be agreed so that demarkation disputes seldom occurred. The role of the various professional workers could be defined by discussion and agreement.

The physician had an opportunity to learn about psychiatry and the functioning of the psychiatric hospital and received a fresh challenge to his clinical experiences. This flexability was in part made possible by the fact that laboratory, x-ray, physiotherapy and occupational therapy facilities were available at the psychiatric hospital, so that patients could receive active treatment for physical conditions.

The organisation of nursing care was as important as the distribution of medical skills or the placement of patients. The old people who caused trouble on general wards often settled down in a psychiatric ward with its large day rooms, security facilities, and, above all, staff who knew how to handle them. The nursing of geriatric patients was very hard work and it was important to stimulate the morale of those doing it. The rotation of staff and the sustained interest of the consultant in his wards and patients, were both helpful. It took time, but it was essential if standards were to be maintained. In the enthusiasm to empty mental hospitals, Dr Portsmouth said, it was important to remember that patients still needed treatment and long-term continuing care. The workload of geriatric physicians was already too heavy if they were responsible for some 200 beds, running out-patient clinics, making home visits, teaching etc. The Royal College of Physicians had suggested that 100-125 should be the maximum number of beds. The task of caring for the mentally impaired would have to continue to be shared and though some misplacement and movement was inevitable, the two settings were necessary to meet the needs of patients and were likely to continue to be so.

A consultant psychiatrist's view

Dr Tom Arie of Goodmayes Hospital said that, while the Department's new document was a humane and sensible peice of work it lacked the sense of urgency which was felt, apparently even within the DHSS itself. It contained no deadlines for reform but might prove to be an important official stimulus to do something rather than nothing. It raised a number of points. Firstly, that the psychogeriatric services must have facilities and standards as good as, or better than those of other services. The physical, mental and social needs of the patients were integrated, and a way had to be found to get the services catering to those needs to work together as a unity. Every district within the new area health authorities needed a unified service so that whatever the point of contact, the system would take over and redistribute, rather than bounce the patients back. He was glad that the latest Departmental guidance did not confine itself to the hospital service. His work on the Collaboration Working Party, in connection with the reorganised Health Service, had indicated that collaboration was, in practice not easily ensured.

Other points which had to be borne in mind when considering the organisation of psychogeriatric care were that nurses were much more readily available than social workers; and that any integrated pattern had to be flexible to allow for a different approach to acute and long-term needs. In this context, Dr Arie said that he was not happy about the Department's classification based on degree of dementia. He thought that the appropriate setting for care would be more appropriately based on degree on behaviour problem. Those few patients who needed long-term care because of severe behaviour disturbance could be cared for in the District General Hospital, but most ambulant demented patients, after assessment and regular reappraisal, should be cared for in non-medical setting. This was better for the residents and better for the morale of the staff. There was cause for great anxiety about the "small hospitals serving local communities" mentioned in the Document. These were often to be existing hospitals which were not good enough to be District General Hospitals; which were in fact 'dumps' already and a far cry from the cosy cottage hospital which the title "community hospital" implied.

Dr Arie next turned to joint geriatric/psychiatric units, although he was not keen on the designation 'psychogeriatric assessment units' because this meant so many different things to different people. He preferred them to be thought of as 'joint patient units' and thought that they were particularly valuable at the present time when the general and psychiatric hospitals were separated. They made it possible to bring together patients who needed joint assessment and joint care, but he was not sure that they would be necessary in a new district general hospital where geriatric and psychiatric wards would be side by side. He further thought that the need for such joint assessment beds was less than the circular had suggested and that many patients did better in a psychiatric unit. This was something which needed evaluation. There was a lack of central data on the nature and number of existing units.

There was an urgent need for some psychiatrists to take a special interest in the care of old people, although they should also remain active in general psychiatry. They should be concerned with all aspects of mental illness in old age and not be just 'dementia and confusion' doctors. They should be prepared to take responsibility for the whole service from assessment to long-term care and to build relationships with colleagues in the general hospital field and in the community. A coordinated service for old people could not function when six or more psychiatrists were involved. The specialists would be part of the new district geriatric Health Care Teams. People suggested that such posts would be hard to fill but this was, he thought, due to the poor facilities offered rather than a lack of professional interest. The care of old people covered all aspects of psychiatry and medicine and allowed scope for evaluation and monitoring. There were now psychiatrists meeting regularly in London to discuss their interest in the psychiatry of old age and a branch of the Royal College of Psychiatrists was going to be concerned with geriatric psychiatry.

Much of the problem stemmed from deficiencies in medical education. Most trainees in geriatrics were doctors from overseas, at a time when almost half the beds in the health service were occupied by old people. In late 1971, there were only 1200 geriatric beds in teaching hospital groups out of 40,000. This was far below the rate for other specialties and in only two groups were the beds in the main teaching hospital; a total of 43 such beds in all. There were too few chairs of geriatric medicine, and none in London. There was no post graduate institute of geriatrics. In this respect there was often a chasm between what was taught to medical students and what the public needed of them as doctors. The Department circular did not mention teaching hospitals and should have reinforced the need for medical students to see good psychiatric care of the elderly. In face of the escalating problems, he felt that the answers lay not only in administrative reform and more money, but also in a change in the priorities, and a speed up in the pace of change of undergraduate medical education.

Points arising

In the discussion period which followed these papers, Dr Brothwood was asked whether or not the mental hospitals would be closing. He said that the primary objective was to improve the psychiatric service and not to close mental hospitals, but that in many cases, this would be the result because they were old or unsatisfactory. Staff need not fear for their jobs. The same number of personnel would be needed, if not more, and there would be opportunities for redeployment. He could give no assurance that the total number of hospital beds would remain the same, because an increase in day hospital places at the district general hospital and in local authority accommodation might reduce the need for in-patient beds.

Dr Arie agreed that it was the total provision of caring amenities that was important and said that the present administrative arrangements made it hard to see this as a spectrum.

Asked whether he saw the psychiatrist's special concern for old people as a management function or a clinical interest, Dr Arie said that, in view of the problems created in some areas by large concentrations of old people, it would be hard to get an effective service unless it was also a management function. He had taken his present post at Goodmayes Hospital on the condition that he saw all patients aged over 65, whatever their diagnosis; with the result that he was both a "manager" of his service and a clinician, able to plan and deploy the whole economy of his service.

The next questioner said that while the DHSS might be convinced of the need for comprehensive psychogeriatric services he wanted to know how they proposed to put this over to the elected representatives in local government who assessed local priorities. A director of social services supported this question and said that money for the mentally frail did not win votes. The only stick available to threaten local authorities appeared to be that if they did not do well enough they would lose social services just as they had lost health services. Professor Ferguson Anderson agreed that something had to be done or the whole system would collapse. On the subject of training, he went on, Glasgow had introduced a new cirriculum for medical students which increased the emphasis on geriatrics. There was a danger that the present system was training students to look after the type of patients that they were unlikely to see once they had qualified. Pre-registration house physicians who had trained in London, adapted to other conditions very quickly once they were given an opportunity to exercise their excellent general medical skills in a geriatric setting. The young medical student was very interested in old people, and had more awareness of their social involvement than previous generations.

This session ended with discussion of the role of the community physician. A questioner suggested that this appointment would be crucial to knit together health and social services but wondered who would get the appointments at district level. Would it only be those who had failed to get posts at a higher level? The Hunter report and other documents suggested that the community physicians would have a geriatric or psychiatric designation that and the greatest care would have to be taken over these appointments. They would have to come in at the point where the components of the NHS confronted one another and to go to these components for expertise. He favoured the idea of a community physician with an administrative interest in fostering a service for geriatrics but thought that if the same man was going to be expected to do community assessments, give advice to the staff of residential homes etc. they would be missing the point. The component parts of the service should be allowed to come together over the needs of the patient without any person in between.

Responsibilities, roles and skills

A great variety of questions were covered by participants in syndicate discussion during the afternoon session. A group which was asked about the responsibilities of the various professional groups and their coordination with the social services department, suggested that health visitors should be in direct contact with the social services department, that the general practitioner should function as a lynch pin to avoid a short circuit on social needs, ie be able to get a patient a bed when necessary; and that the social service departments should have adequate resources to meet needs, a 24 hour service and duty officers who were capable of making decisions and implementing them straight away.

This group also felt that relatives should only be expected to keep the elderly confused at home if the situation was adequate with or without existing domestic services, including rehousing, to provide the necessary space to allow them to provide the necessary care.

The second group was asked about psychogeriatric assessment units and said that, while they believed in a comprehensive, integrated area service with no buck passing, they did not feel that a psychogeriatric assessment unit would be a necessary part of this service in every area. This would depend on geography, availability of staff etc and the size of the unit, where needed, would be small and it would only have a limited role. It would not necessarily admit emergencies or be a full ward, but it should include domestic assessment, day assessment etc. There was a lack of knowledge about such units but, the group thought, they should probably be located at the district general hospital so that x-ray facilities, therapists' assessments etc were available. One consultant should manage the beds, although consultants would retain control of their own patients until they were reassigned. The general practitioner would be welcome in the unit but a key member of the team. There would have to be liaision for cases conferences, including contact with the local authorities. This would cover the avoidance of unnecessary admissions, provision of services after discharge etc. Finally, they said that they had found the question hard to answer and suggested that there should be more experimental schemes and analysis of their results.

Asked about the coordination of professional skills, the third group said that this had to be considered in the light of a situation of acute demand and chronic need. The general practitioner dealt with the first aspect and referred his patients as appropriate. He was also the pivot in the chronic situation where the health visitor, home help, district nurse were as important in monitoring need as the GP, who should be able to make monthly visits to his elderly patients as appropriate. The group suggested that health visitors could help in the production of a practice register of all patients over 75 indicating their disabilities etc. They felt that general practitioners should attend case conferences, possibly on a rotating bases, and multi-disciplinary discharge clinics. They hoped that consultants would become more involved in making home visits and looked forward to the creation of more day centres and the attachment of social workers to the GP team, although this would need a greater clarification of overlapping roles with particular attention to that of the health visitor. They favoured the appointment of psychiatirsts with a special interest in the elderly but thought that this was, in any case, a growing part of psychiatry.

The fourth group, which was asked to discuss the problems which arose out of the separate organisation and financing of the health and social services and ways in which these problems could be overcome, said that the imbalance between the political pressures which could be exerted in the two areas could lead to great difficulties in areas such as the 'costa geriatrica'. The GLC for example was already building old people's flatlets in coastal areas without providing any supporting services. The groups suggested that social services should be included under the new area boards or the Secretary of State given mandatory powers in this field. They supported the need for specialists in the field of community medicine and suggested that they would act as advisers to social service departments. They expressed concern at the effects of the Seebohm reorganisation and especially at the possible loss of the medical social workers, and suggested that voluntary organisations should be encouraged to act as pressure groups and seek publicity through the media. The group had, however, ended up by questioning whether they, as ratepayers, would like to lose control of social services to central government and whether the proposed consumer councils would be an adequate check on the new health service authorities.

Group five was asked who would be responsible for monitoring the effectiveness of services to psychogeriatric patients and how this process should be organised. They began by trying to define the word 'monitor' and suggested that there should be a group which received information 'monitored' it and adjusted services according to needs. Some thought that this should be a DHSS responsibility so that there could be national standards which a local group could adjust or add to according to local needs. They pointed out that not every facility constituted a service and suggested that the monitoring process should include a feed in of general, ie not medical or social, information. They thought that a properly organised team would be self-monitoring but others thought that this had to be done by outsiders such as the Hospital Advisory Service. The proposed health care teams would have a monitoring role and it was possible that patients themselves could be asked to feed in information.

The organisation of aftercare for the psychogeriatric patinet was discussed by the last group. They said that the general practitioner was responsible for clinical care and for holding an age and sex register or other information to identify the elderly at risk. He also should help to train other staff. The group had not included a health visitor and had felt unable to define her role, but they did support the request for a community nurse whose role would include liaison with the social service department. They felt that the consultant should be there to be consulted and should be prepared to admit on a short-term basis, and then return the patient to his GP. They thought that too many old people were asked to return to out-patient clinics unnecessarily, perhaps for a monthly appointment with a junior doctor. They asked for better letters from hospitals to community workers and for better post-graduate education opportunities for all caring staff. On the question of coordination of aftercare with the social services department, they suggested that the departments should consider a service for emergency social admissions to residential accommodation to avoid the use of hospital beds for this purpose; that generic social workers should be attached to general practitioner groups and able to call in specialist social workers as appropriate, that there should be a medical representative with administrative duties within the social service department and that discharges should be better planned to end the 'You're going home tomorrow' approach. This meant taking time for liaison and nurses should do this if there were no social workers available.

The effect of reorganisation

In the final period of open discussion, the organisation of services for psychogeriatrics was looked at in the light of the proposed new structure for the health service. A participant questioned whether the community health councils would be able to monitor services. He did not set great store on impotent bodies such as these or the joint consultative committees. They were the weakest link in the new structure and would be dead before the service got off the ground. A nurse pointed out that while there were 46 doctors at the conference, there were only 2 nurses. Did this reflect their role in this field? Nurses should be prepared to intervene in cases of social need and in some areas of medical need if the medical policy was known and they were trusted and had delegated others to do this. Health visitors should be working for all age groups, doing psychogeriatric assessments etc but this was only possible if they were working in attachment or at a health centre. Professor Ferguson Anderson agreed that they had a tremendous role in the ascertainment of need, and especially with regard to the elderly. A speaker pointed out that some boroughs had a special geriatric health visitor who liased with the general practitioners, the hospital geriatric unit, the social services department and all attached health visitors.

It had been found that consultants were less likely to call their patients back to out-patients if they came from a practice with an attached health visitor. Hospitals were not trying to stop the general practitioners caring for their patients but they had disappointments in the past which meant that they were now extra careful.

A participant drew attention to the fact that nobody had mentioned the new community physician in the context of the monitoring of services. The Hunter report had envisaged that he would be a medical administrator concerned with the evaluation and planning of services, epidemiology and medical information services and not a clinician. He was the obvious person to have responsibility for monitoring. Summing up Professor Ferguson Anderson said that the psychogeriatric field was crying out for further research. It was not a dead end or uninteresting. The mental problems of the elderly were largely unsolved. If we were able to find a useful place for old people in our community, it would make an enormous difference to us all.

CARE FOR THE ELDERLY MIND

Conference on Tuesday, 14 November, 1972

(Held at Luton & Dunstable Hospital)

Chairman: Mr R Lomas
Editor, North Herts Gazette Series
Chairman, Finance & General Purposes Sub-Committee
Luton & Hitchin Group Hospital Management Committee

10.15		Welcome and introduction by the Chairman
		CARE FOR THE ELDERLY MIND
	I	PROBLEMS & PRIORITIES - THE COMMUNITY VIEWPOINT
10.30		Dr G E Pinkerton, General Practitioner, Dunstable
10.50		Mr C W French, Assistant Director of Social Services, Bedfordshire CC
11.10		Dr L G Nicol, Principal Medical Officer, Mental Health Bedfordshire County Council
11.30		Miss W Frost OBE, Director of Nursing Services, Bedfordshire CC
11.50		Interval
12.00		Questions and discussion
12.45		Buffet lunch
	II	PROBLEMS & PRIORITIES - THE HOSPITAL VIEWPOINT
2.00		Dr J Clifford Firth, Consultant Physician in Geriatrics, Luton
2.20		Dr B L Mallett, Consultant Psychiatrist, Fairfield Hospital
2.40		Mr J P Browne, Nursing Officer, Rosehill Hospital, Letchworth
	III	THE LUTON & HITCHIN GERIATRIC ASSOCIATION
3.00		Dr J Clifford Firth
3.15		Questions and discussion, with panel of all the speakers
4.00		Summing up by the Chairman
4.15		Tea

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4.45 Optional visits to Geriatric Wards of Luton and Dunstable Hospital

CARE FOR THE ELDERLY MIND

On 14 November, representatives of the health and social services in the Bedfordshire/Hertfordshire area met at the Luton and Dunstable Hospital to discuss problems and priorities in the planning and organisation of future psychogeriatric services in that area organised by the King's Fund Hospital Centre in association with the North West Metropolitan Regional Hospital Board, this conference set a new pattern of co-operation among workers in the field of psychogeriatrics.

Under the chairmanship of Mr R Lomas, Editor of the North Herts Group Gazette, two teams of speakers discussed the problems and priorities in the care of the elderly mind from the viewpoints respectively of the community and the hospital.

The community viewpoint

Speaking from the community viewpoint Dr G E Pinkerton, a general practitioner from Dunstable, pointed out that as each patient was an individual, clear division into categories was rarely easy. He divided psychogeriatric patients into three main groups. The long-term cases can often be helped by their families. It was essential that both body and mind should be kept active and there was much opportunity for voluntary workers in this field. There was a growing interest in pre-retirement classes but two problems to be appreciated were the greater expectations of life at retirement at 60 and the dangers of moving from a familiar environment. The second group could be described as the 'something must be done' syndrome, where minor crises observed by relatives frequently served to draw attention to the problem. Such cases, however, could develop into full-blown acute cases. Here the general practitioner faced the difficulty of adequate assessment. To whom should he turn - to the geriatric services or the health visitor? Commenting on the frequent time-lag before the particular needs could be adequately met, Dr Pinkerton thought that the basic cause was lack of beds.

Turning to possible solutions the speaker felt that the first essential was to estimate the actual size of the problem, but this was not easy in general practice. To attempt to produce a register of those at risk could well infringe on the liberty of the subject, and age only was an insufficient criterion. Basic research on the preservation of the mind and the processes of aging was urgently needed.

General practitioners, too, must have the tools for the job. At present it was more or less a matter of 'learn as you go' although present-day medical students were being offered better opportunities of learning something about the elderly. Geriatricians, Dr Pinkerton felt, were too often weighed down with administrative work; they should be free to devote their time to clinical work. There was a need for more beds, not only in hospitals and local authority homes, but also in sheltered accommodation in the community. Better methods of calculating requirements were also necessary; rural and urban areas differed widely in their needs. Close liaison was needed between hospitals, welfare authorities and voluntary bodies which was a challenge to those designated as community physicians. He hoped that the present opportunity to fix the future pattern of the care of old people would not be permitted to slip away.

For Mr C W French, the answer could be given in two words "more beds". He felt that there was need for more social research. Not enough at present was known about the effects of hereditary and other circumstances on aging. With insufficient knowledge about causes it was not possible to estimate whether the results of various types of treatment were preventative or only palliative. We were not yet sure what kind of intervention would be the most appropriate for each case, not at what point the intervention should be made. Are we, he asked, providing too many homes for each type of problem? Mr French felt that much more attention should be paid to planning and investigation of new ideas however difficult the problems that this might present for the local authority services. Planning should not be regarded as an end in itself, rather as a statement of intent, aiming at a particular target. Plans must be realistic and every effort must be made to avoid breaking the good relationships that had already been established between the various departments involved.

The third speaker, Dr L G Nicol, Principal Medical Officer (Mental Health), Bedfordshire County Council, spoke of the problems of depression and dementia in the elderly. Depression, he thought, frequently masqueraded as dementia and not enough was done in the community by relations and volunteers to combat the problem of depression. Assessment by general practitioners was often inadequate and geriatric physicians were too often overwhelmed with work. Cases referred to local authority homes were often unsuitable and those homes could become silted up with unsuitable clients. Another problem was the use of untrained staff.

Miss W Frost, Director of Nursing Services, Bedfordshire County Council, was the team's final speaker. Miss Frost considered that the main conditions for which a comprehensive psychogeriatric service should be provided were depression and dementia. An adequate service to help with the prevention, assessment, treatment and care of such patients required first of all adequate staff, whether in hospital or at home.

Four types of accommodation were necessary. Hospital accommodation should include beds for assessment as well as facilities for day patients and out patients.

Local authorities should provide adequate accommodation in homes for the mentally and physically frail as well as blocks of flats with warden service for the more able-bodied. Lastly there was a need for privately registered homes for the elderly.

Miss Frost thought that health and social service authorities were aware both of the needs and the urgency for an adequate service for the elderly but the provision of such a service was hindered by a combination of factors. These included lack of money, the belated recognition of the size and urgency of the problem, and the present tripartite structure of the Health Service. The lengthy transitional period of change from large isolated hospitals to smaller units in District General Hospitals, and the transfer of the mental health service to the social services were also important factors. Making a plea for increased co-operation between authorities Miss Frost declared that at present adequate direction was lacking. There was also an urgent need for members of the caring team to attain a greater appreciation of each others roles.

Looking ahead to a future comprehensive service, Miss Frost felt that the most profitable line to pursue at present was a development of liaison between the various services. This would form a sound foundation for the collaboration between area health authorities and local social service authorities in the reorganised National Health Service.

PSYCHOGERIATRIC CARE

Conference on Wednesday, 24 January, 1973
(held at Kingston Postgraduate Medical Centre)

Chairman: Mr H W Payne
Chairman
Kingston & Long Grove Group HMC

9.45	Coffee on arrival
10.15	Welcome and introduction by the Chairman
	DEPARTMENTAL VIEWPOINTS
10.20	THE CONCEPT OF THE HEALTH CARE PLANNING TEAM Dr D H D Burbridge Senior Principal Medical Officer, Department of Health & Social Security
10.35	THE ORGANISATION OF PSYCHOGERIATRIC CARE Dr J Brothwood Principal Medical Officer, Department of Health & Social Security
10.50	Questions and discussion
	PROBLEMS AND PRIORITIES - COMMUNITY SERVICES
11.15	Dr C J Rowland General Practitioner, Surbiton
11.30	Mr S R J Terry Director of Social Services, Royal Borough of Kingston upon Thames
11.45	Dr A H Fairlamb Deputy Medical Officer of Health, Royal Borough of Kingston upon Thames
12.00	Miss B L Shippam Director of Nursing Services, Royal Borough of Kingston upon Thames
12.15	Questions and discussion
1.00	Buffet lunch
	PROBLEMS AND PRIORITIES - HOSPITAL SERVICES
2.00	Dr Phyllis D'Netto Consultant in Geriatrics, Kingston and Long Grove HMC
2.15	Dr J S Bearcroft Consultant Psychiatrist, Kingston and Long Grove HMC
2.30	Mrs R McNulty Nursing Officer, Long Grove Hospital
	PROBLEMS AND PRIORITIES - VOLUNTARY ORGANISATIONS
2.45	Mrs C E Hobkirk Chairman, Royal Borough Joint Old People's Liaison Committee
3.00	Questions and discussion
3.50	Chairman's summing up
4.00	Tea

She called for increased development of the day hospital movement, and for additional housing for the elderly. Referring to nursing services, she pointed out that the pattern of training proposed by the Briggs Committee would include three months work in the geriatric field during basic training.

Miss Frost felt that the presence of a management team at district level in the reorganised health service would enable a truly comprehensive psychogeriatric service to evolve, provided that the urgency is sufficiently pressed and adequate funds are forthcoming. Permanent health care planning teams were necessary to produce an adequate psychogeriatric service and the same quality of attention should be given to psychogeriatric conditions in the field of psychiatry as was given to maternal mortality in the field of maternity and child welfare.

The hospital viewpoint

The opening speaker for the afternoon session was Dr J Clifford Firth, Consultant Physician in Geriatrics, Luton, who considered some of the problems and prioities from the viewpoint of the hospital. One great problem was lack of adequate communication between patients and doctors, between doctors themselves and between general practitioners and hospitals. Another problem is the lack of adequate knowledge of the subject; gerontology is still in its infancy. Lack of research into the problem of aging means that too little is known about heredity and the significance of different stages in aging. Additional staff and more time for consultation are needed to provide an adequate service. The problem of aging could best be dealt with by a team approach, each team consisting of a nursing sister, occupational therapist, speech therapist, district nurse, health visitor, geriatrician and geriatric liaison officer. In the meantime we should make the most efficient use possible of the available resources.

Dr Firth was followed by Dr B L Mallett, Consultant Psychiatrist at Fairfield Hospital, who pointed out that the already large problem of geriatrics will increase since one in eight of the population is over the age of 65. Outlining various problems of aging, Dr Mallett put forward suggestions for meeting them. It was vital to maintain a respect for the elderly person and to provide the necessary care unobtrusively, allowing the individual to contribute his share to society. The very wide range of services and advice required should be readily and easily available to the patient and his family. The available services, he thought, could be provided most effectively through group practice. The quality of life available for the old person will depend largely upon the flexivility of the district service and the provision of help for the individuals where they are.

Briefly reviewing the resources needed Dr Mallett said that the psychiatric hospital still had a part to play in the total pattern of care. He thought that staff should be trained to help patients to die with dignity and without distress. It was important to look closely at present provisions and to ponder the merits of alternative solutions.

Mr J P Browne, Nursing Officer, Rosehill Hospital, Letchworth, was the third member of the team. To him the main problems were lack of money, shortage of staff and minimum standards of care. He hoped that the reorganisation in 1974 would relieve hospitals of some of their present pressure. At the moment, he felt that it was difficult enough to care for the physical needs of the patients and consequently patients tended to deteriorate mentally.

Staff ratios at present were too low and additional occupational therapists were needed in hospitals for the psychogeriatric. "We strip the patient of everything" he declared; "they need emotional warmth and understanding". What was required was small units easily available to the patients' homes so that families could become involved.

Dr Firth reported on the progress of Luton and Hitchin Geriatric Association which had been formed following the series of conferences held at the Hospital Centre in 1970 on geriatric care.

In the discussion that followed, the hope was expressed that the DHSS would consider revision of the ratio of 200 beds per consultant. Methods of successfully keeping elderly people out of homes and institutions were discussed and the problems of staffing were also considered. It was reported that a working party was looking at the work of ward orderlies and aids; methods of retaining staff to work in the old mental hospital environment were also discussed.

It was felt that there was a need for more day care and for care of the elderly at home. The siting of welfare homes and the value of half-way houses was also considered.

In his consluding remarks the Chairman emphasized the need to treat old people with care, consideration and dignity without condescension. It was necessary to identify the problem clearly before attempts could be made to solve it and for this research was needed. These objectives can be worked out by all those concerned with services for the elderly working together to a common end.

PSYCHOGERIATRIC CARE

The last of a series of meetings on psychogeriatric care, organised by the Hospital Centre, was held at the Kingston Post-graduate Medical Centre on 24 January, 1973. Doctors, nurses, administrators, social workers and others interested in the care of mentally frail old people from the South West Metropolitan Regional Hospital Board area attended this meeting to discuss problems and priorities in the planning and organisation of future psychogeriatric services. Participants were welcomed to the Centre by the conference chairman, Mr H W Payne, chairman Kingston and Long Grove Group HMC. He drew attention to the considerable increase in elderly and very elderly people in the population which was expected over the next decade and said that the problem was particularly complex in the areas where the authorities providing health and personal services had a joint responsibility. Elderly people were indeed being launched into the 'maze' described in the Hospital Centre publication 'The Elderly Mind' and needed a guide to help them emerge from this.

The concept of the health care planning team

The meeting opened with two departmental viewpoints, the first of which was provided by Dr D H D Burbridge, Senior Principal Medical Officer, DHSS. He listed a number of converging trends which pointed the way to the new Management Organisation. Salmon and Mayston Reports had heralded the emergence of the Nursing Profession as an equal partner. Cogwheel organisations were helping doctors to look at and stratify their demands for resources and to participate in policy making at the apex of local administration. There was a trend towards multidisciplinary management both within and without the Health Service. It was highly desirable for those providing the service to be involved in the planning of that service since involvement was half way towards commitment. The Department had been looking at the concept of Planning Programming and Budgeting systems which required one within functional programmes to determine objectives, the activities required to achieve those objectives, the resources needed to enable those activities to take place and finally to monitor the outcome to assess effectiveness. In determining such programmes the concept of client groups emerged - age specific groups or groups calling upon the resources of particular disciplines and having needs for which one can provide in a clearly identified way.

This concept of client groups was itself reflected in the reorganisation of the Department in anticipation of the new NHS; and there was a general hope that we could move from meeting demand to ascertaining real need and attempting to meet it. The first step towards this would have to be taken at the local district level and again a number of relatively deprived groups obviously emerge for consideration eg the elderly, the mentally ill and the mentally handicapped. To consider the problem of these specific groups at the local level it was intended to establish Health Care Planning Teams in which all disciplines with an interest in the subject would be represented and whose activities would be maintained and co-ordinated by the District Community Physician and his administrative staff. These teams would be encouranged to plan in systematic way, would be provided with data in a standardised form and would express their aspirations for their particular group in a standardised way which could then be built into the off care plan for the district. They would of course be operating within guidelines handed down and within anticipated resource limits.

Finally the propsed Community Health Councils should be involved in the service in their area not just by building recommendations upon complaints but by dynamic involvement in the thinking of these Health Care Planning Teams. The consumer interest would be complementary to that of the service providers and not at war with it.

The organisation of care

Dr J Brothwood, prinicpal medical officer, DHSS, said that factual evidence about mental disturbance in the elderly was now emerging and that papers on the subject were appearing from professionally interested people. There had also been a recent DHSS memorandum on the subject and this defined the term psychogeriatric in a general way to take in all mental disorder manifesting for the first time in old age roughly defined as those aged 65 and over. It covered depressive illness, schizophrenia, dementia and confusional states. The depressive illnesses were the most common; then came the dementias due either to primary brain disease or secondary to vascular disease. Dementia was present to some extent in 10% of the population aged 65 and over and about half of these were severly affected. This proportion rose steeply with age which was very relevant in view of the expected rapid increase in the over 75 population. Schizophrenia was less common in old age but the confusional states were important and often arose as mental complication of physical conditions so that prompt medical treatment was frequently very effective.

Psychogeriatric patients fell into three main groups: those who had grown old in hospital, the so called 'graduate' group; the number who entered this group each year was falling. It was unlikely that many could be discharged to community care but improved facilities were essential for them. In general the depressive illnesses in old age responded well to treatment and no special hospital provision, over and above the general hospital provision of 50 beds and 65 day places per 100,000 population was required for them. Close collaboration with the social services was, however, necessary for this group so that discharge took place as soon as the patients no longer required hospital inpatient care. Finally there were the patients with dementia and it was felt that no significant change was desirable in the balance of responsibility as between the psychiatric and geriatric services. Both shared a considerable load. The necessary physical resources had been defined as 10 beds and 2 day places per 1,000 population aged 65 or over in geriatric units and 2.5 - 3.0 beds and 2-3 day places in hospitals over and above the general provision already mentioned. The distribution of patients between these beds was an organisational matter and the collaboration between the services would depend on factors such as the arrangement of buildings, the organisation of nursing services and other local factors.

Then, there were the patients with confusional states. The majority had conditions which were due to physical causes and so were the responsibility of the geriatrician, but a number might need to go to joint assessment units. Sixty per cent of district nurses were now attached to general practitioners in primary care teams and this had a number of potential advantages. The screening and regular visiting of old people was likely to increase. There had been organisational changes in the social service departments and they were now working on the basis of areas of 40-60,000 population and encouraging 'good neighbour' and other support services. There were also a few part-time social work attachments to general practitioners. Forty per cent of the elderly population in residential care were in local authority homes and the local authorities had been advised that they should aim for a provision of 25 places per 1,000 population over 65. This would take place over the next ten years and add about one third again to the present complement of places.

Within the hospital service, geriatricians were coping with 5-6 admission of old people for every 1 in psychiatric hospitals. Forty-five per cent of psychiatric hospital patients were aged 65 or over but day attendances were low. They were likely to increase when accommodation could be provided at the general hospital rather than at distant psychiatric hospitals.

Finally, Dr Brothwood said that he saw a need for improvements in four areas. There should be more preventive work and assessment of existing schemes. Could screening prevent the development of more serious problems perhaps avoiding the need admissions, for example? This was something which came within the province of the community physician. Secondly, there was a need for improved assessment. Pre-admission screening was increasing and was better if it included a home visit. A better use of resources should lead to a reduction in admissions. Thirdly, he hoped to see improved collaboration. Psychogeriatric units had increased the collaboration between psychiatrists and geriatricians and had brought in social workers. They could act as a focus for collaboration and provision with in the district general hospital should further help. Fourthly, within the hospital service, more psychiatrists were now interested in psychogeriatrics and there were 25 in posts where they spent the bulk of their time with old people. There was a group concerned with this problem within the Royal College of Psychiatrists and three professorial chairs of geriatrics were now established in England. These both improved the teaching of the subject and increased its career attractiveness.

A brief opportunity for questions followed which started with a question on the basis for the allocation of financial resources to the new health areas. Dr Burbridge said that the DHSS would allocate to regions and might not dictate the percentage to go to the various areas. The present allocation to RHBs was moving towards more objective criteria and was based 50% on age and sex distribution, 25% on existing hospital beds and 25% on throughput for those beds. The same formula might not be applicable when the new authorities included personal health services but any allocation would have to begin with existing expectations and then adjust to move towards more objective criteria. A doctor then questioned how local authorities could be persuaded to increase personal social services as indicated. Dr Brothwood said that the overall ten year target was not felt to be unrealistic but that he recognised that it would not solve urgent problems now. The organisation of the new structure included health areas with a coterminous boundary with local authorities and a responsibility for joint planning at member and officer level. Community health councils would bring in district councillors with a housing responsibility etc.

The spokesman for a voluntary organisation asked whether it was really going to be possible to close the mental hospitals in ten years. Graduates were still being fed in to the geriatric mental hospital population. Dr Brothwood said that the DHSS did not see a need for large scale building for this group. Some would need continuing hospital care but others could go into local authority care for the mentally ill and this would be covered among the suggestions in the new circular being produced for local authorities. It was not possible to make a national rule on the closure of mental hospitals. It would depend on the facilities and priorities of the individual regional health authorities. A director of social services pointed out that their ten year plans were being made without all the relevant information and were not likely to be truely related to need within five years. He was conducting discussions with health and voluntary services on the relative provision from the various sources. A ward sister suggested that many of the depressive and confusional states in old people arose from neglect which followed retirement. If there could be more day centres which offered light paid employment as well as food and entertainment this might help to get them back into circulation, help them to look after themselves better, and take some of the onus off the hospital service.

A general practitioner's view

The first speaker on the problems and priorities for the community services was Dr C J Rowland, general practitioner in Surbiton. He described the organisational arrangements in his group practice and the framework within which he could care for psychogeriatric patients. He too, drew attention to the fact that this problem was increasing in magnitude, but at a time when children were increasingly depending on the state to care for their parents in their old age. The general practitioner was in a priviledged position in the area of psychogeriatric care in that he knew more of a patient's background than a psychiatrist or a social worker could possibly discover in a one hour interview. This knowledge could be of great help to the providers of services.

When the GP was called in on such a case, he had to begin by excluding any physical cause for the mental condition and to make the necessary time for this. There was a great danger in quickly labelling a patient 'psychiatric' without getting to the root cause. He personally, was fortunate in being able to admit patients to a GP hospital for observation and assessment. Many patients were able to return home after a short admission and followup was essential, through contact with the social service department. This contact had to be made at the time of admission if the patient was leaving an elderly spouse at home. Where patients lived with relatives, use could also be made of holiday admissions and in and out schemes, whereby one bed was used for three patients in rotation, to give their families a break. There was also a great need for more day centres and lunch clubs which saved patients from having to be alone all day while relatives were at work. This was a field for activity by the voluntary bodies and helped to build up a spirit of interest for patients: what Sir George Godber had termed the 'caring community'. Patients were sometimes discharged home to a situation they could not really cope with. There was a shortage of Part III accommodation and many patients were in any case not really suited to this. Housing Association accommodation was often more suitable and this was another field in which voluntary bodies were active. Elderly gentlefolk in particular found it difficult to cope with large residential homes.

Dr Rowland agreed that there was a certain amount of mistrust among general practitioners towards the new departments of social service but thought that this arose out of ignorance about the content of the Seebohm report itself, and of the work which the Departments had been doing since their inception. GPs were very conservative and reluctant to discuss medical matters with lay workers and one-way past this might be to offer them social worker attachments, and thus to make social workers an integral part of the community health team. They were particularly fortunate in Kingston, in that the HMC had set up a geriatric working party with representation from all branches of the health and social services and this was likely to prove very useful in the next 18 months during the preparations for the reorganisation of the health service. In this context, the most helpful development for general practitioners, with reference to the care of psychogeriatric patients, would be for the psychiatric and geriatric hospitals to have matching catchment areas.

A social service view

Mr S R J Terry, director of social services, Royal Borough of Kingston upon Thames, said that a requirement had been placed on social service departments actively to promote the welfare of the elderly and that positive steps had been made in Kingston. Real poverty still existed in this age group despite state provision.

Benefits did not always go to those in most need, because they did not know their rights, found the forms too difficult or were unwilling to apply. He hoped to have an expert on citizens' rights in his department, to use the Citizen's Advice Bureaux, and to get intelligent volunteers to help old people to fill in forms. He, personally, felt that the present retirement pension was inadequate and that local benefits were too selective to fill the gap. Reduced fares, for example, only helped the ambulant, while the housebound got nothing.

Housing was an important local authority responsibility. Kingston was concentrating on old people's housing needs including the provision of sheltered accommodation with some communal facilities. Where old people lived alone in their own houses they were prepared to offer suitable accommodation, if they wanted this, and to purchase their house which added to the housing stock for families. The Kingston survey of the disabled and handicapped had included the elderly and they were likely to have some idea of the size of the problem in the Borough by mid-summer. They hoped to make this information available to colleagues in other services. Mr Terry saw a need to identify those at risk so that they could offer particular support through good neighbour schemes etc. There had been an increase in referrals to the Department, though apparently not from general practitioners. His service expected to offer full spectrum of support from regular contact with a social worker to a volunteer employed by the Department visiting regularly. The home help service was another vital and flexible resource and one which was not used imaginatively enough. Kingston was examining ideas on this including taking over launderettes twice a week for home helps to do washing for old people. This service and others such as holiday schemes and meals on wheels needed expansion. The latter were to be provided from new residential and day centres and developed to operate seven days a week throughout the year. Giant steps were needed if more old people were to be successfully maintained in the community.

Transport was always a problem and Mr Terry said that he would like to see joint use made of resources such as ambulances. They hoped to expand day care particularly for the housebound, picking up old people in ambulances and providing care and social activities. This would not duplicate the work of the voluntary bodies who provided social clubs; and there was a need to get together with doctors to establish the criteria for admission to day hospital, day care and social club attendance. As to old people needing residential care, Kingston had boarded out one elderly psychogeriatric and employed a full-time boarding out officer who had, up until now, concentrated on placing children. A number of new residential homes were planned for 1974-75 and this would increase the provision of beds by 120. They would include day care places and meals on wheels kitchens. Residential homes had many problems to face including the need to rehabilitate some residents back into the community. There were no plans for separate psychogeriatric residential provision and this was something for further discussion. The key to good planning was early information and all agencies had a responsibility to communicate and liaise. They were likely to be difficulties but it would help them to understand their relative skills and responsibilities and to define their roles. Mr Terry thought that the Kingston area was moving towards joint planning for the elderly and that it was not necessary to wait for 1974 for real collaboration.

A health department view

Dr A H Fairlamb, deputy medical officer of health, Kingston said that the management of the psychiatric patient was one of the most challenging aspects of medical practice today and that complex and special problems arose in old age which needed a multi-disciplinary approach to get logical solutions.

About 40% of psychiatric hospital beds were occupied by the elderly. There had been an uneven development of services and decisions based on intuition rather than research or facts. Evaluation was very important in these circumstances and was part of the task of the community physician. The establishment of priorities and sound planning were essential in face of rising costs and the need to compete for scarce resources. This included joint planning with voluntary bodies to avoid any duplication of services. The setting up of geriatric liaison committees could only help this process and lead to the provision of better services.

Dr Fairlamb then went on to speak about demographic factors, notably the expected large increase in the number of psychogeriatrics and of the DHSS recommendation for a shift in emphasis from hospital to community care. This required a rapid mobilisation of statutory and voluntary community resources to improve the quality of services and so avoid the distress and indignities that some of the elderly presently had to bear. In view of the heavy burden involved for the relatives of psychogeriatric patients, one urgent priority was the provision of supportive services to families at risk, eg an elderly spouse. The general practitioners needed the active support of health care teams so that preventive and therapeutic services could work together. He thought that social workers should be part of the team and that health visitors should have more time for home visits, as they could make assessment and identify old people at risk. 77% of district nurse visits made in Kingston last year had been to the elderly, and this service was likely to have to expand in the future. There was also a place for the psychiatric nurse as a specialist member of the health care team and particularly with reference to psychogeriatric patients. This had been found to be very useful in Northampton.

Dr Fairlamb drew attention to the value of psychogeriatric assessment units in avoiding misplacements and in meeting the individual needs of patients and of community based geriatric assessment and screening clinics. He stressed the importance of better housing for the elderly, and especially sheltered housing, and of an expanded home help service. Special training should be given to those home helps who dealt with psychogeriatric patients as they were often able to establish a rapport with a patient where others had failed. There was scope for an expansion of day care facilities of all types and for better preparation for retirement. Post-retirement depressive illness was a common feature of our society and was a subject which merited more research.

The community nursing service

The development of community health teams was described by Miss B L Shippam, director of nursing services, Kingston. She said that the inclusion of more nurses with both general and psychiatric qualifications would further strengthen such teams. The acceptance of attachments had taken time, especially with reference to health visitors, and this applied equally to present suggestions about the inclusion of social workers. The health visitor was a key figure in the care of psychogeriatric patients. Her role was supportive, advisory and preventive, and particularly involved liaison with the other services. The district nurse was concerned with aspects such as the administration of drugs, incontinence, diet, mobility etc and the involvement of auxiliaries had allowed an extension of this service and the provision of a night sitter service.

The psychogeriatric who lived alone was especially vunerable in the absence of a referral to community services by the general practitioner, and attachment might reduce the nurses 'local' knowledge of such patients.

Where the psychogeriatric was cared for by relatives and neighbours, the nurses' role was supportive, but the problems of the relatives should not be underestimated. The amount of support was often crucial to keeping the patient in the community and a case conference might be necessary to establish this to bring in the voluntary bodies and prevent the patient playing one service off against another. The proposed changes in nurse training would increase the stress on nursing in the community and, Miss Shippam hoped, establishment committees would continue to be generous over the staffing of this very important service.

Questions and comment

The question period opened with a comment on the prescribing of large quantities of drugs without adequate explanation to old people by general practitioners and which was, Dr Rowland thought, a result of the size of general practitioners' lists. Another speaker suggested that more houses should be built with the necessary flexability, eg a second living room to allow an old person to live with his family and a nurse suggested that the newly retired should be involved in voluntary work for people older than themselves through social clubs, meals on wheels etc. A community medical officer described the operation of screening clinics for the elderly and Dr Fairlamb suggested that there should be more evaluation of results to see if they justified the cost of their more general introduction. Miss Shippam told a questioner that while some ex-psychiatric hospital patients might benefit from visits from a nurse they had got to know and trust in hospital, many could be discharged to the care of a psychiatric nurse in the community team. Problems arose now when discharges were made without immediate reference to the general practitioner or community services and the patients were left, as a result, without any community care.

A number of questions were asked on the attachment and method of work of social workers. Dr Rowland agreed that general practitioners would have to be more cooperative over access to medical records but was not sure how this could be achieved. Mr Terry said that Seebohm had been concerned with a generic training and not with generic social workers and that, while some social workers would take a general caseload for reasons of interest or training, others would develop specialities which might not be the same as the special interests which had existed in social work in the past, and which were likely to effect future relationships with health care teams. He had not yet thought about attachments as he was still concerned with basic departmental problems and priorities. The present arrangements with regard to area teams and the allocation of cases to social workers could be modified to meet the changing pattern of needs, which were in themselves, not yet known. The Department was less than two years old and he was prepared to admit that they did not yet know all the answers to meet the needs of Kingston. Asked by Dr Burbridge if social service area team leaders would have the authority to make decisions in joint planning with district health planning teams, Mr Terry said that he envisaged the delegation of this authority to area level.

A geriatrician's view

The first speaker on the problems and priorities in psychogeriatric care from a hospital point of view was Dr P D'Netto consultant in geriatrics, Kingston and Long Grove HMC. She said that many of the problems had arisen from the many and varied interpretations of geriatrics. The classification in the recent DHSS circular into three groups was helpful, ie those who had been in psychiatric hospitals for many years, those with functional mental illness and those with dementia. The district geriatric unit was usually a 'sorting area' for the elderly referred to hospital and that of the Kingston Group was no exception.

It provided 8.3 beds per 1,000 population over 65 years in Kingston and other parts of the catchment area which was less than the recommended 10 per 1,000 and led to great pressure. The turnover including long-stay beds was 3.3 patients a year and the readmission rate 7-8%. The nursing staff made great efforts to contain borderline psychogeriatric cases through the use of sedation etc. Relatives were often resistant to a change to a psychiatric hospital unless they could see efforts being made in this way. As a result, there were only 2 transfers from the 238 geriatric beds in the Group in 1971 and 11 in 1972. Some general practioners referred demented patients with little or no physical disorder to the geriatric rather than the psychiatric hospital chiefly because visiting was easier and only partly because of past ignorance and prejudice among relatives. This was unlikely to change until both types of facilities were brought into the district general hospital.

The pressure on the geriatric unit and the size of its catchment area made it difficult for one consultant to do most of the home assessment visits and senior registrars and medical assistans had to be involved, which was to their benefit. There was close liaison with the psychiatrists who had a working interest in psychogeriatrics and a knowledge of each others facilities and difficulties, a willingness to cooperate to provide a comprehensive service for the elderly and for the geriatric unit to continue as a sorting area, though there was some problem where general and psychiatric hospital catchment areas did not match. As a number of geriatric waiting list patients went straight to the psychiatric unit, a psychogeriatric assessment unit would seem to be a necessary part of their service,and especially so in view of the overall shortage of geriatric beds in the area. Even without such a unit, it was useful to have an interchange of medical and nursing staff and a mixture of SRN and RMN nurses to care for the elderly. Both the old people and the staff would benefit from such an arrangement and senior nursing posts, particularly in assessment units and day hospitals, should be held by doubly trained staff, wherever possible. Dr D'Netto thought that if an assessment unit were to be established it should be at the DGH, partly because the geriatric resources were too limited to support a unit at the psychiatric hospital and partly because the necessary rehabilitation facilities would be more readily available. She hoped, however, to see the development of rehabilitation facilities at the psychiatric hospitals, because this was essential to the resettlement of patients into the community, which would help to free beds for other elderly dements.

Dr D'Netto then went on to speak of the vital role of the day hospital in the assessment of all types of geriatric patient except the acutely ill. Examination, investigation and treatment facilities were available and could so improve the state of the patient as to make them more acceptable to their relatives or residential home. The long waiting lists for this facility meant that it was impossible to keep patients in the day hospital when they were ready to move on to day centre care, although there was no day centre in Kingston. This made the case conferences to decided on support after discharge particularly vital. These were attended by a wide range of staff and despite their careful planning and liaison the need for several day centres was obvious. There was also a day hospital at the psychiatric hospital and patients could be transferred from one hospital to another as necessary. The expected increase in the number of old people in the population should be matched by by an increase in day hospital provision, improved staff/patient ratios, more involvement of voluntary workers and more day centres for patients no longer in need of hospital care. Transport was necessary for nearly all patients attending day hospitals and day centres and had to be realistically planned. Many patients feared that their bladder capacities would not allow them to make a two hour journey without embarrassment.

Pre-discharge conferences were vital in reducing the readmission rate to hospitals in the Group, although it was not always possible for the local authority to provide all the services that might ideally be desired. There was insufficent room at the day hospital for follow up clinics and it was hoped to get additional space for out-patient clinics at the DGH. The local authority night nursing service was very helpful and Kingston had employed two nurses with psychiatric experience. They were invaluable in keeping an eye on elderly dements living alone, and in support of relatives caring for such patients. She hoped that this branch of the domiciliary nursing service would increase rapidly as there was very little call from relatives for intermittent admissions, probably because they too feared the deterioration which followed each upheaval and the probable decrease in longevity.

Reorganisation after the Seebohm Report had made for difficulties in communication with colleagues in the social services department but it was also valuable in that hospital staff now had a chance to discuss policy and plans with senior SSD staff at monthly meetings. One of the major problems for the hospitals was the shortage of places in residential homes and the fact that their structural conditions made them unsuitable for many hospital patients and other prospective residents who could be classified as 'frail ambulant'. Residents were now much more frail on admission than they used to be. The homes were poorly staffed and few matrons had any psychiatric nursing experience. Dr D'Netto said that it was hoped that some of these problems would be remedied when the planned new homes came into use but that meanwhile much could be done to improve conditions by an immediate increase in staffing and the provision of training courses in hospitals to improve staff attitudes, understanding and perseverance. Psychogeriatric residents were probably better on their own in a suitably equipped and staffed home. Research in Scotland had indicated a need for about 5 places, per 1,000 of the elderly population, in psychogeriatric homes. Finally, Dr D'Netto expressed appreciation of the work of the SSD liaison officer who always acted promptly to channel and solve problems and who had reduced the need for several case conferences. A geriatric health visitor who acted as liaison with the health department had acted in a similar way and both had saved patients from long delays in obtaining a solution to their problems and had spared their colleagues' time. She hoped that neither type of liaison officer would be lost in the future.

A psychiatrist's view

Dr J S Bearcroft, consultant psychiatrist, Kingston and Long Grove Hospitals agreed with previous speakers on the need to assess an elderly patient's whole situation to avoid wrong placement, the stigma of unnecessary mental hospital admission, and the lack of visiting from relatives. There was very rarely a need for emergency admission and this was when misplacements were most likely to arise. The initial assessment should be done in the community and the consultant's role was often to prevent admissions in the patient's own interest; either because they had no real need for psychiatric nursing or because the necessary drugs and medical advice were available outside the hospital. The best use had to be made of the slender psychiatric nursing resources and many of the old people in psychiatric hospitals did not need specifically psychiatric nursing care. This was providing care "on the cheap". Psychiatric hospital beds were cheap as hospital beds went and a large psychiatric ward could not compare with a patient's own home in terms of human dignity etc. The chronic sick always came off second best in terms of buildings, resources etc and this could only be balanced by the intervention of an independent organisation such as the Hospital Advisory Service.

The process of assessment began with the general practitioner whose responsibility it was to exclude physical illness and then might involve the health visitor, the social worker and possibly the consultant psychiatrist to examine the patient's other problems.

They would begin with a number of visits to see how the old person coped with life. Following the assessment, there were a number of alternatives for the patient who remained in her own home. The day hospital provided treatment opportunities and the day centre could offer care and stimulation. The former allowed full medical assessment to continue without the patient losing her home and meant that the best use could be made of scarce in-patient and residential home beds. He hoped to see an increase in flexibility and joint usage between day centres, day hospitals and residential homes to further improve this situation. There might also be one or two beds in conjunction with the day hospital for short-term crises relief for relatives and patients living alone. Psychogeriatric assessment units, Dr Bearcroft thought, were chiefly important to get people working together and where a good relationship already existed their role was less important.

Dr Bearcroft went on to speak of the groups of elderly psychiatric patients who had grown old in hospital, which had been described in the recent DHSS circular. This group was likely to get smaller with time. Those patients with an acute mental illness could be treated as they would be in any age group, and better assessment and treatment in old age should reduce the stay of especially those suffering from depression. Those with mild dementia were often a problem. They might be agressive and too much for their relatives too handle but yet not bed enough to need to go into hospital. Those with severe dementia without physical disability might be contained within the community hospitals where there should be at least a nucleus of suitable trained staff. Finally, Dr Bearcroft said, it seemed to him that it was always the same group of people who cared for the elderly whatever the organisational structure. It was a field of work which did not carry adequate status in terms of the energy and skills involved and there was, therefore, a great need for cooperation between all the variety of professional staff and to involve the community itself and voluntary resources.

A psychiatric day hospital

The work of the psychiatric day hospital at Long Grove Hospital was described by Mrs R McNulty, nursing officer at the hospital. She said that the unit had a total of 10 male and 18 female in-patient beds and an average attendance of about 200 patients per quarter. They were sometimes referred by general practitioners, although there was some ignorance of the existance of the facility which resulted in some patients coming in in crisis situations. The unit had an open door policy and patients' relatives were very welcome at all times. This helped the unit to build a relationship with the community. Mrs McNulty went on to describe the staffing arrangements and said that the in-patients beds were most useful to allow them to make a round the clock assessment of a patients prior to a case conference. The average length of stay was 8-10 weeks, with the day patients staying slightly longer. They had a varied programme of activities including gardening, industrial therapy, musical sesions, knitting, walks in the grounds etc. A relatives' group was held in the evening to give them an opportunity to exchange ideas on problems at home, and to possibly arrange to help each other with sitting in etc. The unit took patients to give relatives a holiday break and prior contact gave everyone confidence that the patient was not being thrown into an alien environment.

Full use was made of all the hospital services including the chaplaincy. It was found that the patients mixed more happily in a group of their own age and that they were able to share experiences such as their grandchildren which reduced loneliness and as a result the depression which was often the original reason for admission. The social worker was a very important member of the team and one of her primary jobs was to keep a place open for the patient to go home.

She might put the patient in touch with an organisation such as a Darby and Joan club or a gentlewoman's association to maintain their interest after discharge. Nursing personnel visited the patient within a week of discharge to check that the necessary services were being provided and to give injections where drugs had been prescribed. These visits were then tapered off and taken over by the general practitioner and district nurse. The aim at all times was to prevent the need for further admissions but if deterioration did take place patients could be taken into the long-stay wards for prolonged nursing care.

The role of the voluntary organisations

Mrs Hobkirk, chairman of the Kingston Old People's Liaison committee told the conference about the wealth of voluntary resources which were channelled through the committee and drew attention to the fact that very little provision for old people had existed in 1946 when the old people's welfare committees were set up. The Kingston committee had been established in its present form when the Royal Borough was created in 1965 and received an annual grant of £9,000 from the council. A considerable amount of the work was concerned with the effort to keep the health ambulant old people busy and active so as to delay or avoid the need for them to occupy a psychogeriatric bed. Social clubs, holidays, cheap meals etc might seem trivial, but they were the first bulwark against a retired person's premature withdrawal from life. The weekly clubs were run and financed by the old people themselves and attendance meant that they were no longer on their own and that there was an opportunity to keep an eye on them.

On the subject of sheltered housing, Mrs Hobkirk said that if only this was available to all old people at the moment when they asked for it, then many of the problems of old age would disappear. There was a waiting list for the accommodation that was available, but old people could not wait; they deteriorated too fast. She had been connected with a number of schemes in the area and the health record of the residents had been exceptional. They did not have to move on to Part III accommodation and flourished until near the end of life. Two residents who had become senile had caused more problems than all the others put together because this condition worried the house mother, other residents etc. They probably should live somewhere where there was special staff or psychiatric nurses available to contain them. There were old people who were 'unclubbable' and too little attention was paid to them. Mrs Hobkirk suggested that imaginative thought should be put to seeing what would be acceptable to those people who wanted to keep themselves to themselves. It was difficult to observe their needs but a crisis hospital admission often served to break down these barriers. The old person might then lose the habit of being alone and accept a move to sheltered housing, or join a club but good medical support was vital if old people who had recovered sufficiently to be discharged from psychiatric units were to be successfully contained in the community.

The provision of home helps was a very important service but there were not nearly enough. The meals on wheels was still partly voluntary and available only five days per week. Here again there was a priority to do more. Some old people ate more readily if they were able to go out to clubs; transport had to be arranged in minibuses and private cars, and it was possible to find volunteers who were willing to do this when they did not feel able to take on other work. Volunteer visitors went to see old people on a friendly basis and it was soon difficult to say who was getting most from the relationship, the old person or the visitor. It was, however, not found easy to get volunteer night sitters to sit with the senile while relatives went out. Voluntary bodies could not make a contribution in all areas and this included home visiting of the senile, in the absence of response by the person visited.

Few senile old people could in fact be maintained happily at home. The demands they made could lead to the breakup of families, and arrangements to get the old person out to a day centre might only serve to increase their confusion. Mrs Hobkirk thought that the need was for more sheltered accommodation in small groups with psychiatric trained staff who could give controlled care near enough to the old person's home for the relatives to visit. It had to be remembered that the relatives might be in their sixties themselves and not up to long journeys to distant psychiatric hospitals. The location of homes in centres of population meant voluntary bodies could also be involved in group visiting both to relieve the boredom of the residents and possibly to help the nurses who were being asked to bear a burden which the rest of us found intolerable.

Discussion and summing up

The discussion opened with a request from a community nursing officer that the conference should get down to the real problem of the here and now. What was she supposed to do for four old ladies of 90+ who lived on their own and were alone all day? Geriatric health visitors were scared to go and look for problems such as these because there was a lack of resources to meet the needs which were being uncovered. Mr Terry was unable to offer much comfort. He agreed that social service departments were not yet able to cope with all the demands which were being made on them. There had to be priorities and some people could not have the services they needed. Dr Rowland said that general practitioners were often blamed for not knowing about the needs of all their elderly patients and the results of Mr Terry's survey should be most enlightening for them. A participant suggested that, at the present time, more use should be made of 'good neighbour' schemes in liaison with an old person's general practitioner or geriatric health visitor, or of the volunteer bureaux run by councils of social service and under the medical cover of a general practitioner of a member of the medical officer of health's staff. A council of social service spokesman said that volunteer bureaux needed a paid organiser as they could then realise community resources for a comparatively small outlay, and that they needed to be able to pay the expenses of volunteers, eg petrol costs for those providing transport. A DHSS spokesman said that it would be part of the function of the health care planning team to assess such problems as the needs of the old ladies mentioned by the questioner and to look for solutions on an overall basis.

A nursing officer referred again to Mr Terry's survey of the handicapped and disabled in Kingston and was told that it was designed to show up the size of the problem and not to identify individuals. There was a lot of information on need which was not yet available to the social service departments. A recent meeting with the Gas Board to discuss their planned industrial action had revealed the board as a valuable source of information on old people. A participant pointed out that the executive council or old age pension lists were likely to be virtually complete and that these might be used, but that is the departments of social service were to compile their own information it sounded more acceptable to call it a 'list' rather than a register.

A participant suggested that the problems created by old age should be tackled by trying to reverse the march of social evolution so as to get back to the extended family situation and that housing units should be made more flexible to meet changing family needs. Another speaker thought that housing alone could not change an attitude of mind but there was agreement that where the extended family did exist and supported its old people, it was foolish to destroy it in the cause of housing redevelopment as was being done in some of our inner cities.

Summing up at the end of the day, Mr Payne said that a number of problems seemed to have come through from all the points made during the day.

These were, firstly, the organisation of cooperation, coordination and joint planning between all the authorities and bodies involved. Secondly, the loose way in which the term psychogeriatric was used indicating a need for assessment, and for clear guidance as to what was the responsibility of the geriatrician and what the responsibility of the psychiatrist. This had not come through so far. Thirdly, it was clear that hospital admission could cause more problems than it solved through the devlopment of other conditions, the increase in confusion, loss of contact with family and community etc. Mr Payne went on to identify a number of priorities which he felt had emerged. These were: closer cooperation between hospital, local authority and general practitioner services and, after 1974, between health and social services and value of liaison committees, the provision of more housing and especially of sheltered housing for old people; the large and continuing role for general practitioners in the care of the elderly including early assessment and referral and, fourthly, the need for research in all areas and especially into education for retirement to try and prevent many of today's problems from developing in the future.

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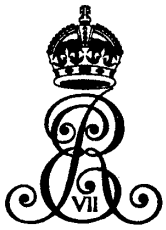

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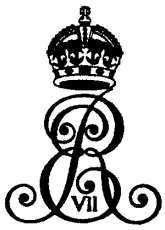

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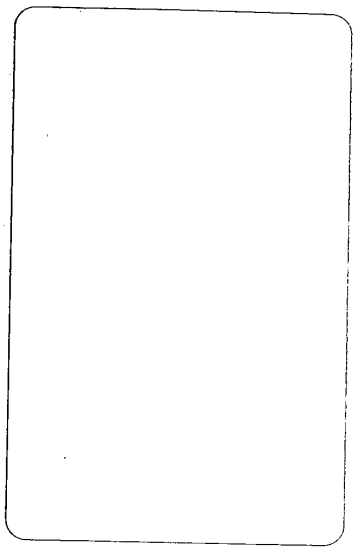


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