"Those who do not learn from history are doomed to repeat it."
George Santayana (1863–1952)

This extraordinary newsletter commemorates 21 years of old age psychiatry since it was accorded specialty status by the Department of Health in 1989. The idea for this celebration evolved from a determination that such a landmark should be remembered, rather than from an ambition to declaim great historical or philosophical teachings. Nevertheless, learning from the past may help inform debates about future directions, especially at a time of major changes within our health services. We believe that what follows includes reflections and ideas that will enthuse and enrich the readership.

We initially approached people known to us personally to contribute 'Janus' articles – looking forwards and backwards – from their own specific perspectives. We had intended to open the invitation wider, but time constraints and the overwhelming enthusiasm of those we approached directly meant that that was not possible for a single newsletter. Indeed, we are aware of the gaps in our current edition – in particular from primary care and National Health Service senior management. We are also most grateful to our colleagues in the localities where we both work for their enthusiasm in sharing their ideas, although this does give a marginal bias of contributors from Manchester and north-west London.

On the important issue of style, this newsletter was planned to be informal, and we have deliberately not referenced every quoted text, especially where they are easily accessible on the internet (e.g. National Service Frameworks).

Setting the past 21 years in context, we must not forget that the roots of our specialty pre-date the 1989 recognition by well over 40 years, and some people have alluded to these earlier periods in their writings. It is not just the wisdom of the most experienced that we have included, but also the visions of younger people involved with the specialty. We need to pay heed to them as much as to our experienced colleagues. Their suggestions and wishes for the future at times call unsuspecting for the re-establishment of aspects of our services which have been demolished during these 21 years under the rubric of 'cost improvements' and other managerial jargon.

If you would like to respond to any of the issues raised, letters of up to 200 words would be welcome; the newsletter editor, Jonathan Hillam, will consider publishing them in a future edition.

Please enjoy this newsletter, and stretch your knowledge and imagination, perhaps with your team members, family or friends, with the party games!

Claire Hilton (claire.hilton@nhs.net)
Dave Jolley (david.jolley@manchester.ac.uk)
Guest Editors
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I became a consultant old age psychiatrist in Liverpool in 1989, just as old age psychiatry became a National Health Service (NHS) specialty. Catchment population 28000, one community nurse, one senior house officer (Carmello Aquilina, creator of the Newsletter), long-stay beds in a fire-condemned wooden building in the grounds of a decaying mental hospital 20 miles away, some decent acute beds, a 20-place day hospital in the basement room of a gastroenterology unit, with one toilet and me – and I loved it. So much to change. All I could see was potential and I was part of the most complete biopsychosocial specialty in medicine.

The private care sector had exploded – long-stay beds were closing, a few asylums were still going, NHS management just introduced, battling for resources with general psychiatry and managers, imaginative new ways to deliver services and some serious academics appearing. Although essentially a service specialty grown from necessity, it was beginning to develop an evidence base. The next 10 years was a period of significant service expansion and better research with general psychiatry and managers, imaginative new ways to deliver services and some serious academics appearing. Although essentially a service specialty grown from necessity, it was beginning to develop an evidence base. The next 10 years was a period of significant service expansion and better research with general psychiatry and managers, imaginative new ways to deliver services and some serious academics appearing.

Rose-tinted bespectacled people who tell me it was better 21 years ago are infuriating. Yes, we have lost some things that were worth retaining for longer but is treatment for patients better now? Of course it is. Is training better now? Of course it is. Is knowledge greater now? Of course it is. Are there better resources now? Of course there are.

But is it more bureaucratic, more risk averse and more administratively tedious now? Unfortunately, yes it is, but change is never all good or all bad but a mixture of both and if more of the former then it’s progress while the bad bits trigger the process of change to continue.

In the past 10 years the political profiles of the specialty and older people’s mental health have developed rapidly. We now have universal acceptance that there is discrimination and neglect of older people and of the seriousness of the ageing population. Age-inclusive policies, the National Dementia Strategy and equality legislation represent huge steps forward and mean older people have a greater chance of a fairer future. Old age psychiatry has been a key partner in these developments and I think that the specialty’s own policy response to the changing position is an important statement that was overdue.¹

Will these things stay high on the political agenda? I think so.

Aneurin Bevan said that priority is the language of politics. The ageing priority is pretty clear. The Centre for Workforce Intelligence advises the government; for psychiatry, until 2018, it identifies the greatest percentage increase needed in training posts and consultant numbers to be in old age, more than double any other psychiatric specialty.²

The future

Will it be in another 21 years? I have no idea because unforeseen things happen and it need not concern us. Will it be different? I would be surprised and disappointed if it isn’t. Will it be better? Probably. Will treatments be better? Pretty likely. Will healthcare be fairer to older people? Probably.

How will that healthcare be delivered? I don’t know, but it will, and more of the people queuing up outside the door of the surgery, clinic, hospital and Social Services will be older people and, unless we find more effective ways of preserving and improving their health, then health and Social Services will be unsustainable as we know them today. We can be sure that we will need leaders, innovators and research that provide us with a better understanding of the conditions we treat and with better treatments. That would change everything and I hope I’m around to see it.

Mainly from the Clinical Old Age Perspective

21 years as a consultant in old age psychiatry

Dave Anderson
Consultant Old Age Psychiatrist, Mossley Hill Hospital, Liverpool
I think that what people and services are whatever you need them to be. The needs of the next 21 years will be different and so people and services will need to be different. But that is how old age psychiatry was born, responding to need and in different ways. It must remain a specialty that is defined by the needs of its patient population: train people to acquire the competencies to meet that need, understand the agenda and drivers, seize opportunities and prepare to adapt to change because change is as inevitable as the passage of time.

Old age psychiatry should be pleased with its progress after 21 years. If I was starting as a consultant now, I would be as excited as I was 21 years ago. What great opportunities there are to do things better – just what I thought 21 years ago.

Happy birthday old age psychiatry!

In 1989 I was a consultant old age psychiatrist in central Manchester, based at Manchester Royal Infirmary, and I remember the feeling of elation when we achieved specialty status. I had been appointed consultant in 1984 after training in the North West, including a stint with Dave Jolley (having had to choose between psychotherapy and old age psychiatry). There was an issue then about what we called our specialty and the usual disagreements with general psychiatrists about whether their crazy ideas should influence our practice – curious how everything changes but somehow things stay the same. My employers generously supported my training in family therapy at the Family Institute in Cardiff and I discovered that I enjoyed service-based research, writing and teaching.

**A change of job**

I soldiered on in central Manchester until 2001, surviving a series of reorganisations. Discovering an unlikely passion for windsurfing helped me: I’m not very sporty so I can’t think of anything else when I’m on the water and the first time I fell in I knew I was hooked. However, eventually I decided I needed to bang my head on a different wall for a change and moved to a consultant post in Wolverhampton alongside Dave Jolley. This brought new opportunities (including Chasewater and canal boating). I cashed in an insurance policy, bought a narrow-boat and moored it near Wolverhampton. When an appointment with the National Institute for Mental Health in England as National Fellow in Mental Health and Ageing was advertised, I applied and was successful. It felt, at the time, as though the role might allow me to work with others to develop older people’s mental health services nationally, and we did our best. It also brought me into contact with colleagues now based at the Centre for Ageing and Mental Health at Staffordshire University. This group has grown and my colleagues continue to offer mutual stimulation, creativity, comradeship and support. I surprised myself in 2009 by taking advantage of my mental health officer status and redesigning my life. I took ‘early retirement’ from my National Health Service consultant post, set up Older Mind Matters (www.oldermindmatters.com) and have been developing...
a portfolio of work involving a combination of education, training and research, while writing a PhD thesis on service user and carer participation in old age psychiatry. If ‘retirement’ taught me anything, it taught me that what matters are the patients and we lose our focus on them at our peril.

**Old age psychiatry and the current NHS**

One of the current difficulties for old age psychiatrists and our colleagues from other professions working with us is to look after ourselves and each other. I fear the NHS is becoming a toxic environment. In the past, one could take an idea to a manager and work with them and other colleagues to develop a service improvement. By the time I left the NHS the managers no longer appeared to care about the views and experiences of the highly skilled professionals working in the service and bombarded us with a series of major changes resulting from their biases and political fashions rather than any attempt at evidence. I could no longer look the service users and their families in the face and justify the changes that were being imposed or tell them that they would get a service that I feared would not be delivered. When Dave Jolley and I worked on stress and burnout in old age psychiatry I wrote about what constitutes a balanced job in an article that, I think, remains as relevant now as when it was written.¹

> We still need old age psychiatry. In fact, I think we need it more than ever. When services are under threat, when money is tight, whatever the politicians might say about equality and age discrimination, older people come way down the agenda whether they have dementia, depression or a combination of chronic physical health problems. It may feel as though we are sailing into the wind but we need old age psychiatrists to continue to speak up for those who use our services and to stand by them when they speak up for themselves. As professionals we need to be proud that we are medical practitioners and that we apply our expertise in medical, psychiatric, psychological and social treatments in the interests of our patients and their families.

**Reference**

¹ Benbow SM. Jam on the outside. Association of Clinical Pathologists 2003; Summer: 35–6.

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**Two fascinating decades**

**Tom Dening**

*Consultant Old Age Psychiatrist and Medical Director, Cambridgeshire and Peterborough NHS Foundation Trust*

I’ve been a consultant in old age psychiatry in Cambridge since 1991. The most obvious change is that a whole generation of patients has moved on. When I took up my post, there were still some people alive who had been born in the 19th century. First World War veterans were not uncommon. Many rural patients had grown up in primitive conditions, with no sanitation, hardly leaving the parish they were born in. Nowadays, men and women who served in the Second World War are becoming scarcer. Relentlessly, the dates of birth of my patients have converged on my own – indeed, some with young-onset dementia are now younger. When I started, several people thought I looked too young to be an old age psychiatrist (they expected someone more august!). Sadly, this hasn’t happened for several years now. The average age of patients referred to our service has increased and is now probably well over 80. Referrals of patients aged over 90 were unusual in 1991, not so now. We still don’t get asked to see many centenarians but in 20 years’ time, this will have changed too. The children of our patients are often retired and their grandchildren are often well into adulthood themselves.

The biggest changes in the services we provide are that we have far fewer beds, in newer and more pleasant accommodation, and that there are far more personnel. When I was a registrar in 1985, there was one consultant and two community psychiatric nurses. There were nine...
grim wards, all in the old 19th-century hospital. Even when I started as a consultant, I had half a colleague to cover 50,000 people over the age of 65. We have closed long-stay wards and invested money in community mental health teams, consultants and other skilled staff. There are now 6 of us in Cambridge and 12 in the trust covering the whole county, yet we all seem to be busy! We will appoint a professor shortly, something my predecessor dreamed of.

At the Department of Health
Between 1999 and 2002 I had the privilege of being a professional advisor at the Department of Health. This was exciting as it was the period of developing the National Service Framework (NSF) for Older People. There has been disappointment that older people's mental health was separated from the rest of mental health, since the NSF for Mental Health appeared earlier and carried resources which the NSF for Older People did not. The latter therefore contained a lot of good sense but did not oblige commissioners to do much. Investments in services for those under 65 years were not matched for older people. On the other hand, old age psychiatry seems to have missed most of the mayhem that followed New Ways of Working.

I also worked on other issues, such as the revision of the Mental Health Act 1983 and the drafting of the Mental Capacity Act 2005. Personally, I don't think these items of legislation are entirely satisfactory and the interface between the two (e.g. giving electroconvulsive therapy to an informal but incapacitous patient) is difficult for clinicians. After a few years, I reached a point where one either should become a civil servant or else relinquish the role, so I left for the roller coaster ride of being a medical director.

Moving forward
Compared with 20 years ago, some things work better but other aspects are actually less satisfactory. For example, the standard of care in care homes is better and more consistent, with more attention paid to dementia care. We have cholinesterase inhibitors and their modest benefits. Through DeNDRoN (Dementias and Neurodegenerative Diseases Research Network), we have more support for research and drug trials. We assess nearly all our new referrals at home without a waiting list and we have an intermediate care team to offer intensive support at times of crisis. The standard of our service is high and old age psychiatry has the highest level of general practitioner satisfaction among the services offered by our trust.

On the downside, resources are tight. Despite the increasing older population, almost all our developments have required reinvestments of our own money, so we are probably less well resourced now than before. Local Authority cuts will affect social care and seriously deplete day services. In 1991, we already had integrated community teams with Social Services. Over the years these have been separated and then slowly and painfully put back together again but still do not work as well as originally. In dementia, we have concentrated on diagnostic assessment and the management of behaviour problems. Thus we offer less continuity to patients and families than was the case, even though the National Dementia Strategy shows that continuity is highly valued.

The future: a paradox
Although we should be extraordinarily confident about the future of our specialty, we actually feel threatened about its existence. We still are faced with the stupid argument that old age psychiatry is ageist, and there are moves to subsume functional disorders into an all-ages service. My mantra is 'Make yourself indispensable and they can't get rid of you.' In other words, there are irrefutable arguments about the epidemiology of the ageing population. Beyond a certain point, the distinction between functional and organic is pointless. It requires specialist skills to assess whether something is early dementia or not, or whether there is depression that needs treatment as well as cognitive impairment. The people who can make these distinctions and manage older patients without killing them with overtreatment are old age psychiatrists. So even if we may need to redefine our boundaries, there is plenty of work to be done.
It is a real delight to contribute to this special 21st-birthday edition of the Faculty newsletter.

Looking back in nostalgia, I worked in old age psychiatry as a trainee in 1972, going on to serve as consultant from 1975 until retirement in 2002. Having taken to psychiatry, not out of choice but out of necessity, I can look back and say it has been a most exciting, exhilarating and challenging career, especially my work with the elderly mentally ill. If I had to make a career choice again I would choose psychiatry and especially old age psychiatry.

There were uncertainties when I first walked onto the old age psychiatry unit run by the late Pearl Goddard in the early 1970s as to what it had to offer me. Within 24h I realised this was my future. The fulfilment and satisfaction a lifetime’s service in old age psychiatry has given me is unimaginable and immeasurable.

The 1970s and 1980s

In those early years, innovation in care, running educational and training programmes, working collaboratively with voluntary organisations locally, regionally and nationally was the norm. At Portsmouth, the development of the UK’s first travelling day hospital for the elderly mentally ill and the Wessex regional day-release course in old age psychiatry, which I ran single-handedly for 5 years, were improvements that I can look back on with pride. Having established a nationally recognised service in Portsmouth I moved to Winchester to set up a community-based, innovative service in collaboration with Social Services and voluntary organisations, starting from nothing.

Challenges of long-term care since the 1990s

Working as a consultant in Winchester from 1994 was a demanding and challenging task. It was also a time when I had to stand up to management and be my patients’ advocate. This stand, to protect my patients with end-stage dementia and close to death being discharged into community resources, which had no experience in caring for this patient group, led to several inquiries. Most importantly there was the Ombudsman inquiry and Parliamentary Select Committee scrutinising the decisions made by managers.1

The Parliamentary Select Committee roundedly condemned the action of managers who acted against my advice leading to the highest mortality of any group of discharged elderly patients in the UK. A third died within 2 months of discharge and the deaths were painful and distressing. Following this, clear guidelines were issued by the Department of Health that each trust should have clear continuing care criteria and should provide some long-stay provision.

Looking back over four decades of clinical practice, old age psychiatry has progressed and in every district specialist services are meeting the needs of the elderly mentally ill. Research is marching ahead, increasing our knowledge of and widening treatments for those with dementia. However, we still have a long way to go in providing humane, sensitive and appropriate long-term care for those who can no longer live on their own due to advanced age and end-stage dementia.

We are the fourth richest country in the world. Providing good homely care for this most vulnerable group of our society is a hallmark of a civilised society. I very much hope that this will be achieved in this decade.

Reference
1 Select Committee on Public Administration. Second Special Report. North and Mid Hampshire Health Authority, Loddon Community NHS Trust – Hospital Discharge Policy. HSMO, 1997 (http://www.publications.parliament.uk/pa/cm199798/cmselect/cmphubadm/396s2/pas205.htm).
The year 1989 was an eventful year. The Berlin wall came down, the Tiananmen Square massacre took place, Margaret Thatcher celebrated 10 years as Prime Minister, and old age psychiatry was finally recognised as a specialty in its own right by the Department of Health.

Recognition and equality of our specialty

Recognition meant that official data would finally be collected on older mentally ill people to enable planning and resourcing of services, and that training programmes for the specialty would be formally established. Before then, despite many specialist old age teams emerging, data were inadequate and individual training placements often needed to be fought for. The Section for the Psychiatry of Old Age, the forerunner of the Faculty, conducted surveys and collected data itself, often under the watchful eye of John Wattis.

The period of gestation had been long, since the 1940s. Amidst debates about whether old age psychiatry was part of general psychiatry or a specialty in its own right, its birth was not straightforward. The midwife was just as much a part of the Royal College of Physicians as the Royal College of Psychiatrists. A specialist service for older people was often opposed by general psychiatrists; such specialist services would risk removing resources from their departments, and since old people required more domiciliary assessments, if that responsibility was handed to psychiatrists specialising in old people, they would lose out on payments for those visits. Our closest colleagues were not always our supporters.

The position of old age psychiatry as a distinct discipline or not echoes today, as we are told to abolish age cut-offs for referrals to our services, as that would be discriminatory. Age cut-offs for child and adolescent mental health are not regarded as discriminatory. Driving, marriage, voting, retiring, watching films, bus passes and railcards (even for students) and other aspects of society are all similarly regulated. Equality must promote the interests of different groups, not destroy previously positive achievements. An entirely needs and ability base for every permissible role would be virtually unworkable, even if ideal.

My 13-year-old son would like an exam for those under 18 years of age who want to vote; if they know enough they should have the vote too. It is a sensible idea, avoiding age discrimination, but it would probably prove unworkable.

Clinical responsibilities and discrimination

We have made progress during the past 21 years. There are new drugs, especially for Alzheimer’s disease, access to various brain scans, more people in the multidisciplinary team, and some extremely patchy input into psychological interventions, liaison psychiatry and intermediate care. Every locality now has some sort of old age mental health service. Some are gold star, well-resourced services and a paragon of good practice. Others are not.

An age cut-off for referrals to old age mental health services is appropriate as organic conditions become more frequent, mood-related symptoms co-exist and confound, and age-related medical, social and physiological factors overlap. Psychiatrists working with younger people often have neither the desire nor experience to make these clinical formulations. ‘Dual diagnosis’ has come to mean substance misuse and functional disorders mainly affecting younger people for whom services such as assertive...
outreach are resourced.7 Our old age versions of dual diagnosis, organic plus functional or dementia plus delirium, are not recognised, but are also complex, costly and life threatening when detection and treatment are inadequate. The widely implemented multidisciplinary New Ways of Working approach to assessment does not do justice to those with complex diagnostic conundrums.

Treatment, however, may need a different age paradigm. Some people well over 65 need services generally restricted to younger people, and some younger people may be better served by services for older people. The treatment part of our services should be needs- rather than age-based.

For younger people, there has been a burgeoning of specialist services such as assertive outreach, intensive care, crisis response, and greater access to psychological therapies, all of which could benefit some older people. Abandoning age cut-offs for older people is in part related to concerns about access to these developments. But why not let old people access them if clinical needs demand? We are at risk of returning to the days when old people were not offered parity of care with younger people precisely because they had the same ‘all-age’ consultants; pessimistic attitudes to old people and misunderstanding of their needs were, and remain, commonplace. For example, a National Health Service mental health newsletter (August 2010) cautioned using antipsychotics ‘where patients also have physical health conditions, e.g. cardiovascular disease, renal impairment, epilepsy, old age and diabetes’. Old age may be a risk factor for illness, but it is no more a ‘physical health condition’ than childhood. I was informed that the inclusion of old age had been a mistake, but such spontaneously arising slips underlie common beliefs and stereotypes.

In the past, old age psychiatrists developed services and evaluated them. Today we do not have free rein to do this. Large provider trusts, the commissioner–provider divide, plus the dominance of managers, all tend to favour their model of what should be done, often lip service being paid to the experience of clinicians. If summed up, the total old age psychiatric experience of consultants in our trust would be in the region of 200 years. Managers cannot match that.

**Future old age mental health equality**

Equality legislation may help change negative attitudes towards older people. However, ‘prohibition on age discrimination in services and public functions’ is one area of the Equality Act which the government remains undecided about how best to implement. There is a risk of inappropriate implementation of the Act by sticking to the letter of the law rather than interpreting its message to avoid disadvantaging older people.8

On our 21st birthday we celebrate our past and look forward to our future. Unfortunately we continue in our predecessors’ footsteps using ‘occasional militancy… to gain for the elderly a fair share of scant resources, to put them to best use, to make do with too little while wheeling, dealing, and fighting for more’.

Although much has been achieved and we continue to work to the best of our ability, sadly we still have to justify our existence and fight for resources probably more than other specialties, recession or not. Underestimating the value of old age services is a past, current and probably future theme. Perhaps ageing baby boomers and equality legislation can improve services for mentally ill older people, but I suspect that such change will have to come from us persisting with our long-learned skills.

**References**

1 Pitt B. Audio-recorded interview, 2006.
Memories from Goodmayes

Hilary Kinsler  
Consultant Old Age Psychiatrist, Goodmayes Hospital, Essex

Goodmayes has often been a place of innovation, but many of these have been somewhat quiet. Everyone seems to know about Tom Arie and the early days and I am often asked if I am one of his ‘Goodmayes’ girls.

Some people still in the service remember Rae Smith, whom everyone adored. She set up an integrated, multidisciplinary community mental health team in the 1980s. This was well before anyone had thought of New Ways of Working or even integrated mental health teams. She also set up Grovelands Day Hospital, when day hospitals were heralded as a way of reducing in-patient admissions.

Yong Lock Ong was a pioneer in transcultural psychiatry and found Redbridge to be fertile territory for research. His new book promises to be fascinating, as was his gentleman’s club; many of us were lucky enough to be invited to his rather grand club in central London, which had areas that were for men only.

Mark Jones introduced a memory clinic in 1999. He managed to get permission from the health authority to treat 50 patients with brand new anti-dementia drugs. It is a good job that that health authority is no longer around to count how many patients we have now. The community mental health team and the memory service are still thriving. Other innovations have been more brief such as an in-reach service to Black and minority ethnic community groups many years ago, and more recently a home treatment team, both lost in various rounds of cuts.

Personally, I may be up for some sort of long service record. I first worked at Grovelands as a senior house officer in 1991 and when pouring a glass of water (whiskey may be more appropriate!) after a long memory clinic I noticed a plaque saying that Grovelands was opened in 1991 by Professor Elaine Murphy. I remember that day, in part because the pizzas I had agreed to make were so soggy they dripped tomato sauce over everyone’s smart clothes. I am so much better at making pizza now. I returned as a locum staff grade about 3 years later, and made it clear to Zenub Kahn, who was holding the fort as usual acting up as locum consultant, that I would very much like her job. She was always quite clear it wasn’t available. I then returned after senior registrar training in 1999, job-sharing with Mark Jones. It was fairly innovative to job-share in those days.

Consultant numbers have since expanded. A new, whole-time post was created (Professor Martin Orrell’s business plans often did the trick) and Steve O’Connor was appointed, only to be rapidly promoted to an assistant medical director in Havering when his potential was spotted. I still have another 10 years to go before retiring. Not that I am counting of course! It would be rather unusual to retire while still working at Goodmayes.

We still have areas of innovation which promise much for the future. The Redbridge Dementia Partnership, a collaboration of health services, Social Services and voluntary organisations is blossoming. We have a small, lottery-funded palliative care project and we have two young bright new ‘Goodmayes’ girls, Kate Maxmin and Viv Gould, to bring some new innovations.

Reference

Goodmayes: home of old age psychiatry

Kate Maxmin
Consultant Old Age Psychiatrist, Goodmayes Hospital, Essex

In my career as an old age psychiatrist, Goodmayes Hospital has often been quoted as ‘the home of old age psychiatry’, so now to be a consultant here with all the history that goes before and hopefully after I have joined feels quite special.

**Goodmayes’ girls**

Tom Arie, Goodmayes and old age psychiatry in general have also been pioneers and keen supporters of women doctors and flexible working. Our predecessors at Goodmayes include Nori Graham (who Viv Gould and I were fortunate enough to work with as senior house officers (SHOs) at the Royal Free) and Baroness Elaine Murphy. Currently, our department consists of three substantive part-time consultants: Hilary Kinsler, who first worked here as an SHO in 1991 and returned as a consultant in 1999, and me and my job-share colleague Viv Gould, who started in September 2009. We would apparently have been affectionately known as ‘Goodmayes’ girls’ in those early days.

**Learning from our predecessors**

We owe a great deal to the enthusiasm and determination of those who have gone before us as we do our best to keep alive the values and uniqueness of old age psychiatry in Goodmayes as we undergo service reorganisation over the next few months.

Old age psychiatry developed here with Tom Arie as the clinical leader. He described how the ageing population and the development of geriatrics as a specialty highlighted that older people deserve and warrant specialist care. Tom Arie’s psychiatric service for the elderly began at Goodmayes in 1969. I find it fascinating to read about his team’s strong views on the importance of domiciliary visits, joint working across services and the need to see old age psychiatry covering the spectrum of psychiatric presentations in the older person, functional and organic, acute and chronic. How relevant these issues are today; the split within our speciality between in-patient and community, and the worries about potentially losing our functional patients to our general adult colleagues and becoming a ‘dementia only’ service permeate all our meetings about service development.

The focus on maintaining morale within the team is also pertinent when thinking about old age psychiatry services today. It was recognised in the early days that inspiring medical students to enter psychiatry in general and, more specifically the old age specialty, was the key to maintaining quality within the service. It is again high on the agenda of consultants in 2011.

Last week our community mental health team manager was recounting how she had been clearing out piles of dusty files from a retired colleague’s office. She was astounded to see volumes of abandoned paperwork concerned with service reorganisation, epidemiology of the borough and the effort put into past attempts to change the service to meet the evolving needs of the population. We had little idea about what had gone before. It is a shame that we do not automatically have this wisdom to hand as new consultants today, with the added pressures of this harsh economic climate. Remembering how the unit started here and the aims of the service 40 years ago is a very good place to start and keep in mind.

**References**

Relinquishing youth and encouraging maturity

Colm Owens

Consultant Old Age Psychiatrist, Central and North West London NHS Foundation Trust

As a recently appointed consultant, I suppose it is inevitable that it seems to me to be a particularly daunting and exciting time in old age psychiatry. Notwithstanding this, there do seem to be a number of challenges in our specialty at the moment. We face something of a perfect storm of financial stringency, service redesign and significant sociodemographic change. However, these challenges do provide us with an opportunity to think carefully about why our specialty should exist and whom it should serve.

I have been fortunate enough to have completed most of my training during an era of continuous growth in healthcare spending. Now this has come to an end, we will inevitably face difficult choices regarding the allocation of resources. Despite assurances about ‘ring fenced’ budgets, additional pressures will arise as our partners in social care face very real cuts in their financing.

Our specialty was established by colleagues who had a vision of improving the quality of life for a particularly ignored group in our society. In certain quarters, it now appears to be having its raison d’être questioned. In numerous National Health Service trusts, reorganisations are taking place which will split off ‘organic’ or dementia services and place the care of cognitively intact older patients in the same services as younger adults with potentially very different needs. The thought processes leading to such changes are not necessarily malevolent but often stem from a lack of understanding of the needs of the older population. A case was made over 21 years ago for equality being better served by acknowledging differences rather than imagining that the expertise needed to deal with pathology in patients of 20 and 80 was the same. The counter argument to this is that services should be needs-based rather than age-based. I would agree. There is, however, a real danger that this kind of assessment could pay too much heed to cognition and ignore other differences and vulnerabilities. It is difficult to imagine a septuagenerian with depression being prioritised in a service more used to dealing with younger people with impulsive and more (noticeably) harmful behaviour.

Reality check

Over the last two decades, the most marked demographic change has been the steady ageing of the population. We have yet to truly acknowledge this as a society. The cult of youth is becoming ever more visible as our society ages. A significant proportion of us will face a period of relative frailty for a number of years before the end of our lives, during which time mental and physical illness will be likely. This may be seen as a pessimistic portrayal but I think that it is a realistic one.

Such a stark view may elicit a number of reactions. We may be tempted to bury our head in the sand and imagine that it may never happen to us – the forlorn hope that we will be in the peak of health one day and suddenly dead the next. However, advances in modern medicine are making that increasingly unlikely. There is no panacea or cure for ageing, no matter what advertisements for cosmetic surgery tell us. Until we face up to this, it will remain commonplace to ignore and disdain the elderly and to project our fears of ageing onto them.

Such willful ignorance results in the woefully inadequate standard of home care and residential homes in this country. We know that over two-thirds of general hospital in-patients are elderly, and according to the National Confidential Enquiry into Patient Outcome and Death, only a third of those who require surgery receive an acceptable level of post-operative care.

Successful ageing

What we also know from our patients is that many of them can recover in the face of great adversity and lead rewarding lives despite impairment. This is the message that we need to send out; we will almost all get old, we will have greater needs and vulnerabilities, but despite this it is still possible to have a good quality of life. Old age psychiatrists are uniquely placed to get this message across. We have regular contact with older patients, their life stories, their families, their neighbours as well as our colleagues in social work, general practice, old age medicine, emergency departments and a broad sweep of other medical specialties. There is casual discrimination against the elderly despite their increasing numbers and we can do something about this. We need to redefine our specialty and we need to work much more closely with providers of residential care.
care as well as our colleagues in general hospitals. Huge amounts of psychopathology are concentrated in these settings and yet psychiatric input is patchy. This means that these patients are cared for by staff that have very little relevant mental health training.

Mature services
There is a real case to be made for joint elderly care services. It seems increasingly artificial to draw boundaries between physical and mental healthcare in this age group. Many of the older patients in general hospitals will have a diagnosable mental illness. The overwhelming majority of our patients have physical comorbidity. Social workers and care staff deal increasingly with the elderly and the complex issues of capacity and risk assessment that can arise from mental illness and physical frailty. Yet it is more common than not for physicians, psychiatrists and social workers to work in different organisations. This is astonishingly myopic. Truly, there is no health without mental health. This phrase is particularly resonant as we age. Old age psychiatry has an important job to do over the next 21 years but we need to look outside of the traditional areas occupied by mental healthcare.

References

The memory clinic
Michael Philpot
Consultant in Old Age Psychiatry, Mental Health of Older Adults and Dementia Clinical Academic Group, Maudsley Hospital, London

‘While detection of a dementing illness may not be of direct benefit to the sufferer, it may assist patients or their families and carers to come to terms with the diagnosis and plan future management, particularly if counselled sympathetically.’

Apart from hoping that that was the last time I ever used the word ‘dementing’ in any sense, I think the basic sentiments expressed are certainly valid today and are indeed enshrined in the National Dementia Strategy (2009). However, it is easy to forget how unusual those practices were 30 years ago. The drive to make an early diagnosis has gone hand in hand with the growth of the ‘consumer’ culture in healthcare, and perhaps accounts for the memory clinics’ success.

Memory clinics originally appeared in the USA in the 1970s and the idea was exported to the UK in the early 1980s. Clinics were founded by geriatricians in London and Cardiff but the first with an old age psychiatry focus was set up at the Maudsley Hospital in 1984. Raymond Levy had just been appointed professor of old age psychiatry at the Institute of Psychiatry and a few months later, Barbara Sahakian and I were appointed his lecturers. It took a few weeks to organise the clinic routine so that much of the clinical assessment and brain computed tomography scanning were carried out on the same day. We saw our first patient on 15 May 1984, ironically a man with very severe dementia. My role was to clerk the patients, book the investigations, present the case to Professor Levy and write back to the referrer. Barbara conducted the detailed neuropsychological assessments and, in those early days, pioneered the use of problem-solving and memory retraining techniques. The interview with Professor Levy rounded off what was a busy day for the patient and their family, and concluded with him giving his honest view of the likely diagnosis. At follow-up visits, patients were helped to come to terms with this and then usually recruited to one of the trials. After a few months the clinic was joined by a succession of research workers including Nigel Hymas, Eileen Joyce, Alistair Burns, Gemma Jones, Melanie Abas, Sarah Eagger, Osvaldo Almeida and many others. For us juniors the clinic was an ideal and inspiring setting for training,
and frequent visitors from home and abroad helped make its reputation.

Of course, one of the main purposes of the clinic was to involve all the patients in research. Margaret Reith was employed as a nurse to coordinate a series of drug trials (lecithin, 2-methyl-alpha-ergokryptine, and later tacrine) and other studies, and many patients also took part in the studies of computer-based cognitive testing, neuroimaging and neurophysiology. The dedication required in some of this effort might surprise today’s trainees. For example, before the days of cholinesterase inhibitors, acetylcholine precursor-loading with choline and lecithin was attempted. Choline left patients smelling of fish and in the first lecithin trial at the Maudsley the drug was delivered in liquid form, like a greasy milkshake. For the second trial, we sourced lecithin flour which could be transformed into delicious cookies that we had to bake ourselves. The photo above was taken after one such baking session, late one evening in the Institute’s kitchen. Raymond’s white coat is not a lab coat but his chef’s uniform …

When James Lindesay conducted the first national survey of memory clinics in 1993\(^2\) there were 20 such clinics, mostly research-based and in university centres. By the time of his second survey in 2001,\(^3\) the number had grown to over 100 but the focus had shifted away from research to the provision of basic clinical and psychosocial care, as well as to the prescription of drugs for dementia that were by then available on the National Health Service; and the newer clinics were more likely to be run by old age psychiatrists. Now Wikipedia tells us that in 2009 there were 246 memory clinics in the UK! Some have extended into the community in a variety of imaginative ways, some have become highly specialised and some are in the private sector.

At the Maudsley, the Memory Clinic ceased to operate in 1997 but its functions were incorporated into the local community mental health teams with out-patients as an option for follow-up. We should have called this model something sexy and distinctive. However, we have recently implemented a major objective of the National Dementia Strategy and set up a new memory service, serving all adults in two boroughs, and based on the service pioneered by Sube Banerjee and David Matthews in Croydon.

It’s comforting to be almost back to where I started.

References

Reflections

John Wattis
Professor of Old Age Psychiatry, University of Huddersfield

Before I became a consultant, I was lucky enough to be the first lecturer in psychiatry of old age in Tom Arie’s then new Department of Health Care of the Elderly at Nottingham Medical School. We chronicled the early development of old age psychiatry in a series of surveys.\(^1,2\) This work was instrumental in getting recognition for the specialty.

Instead of reciting detailed history, I want to use the space I have been given for a few personal reflections. First, the post-war culture in which old age psychiatry services had their roots was very different from the present culture in which ‘the market’ is regarded as some kind of deity. In the 1960s and 1970s there was a political
consensus about public services and a recognition that health services were better provided on a national basis, with equality of access and treatment. In many areas the asylums were still around and provided free National Health Service (NHS) accommodation for old people with severe dementia and behavioural problems (so-called elderly severely mentally infirm). Geriatric medicine still provided free NHS accommodation for those with severe dementia and immobility. Most of the non-hospital residential care was provided by local authorities in ‘Part 3’ homes (some specialising in the elderly mentally infirm) and nursing homes were generally run privately for the well off. It was all very different! The early ‘psychogeriatricians’ developed community services by closing some (but not all) long-stay beds and using the money to develop day hospitals, better acute inpatient facilities and, most importantly, to pay staff to work in multidisciplinary community mental health teams for the elderly.

Old age psychiatrists were in the vanguard of setting up decent services for people with dementia and in setting up effective treatment and care for those with other conditions, principally depressive disorder. Other disciplines tended to follow the medical lead, and managers thought that psychiatrists knew how to design and deliver services for old people! After Thatcher it all changed; the market ruled. Residential/nursing care was effectively privatised through changes in the social security rules and the gradual withdrawal of free NHS long-term care. The care and undoubted abuses in some of the old asylums and some ‘Part 3’ homes were replaced by care in private nursing and residential homes, some of which turned out to be equally abusive. To some extent, all experts, but psychiatrists more than most doctors, were marginalised as a new managerialism took over. More recently the Mental Capacity Act 2005 has brought a whole new layer of bureaucracy, and some increased protection for those lacking capacity.

Alongside these social and political changes there were significant technological advances in the treatment of psychiatric disorders in old age, including: new techniques for imaging the living brain; the emergence of cholinesterase inhibitors for some forms of dementia; a better understanding of genetics and the preventive measures that could reduce the incidence of vascular and possibly Alzheimer’s dementia; the emergence of diffuse Lewy body dementia as a significant diagnostic category; and the application of psychological therapies still all too rarely available to old people in many areas.

Looking to the future is always dangerous. Social and political changes are always with us and some of us hope (probably in vain) that the banking crisis of 2008/9 will lead to a reappraisal of the position of market forces as the chief deity in the modern pantheon, followed by a return to a more equal society. We shall see. Technological changes seem very likely to have a big impact, particularly in the area of prevention and treatment of dementia, and psychiatrists will probably find their place more as the ‘advanced diagnosticians’ of the many mental disorders found in old age, with routine treatment schedules (care pathways) largely managed by others. I hope that old age psychiatrists will also continue, with the assistance of voluntary bodies such as the Alzheimer’s Society and Age Concern, to be strong advocates for the needs of old people with mental disorders. Happy 21st!

References
A Scottish perspective

In 1989 I was a fresh-faced consultant having been appointed on 1 October 1987 to Murray Royal Hospital in Perth. I may have been the first person in Scotland to complete a specifically designed 3-year training programme in old age psychiatry and certainly at that time I was the youngest old age psychiatrist around. I am still in the same place but, like a favourite axe, there have been three new handles and two new heads, but the axe is still the same!

Fifteen months into the post, the Scottish Health Authorities Review of Priorities for the Eighties and Nineties was beginning to recognise the growing number of older people. The number of care homes seemed to be mushrooming in an unplanned way, with a new population of dementia in their midst. The noise of their doors locking as a patient entered only just drowned out the more important sound of case files closing. Older people with functional mental illness were in the same ward as younger people, which was an absolute disaster. Community nurses had huge case-loads, usually a mixed bag of diagnoses. We did have a social worker as part of our team (now lost through ‘improvement’), even though she had a huge rural area to cover. In the general hospitals, people with delirium and dementia were managed poorly and colleagues there anticipated removal of people who were troublesome.

In the intervening years there has been a huge national expansion of consultants, nurses and other professionals working with older people with mental illness. Most of the pioneers are now enjoying retirement, hopefully without the need to access our services. A whole new cohort of academics has helped improve research, although the academic profile of old age psychiatry is less evident in the devolved nations. Cholinesterase inhibitors, although having modest effects, brought a new population into contact with us and changed the way we managed dementia. We can now find examples of state-of-the-art services in early recognition, post-diagnostic counselling, innovative forms of community service, care home or general hospital liaison services and end-of-life care. Perhaps it is a pity that we would struggle to find a service which was doing all of these particularly well.

A Faculty perspective

Two questions I was asked recently.

1. Is there any point in being an old age psychiatrist?
2. Is there any difference between a 40-year-old with depression and a 75-year-old with depression?

The fact that the answer to the latter question is positive makes the answer to the first resoundingly so. In 1989 most patients tended to be in their mid-70s, with a sprinkling over 80 and the over-90s only rarely seen. Now we inevitably deal with people in their mid-80s, and, over the next 21 years, we can expect to focus even more on people in their late 80s and 90s, who will have very different causes underlying their illnesses and very different expectations of the recovery process than someone aged 40. Old age psychiatrists have become uniquely skilled at identifying and managing all of the complexity of diagnosing and all the interplay of multiple comorbidity that increased age brings. It would be madness to give it all up now.

The Faculty has become more political and must prepare itself to be in a strongly influential position once the current financial crisis begins to resolve. We must also recognise that we cannot manage every part of old age psychiatry equally well. Although not advocating multiple subspecialisations, as with younger adults, we need to have a way of improving conjoint working so that we can access skills in substance misuse, mentally disordered offending, liaison services and so forth, while still maintaining a high level of specialisation in the problems of...
older people. We need to make the most of research networks, not simply to promote the importance of academic old age psychiatry, but also to inhibit silo thinking and, most importantly, to increase recruitment into studies to ensure that research findings shape clinical practice much more rapidly than at present. We need to improve the sharing of best practice, but value in doing so will be limited if service commissioners do not rise to the challenge of developing innovative services. Many of the illnesses we deal with are the result of devastating neuropathological changes and we must resist wholesale socialisation of the mental illness, something which does a disservice to older people. We need to ensure that the UK remains at the forefront of plans to increase recognition of old age psychiatry internationally, and does not return to the dark ages where the needs of older people are always second best.

I wonder whether, if I went back 21 years, there wouldn’t have been someone saying exactly the same thing. Oh well, maybe that was me!

Reference

Services for elderly people in Scotland: from the inside

Sam (R. A.) Robinson
Formerly Consultant Psychiatrist, Crichton Royal Hospital and Edinburgh

In my opening remarks at the Witness Seminar in 2008 I said that the infirmities of old age took even geriatricians by surprise. Little did I realise how soon I was to test this statement.

Shingles!
What an innocuous sounding term for such a diabolical condition!

Looking back, it began with shooting pains in my left wrist and elbow. I thought at first of coronary insufficiency but the episodes seemed to be too transient for that. Two days later the cause was revealed. A wild-looking purple/red rash extending from left axilla to midline, front and back (C5/6).

It was a Sunday morning so I decided to ring NHS 24 – without revealing my medical background – more as a test than in expectation of results. However, the response was immediate and surprising. I was offered a medical consultation at the Royal Infirmary, Edinburgh, within the hour. There, my diagnosis was confirmed. The doctor told me that it was an indication that my immune system was impaired and that I should keep clear of people with coughs, colds and flu. He expressed surprise that I seemed so well with such a severe rash – prophetic words! In fairness I should add that a subsequent enquiry was dealt with somewhat less briskly.

I was still feeling quite well and on the way home stocked up at a local supermarket for what I thought might be a week or two of invalidism. Aged 86, I live alone. During the next few days I was well enough to browse the internet for recent news about shingles. Most of the articles dealt with the painful rash and its treatment. There was little about the systemic symptoms which were now beginning to afflict me. Increasing anergia, nausea, anorexia and insomnia. I had continuous ‘white nights’, a sort of coma vigil. I suppose I must have slept a bit but it didn’t seem so.

My doctor got his community nurse to apply absorbent dressings to my discharging rash and later lidocaine patches. As I was getting no better, a relative agreed to take me in. Then I had an attack of Ménière’s syndrome; my last one had been 35 years earlier and I had thought I was free of it. There were four attacks in a month. Again I had to call on NHS 24 – after some delay a male nurse came and injected me with prochlorperazine. He assured me that it would be effective within 30 min – and so it was. He also gave me a supply of Buccastem, which proved effective in subsequent attacks. I was relatively comfortable only in bed, reading.

Eventually my family decided that I was well enough to try living at home. My daughter came from Leeds to help look after me; soon
I was able to manage everything except showering. She arranged for a social work assessment, as a result of which an occupational therapist provided a toilet chair and a cushion to help me rise from my chair. My daughter suggested (sensibly) that I should move to a sheltered flat. This had been my long-term intention. But none was available in the desired location. Unusually and providentially (it seemed) one was offered on a short-term let. So I moved, dependent on family assistance.

Numerous problems developed; moth infestation, faulty appliances and plumbing, and so on. I never felt at ease there. I was kept awake one night by persistent vomiting. My new doctor came, found that I had a slight pyrexia and said that his ‘best guess’ was that I had a urinary infection. He started me on trimethoprim – later it was found that the organism Klebsiella was insensitive. He also set up a Crisis Care package – although after a day or two I was able to cope alone. My vomiting ceased but was replaced by renewed nausea.

**Depression**

Meanwhile my spirits declined sharply. I was neither eating nor sleeping properly, even with hypnotics. One evening, due to a faulty fridge door, I fell heavily. The pain in my right leg was excruciating if I attempted to move. I could not reach the Careline alarm cord. Fortunately my daughter was in the building and found me within a few minutes. The subsequent ambulance ride to hospital was prolonged torture in spite of a shot of morphine. There the diagnosis of ‘displaced intracapsular NOF [neck of femur] fracture right hip’ was confirmed and an operation was arranged for the following day.

The bipolar hemiarthroplasty went well and I woke in an orthopaedic ward in the Royal Infirmary. The pain was much diminished. Then, subsequently, analgesics were liberally prescribed. The following day I was mobilised and to my surprise was able to walk a few steps. Numerous appliances, a stand-upper and several others which I had never seen or even imagined, helped in the process.

At first my depressed mood was regarded as reactive and ascribed to the numerous physical and lifestyle setbacks which I had experienced in the preceding 9 months. It was felt that I would gradually improve, but I was not so sure. Eventually, mirtazapine 30 mg was prescribed, with disastrous results. The following morning I was so sedated that I could hardly open my eyes and required help with feeding and dressing. I refused further doses until I had seen a doctor. Eventually, citalopram 10 mg was substituted. I have to say that in spite of its adverse effects I felt that there had been a lightening of my mood after the mirtazapine episode. My urinary infection responded to 3 days of ciprofloxacin.

**Recovery**

Thereafter my progress was encouraging. I could soon walk fairly well with a Zimmer frame and later with two walking sticks. I began to sleep better, although the early morning arousing, for the blood pressure round, was a constant trial. My appetite returned and the meals were quite good. I had numerous assessments, in addition to walking and climbing a few stairs, dressing, showering, bathing and kitchen tests were all passed successfully, if slowly. I began to enjoy my stay; the supported life in Ward 108 seemed almost preferable to the probable trials which I faced at home.

Three weeks passed and preparations began for my discharge. A bath seat, magnetised ‘pick up’, walking sticks and a long shoehorn were prescribed. A ‘package of care’ was arranged with Social Services. I was to have ‘carers’ morning and evening, and visits from a community psychiatric nurse and physiotherapist. All this is free in Scotland.

It came to pass without any effort on my part; and all worked perfectly. I have two regular helps – Janice and Jacqui – in the morning, rotating every 4 days. They help me shower, dress, apply various creams, put on my support stockings, make my bed, prepare sandwiches for lunch and attend to any other personal care that I require. Their constant cheerfulness and encouragement is a great morale booster. In the meantime I have moved to a new flat which I like. This would not have been possible without the organisation and help of my daughter, son and family.

Just when I thought that all was going well I fell heavily as a result of an overenthusiastic knees-bend. My legs collapsed beneath me with considerable pain. With difficulty I got to my feet only to fall again in the same way. This time I couldn’t get up and had to summon help. I had pulled all the muscles of my ankles and knees. Fortunately my hip was spared. This episode, in terms of disability, has been worse than my fracture. I can only get about with the support of my trolley or three-wheeler. Otherwise I am improving, still on citalopram, now 20 mg.

**What of the future?**

Personally, I feel that I am almost within reach of shops and facilities in the locality and will have to be content with that. Carers will still be required for an indefinite period.

Can the munificence of Social Services be maintained in the future economic climate? I estimate that without their help I would be in a care home costing...
me maybe £1250 weekly. It seems possible that means-testing or limitation of services will be necessary. In the longer term, economics may determine future developments. Faced with the ever-increasing elderly population, who knows what will happen. Maybe in another 21 years voluntary termination of life at age 85 will be an acceptable option. Happy Death Day!

References


Dr Robinson, formerly a consultant psychiatrist, Crichton Royal Hospital, then Royal Victoria Hospital, Edinburgh; senior lecturer, University of Edinburgh; and chairman of the Section for the Psychiatry of Old Age 1978–81.

A view from Swansea

Don Williams
Honorary Consultant, Cefn Coed Hospital, Swansea

September 1974 was the beginning of my only consultant post at a traditional psychiatric hospital in Swansea. My training was in general psychiatry with an interest in psychotherapy. In 1976 the hospital needed a dementia service. I had attended the Maudsley Bequest lectures when Tom Arie had convinced me that this work was a rewarding challenge. I responded to the need. I enjoyed the work and was rehabilitated as a proper doctor diagnosing medical conditions including constipation-with-overflow.

Soon I attended meetings of the Section for Old Age Psychiatry. The afternoon meetings were lively; one paper then tea followed by an open meeting focusing mainly on developing services. During these meetings the idea emerged that old age psychiatry should become an independent specialty. Two colleagues were really inspirational, Tom Arie and Brice Pitt; they reinforced the challenging nature of our work, which was also enjoyable and rewarding. Working in a clinical field, which was evolving and developing, was also stimulating. One had a mission which could be delivered.

The first task was to establish a dementia service; once achieved, the next phase was creating a comprehensive old age psychiatry service. Age was not a criterion, it was a service for patients who were ageing or it was considered that their care would be better met in an old age service. In time we had separate facilities for patients with dementia and functional impairment.

Achieving recognition

By the mid-1980s the idea that the specialty should become an independent discipline had gathered momentum. There were lively meetings, when the majority of colleagues were enthusiastic for change. By 1989 this was achieved. Now 21 years on, it is timely to consider its significance and benefits. Certainly it improved our image and status, which hitherto had been considered a Cinderella specialty. We felt on a par with general psychiatry. The esprit de corps of the new discipline was palpable but as it became established, and with more consultant posts created, this evaporated. After separation from general psychiatry we had more clout in determining our training needs and during the early years a number of important reports were produced.

Further developments

Our hopes of having better relationships with geriatricians were not realised. And it was disappointing that Tom Arie’s vision of a unified hospital service for the elderly could not be replicated. Geriatric physicians had their own problems of maintaining professional parity with their...
medical colleagues, particularly when general medicine changed into a grouping of organ specialists. It was difficult to maintain the core values of geriatric medicine. At this point old age psychiatry should have incorporated more general medicine into its training programme to ensure comprehensive care for its vulnerable clientele.

The momentum generated to create a new specialty was not maintained. As secretary of the Section, Nigel Tyre created the Seize the Initiative agenda. Although adopted, instead of establishing the bold big picture of the way forward, it became a ‘to do’ list. We failed to maintain a progressive strategic vision and there are areas where this new specialty should have done better.

As comprehensive services became the norm, a key element should have been palliative care for terminal dementia. Instead, new practices emerged; the indiscriminate use of flu jabs, PEG (percutaneous endoscopic gastrostomy) feeding and memantine, and as a result, non-intrusive caring and acceptance of the timely end of a distressing illness was replaced by measures which prolonged suffering.

Our specialty has been preoccupied with treating dementia and has expended much time and energy insisting on the wide availability of drugs, which are only of marginal benefit. In view of the prolonged uncertainty which existed about the efficacy of these drugs, we should have campaigned vigorously for a large multicentred Medical Research Council trial to establish the facts. This would have been similar to the landmark study by Thiery,1 which created the modern foundation for the treatment of depression and would have reflected well on an emerging specialty.

Since being a separate specialty we have allowed almost all the long-term care for dementia to be provided by the private sector. This is to be regretted, adequate beds for this purpose should have been retained in the National Health Service as a vital component of a modern comprehensive old age psychiatry service.

During these 21 years much has been achieved. We must celebrate and congratulate ourselves for creating a much needed modern popular specialty. However, as this is being done, we should be redefining our strategic vision for the new century.

Reference


From Geriatric Medicine

The future of old age psychiatry: a geriatric trainee’s perspective

Shuli Levy

ST4, Northwick Park Hospital, Harrow

As I write this from my geriatric ward, out of the corner of my eye I see a nurse gently offering painkillers and water to a man with dementia, admitted with a hip fracture and a subsequent acute delirium. He gives her his usual blank stare, then out of nowhere he roars ‘b****r off’ in a rather pleasing Irish lilt and hurls the cup of water into the unsuspecting hoist next to him. We are delighted – the man speaks! After 2 weeks of silence and somnolence, of titrating analgesics, reducing sedatives (too quickly as it turned out), removing catheters, meticulous pressure care, treating infection and rehydrating – he finally speaks!

What was last week’s old age psychiatry highlight? It’s one of two, possibly three. On call, a 70-year-old lady with Parkinson’s disease and an apparent conversion disorder woke in the night to find she could not move her legs at all. Clinically this was purely voluntary and the consultant physician on post-take wasted no time in pointing this out to her, after which it spontaneously resolved. Meanwhile, on the ward, a man with cerebrovascular disease, alcohol dependence and possible depression developed...
paranoid ideas about some of the staff and other patients, then demanded his release from ‘this prison’, stating he knew his rights. A flurry of activity ensued – discussion with his wife, with the multidisciplinary team (MDT), with his general practitioner, assessment of capacity with a speech therapist, a call to the social worker...and then, does anyone know how to fill out a Deprivation of Liberty Safeguards application in this hospital?

The man, who took to his bed (after the consultant decided he did have capacity and discharged him), is also on course for a brush with a dementia screen and a computed tomography scanner. ‘Are those your cats by the window?’ he asked me yesterday between mouthfuls of Ensure. I am preparing to ignore this question as I walk away, then stop in my tracks as I remember he is on a trial of carbidopa–levodopa from another geriatrician for possible Parkinson’s disease. A mini Eureka moment! Dementia with Lewy bodies perhaps?

A brief survey of my current in-patient list reveals that a staggering 14 out of 24 have one or more psychiatric problems – mostly dementia but also bipolar affective disorder, depression and delirium. This high proportion reflects not just the rising prevalence of dementia, but also the physical frailty and reduced survival rates that the disease engenders. These patients are vulnerable and have complex needs, and require detailed assessments by trained and caring professionals who can create individualised management plans and monitor their implementation. We do our best to do all those things but we recognise that some patients – often those with no meaningful communication and no relatives – get short-changed due to lack of both expertise and limited resources.

Three wishes …

Without being too clichéd, I have three wishes for your 21st birthday. From my perspective as a hospital trainee, an expanding role for liaison old age psychiatry, in greater numbers and with much more time, would considerably improve the level of care we are delivering. It would also allow for more training for all relevant hospital specialties so that day-to-day problems such as newly recognised cognitive impairment, delirium, consent and capacity, alcohol withdrawal, prescribing sedatives and discharge planning are managed correctly and referred on appropriately.

Next, I wish for shared care wards to manage patients with multiple complex needs, with regular old age psychiatry and geriatric input, a coordinated MDT and a fully patient-centred approach to care (this last point may be obvious to some, but in an acute setting, the MDT is discharge- rather than patient-oriented). The icing on the cake would be ongoing community follow-up by the same geriatrician and psychiatrist, enabling admission avoidance, advance care planning and, where necessary, timely terminal care.

Finally, perhaps there should be more geriatrics in old age psychiatry so that the interface between us isn’t quite so rigid and impenetrable. It sometimes feels like we gingerly dip our toes in each other’s specialty pools when in fact we need to take long, regular swims and gradually absorb knowledge and skills. I gained a huge amount from a (mandatory) 2-week attachment in old age psychiatry, and I hope to do more at a later stage in my training. Wouldn’t it benefit old age psychiatry trainees to spend time with us and experience things from our perspective?

Past

It was 1976, the hottest summer for years and my first experience of geriatric medicine as a senior registrar. The flame-haired registrar in psychiatry was extremely kind and helpful to my elderly patients as well as being very clever and great fun. I used to ask her to see them in order to read her very entertaining and useful notes about these vulnerable older people. They often had major psychiatric problems in addition to their physical ones. As a psychiatrist she seemed to have a much broader understanding of their needs than I had as a mere physician. I spent many months trying to persuade her to do old age psychiatry as she seemed...
made for it. She went off to do an MD and later to become a distinguished professor of old age psychiatry and then a working peer. Her name is Elaine Murphy.

In September 1976 I spent a wonderfully informative few weeks with Dr Tom Arie at Goodmayes Hospital in east London. He later became professor at Nottingham. His incredible enthusiasm to the importance of shared approaches to the care of older people was extremely infectious. His clinical and academic approach was so successful that he was then able to set up a Department of Health Care of the Elderly at Nottingham combining both medicine and psychiatry for older people. Later on when I became a consultant physician at St Mary’s and St Charles, London, I took my colleagues to visit the department to demonstrate the advantages of this form of care.

In 1983 the Department of Health awarded us, at St Charles, £250,000 to pump prime a department of old age psychiatry based in a purpose-built unit. Dr Mark Arden was appointed as the consultant to lead the psychiatry team and to work with us in the Department of Medicine for the Elderly. Mark was a wonderful colleague and for quite a few years a very successful joint department of medicine and mental health for the elderly was run – in some ways similar to the Nottingham model.

Sadly, the benefits of collaboration were seen to be secondary to the development of larger separate departments of medicine and mental health.

On taking up an appointment at the Royal Free Hospital in London in 1985, I was very fortunate to work with Dr Nori Graham, who had previously worked with Tom Arie. Together with Professor Archie Young and Professor Shah Ebrahim, we commissioned a new rehabilitation and old age psychiatry unit on the top of Hampstead Heath. It was called Queen Mary’s House. Nori is a wonderful clinician and always dispensed extremely wise advice about my complex and often challenging patients. While I worked with her, despite chairing the Alzheimer’s Society, she was always there for our patients and us. I first met Professor Gill Livingston when she was a senior registrar with Nori. She used to attend my medical ward rounds at the Royal Free. I have very fond memories of enjoyable challenging afternoons spent with her. Dr Amanda Thomspell worked with me and then saw the light and started her training as an old age psychiatrist with Nori.

Present

Amanda went on to develop an outstanding liaison service for care homes in Southwark. Queen Mary’s no longer has rehabilitation beds but is a thriving department of old age psychiatry, which is led by Dr Suzanne Joels in her role as associate clinical director. Suzanne and Ruth Allen share what was Nori’s post. They now offer much more intensive liaison support to the older patients who so often present with delirium when acutely unwell. Dr Tony Katz, who is supported by two liaison nurses, mans this with additional help from a dementia nurse provided by the Royal Free acute trust. He also provides a wonderful liaison service at University College Hospital. His sense of humour and fun does so much to relieve stressful situations.

Nottingham’s Queen’s Medical Centre has taken this one stage further. Professor Rowan Harwood, a physician, has set up a medical and mental health unit to improve the care of patients by providing a more relaxed environment and training nurses to deal with mental health problems. He works in partnership as dementia lead with psychiatrist Dr Richard Prettyman.

For the past 3 years Gill Livingstone and I have been collaborating on end-of-life care in advanced dementia in a 120-bedded Jewish Care nursing home. Her logic, intelligence and wisdom are very useful attributes. The project, funded by the King’s Fund, is in the last 18 months of a 3-year grant.

The message

I think that the essential components of all these relationships and partnerships are a shared approach to the care of older people. For the healthcare of older people to continue to improve and be delivered with compassion and humanity there is a need for physicians and psychiatrists to work together. While 40% of people occupying acute beds and 70% of older people in care homes have dementia, we can no longer work in silos. The National Dementia Strategy should help this to become a reality.

Jackie Morris, consultant physician, St Mary’s Hospital and Royal Free NHS Trust London, 1979–2006.
‘The simplest remedies were perhaps the best.’

Mary Seacole

The history of community mental health nursing goes back many years before the Department of Health recognised old age psychiatry as a specialty.

In 1961, Enoch Powell in his Water Tower speech envisaged the closure of large institutional hospitals. The Hospital Plan for England and Wales was published the following year. However, it was not until the 1980s–90s that these hospitals were closing in greater numbers. This signalled a significant increase in community-based nursing services. However, older people’s community services lagged behind.

Training in Scotland

When I was a student nurse in Scotland in the early 1980s, the curriculum had just been reviewed. Nurses trained on a common foundation course, similar to the much-maligned Project 2000. The course involved all students initially working in older adults’ services, with mental health nurses working in the mental hospital and general nurses working in physical care. We then progressed together as one group to medical, surgical and mental health placements in a hospital setting before specialising. Once we specialised there was a new world open to us but only for a short period – working in the community, health visiting and maternity, even for mental health nurses – then back to the hospital for more learning.

At the start of my career, nurses were mainly trained in hospital, an environment where both patients and staff could live without setting foot outside. I, for one, spent a week in the main hospital building, going from the nurses’ home to the college, to the ward and to the canteen without setting foot outside the Crichton Hall. In the large rural community we covered (about 65 x 45 miles), student placements were available, but with only two general psychiatry community health nurses for the entire area. This significantly limited any experience a student could have at caring for people outside the hospital. Now, students expect and demand experience in all areas of mental healthcare, including the community, that is widely available to them.

There are some who argue that the profession has lost the skill in caring and has become more academic. In some ways I agree. I would also argue that if the right person is selected and is trained to a high academic standard then the profession will improve and the person being cared for will have better care; you go to a specialist because of their specialist knowledge and skills, and that is what we should provide.

Community nursing then was as broad and complex as it is now but without the support of community mental health teams and comprehensive social care. On the whole, older people were offered support in day centres and day hospitals but, owing to the lack of community support, admission to residential homes and long-stay hospital was arranged far earlier than would even be considered now. It is noteworthy that people were ‘coped with’ in the communities in which they lived because of the network they had, but there was little support available to carers.

Since the National Service Frameworks

Over the next few years there was a significant increase in community-based services. The National Service Framework (NSF) for
Mental Health in 1999 prescribed the need for both health and social care staff to work together in community mental health teams (CMHTs). This was closely followed by the NSF for Older People in 2001. Unfortunately, the NSF for Older People came with guidance, rather than prescription of what was to be provided, and little funding. By this stage many areas had functioning CMHTs and crisis teams for people under 65 years of age but there was still poor provision for those over 65 years. Undaunted, some older adult mental health services developed home nursing and home treatment teams providing extended domiciliary assessment and treatment. There was recognition by the voluntary and statutory services of the need to work better together to support older people. Other key initiatives to capture this energy were set up, such as the Dementia Liaison Group, a networking and campaigning group in Kensington & Chelsea and Westminster. The role and scope for community nursing of older people changed beyond belief.

Where will nursing go to over the next 21 years?
The profession needs to continue to take on the challenges presented to us and take control of what we will do. One of the most exciting documents for nursing in the last few years is New Ways of Working. This is a real opportunity for nurses to take on roles that they are best placed to do, being at the centre of people’s care. Although other professions try to maintain their ‘specialist’ skills, I would argue that nurses are the best skilled generic workers.

I believe that nursing is the profession people want to see being developed, as they trust us and we can become the key people in healthcare. The Readers Digest report in 2009 polled 1700 people and found that 95% of people trust nurses ‘a great deal’ or ‘quite a lot’, whereas only 87% of respondents placed the same level of trust in doctors. The figure was increasing for nurses but decreasing for doctors.

We are taking on roles from which others may shy away such as care coordinating complex cases where there is high risk and out-of-hours work. Nursing has already taken on skills from doctors such as prescribing, building on our skills of monitoring effects and side-effects of medication. There are opportunities now to become approved mental health professionals. Most nurses can and should be commissioning social care packages alongside patients to meet their physical, psychological and social care needs. Nurse consultants run and manage clinics independently. One of the most striking changes for me is the recognition of diagnostic skills which nurses have always had but have never embraced. It is only in the last few years that we have been confident enough to recognise we don’t need a doctor using information we have collected to formulate a diagnosis and plan care. I have always known we have been able to do this but it is only now we are recognised and, more importantly, believe we can do it. This is not to detract from the specialist skills of other professions but to recognise the skills we have.

In essence I believe that nurses need to embrace their generic working role and are best skilled, best placed and most trusted to work on building care packages around people’s needs by using the simplest of remedies.

Eric Craig qualified as a mental health nurse at Crichton Royal Hospital, Dumfries, Scotland, in 1983. He has held various clinical and management posts in mental health.

The essence of our care: a nursing perspective
Sue Hadden
Ward Manager, Cavendish Ward, Manchester Mental Health and Social Care Trust

In 1985 I chose to work as a new registered mental nurse on a ward that had inspired me during my training. Senior staff were perplexed that I wanted ‘psychogerries’ – an area traditionally seen as an unpopular Cinderella service, unsurprising with such a derogatory label. Yet it was clear to me that on the ward we had the chance to truly assess all aspects of a person, observing holistic care in action rather than in a textbook. To be able to discover what needs someone has through talking, offering physical care and observing interactions and behaviour in a safe, supportive environment was the key to successful treatment and recovery. Twenty-five years later,
my confidence in that principle remains, despite innumerable changes along the way.

What I remember fondly is the pride we took in maintaining a homely environment and a flexible routine that has matched as near to a person's lifestyle as we could. Colourful knitted blankets, chip-shop treats on a Friday and a range of clothing for those who had nothing were all part of the informality and were much appreciated. Health and Safety and Infection Control rules have gradually eliminated all of those touches, but the aim of a calm and welcoming atmosphere is still preserved and vital to building confidence for patients and families.

In 1989, old age psychiatry was given specialist recognition and it did begin to feel different. We still had limited resources. I remember the medicine trolley having just a handful of psychiatric medicines – promazine, thioridazine, orphenadrine to combat side-effects, a couple of tricyclics and a large bottle of lactulose! Today our bulging trolley contains so many more options, with slow-release or patch options that would have been unimaginable then. But in each comparison I also see similarities. The careful teaching to student nurses about vigilant observation of effects and side-effects remains the same however extensive the range of prescriptions. Also, the advance in physical treatment options encourages ongoing learning for staff, so we can continue to nurse people with a range of physical health needs.

I remember the first couple of people I nursed with Lewy body dementia, although it didn’t have a name in the early days. We saw a collection of symptoms and distressing behaviour patterns in these people that were clearly connected. Staff still recall the emotional intensity of care that was needed and how we devised innovative care plans to meet those needs.

Through the 1990s we had the development of specialist old age services such as memory clinics and trials of new drug treatments for dementia. My ward grew bigger and we saw early-onset dementia admissions and the increase in the care of ‘challenging behaviour’ (a term I don’t recall until then). We continued to offer reminiscence – but Max Bygraves was superseded by Elvis and The Beatles. We recently had a lady complain that we had no Westlife or Madonna records, a lesson that sometimes staff have to catch up with changing times!

**Today**

What are the differences between now and then? Fondness for the simplicity of the early days is understandable but not always accurate. High-quality care was and remains paramount, but our care then was at times paternalistic and we presumed compliance. Today we work much more collaboratively, taking time to reflect on plans and ensuring the patient and their family remain central to and part of all decision-making. We stress the importance of active listening and careful assessment. Noticing subtle changes in mood or behaviour is a skill often undervalued, but crucial to getting a clear diagnosis or amending a treatment plan. These qualities are timeless; staff still need the same understanding and confidence to share their observations as they did 21 years ago.

The days of three staff per shift have happily gone – our staffing levels are matched to daily need. Safety and quality issues are embedded in treatment and documentation, and there is more opportunity to question or lead with new ideas. We have waiting lists of staff wanting to work on the ward and students requesting older age as a specialty. The multidisciplinary team has grown vastly from the early days, offering wider options for specialist input for individuals on the ward and a range of follow-up care when someone leaves hospital.

As I have reflected on the evolution of our service, it has been heartening to realise that the standards that mattered so much in the earliest days are still embedded and thriving. I hope those standards will continue to be shared more widely, passing on our positive messages to general hospital teams and nursing homes. This will enable old age psychiatry to be fully appreciated in the wider health service – Cinderella no longer!

Sue Hadden started her career as a general nurse gaining her SRN (RGN) in 1982. Quickly becoming disillusioned with the ‘conveyor belt’ care of older people, Sue did a post-registration RMN course and qualified in 1984. Her first post was on the ward where she still works, although it has expanded and moved location twice. Cavendish Ward is now a 24-bed acute assessment ward for older adults and Sue has been the ward manager since 1985. Her current role is barely recognisable from the early years, but despite the politics and paperwork, she is proud to lead the nursing team as they continue to find innovative ways to improve care.
And what about occupational therapy?

Maggie Lee
Occupational Therapist, Central and North West London NHS Foundation Trust

A long-stay unit in the 1980s
My first ever role as an occupational therapy assistant was in a long-stay unit. It was well staffed, with three members of the occupational therapy team, psychologists, music therapists, speech therapists, physiotherapists, a volunteer coordinator, police cadets on placement from Hendon, as well as doctors and nurses. It set a standard I have yet to see replicated. It was before person-centred care but we knew everyone's life stories, individual preferences and what engaged them. It was before social inclusion but we had access to a wealth of opportunities around London.

One abiding memory is a man who could no longer verbally communicate holding up his hands and gasping in awe at an original Renoir painting during a visit to an exhibition. Infection Control would probably now frown upon the guinea pigs and cats we kept and I doubt the weekly pub session would now be allowed, but we reasoned these things were part of people's lives and that residents should have access to them. It wasn't perfect (the toileting regimes were rigid and the hairdresser only seemed to have one style) but it was enough to inspire me to want to train as an occupational therapist and was what I expected other places to be like when I qualified. (They weren't!)

Occupational therapy and older adults with mental health issues
One of the things that initially struck me was the lack of occupational therapists in older adults' mental health and the lack of therapists apparently wanting to work with the elderly. A lecturer on a recent course stated that if you wanted a career as an occupational therapist in the 1980s, you didn't work with older people. For the first 10 years of my career I was often the only candidate applying for the post. Although thrilled to have no competition at interview, the apparent general lack of interest was disappointing as I strongly believed we had much to offer this client group.

Occupational therapists believe that occupation, ‘doing, being, becoming,’ is fundamental to health and well-being. What we do influences how we feel, how others perceive us and how we perceive ourselves and the possibilities open to us. The environment has a major impact on this – both in terms of physical resources and social support or constraints.

Irrespective of the medical condition, the occupational therapist’s role is to help people engage in those activities which are meaningful and important to them and to build confidence and skills or change the environment to enable this. Mental health services for older adults is a perfect environment in which to put this into practice and our dual training makes us able to address both physical and mental health needs. What is sad is that so often referrals acknowledge only a small part of our skills – a bath-board, a tea-making assessment, ‘boredom.’ Occupational therapists need to market themselves better and make others aware of the evidence available, which clearly demonstrates our efficacy and cost-effectiveness. National Institute for Health and Clinical Excellence guidelines in 2008 called for our services, and we must deliver.

Core beliefs: lost and found
I believe occupational therapists in mental health lost their way around the 1990s, with many wanting to be involved in talking therapy rather than in ‘doing.’ This trend has shifted as we rediscover our roots and better value and articulate our role. We deal with all those taken for granted aspects of daily life – self-care, meaningful routines, leisure pursuits; there is more to focus on in a person than just their ability to take medication or dress themselves and our services should acknowledge this.

So what helped this return to occupational therapy’s core beliefs? Models of practice have developed significantly since the 1980s, providing an evidence base for assessment and intervention, offering a more client-centred approach than the old Activities of Daily Living (ADL) tick-box lists, and looking not just at what someone can or can’t do but what supports or inhibits them from doing so.

Therapists have benefited from developments such as the person-centred approach and validation therapy, which released us from uncomfortable reality-orientation methods, instilled hope that we could make a difference, and allowed us to see the person behind the dementia and the impact of our own behaviour on an individual’s well-being.

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cognitive stimulation therapy has reintroduced an aspect of reality orientation, it feels far gentler than the old methods and is a small part of the overall programme.

It grieves me that I still see large groups being run as the norm. It was once said that lots of people sitting together doing the same activity does not mean that it is therapeutic. One size does not fit all and services require adequate staffing and training to allow clients to receive needs-led interventions, not crowd control.

What the patient wants

Another challenge now is that we are involved much earlier with people with dementia, particularly through memory clinics. Tele-care has been a major development, although each borough appears to provide this differently. It is interesting that, although I often get the ‘Are they safe with the gas cooker?’ referrals, when I visit the individual, the cooker is not their priority – they want to know how to put their affairs in order, how to tell their friends and how to remain engaged in activities that are important to them. Do our services adequately address this?

Where our services sit has been much debated over the years – with psychiatry or care of the elderly? I have experienced both and have sometimes felt a poor relation either way. I found myself with three mantras – ‘And older adults!’ with psychiatry colleagues, ‘And mental health!’ with care of the elderly, ‘And occupational therapy!’ with everybody.

A survey of occupational therapists working in mental health services for older adults\(^4\) indicated good job satisfaction. Several comments had resonance. Some referred to enjoying the challenge of ‘working with a marginalised group,’ whereas others felt that older people were ‘not viewed in a positive light even by other occupational therapists’. There was a feeling that resources for older adults’ services were limited in comparison with other services, with one person commenting they felt ‘like a Cinderella service with no prince in sight’. One person asked for ‘more respect from colleagues who work in other fields – they do not appreciate what skills are required to work with older people with mental health needs’. Olshansky\(^5\) described ‘stigma by association’ in which not only family but therapists associated with stigmatised members of society themselves become victims of prejudice and devalued simply because of their interactions with that person. Could this apply to our services?

Challenges for the future

Challenging times are upon us. Payment by results looms and although I strongly believe that occupational therapists can demonstrate outcomes, I hope we are afforded the time and opportunity to do so. Occupational therapy interventions generally take longer because they involve the client actually doing something not just talking about it – those developing the systems recording ‘face-to-face’ interventions need to understand and respect this.

Overall, although challenging, working with this client group has been enormously satisfying and rewarding. There are opportunities for occupational therapists to make a significant contribution to services but we need to promote ourselves. There is some mileage yet in the mantra ‘And occupational therapy!’

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As a lecturer in social work in the 1970s, I learned about working with people with dementia and their families from David Jolley and his colleague, social worker Pat Smith, when I placed students in their unit. They were by no means typical in their approach of seeing the world from the point of view of the person with dementia. Generally, dementia was seen as a hopeless condition and the only help offered was support for relatives. Tom Arie provided a shaft of light with his energetic insistence on teamwork. Six months as a social worker in Victoria, Australia, in 1982 convinced me of the value of the social model of dementia care; they were developing small housing units and community day-care centres in contrast to their medical model which was deeply pessimistic, like ours at the time.

I was subsequently able to maintain my interest in dementia as the director, first of Age Concern Scotland and then the Dementia Services Development Centre at the University of Stirling. I also helped to edit the British Association of Social Workers’ book on working with people with dementia, which helped me to see a social model of intervention more clearly. As a social worker, you are interested in the interaction of the person with the impairments, with a range of factors including personal history, health, social circumstances and the built environment. I was especially interested in the impact of the last of these and I vividly recall being ridiculed at an old age psychiatry meeting because I could not produce any evidence. Evidence remains an issue with old age psychiatrists drilled in only believing randomised controlled trials (RCTs) and us social scientists trying to take account of a range of interacting factors which are not appropriate for RCTs. Our kind of research accumulates to give a sense of direction.

It is very hard to generalise about old age psychiatrists since you are such a varied bunch. I do detect a most welcome trend (on the basis of very little evidence!) that you are increasingly interested in the way services are delivered. At your international conference in Newcastle I was one of the only non-scientific speakers, whereas at your conference in Leeds in 2010 there were a great many papers on how best to provide a service to people with dementia in a whole range of settings, including the acute sector.

This does not mean that I think you should not take medical science very seriously indeed. It means that you are beginning to be seriously interested in the interaction of people with dementia and their social and built environment, which potentially causes a great deal of extra and unnecessary disability. What I hope is happening is an increasing respect for the social model of care. Psychiatrists do not have to be experts in it; you have your own area of expertise, but you do need to accord a proper regard for those of us who do know about it. I see the medical model and the social model as two equally relevant ways of approaching dementia and they need to stand side by side.

In the future I would like to see old age psychiatrists working with others to ensure that a range of interventions, not least those that are as effective as cholinesterase inhibitors (so far activities and psychosocial interventions with carers have the RCT evidence behind them), being available to all people with dementia. I am concerned at the preoccupation with medication rather than the full range of interventions. I know there are increasing numbers of active and energetic social scientists, as well as social workers, with a passion for dementia, who will make strong partners in both care and research. An emerging concern for rights and ethics is linking us increasingly closely. I also think that we will be hearing more of the voices of people with dementia, which will help us all to remain outraged at the poor standards that are so often tolerated.
To age or not to age: that is the conundrum

Marie-Clare Mendham

Consultant Psychologist, Head of Older Adult Psychology, Central and North West London NHS Foundation Trust

To age or not to age is not so much a question these days as a rite of passage. Although medicine has allowed us to live longer, are we all living psychologically healthier? For many years, clinicians treated geriatric mental health (as it was) with cavalier condescension, regarding anyone over 50 as ‘past it and no longer a valuable member of society worthy of treatment. Himself a sprightly 49, Freud considered that ‘Near or above the age of 50 the elasticity of mental process, on which the treatment depends is, as a rule, lacking – old people are no longer educable’. Such therapeutic nihilism has had a profoundly negative effect on psychotherapy/psychological theory and mental health services, a corrosively dismissive view that has seeped into wider society. How many times do we hear our clients mutter the mantra ‘I am too old to change’? How often do colleagues in adult mental health services suggest that all we do is ‘have a chat with a sweet old dear’? In Western society we are increasingly attuned to combating sexism and racism; however, ageism has lagged in their wake, as a youth-obsessed culture tries to forget that we will (almost) all be old one day. In this respect, it is older people who are by far the most discriminated against group, not to mention older people and mental health – two taboos that we would rather just ignore.

Although the media is bringing this very fact into our conscious awareness, there is a tendency to avoid that which provokes anxiety for us all, namely, getting old and potentially ‘losing’ our minds – we are all perpetually 22 in our mind’s eye. Have advances in psychological knowledge managed to counter, in any way, the most personal and general of fears?

The 1970s until 2000

If we look back to the early 1970s, psychologists’ work with older people was almost totally confined to assessment, in particular neuropsychological assessment, with the sole aim of assisting the old age psychiatrist with diagnosis. Little intervention and even less involvement with the wider population and organisations was forthcoming. By the late 1970s we saw an increasing interest in intervention models but with little thought or funding given to their application, although there was a slow emergence of specialty psychologists.

The 1980s saw the development of a bespoke, specific component in the training related to older adults. In 1980, a proactive and passionate group of psychologists formed the UK-wide Psychologists Specialist Interest Group in the Elderly (PSIGE), which was later to become a Faculty of the Division of Clinical Psychology of the British Psychological Society. Its regional groups have been an important influence in developing, teaching, research and practice in this hitherto neglected area.

Murphy surveyed the prevalence of availability of psychological therapy services for older people in the UK; 87% felt that their services failed to deliver to older people, with low expectations of treatment and disproportionately low referral rates.

So where are we 10 years on?

There has been some progress: the emergence of the older adult psychologist, understanding psychological theories of ageing, providing psychological treatment, and a plethora of research. We are able to move on from assessment, sifting the stream of evidence pertaining to change, including rich data fields from interventions such as cognitive–behavioural therapy, cognitive analytical therapy, interpersonal therapy, systemic therapy, and even Freud has got in on the act with psychodynamic therapy proving it has its place.

All these interventions and more have advanced our understanding for people with functional as well as organic disorders. We in older adult psychology have become quite good at understanding the true meaning of biopsychosocial. However, poor referral rates persist and discrimination and abandonment permeate the mindset of both professionals and society as a whole.

The development of IAPT (Improving Access to Psychological Therapies) brings along as its handmaiden another question, ‘to merge or not to merge’. Access is a pertinent subject for inquiry, for data suggest that older adults are not accessing these services as they are not seen as age-friendly and have a focus on getting people back to work. Are we only valuable to society if we work? However, once you allow people to self-refer, then providers see
an increase in access; so who is it
that is currently blocking access
and perpetuating discrimination?
General practitioners perhaps?
Is there a widely held view that
being forgetful and grumpy really
are a natural part of ageing, as
opposed to being a treatable
mental illness? Sadly, I suspect
that this is frequently the case.
There is also strong pressure
to dissolve older adult services,
incorporating them within ‘adult’
services. Anti-discrimination
legislation is being used as
a weapon against specialist
services, services we have fought
hard to develop. Although all
are regarded as equal, some are
far more equal than others, with
Western society turning a deaf ear
to its rapidly ageing population.
We have not moved on far enough
yet to merge; we must champion
the rights of the older adult with
their distinct requirements, rather
than allow them to become a
bolt-on to generalised services
whose needs and priorities are so
very different. Older adults need
special attention, for as Michel
de Montaigne once noted: ‘Age
imprints more wrinkles in the
mind than it does on the face.’

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Now I am 71 and you are 21
Norma Raynes
Executive Director, Intergen Community Interest Company

When I wrote this I was in
Hamburg at a symposium
organised by the Koeber
Foundation on initiatives in old
age. What could you have learnt
dear psychogeriatricians if you
had been there? Many things I
think, not least about the layers,
the resilience and the learning
that comes with age.
But you know about these things,
I hope, for I think that you have
been learning something too in
the past 21 years, and sharing your
knowledge with non-medical as
well as other medical colleagues.
I remember when you did
not exist and I could write the
following small story told to me by
a woman aged 82 in a residential
care home. I asked her to describe
her day for me.

‘I get up, I get dressed. I get breakfast. I
get up and I sit. I get up and I go to the
toilet and I come back to the day room
and I sit. I get up and eat lunch and I
come back and I sit. I get up and I go to
the toilet and I come back. I sit, and I sit.
I get up and eat supper and I come back
and I sit. I get up and go to the toilet. I go
to bed.’

I’ve spent 30 years of my
life undertaking research into
institutional care. Some of the
institutions were designed for
older people, some for people
with intellectual difficulties, some
for deprived children and some for
children with physical disabilities.
They had, as we all now know,
many things in common. If I were
to go back to the home where
I met the 82-year-old lady who
described her day to me, what
would I find?
The Department of Health asked
me to revisit, after a period of years
and a lot of research, a hospital
for people with intellectual
difficulties. What happened? Did
I find nothing had changed? No,
it was worse than that. Research,
which had underpinned new
developments at policy level,
had been transformed at ward
level to fit the new system and
the value that was placed on
personalised care in the form
of own clothing and places to
put it in such a way that new
deprivations, humiliations and
depersonalisations for the
residents were now visibly in place.
Meanwhile, the clothing and the
new lockers shone as beacons
of research-based practice and
improved care.
I hope now that you are part
of the solution and the service,
that if I were to go back to that
institution where my 82-year-old
lived, I would not discover the
distortions of research findings
and poor practice which the
Department of Health paid me to
see.
I know that little love is lost
between psychiatrists and
psychologists, but perhaps unlike
your colleagues with other clinical
populations to serve, you have
learnt the value of partnership
and respect. For if the old people
you treat will have taught you
anything, it must be both respect
for others and the need to do
things together such as cognitive–
behavioural therapy and drugs,
tergenerational activities and
laughter therapy, gardening and
walking, and running and jumping
and standing still.
Happy birthday all of you,
and may there be many happy
returns.

Now I am 71 and you are 21
Norma Raynes
Executive Director, Intergen Community Interest Company

When I wrote this I was in
Hamburg at a symposium
organised by the Koeber
Foundation on initiatives in old
age. What could you have learnt
dear psychogeriatricians if you
had been there? Many things I
think, not least about the layers,
the resilience and the learning
that comes with age.
But you know about these things,
I hope, for I think that you have
been learning something too in
the past 21 years, and sharing your
knowledge with non-medical as
well as other medical colleagues.
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following small story told to me by
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Happy birthday all of you,
and may there be many happy
returns.
Unlike many other people who have entered the old age field with the intention of looking after and caring for people in later life, my entry took a different route. After the period during which I was a psychiatric registrar I felt the need to obtain some research experience to broaden my education and improve my prospects of a good consultant post.

In the mid-1960s I had two and a half children and could not wait around for some ideal opportunity. However, Martin Roth in Newcastle upon Tyne had advertised a post offering research experience, carrying out a survey of the psychiatric, medical and social needs of the elderly living in their own homes. The sample population had already been developed and had yielded epidemiological data under the supervision of David Kay.

Like many doctors brought up in the ambience of the teaching hospitals I had been imbued with a fairly negative view of elderly patients suffering from generalised decrepitude and being labelled as ‘bed blockers’. My contact with the community resident elderly yielded by random sampling came as a great surprise and I realised I had a lot to learn. The picture I obtained of the majority of my respondents was of energetic, busy, motivated people who help their younger relatives more often than receiving aid from them and who socialised energetically in a variety of settings. This aroused my interest in looking at old age as a coping period successfully undertaken by the majority of people in the absence of disabling ill health or psychiatric disturbance.

My interest in the care of the elderly was aroused and my awareness of what they could achieve made the understanding of physical and psychiatric disorder seem both important and therapeutically optimistic. Coming from a psychodynamically oriented department under Erwin Stengel, I looked to see what was known about neurotic disorder in the elderly. I found little to help me understand either the prognosis of long-standing neurotic disorders in later life (where do the flies go in wintertime?) or about the advent of emotional problems in old age. The focus of my own research went in that direction.

My interest in other old age research was also aroused from my contacts in Newcastle. Martin Roth had in many ways established clear and reliable diagnostic criteria and in my view could be regarded as the Kraepelin of the old age field. His definitions were employed in the majority of early epidemiological studies. David Kay had produced a number of publications based on his Scandinavian work on a longitudinal hospital sample. He also established the sampling base in Newcastle upon Tyne, with stratifications across the social spectrum in order to obtain a representative sample.

During my time in Newcastle, Bernard Tomlinson and Garry Blessed produced standardised assessments of memory and behaviour and quantifiable neurological measures such as the mean plaque count and volumes of infarction, and demonstrated significant correlations between such measures and the clinical picture.

Other research in the 1960s

Further away from Newcastle, the clinical research published by Felix Post at the Bethlem Royal and Maudsley hospitals shed light on many clinical aspects of paranoid disorders and depressions. Sam Robinson at the Crichton Royal Hospital published many clinical papers and descriptions of the organisation of care. In Edinburgh, Jimmy Williamson carried out a general practice-based survey of the physical, psychiatric and social problems of the elderly. In Chichester, Peter Sainsbury and his fellow workers investigated the comparison between hospital- and community-based programmes of care for the elderly, taking particular note of the problems and wishes of their carers. In Essex, Nick Corsellis collected a large sample of brains.

From the Academic Old Age Psychiatry Perspective

Research and me

Klaus Bergmann
Retired Consultant, Bethlem Royal and Maudsley hospitals
from elderly patients and assessed the relationship between the extent of brain damage and the severity of cognitive impairment.

The value of research
I have often been asked 'Has research in old age psychiatry been worthwhile?' The suggestion behind this question appeared to be that the organisation of services and development of care should be the major concern of old age psychiatry and indeed much worthwhile work has been published covering these topics. My answer has always been a strong affirmative to clinical and experimental research in the old age field. The diagnostic differentiation of various psychiatric conditions in later life has led to a more therapeutically optimistic view of the care of older people. Developments in the field of epidemiology and the introduction of standardised computer-compatible diagnostic questionnaires by John Copeland and his co-workers have allowed cross-national comparisons of the prevalence of psychiatric disorders to take place. The planning of services has also benefited from being able to estimate the size of the problem and to give prognostic information to service planners.

Klaus Bergmann, consultant old age psychiatrist, Brighton, then Newcastle upon Tyne, then the Bethlem Royal and Maudsley hospitals.

Of pioneers and progress, but prognosis guarded
Robin Jacoby
Professor Emeritus of Old Age Psychiatry, University of Oxford

At the Maudsley
My formal training in old age psychiatry consisted of 6 months as Felix Post’s registrar. Other than that it was learning on the job. I never dreamt of going into this specialty but it happened thus. I had spent 18 months as a trainee at the Maudsley before which I had been a medical registrar. I was a little disillusioned with psychiatry and thinking of going back into general medicine. Given the nature of the career pyramid at the time, I believed that I had no hope of getting back into mainstream medicine but only geriatrics. So I thought that I had better do 6 months of psychogeriatrics as it was then called. I was assigned to Felix Post and never looked at general medicine again.

Felix had a reputation of ferocity towards registrars, but this was only because he was anxious about the care of his patients. Once he felt they were safe in your hands he was relaxed and kind. I found this no problem, and he soon emerged from his rather prickly cocoon as a kind and humorous albeit reserved person. He was not rigidly medical, but he had read Jaspers and understood the difference between causal and meaningful connections.

At the Maudsley, old age psychiatry was almost exclusively an in-patient and out-patient affair then. After Klaus Bergmann was appointed when Felix retired, and later I myself joined him, the number of our own home visits increased. Of course, this was also a time (the 1980s) when community psychiatric nurses were appearing in greater numbers. By the time I moved to Oxford in 1994, the service there had become highly community-based with no out-patient clinics but only home visits. Since my retirement and extreme cost-cutting, out-patient clinics have returned.

Research
Before I became a psychiatrist there were two major players undertaking essentially clinical research in the UK: Felix Post and Martin Roth. The great change in my lifetime was the proliferation of their heirs. In the north in Newcastle, Martin Roth, Gary Blessed and Klaus Bergmann, starting from Roth’s epidemiological work in Chichester, produced landmark studies in the community and equally important

The development of brain imaging, of biological and biochemical research has attracted many gifted and talented scientists into the area of old age research. This gives us some hope for the development of rational treatment for the dementias. Our knowledge is certainly not sufficiently advanced to relegate the priority of research in this field.
neuropathological investigations with Bernard Tomlinson. In the south at the Maudsley, Felix Post had published clinical descriptive studies that still form the basis of our understanding of affective and schizophrenia-like disorders in old age. Into this north/south mix we must add the biochemical discoveries of cholinergic deficits in dementia by David Bowen in London and Elaine Perry in Newcastle. Not only were these vital discoveries in themselves, but almost more importantly they made dementia a sexy subject for young scientists, which has completely transformed our specialty.

My own research career was nurtured by Raymond Levy who, while making major contributions himself, was especially good at encouraging younger talent. It can be invidious to mention names, but I have to point out that Simon Lovestone and Rob Howard, two current major players in our field, were both Raymond’s protégés.

The future
I am confident about the future of research in old age psychiatry because the dementia tide will sweep it along, and I predict disease-modifying treatments for Alzheimer's disease within the next 25 years. I am much less confident about the state of clinical services. The drive in Western countries to cut costs has already caused serious damage to many good and some outstanding local services, possibly beyond repair. In this short piece I have not mentioned the great service innovators of the 1970s and 1980s such as Tom Arie and David Jolley because I am sure that they will be given due credit elsewhere in this collection. However, considering the dire state of service deterioration, if they were dead, which thank goodness they are not (!), they would be spinning with distress in their graves.

From 1984 to 1994, Professor Jacoby was a consultant at the Bethlem Royal and Maudsley hospitals, latterly exclusively an old age psychiatrist.

An old age psychiatrist at work and play: a research perspective

Raymond Levy
Emeritus Professor of Old Age Psychiatry, Institute of Psychiatry, University of London

I was born in Cairo and went to school at Victoria College, where I was a close contemporary of Omar Sharif, with whom I acted in Le Malade Imaginaire. From Cairo, I went to study medicine in Edinburgh – a cultural and climatic shock from which I took long to recover. In psychiatry, Professor Henderson had been replaced by the charismatic and flamboyant Alexander Kennedy, who regaled us with large public sessions of hypnosis, which led many from my year to become interested in psychiatry.

I exercised my hypnotic skills in carrying out the 12 normal deliveries we had to complete as undergraduates. After graduation and house jobs in neurology and neurosurgery, I completed an MRCP in neurology and a PhD in neurophysiology before embarking on psychiatric training at the Maudsley in 1961. Starting at the same time was Loic Hems, who had been at school with me and was a neighbour in a hospital house opposite the Bethlem, Philip Graham, Trevor Silverstone and John Brothwood, who later made a mark at the Department of Health and Social Security.

I soon fell under the influence of Sir Aubrey Lewis and Felix Post, both of whom had fearsome reputations but whom I found to be delightful and civilised men, who appreciated students who stood their ground in discussion and refused to be intimidated.

My first post was in Felix Post's general psychiatry unit and I so much appreciated his teaching that I asked to be attached to his geriatric unit, which was then at the Bethlem Royal Hospital. This set the seal on my future career.

Early research
I immediately applied my neurophysiological expertise to the study of peripheral nerve conduction velocity in Alzheimer's disease as a possible marker for the condition. This became the subject of my dissertation for the Maudsley DPM (Diploma in Psychological Medicine). I found some changes but not sufficient to act as a diagnostic marker. After a period as senior registrar to Michael Shepherd, I moved to the Middlesex Hospital Medical School as a senior lecturer. While there, I established a liaison with John Wedgwood in the geriatric unit and Michael Kremer in
neurology and continued my neurophysiological work on cortical-evoked potentials in the dementias and affective disorders in old age, and also on conversion symptoms in younger individuals. I also became acquainted with the work of John Gedye, who was attempting to develop computerised psychological tests for elderly patients. This was something I later used to test the possible effects of cyclandelate in a collaborative study with Felix Post.

In addition, with Vic Meyer, we introduced behaviour therapy for the treatment of obsessional disorders. This was received with great scepticism as obsessions were considered as defences against psychosis. I have never had so much difficulty in getting a paper published than one describing the treatment in a few early cases. A version of this treatment became a standard procedure when later written up by Isaac Marks and Jack Rachman.

Consultant and research at the Maudsley

In 1971, I returned to the Maudsley as a consultant in old age and general psychiatry and a colleague of Felix Post. As there were then no academic posts in old age psychiatry, I tried to combine my research activities with my clinical duties. This was not easy as funds for research in this field were very limited. However, with Elaine Hendrickson I was able to show that in late-onset depression there were cerebral changes similar to but less severe than in Alzheimer's disease and that these changes were not reversed after clinical recovery.

When I was able to raise funds for the Maudsley to get one of the first computed tomography scanners, Robin Jacoby joined me to carry out the first imaging studies in healthy old people and in Alzheimer's disease and affective disorders in the elderly. I was also fortunate to have the help of the late Mohsen Naguib in studies of imaging and cognitive function in late-onset psychosis, now termed 'very late-onset schizophrenia'. We demonstrated that this was seldom a harbinger of dementia.

In 1984 the Institute of Psychiatry established a chair in old age psychiatry and I applied successfully for this. I did not, however, take up my appointment until I was able to negotiate an allocation of suitable space, something which was then at a premium, and the minimal support of two lecturers. In the meantime, Elaine Murphy was appointed to a new chair at Guy's, so although my chair was the first in the subject, Elaine was in fact the first professor.

I started with the help of Michael Philpot and Barbara Sahakian as lecturers and as funds became available I was able to recruit a cohort of bright young men and women who included Alistair Burns, Simon Lovestone, Robert Howard, Melanie Abas, Barbara Beats, Sarah Eagger, John O'Brien, Adrian Owen, Osvaldo Almeida and Hans Förstl. We were later joined by Clive Holmes and Declan McLaughlan. These were marvellous years when we all seemed to laugh all the time and vicious practical jokes were the order of the day.

On the clinical side, Michael Philpot and I set up the first memory clinic in a psychiatric setting. Later, when Klaus Bergmann took over from Felix Post, we had a long struggle to move the in-patient unit from the Bethlem to the Maudsley (i.e. in the locality where the patients lived) and to set up day hospital and community facilities. At various stages both before and after Felix's retirement we were joined for varying periods of time by Ken Shulman from Toronto, John Breitner from Duke University, David Ames from Melbourne, Engin Ekker and Turan Ertan from Istanbul, and Andrea Spano from Modena.

Following the termination of my period as secretary and then president of the Geriatric Section of the World Psychiatric Association, I became president of the International Psychogeriatric Association and developed extensive international collaboration.

Funding became easier but clinical and academic work...
became more bureaucratic and I retired in 1996. I had by this time attracted a respectable cadre of clinicians and research workers and established links with neuroscience, neuropsychology, neuropsychiatry and epidemiology and set up a number of clinical trials in dementia and depression. Unfortunately, we were not taken very seriously by the predecessors of the Faculty of Old Age Psychiatry or by the Royal College of Psychiatrists itself. Understandably, but I think wrongly, preoccupation lay almost entirely with the development of unevaluated new services. David Jolley, half jokingly, told me that he considered research as a form of occupational therapy. Tom Arie and I crossed swords in the BMJ over the future of biological treatment of Alzheimer’s disease.

Reflections
Looking back, I cannot help but be greatly satisfied by the establishment of our subject as one of the major specialities of psychiatry but somewhat disappointed by the failure to establish a major academic base in more than a few centres. Although funding has become more generous, it has become more difficult to attract new talent. In order to do this we will have to get young people early, preferably as medical students, and to make it easier for them to be jointly trained in old age psychiatry and in associated academic disciplines. Until this is done, the UK will increasingly lose its previous pre-eminence in the field and see it increasingly dominated by other European countries, by the USA, Canada and Australia.

Since my retirement, I have stopped working in the field and, with the exception of an invited contribution to the 25th Anniversary of the International Psychogeriatric Association in Osaka, I have not presented any papers.

This has allowed me to concentrate on tennis and scuba-diving, on polishing my Italian and on trying to write a book on my native city of Cairo. The book is half written and I hope to return to Cairo this winter to complete it.

Perspectives of a (not so) young clinical academic

Nitin Bhalchandra Purandare
Senior Lecturer and Honorary Consultant in Old Age Psychiatry, University of Manchester and Manchester Mental Health and Social Care Trust

I have worked in academic old age psychiatry at the University of Manchester since 1999, initially as a lecturer and since 2002 as a senior lecturer. When I look back at the past 21 years of academic old age psychiatry, I see an era of giants (whom I wouldn’t like to name in case the one I miss comes after me) who developed the research in this neglected field against all odds, especially against the stigma that psychiatry was not really a science. The academic and clinical seeds were sewn together, not just at the Institute of Psychiatry in London but throughout the country, and it’s not surprising that both flourished so well. However, the times and the pace of academic (and clinical) life are changing.

Academic old age psychiatry today
Some of the giants have retired and others are slowing down, while some of the younger ones are succeeding in making their mark. The change in the ethos across universities, with even greater emphasis on grants and impact factors of journals, means that to be successful one needs not only an academic ability and drive but also other qualities such as a business mind and networking abilities, to name just two. The universities often think, and behave, like football clubs but forget three things. First, one should value and use the wisdom of senior players, even if they cannot score as many goals as they used to. Sometimes senior scholars struggle to change with the fluid expectations of universities and this is reflected in the lack of academic growth in some units.

Intentionally or unintentionally, we seem to be moving towards fewer but more heavily research-active departments, which may limit the fertile ground for future academic trainees. The annual meeting of the Academic Old Age Psychiatry Association, which was an opportunity for young and old academics to meet and reflect on the research in old age psychiatry,
has become just a distant memory. The academic Faculty of the Royal College of Psychiatrists offered an alternative forum but the participation of old age psychiatry academics in annual meetings has so far been limited.

Nowadays, academics spend much time chasing or at least thinking about, and many a times worrying about, the shrinking pot of research funds. This inefficient use of academic effort has led to a new initiative by the Wellcome Trust. The Trust will select academics and fund their research for the next 5 years. The academic will have a greater flexibility and can plan a series of projects rather than be at the mercy of funding bodies for individual projects. However, only a few, if any, academic old age psychiatrists are likely to benefit from such a scheme. The focus on impact factors means that psychosocial or health service research may get neglected if all academics are tempted to do more biological (e.g. genetics) research. The shift to citation index may help but has a disadvantage of assessing research on popularity of the subject rather than scientific value alone.

Future academics are likely to need much supportive mentoring to ensure that the pressure to become focused to succeed in an academic career doesn’t lead to focus on the self and losing sight of the primary goal to improve clinical care of our patients through research. Our clinical expertise identifies us as distinct from other non-medical and non-clinical academics. However, the boundaries are getting blurred; disease-focused groups could be a threat to us as an entity, but also an opportunity to reinvent our roles. Other major threats are increasing pressure on National Health Service (NHS) budgets and cuts to the research and development levy that leads to tussles between the NHS and universities over the contributions to the salaries of academics, and contributions of academics to clinical services and undergraduate and junior doctor training. If this is not resolved at an organisational level it could leave an individual academic in a vulnerable and awkward position with clinical colleagues.

Some of the CALM-AD investigators. From left to right: Martin Knapp (health economist), Tony Johnson (MRC statistician), Richard Brown (psychologist), Ed Juczszak (project statistician), Alistair Burns, Peter Bentham, Rob Howard, Clive Holmes, Clive Ballard, Roger Bullock, Robin Jacoby, John O’Brien. With kind permission from Robin Jacoby’s collection.

Should and will tomorrow’s trainees choose the academic path?

Of course they should and hopefully they will. It adds variety to a daily job, keeps you thinking and learning, allows you to travel and meet researchers from different disciplines and countries, and if you maintain your clinical links you can earn the respect and satisfaction that is worthy of the stress of managing three bosses, including family. It is unfortunate that there is less opportunity to do research for specialist trainees. However, academic clinical fellowships and National Institute for Health Research and Medical Research Council fellowships offer new opportunities. I hope that our inquisitiveness as human beings and the rising importance of old age psychiatry, in keeping with the projected growth of the older population, will ensure that academic old age psychiatry continues to flourish in the right direction.

Reference

In celebrating 21 years of old age psychiatry in the UK, it should be acknowledged that the specialty in Australia has its roots in the UK and we owe our flourishing Faculty to the early influential days of UK old age psychiatry.

The British Council courses at the University of Nottingham, which commenced in 1980, with Tom Arie as director, gave Australian old age psychiatry its start when there was no specific training programme Down Under. The late Arthur Harrison was the first to attend, followed by Ed Chiu, John Snowdon, Henry Brodaty, Manjula O'Connor and Brian Draper, all of whom became leaders in the development of both services and the discipline in Australia. To add to this group, David Ames had his old age psychiatry training at the Royal Free Hospital, London, with Anthony Mann and Nori Graham; and Daniel O'Connor was in Cambridge with Sir Martin Roth and Osvaldo Almeida at the Maudsley with Raymond Levy. It is to be noted that all the senior academics in old age psychiatry in Australia, with the sole exception of Nicola Lautenschlager (who trained with Alexander Kurz in Munich) had their training in the UK.

Old age psychiatry and the RANZCP

In 1987, a core group of old age psychiatrists met within the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The initial meeting of the Special Interest Group was hosted by Henry Brodaty at the Prince of Wales Hospital, Sydney, in the presence of Tom Arie (photo). We became a Section of the RANZCP in 1989. In 1999, the transition from Section to Faculty was approved by the RANZCP, to become the second of the only two faculties within the College.

From the start the old age faculty has had a most enviable, vigorous training programme. The constant production of newly qualified old age psychiatrists has seen membership of the faculty swell to over 200 individuals in Australia and New Zealand, while both countries now possess publicly funded, clinician-led old age psychiatry services, which are the equal of any country in the world. Our Faculty is the only part of the RANZCP which is totally self-funded, not needing any financial support from the College coffers!

The work of the specialty

Our international footprint is a proud tradition of our Faculty. Henry succeeded Nori as the chair of Alzheimer’s Disease International. The International Psychogeriatric Association (IPA) positions of secretary (Ed and Daniel), president (Ed), board members (Ed, Henry, David, John, Brian, Nancy Pachana, Gerard Byrne), editor of the IPA Bulletin (David), and editor of International Psychogeriatrics (David and soon Nicola) have all been occupied by Australians.

Old age psychiatry Down Under

Edmond Chiu† & David Ames‡
†Professorial Fellow of Old Age Psychiatry, University of Melbourne; ‡Professor of Ageing and Health, and Director, National Ageing Research Institute, University of Melbourne

In 2016, a core group of old age psychiatrists met within the Royal Australian and New Zealand College of Psychiatrists (RANZCP). The initial meeting of the Special Interest Group was hosted by Henry Brodaty at the Prince of Wales Hospital, Sydney, in the presence of Tom Arie (photo). We became a Section of the RANZCP in 1989. In 1999, the transition from Section to Faculty was approved by the RANZCP, to become the second of the only two faculties within the College.

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Old age psychiatry and the RANZCP

In 1987, a core group of old age psychiatrists met within the Royal Australian and New Zealand College of Psychiatrists (RANZCP).
In addition to these contributions, faculty members have provided leadership in clinical services, policy advice to governments, advocacy on behalf of our patients and carers, education to other health professionals, and regional education and training – many pioneers of old age psychiatry in Asia have had training in the discipline in Australia. In clinical and psychopharmacological research we are more than competitive in the field. Our academic performance has seen very important papers published in refereed journals and the production of many books. Our relationship with the UK Faculty of the Psychiatry of Old Age is strong, as can be seen from joint activities such as statements of importance.

What of the future?

We will continue to be a force in the development of best practice in old age psychiatry and plan to remain proud contributors to the field, while working to give our patients and the community the best quality of service and support to add life to their years.

A view from Hong Kong

Helen Chiu
Chair and Professor, Department of Psychiatry, The Chinese University of Hong Kong

Old age psychiatry in the UK has always been highly influential in the development of psychogeriatric services in other parts of the world. The UK is the country where psychiatry of late life was pioneered. Since the early days of old age psychiatry, Professor Tom Arie, Professor Raymond Levy, Professor Elaine Murphy and many other renowned British psychogeriatricians have inspired overseas colleagues with their visions, wisdom and experience. The well known ‘Tom Arie’s model’, which has taken root in both Australia and Asia, is undoubtedly one of the most prominent examples of such an impact.

Nottingham 1992

On a lovely summer day in 1992, I arrived in Nottingham. We had decided to establish psychogeriatric services in Hong Kong and I had come to England for a period of clinical attachment to Professor Tom Arie’s unit. Looking back, my experiences in Nottingham changed not only my career but my life too. I learned about the principles of a comprehensive and holistic psychogeriatric service model. Essential components included the multidisciplinary team, full range of services from hospital to the community, collaboration with other agencies, support for carers and advocacy. Apart from the high quality of service, I was very impressed by the great respect for the patient’s dignity, autonomy and choice by the professional staff. Professor Tom Arie was extremely patient and kind to me. I was really very lucky and privileged to have such a charismatic and inspiring teacher and mentor. After I returned to Hong Kong, I adapted the UK model to the local setting and psychogeriatric services in Hong Kong developed steadily in the subsequent years. I know many colleagues in Asia and Australia have a similar story, and so the UK model has a far-reaching effect on the development of psychogeriatric services in the Asia Pacific region.

The Faculty

The establishment of the Faculty by the Royal College of Psychiatrists further fosters the role of British psychogeriatricians as leaders in the field. The past two decades have seen exciting developments. The Faculty has been actively involved in the formulation of policies on psychiatric services to older people. It also emerges as one of the key stakeholders in advising the government, non-governmental organisations and the general public on matters pertaining to the mental health of older people. These policies and reports not only guide psychogeriatric practice in the UK but also have implications for old age psychiatry worldwide. For example, the Faculty has campaigned tirelessly, with people with dementia, their caregivers and other professional organisations, to the National Institute for Health and Clinical Excellence (NICE) for better access to anti-dementia drug treatments. Its submissions to NICE provided sound evidence supporting less restricted use of anti-dementia medications and appropriate ways of monitoring, which offered valuable reference to professionals in other countries.

The other important channel of communication between the Faculty and psychogeriatricians...
practising outside the UK is the regular publication of the *Old Age Psychiatrist*. Since its inaugural issue in September 1995, *Old Age Psychiatrist* has proved to be a popular newsletter widely read by colleagues from around the world. I very much enjoy reading this publication. Its informative articles cover a broad array of topics, which range from in-depth clinical discussion to interviews, service development and training issues. Together they give overseas members a detailed and updated account of mental health services for older people in the UK. Overseas colleagues also make use of this avenue to inform their British counterparts of the development of old age psychiatry in their countries. As Professor John Wattis hoped in 1995, *Old Age Psychiatrist* has been able to serve as a good source of help and inspiration for the psychogeriatric community.

I cannot conclude this short piece without mentioning the Faculty’s collaboration with the International Psychogeriatric Association (IPA), the other premier professional organisation dedicated to promoting geriatric mental health. As early as April 2000, the IPA and Faculty organised the first joint meeting in Newcastle upon Tyne, and I am most delighted that the two organisations had another joint meeting in Dublin 2 years ago when I was the IPA president. The cooperation between the two organisations has been further enhanced since then. The Faculty is now affiliated with the IPA. With our conjoint effort and expertise, I believe that we are able to promote mental health of older people and guide the future development of old age psychiatry around the globe.

Helen Chiu is a psychogeriatrician in Hong Kong, an overseas member of the Faculty of the Psychiatry of Old Age, and immediate past president of the International Psychogeriatric Association.

Where will I be in 21 years?
Shirlony Morgan
*Older Adult Psychiatry Specialty Trainee, St Mary’s Rotation, London Deanery*

As a higher specialist trainee, I am a relative newcomer to old age psychiatry. In 1989, the extent of my medical repertoire was limited to administering first aid at school and I was unaware of the transformations in the specialty. I completed my undergraduate training in South Africa and was aware of the differences that exist between the urban and rural areas across the country and between the health services in South Africa and in the UK. Overseas colleagues also make use of this avenue to inform their British counterparts of the

I expected that my clinical experience would be valued and was prepared to work with the limited resources of the South African national health service. Closer to my departure date, I started feeling anxious about the specialised nature of my training and wondered how my new colleagues would view my skills as an old age psychiatrist. I am usually immune to feelings of self-doubt but I couldn’t help recalling a medical school friend once remarking that my choice of specialty would be less beneficial if I intended to work in South Africa again. Fortunately, my colleague was wrong and my anxieties were unfounded.

**Old age psychiatry in South Africa**

Our discipline has only recently been recognised as a specialty by the College of Psychiatrists of South Africa. There are differences in the age demographics (South Africa: 5% >65 years; UK: 20% >65 years) and disease profiles compared with the UK. There is definitely a need for old age psychiatrists in South Africa. In Durban I worked at newly developed memory and older adult specialist clinics. However, working with the Red Cross highlighted the need for these services to extend to rural communities as well. Twice a week I flew to district hospitals as part of the psychiatric outreach programme. Historically, these communities comprise the very young and old, with working-age adults migrating to the cities. I was surprised, not by the number of older adults I was asked to review, but rather by the number of non-HIV dementia cases I diagnosed. As a medical student, I often included dementia as a differential,
but I had seldom seen a patient diagnosed with it. The increase of dementia has been anecdotally observed by local doctors and has driven a number of research studies as well as the introduction of specialist services at larger teaching centres. Prevalence data collection is underway and I worked on an epidemiological study that sampled a population based in Durban and validated cognitive assessment tools. Less is known about dementia in the rural communities and future studies will pose a number of scientific and logistic challenges for researchers.

The memory clinic in Durban is an important first step but it has to serve an area the size of Portugal, with a population of 9.9 million. Up to five patients a month are assessed jointly by geriatricians, psychiatrists, a neurologist, psychologists and occupational therapists. However, this is a diagnostic-only service. Cholinesterase inhibitors are unavailable in state hospitals and there is no national agenda for old age psychiatry.

In the past 17 years, since the end of apartheid, a number of changes in healthcare provision have been implemented, including mental health policy guidelines, mental health legislation and decentralisation of services. These initiatives have been patient-centred and have positively transformed psychiatric services. The collaboration between the Department of Health and the Red Cross to deliver outreach services to patients who were previously unable to access specialist care is a testament of this success.

The differences between healthcare provision in South Africa and the UK are due to many factors, including resource availability, the AIDS epidemic, the previous political regime and geographical challenges. Currently, there are consultations to model the South African health service on a national insurance scheme, similar to the UK National Health Service (NHS). With an increase in spending, introduction of older adult clinical posts and publication of research there should be further pressure to improve old age psychiatric services. The next few years are expected to be challenging as the health service evolves, and for an old age psychiatrist it will be an interesting period.

During my 6 months in South Africa, I tried not to focus on the difficulties of working without the benefits of NHS resources and instead thought of ways to improve the existing service. I am sure that the success of UK services is in part due to the clinicians, past and present, who championed their patients' needs and produced quality research. In the future, I would like the opportunity to work in South Africa as an old age psychiatrist and contribute my experience and enthusiasm to the field as it develops there.

Reflections from Canada

Kenneth I. Shulman
Professor, Department of Psychiatry, Sunnybrook Health Sciences Centre, University of Toronto, Canada

I spent 2 years training in London, England, from 1976 to 1978, first with Tom Arie at Goodmayes Hospital in east London and then with Felix Post at the Bethlem Royal Hospital and the Institute of Psychiatry.

The 1970s
During the mid to late 1970s, the psychiatry of old age was beginning to flourish. The Group, then Section, for the psychiatry of old age was mainly focused on the provision of innovative health services, led by clinicians such as Tom Arie, Brice Pitt and Colin Godber. The field in the UK was led by charismatic and capable pioneers who were fuelled by a collective sense of purpose and challenge to advocate for...
a vulnerable, stigmatised and underserviced population. There was a sense that we were all part of a movement/cause espousing principles and guidelines to inform health policy. Papers on the principles for service delivery emerged, with particular note of Tom Arie's description of the Goodmayes’ psychogeriatric service in the late 1960s and early 1970s.1,2

The 1970s also saw the burgeoning of a new clinical knowledge base related to the psychiatry of old age. Seminal papers by Martin Roth3 in 1955 and Felix Post’s monographs on depression4 and paranoia in the 1960s5 as well as Marshall Folstein’s publication of the Mini-Mental State Examination in 1975,6 all had a profound impact on the clinical specialty. For the first time the psychiatry of old age was provided with a scientific base which brought credibility to the field, encouraging young academically oriented registrars to enter it. Clinical research developments were centered at the Maudsley and Bethlem Royal hospitals with Felix Post, Raymond Levy and Robin Jacoby, and in Newcastle with Sir Martin Roth, Klaus Bergmann and Garry Blessed.

The appointment of Felix Post as the first chairman of the Group for the psychiatry of old age in 1973 highlighted the importance of academic credibility. Felix mainly focused on clinical phenomenology and clinical research. Nonetheless, he supported those psychogeriatricians who were at the forefront of service delivery innovation.

The future?
Speculation about the future should always arouse skepticism as suggested by the luminary Niels Bohr: ‘Prediction is very difficult, especially about the future’. I prefer Peter Drucker’s famous quote: ‘The best way to predict the future is to invent it’. So what should we invent? The nature of psychiatric disorders in old age suggests that an integrative approach with cognate disciplines such as geriatric medicine and cognitive neurology is the best way to meet the needs of our patient population and to understand the mental disorders from which they suffer. In the UK, the focus has been on the collaboration between geriatric psychiatry and geriatric medicine. However, in a review of ten psychogeriatric services in the UK that I conducted in the 1980s, I found little evidence of true collaboration. A notable exception was the successful experiment at the University of Nottingham where Tom Arie created the Department of Health Care of the Elderly that included both divisions of old age psychiatry and geriatric medicine that were collegial, complementary and integrative. Unfortunately, the experiment was not sustained following Tom’s retirement.

My perspective on the future relates to the creation of an umbrella organisational structure called ‘Brain Sciences’ or ‘Clinical Neurosciences’. This moniker reflects the reality that the major psychiatric disorders of late life have a neurobiological basis and are intimately connected with neurodegenerative and cerebrovascular changes in the brain. For example, we are increasingly aware of the troubling relationship between late-life mood disorders and dementia. Thus, knowledge of neurology, neuroimaging, neuropathology as well as geriatric medicine is critical to the understanding and management of old people with psychiatric disorders. Just how we integrate the various traditional medical disciplines to meet the needs of our patient population will be determined ultimately on a local basis. Whether we persist with an age-based discipline or a disease-based one is a mug’s game, as we will likely require a mixed approach in order to meet the needs of old persons with psychiatric, behavioural and cognitive disorders. Can we create a brain scientist with a social conscience?

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A Carer’s View of Frontotemporal Dementia

Multi-agency and multidisciplinary cooperation: where to in the future?

Neville Hughes
Harrow, Middlesex

I welcome the opportunity to contribute to the special issue of the Old Age Psychiatrist, but I enter your academic world with some trepidation. However, having looked after my wife, Nina, who had dementia for several years, I would like to pass on some of my experiences and views. I hope it encourages you to continue your efforts for the future.

Very briefly, Nina started showing unusual behaviour mid-2004 when we had been married 47 years. I suspected some form of mental health problem. I had spent 40 years in a technical role in industry, solving production problems. Nina and I had had a wide involvement in local activities – mine included 8 years as an independent councillor on the Social Services Committee and various other health-related groups. All that experience was invaluable.

Nina had an assessment and I immediately challenged the result – I had no confidence that Nina was ‘depressed’. Fortunately, a further assessment was made by a second doctor. I was advised that it appeared to be one of the less common forms of dementia but it required a magnetic resonance imaging scan. A request to the local hospital was rejected – it was not life threatening and did not meet government targets! I was learning about the National Health Service (NHS) quickly. A private scan showed frontotemporal lobar degeneration. This knowledge made a massive difference to my understanding and contributed significantly to my ability to cope over subsequent years. I happened to meet my local MP, a then junior government minister. He still remembers my vitriolic attack on his government’s policies!

I was very fortunate that about this time the first Admiral Nurse was appointed in Harrow, Kate Lim. We worked very closely together and I pay tribute to their work. I see this service as being at least comparable with Macmillan Nurses and hope that every effort will be made to expand them across the UK.

Nina deteriorated quite quickly, particularly physically. There were many challenges and with support from my Admiral Nurse I worked out how to cope. Eating was consistently a problem and I use that as an example. Getting Nina’s maximum attention was key – no television, instead her favourite music, usually Mozart. Food quality was paramount – perfect puree, with persuasion, persistence and patience (the four P’s of feeding). One detail is perhaps interesting. I filled each spoonful and then gave two taps on the plate. That focused Nina and I found it very successful. I always started with a favourite food. All very simple but logical. And it worked. While still physically fit enough, we did 15–20 min foot cycling, good exercise and good for concentration. I obtained a 6-inch babies ball with a noise inside it and I would throw it to Nina. By then she couldn’t speak but the pleasure when she caught it was tremendous.

Early in Nina’s dementia, I developed a serious health condition and had to be ready to enter hospital within 2 h. It focused my thinking. Potential respite care homes were found and I started writing Nina’s care needs covering everything from food preferences to clothes to medication. I updated it regularly. When Nina had to enter a nursing home, it was suggested I had time to write Nina’s life story, an excellent idea mainly based on photographs. It was a great help to the carers as Nina could not communicate in any way and I also used it regularly. I strongly recommend it; I should have done it earlier.

I have had many challenges but a major reason for writing this article is the reaction I have had at times from the NHS and local government. It is typified by the frequency that professional staff seem to think dementia is synonymous with Alzheimer’s disease. I strongly support the idea that in every general
practice there should be at least one practitioner with a specialist knowledge of dementia. I fought battles over continuing-care funding and despite Nina being absolutely disabled and needing 24-hour nursing care, she did not ‘meet the criteria’. Nina developed breast cancer, no real change in care needs, but it was then approved. When Nina passed away some months later, it was due to the dementia, not the cancer. It is totally unacceptable that dementia often does not get the attention and support it needs and deserves. It also highlights the total lack of recognition of the skill and value of professional, experienced carers. Their role is so often interwoven with nursing, they surely need some form of professional recognition.

Throughout my caring period I had some tremendous support and Nina’s care home was fantastic, but I believe there is much more to be done.

A Word About ...

Collaborating with the Alzheimer’s Society

Nori Graham
Emeritus Consultant in Old Age Psychiatry, Royal Free Hospital, London

In 1987, as a consultant in old age psychiatry (late-onset), I had set up a community-based service in north London that seemed to be functioning well and was keen to consider another challenge. Involvement in a research project, perhaps?

But then the telephone rang. It was Christine Kirk, an old age psychiatrist in York, asking whether I would consider putting my name up for the position of chairman of the Alzheimer’s Disease Society (as it was then called), which she was about to relinquish. Jonathan Miller, then president of the Society, had suggested my name. After some heart-searching I allowed my name to go forward and was elected. I should add that there had not been much of a rush from my colleagues for this position. This did really change my life.

Those early days with the Alzheimer’s Disease Society (founded in 1979) were very hard work. Led successively by two wonderful chief executive officers (CEOs), Noreen Miller and Harry Cayton, supported by a small team of experts in finance, people experienced in the voluntary sector (which I was not), as well as a number of dedicated carers, during the 7 years of my chairmanship the Society really did become much better established. By 1994, with an income that had risen from £300 000 to £3 million (now £60 million!), we were able to offer support to a really significant number of people with dementia and their carers. This involved setting up a computerised central office able to communicate effectively with its branches; they too needed to be computerised. We had to appoint a team of staff and volunteers, prepare an authoritative list of publications, a regular newsletter and training materials, devise a fund-raising strategy, initiate parliamentary lobbying and decide on a research plan.

During this period, old age psychiatry had been recognised as a specialty by the Department of Health. Right from the beginning, I used to drive my colleagues crazy by finding every possible opportunity at the Section meetings to update everyone with the progress at the Society and encouraging people to get involved in their branches. Very gradually interest started to develop, with colleagues wanting to get more closely connected on an individual basis. I always felt that, as professionals, doctors can give status to an organisation, with the result that advocacy for better services is more likely to be effective. Further, as I could testify from my own experience, doctors can learn a great deal from a different type of contact with carers and people with dementia and this improves the clinical service they provide. Gradually too the Section was persuaded to become involved with the Society. Both CEOs were invited to speak at Section meetings. An Alzheimer’s Society Lecture was established at the Section’s annual residential meeting. The Society and Section (then Faculty) developed a close liaison on policy matters relating to dementia.

Alzheimer’s Disease International

After my term of chairman came to an end in 1994 I became
involved in Alzheimer’s Disease International and was chairman from 1996 until 2002. Alzheimer’s Disease International developed a wide range of activities, but the one of which I am perhaps most proud was the support provided to Martin Prince and his 10/66 network of researchers across low- and middle-income countries. My international interest resulted in the introduction of workshops at our annual residential meetings to discuss how the Faculty and its members could facilitate support overseas.

During my travels there was always great interest in hearing about the role old age psychiatry plays in the UK to raise awareness about dementia, its part in diagnosis and support and the close collaboration between old age psychiatry and the Alzheimer’s Society in our country. It was clear then, and it is still the case, that this represents a unique collaboration between equal partners supportive to one another.

**Future collaboration**

Looking into the future, and specifically into collaboration between the voluntary sector and the Faculty, I should like to see joint campaigns on particular issues. Everyone touched by dementia should have easy access to advice and information. Decent, kindly care should be available as a matter of course in every home not only in this country but everywhere in the world. If an equal amount of money, time and energy were put into information and care as we have recently seen go into getting anti-dementia drugs accepted, the UK would lead the world and the world would be a better place. In the world in which we live, most countries have no specialists in old age psychiatry and precious few in general psychiatry; there is certainly no money for pills. But there are wonderful families and carers who, if given information, understanding and support, can ensure a much better quality of life for all those affected by dementia.

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**A Word From ...**

**The President of the Royal College of Psychiatrists**

**Dinesh Bhugra**  
*Professor of Mental Health and Cultural Diversity, Institute of Psychiatry, King’s College London*

The development of old age psychiatry parallels my own journey through my career, initially as a trainee and now as a trainer. As I arrived in Leicester in 1981 to start my psychiatric training, my third placement after academic psychiatry and general adult psychiatry was in a dementia-only service. It was indeed a formative experience in more ways than one. Subsequently, I did another placement in old age psychiatry as a senior house officer, and then I arrived at the Bethlem and Maudsley rotation in 1986 as a senior registrar. I was posted to Eastbourne working in adult psychiatry. I chose to do special interest sessions in old age psychiatry and the services were in the centre of the town. What I remember most, apart from the actual learning and the clinical experience, is the fierce commitment of the members of the multidisciplinary team. At least the latter has not changed. Domiciliary visits in a town where a quarter of the population was over 65 was an interesting experience.

We know that the number of older adults will continue to rise, as will the rates of dementia. It is heartening to see that the government is committed to developing and maintaining dementia services. The challenges over the next few decades are going to be the numbers of people with dementia around the globe. From a personal, clinical and academic experience, another key challenge is going to be the relationship between culture and old age. In several cultures, the elders are venerated and honoured. Filial piety and social expectations mean that children are expected to look after the elderly. Under those circumstances, the burden of disease will have major implications for carers. With changes resulting from globalisation, industrialisation and urbanisation, traditional
Then …

I was enthused to old age psychiatry by Klaus Bergmann, my consultant when I started at Bethlem Royal Hospital, where all the new trainees started. This was a kind of sheltered workshop where we had ample time to delve into the patients' histories and behaviour in great detail. For me, this experience was even more intense because there was a social work strike and very few people with dementia were being transferred to nursing or residential homes. I remember there were two things that intrigued me. First, we used to look after a number of patients who were very agitated and wandersome. Sometimes we had great difficulty managing them but when they were discharged to long-stay National Health Service care at Cane Hill Hospital (at Coulsdon, Surrey), when we enquired a few weeks afterwards how people were, there rarely seemed to be a problem. It was only when I visited Cane Hill that I realised that the space was such that people were able to wander and walk around and pace for a long distance without being blocked – it was that availability of space which seemed to reduce the number of abnormal behaviours.

I recall a similar situation when visiting ‘Part 3’ homes (named from the 1948 National Assistance Act, to look after the elderly and infirm in Local Authority areas) where, because of the 1960s and 1970s design, there was a kind of track where people could walk and never have to stop – a bit like the M25. Although this design undoubtedly solved many problems, there were a number of occasions when I had to ask a confused resident where the exit was.

The second thing which struck me was that many people with dementia were on the ward for so long that they developed deficiencies of some vitamins and several lost weight. This led me to an interest in nutrition which was the basis for my MPhil and sowed the seed of what was probably the least blinded randomised controlled trial. I decided to give vitamin supplements to a group of people with dementia at Cane Hill to see whether it improved their well-being and increased their weight. I managed to persuade a company who made a vitamin...
I can hardly bear to admit what I am about to describe, given that this is intended for an audience of specialists in older people’s mental health. However, when I was responsible for changing mental health services for ‘working age’ adults, one of the most convincing signs that our reforms were proving successful was when old age psychiatrists came to meetings complaining bitterly about being left behind.

I feel able to mention this now, several years later, because this indefensible situation has been transformed. In modern health and social care the mental health of older people is at the top of the list of priorities. We have a national strategy for dementia, we have age equality legislation, and it is no exaggeration to say that a major discovery in the field of...
I remember 1989 very well indeed. I was working 17 hours a day, trying, not very successfully, to combine academic work, clinical and managerial commitments, with days at that less-than-perfect organisation, the Mental Health Act Commission. The government White Paper Working for Patients was separating purchasers from providers, and about to create National Health Service (NHS) trusts. A lot of the donkey work for the forthcoming bill was being tested out and argued over in our district at Guy’s Hospital. It was all a bit of a nightmare. I have never worked harder before or since.

I remember well the sense of triumph and achievement when the Department of Health granted our specialty recognition after so many years of pressure and negotiation by the executive members of the old age psychiatry group in the Royal College of Psychiatrists. It meant so much in terms of training posts, but also in terms of the Department’s understanding of the likely social and economic impact of the dementias. I remember Sir Donald Acheson, the Chief Medical Officer in 1989, telling me how worried he was that the future impact of dementia on health and social care services was poorly understood by leaders of the NHS and local government Social Services. He wanted me to join the Registrar General’s Medical Advisory Group, ‘And keep saying

The House of Lords
Baroness Elaine Murphy of Aldgate

I remember 1989 very well indeed. It was all a bit of a nightmare. I have never worked harder before or since. I remember well the sense of triumph and achievement when the Department of Health granted our specialty recognition after so many years of pressure and negotiation by the executive members of the old age psychiatry group in the Royal College of Psychiatrists. It meant so much in terms of training posts, but in people’s lives, their efforts, their traumas and their achievements. I think that this richness of later life is much more widely recognised in how we offer care to individuals.

But what of older people’s mental health and the psychiatrists and others who practise it? I once tried to track the origin of the fall in suicide in older people that occurred from the mid-1950s in England. It turned out to have begun at roughly the time when the very first appointments of ‘psychogeriatricians’ occurred. I mentioned this to some old age psychiatrists who, because of their natural modesty, thought that the two could not be related. However, I prefer to think that the growing importance of good mental health in later life, which those early appointments were perhaps the first sign of in the NHS, has also been responsible for improved safety in older people who are vulnerable and depressed. In any case, it is a positive reflection on a relatively young profession and an exciting sign of what the combination of science and social values will achieve in the future.
“dementia”, which for a time I did, fighting to find a small voice for our patients simply to have the right to be counted.

Lots of things have got better; dementia is better recognised as a serious problem by the general public; the coalition government has even declared dementia research as one of its key priorities; specialist services are available in every area; access to independent sector domestic and personal care services is more readily available. Some things, however, have got worse; social care services are in meltdown in some local authorities, there does not yet seem much improvement in the understanding of confusion and dementia by general medical and surgical services in hospitals, and many general practitioners are still only so-so at diagnosis and arranging care. The problem of depression in old age and late-onset psychosis remains a key concern of psychiatrists, but is barely talked about outside specialist circles. It seems even more difficult to provide appropriate care for these patients in many districts now than when we all had long-stay NHS beds. I don’t advocate a return to those days but there are problems which have never been resolved. Our specialty has in some ways slipped back a bit from being in the pushy forefront of policy-making; over the years too many of us were preoccupied with fighting for NHS services and beds and too little concerned with the social care aspects of our patients’ lives. Many NHS changes have seen us on the back foot rather than grasping the opportunities and, perhaps saddest of all, we never persuaded the powers that be in parliament to invest in older mental health patients when the money was being thrown about in general psychiatric services.

But my goodness, don’t my colleague peers in the Lords all sit up and listen when I talk about dementia? With a mean age of 68, a third of them will die with dementia. You can be sure the specialty is well recognised down our end of the Palace of Westminster and we have a special All Party Parliamentary Group on Dementia which is now 3 years old and flourishing. I am optimistic that if the specialty adapts to the new environment of the NHS marketplace in healthcare it will flourish; adaptability and responsiveness will be key. I would like to see old age psychiatry once more pushing and shoving its way to the front of the policy debates; the demographics are on our side.

Reference

Elaine Murphy trained in psychiatry in London, became a consultant in old age psychiatry at Goodmayes Hospital in Ilford, then from 1983 to 1996 held the first UK chair in old age psychiatry at the United Medical Schools at Guy’s Hospital (now part of King’s College London). She then moved to NHS non-executive management roles as chair of a trust, then of a Strategic Health Authority until 2006. She became a cross-bench member of the House of Lords in 2004 and is now secretary to the All Party Parliamentary Group on Mental Health.
A medical student

Alasdair Scott
Undergraduate, Imperial College School of Medicine

I must begin by admitting that I’m not in the best position to comment on the 21-year history of old age psychiatry – I was celebrating my fourth birthday when the specialty gained official recognition by the Department of Health. However, as a medical student finishing my psychiatry rotation I am well placed to share my experiences of old age psychiatry in undergraduate medical training.

I’m currently in my penultimate (fourth) year of study but I have to go right back to the beginning for my first encounter with psychiatric problems in the old age population. The integrated nature of my medical degree promoted early patient contact, which for me involved a home visit to an elderly lady with osteoarthritis and comorbid depression. Similarly, my early general medical and surgical experiences were largely dominated by geriatric patients whose physical complaints were frequently complicated by psychosocial issues.

Although the age demographic of these clinical encounters can certainly be explained by the large (and rapidly increasing) proportion of hospital in-patients aged 65 and over, there is another factor that cannot be overstated – time. I found (and still find now) that elderly patients are much more willing to spend time chatting with medical students than younger patients. Unfortunately, I have no evidence base to wield (an interesting audit perhaps) but my subjective feeling is that the old age population derive greater enjoyment from talking to us, are more approachable and are significantly more forgiving of our initial bumbling attempts to formulate a differential diagnosis.

My colleagues and I ‘cut our teeth’ on elderly patients and will be forever indebted to them for it. So although on the one hand many of us will only get formal exposure to geriatrics in specialty modules and even fewer will gain significant experience of psychogeriatrics, on the other hand, elderly patients are perhaps the population with which we are most familiar.

**Multidisciplinary learning**

I’ve had five and a half weeks of general psychiatry, with one afternoon/morning a week devoted to seeing old age patients either in a community-based day assessment centre or as hospital liaison referrals. What I found most interesting was the complex nature of the cases: the interplay between physical and mental health is at its most potent, whereas the distinction between the organic and the functional is at its most subtle. Every case is made challenging by the backdrop of overlapping factors such as housing, finances, family, carers, nutrition, loneliness and autonomy. Does any specialty more fully embody the biopsychosocial model of disease?

These complexities can only be solved by the multidisciplinary approach that is at the core of old age psychiatry. In fact, to think of psychogeriatrics as a solely ‘medical’ discipline is to do it a great disservice; in the absence of a social context the medical interventions become rather lost. It seems to me that the role of the old age psychiatrist is to weave social, occupational, pharmacological and psychological therapy together to create long-term, dynamic support for patients and their families.

It is in this multidisciplinary approach that perhaps medical schools could improve. Although we recognise the necessity to work with colleagues from a variety of disciplines, we do not currently embrace learning with them. It would be interesting to have opportunities to liaise with trainee occupational therapists, nurses, physiotherapists and social workers during our education to gain better insight into our respective roles and to develop the professional skills required to work as part of a multidisciplinary team. A very recent randomised controlled trial demonstrated that medical students learning in multidisciplinary groups with pharmacy and nursing trainees performed significantly better at problem-based learning than groups of medical students alone. Given its nature, old age psychiatry could offer the perfect forum for this kind of learning, improving professional development and enhancing exposure to the specialty.

In conclusion, I’ve enjoyed my experience of psychogeriatrics and have gained an appreciation for its complexities and the roles that psychiatrists and other professionals play. Since my fourth birthday the field has grown rapidly and I’m sure it will continue to do so until my fortieth and beyond. But today we recognise the 21st birthday of old age psychiatry as an official specialty, applaud its successes and wish it many happy returns. Hip-hip-hooray, Hip-hip…

**Reference**

Tom Arie: what’s changed and what’s still the same?

Tom Arie
Professor Emeritus of Health Care of the Elderly, University of Nottingham

My first unit for old age psychiatry was at Goodmayes Hospital, from January 1969. Specialty status came 20 years later. We early ‘district psychogeriatricians’ were chiefly developers of services, teachers and advocates (and agitators). Some of us went on to set up academic departments, in my case at Nottingham University in 1977.

Old people’s hardships and illnesses are little changed, but there are very many more very old people. In the work itself, frustrations continue, differing only in details and mostly owing to a shortage of resources. The satisfactions are still the same. And many more good people have joined us.

Personally, what’s changed? One feels still the same person as one grows old, but to others one is clearly often different. ‘I have an elderly gentleman here’ said a receptionist the other day, telephoning ahead. Who could he be referring to? People give up their seats for me on buses and tubes. I used to think that the ‘Do you need help with packing?’ at the supermarket checkout was personal to me, but they ask everyone, and that is an example of a good ‘universal’ practice of which there should be many more (like clear print, which is good for everyone, while ensuring that old eyes are not disadvantaged).

I am learning about ageing in ways beyond what I ever learnt professionally, from myself and from the lives of contemporaries. ‘Old age is a new country.’

We are ‘part of the furniture’ now

Old age psychiatry is publicly familiar now. Alzheimer was already a household name in 1989. ‘Geriatric psychiatrist’ first appeared in an English novel (Nina Bawden’s Family Money) in 1991. We were already international then – our Nottingham courses in psychogeriatrics for the British Council started in 1980, and the International Psychogeriatric Association began soon after that. The media are good on issues concerning our patients (who have often become ‘clients’), and never better than in Sir Gerry Robinson’s recent television programme on dementia care homes.

Science

I no longer do clinical work, so I don’t see the changes there at
first hand. But I see the science leaping ahead, full of promise. The academic stream is bigger and different now: research in our field is now a many-sided activity, involving the basic sciences and a host of other disciplines and departments, not only medical. But I hope old age psychiatrists, indeed all psychiatrists, along with their research and the giving of advice to other professions, will continue to lead their services, to teach and to work ‘hands on’.

Our professors have changed, as in our sister specialty, geriatrics. The prime quality valued in the first professors, who were few for a long time, was necessarily leadership and innovation. Evidence of scientific excellence, and of grants is what is now most sought. There are many more professors, and often they too are fine leaders, and our top academics hold their own with scientists of any discipline.

Dementia
I worry that dementia often replaces old age psychiatry as the métier ascribed to us. We early psychogeriatricians saw our work as bringing good ‘across-the-board’ psychiatry, with careful diagnosis and skilled management to old people. ‘Dementia services’ don’t appeal to me, for all old people deserve a psychiatric service attuned to their special needs; and a prime task with our patients is to establish the diagnoses. (This is a quite separate question from that of the settings in which different patients should be cared for.)

Ageing
Being old has itself changed. Life expectation and healthy active life expectation have increased dramatically in our time, even in those past 21 years. I am, I like to think, different in my personal style from the generation that were my own elders. (At any rate, I dress differently!)

Age discrimination is outlawed in law, if often not in practice (just now the news is of flexi-scope screening for colon cancer – ‘for those up to 65’). New effective treatments will come, but will the National Health Service provide them? The coming austerity will be cruel for the old. So the need for professionals who devote themselves especially to the aged will be greater than ever. We must continue to be advocates, even agitators – which, after all, is how we began.
Reflections and Conclusions

Claire Hilton† & Dave Jolley‡
†Consultant Old Age Psychiatrist, Central and North West London NHS Foundation Trust;‡Consultant Psychiatrist and Honorary Reader, University of Manchester

Various themes shine through much of this collection of writings, with implications for future practice. Perhaps the most frequent and consistent reflections are on the teachers who have inspired us to work within the specialty.

Most themes, however, have a double edge of opinion attached. They tell us that so much has been achieved to date, but unflinching optimism is muted by heavily counteracted concern for the future. Too many of our contributors have taken the stance of ‘progress good, but prognosis uncertain,’ and some services may have been damaged ‘beyond repair.’ There is a heartfelt distress in the reports of services found to be effective in any locality being cut, and at times recreated under a different guise. Of our two geriatricians, the more experienced mourns the passing of joined up psychiatric–geriatric services, and the trainee wishes for their creation. Parallel comments appear in the contributions of the old age psychiatrists. Other aspects of our services still cause concern, especially long-stay care. No service claims to have reached goals of excellence in all its dimensions, for which we still strive.

Some contributors envisage that supposedly well-meaning anti-discrimination legislation perversely looks set to undermine much of the good so far achieved. Experience tells of the disaster of having old people in the same wards as younger mentally ill patients; will such a situation return under cover of non-discrimination?

Our services have been underfunded. Future funding by reinvesting from previous services is a meaningless and impossible objective for a population group increasing in size and complexity. If we are still a Cinderella specialty, where is the glass slipper? Will a prince (or a tsar) help us escape from the grip of the three ugly sisters, Polly Tick, Penny Pinch, and Pru Judice? We fear not.

Research, too, has its difficulties – too few trainees and too few places with academic departments. Quantitative and qualitative approaches to research both have their place. Undoubtedly research is vital, and the value of good research and technological advance is emphasised in this collection. However, applying it to clinical practice needs caution. Perhaps, it is suggested, there is currently too much reliance on the marginal benefits of anti-dementia drugs; for some they may prolong suffering when perhaps we need a more palliative paradigm of care. Also, to achieve true dignity and respect for our patients, we need to focus on the individuals rather than on the mere implementation of new practice. Two of our contributors refer to narrow ‘silo’ thinking; we need to think laterally and share ideas, and somehow influence commissioners.

Our overseas colleagues reflect highly on past contributions from the UK to old age psychiatry internationally. One wonders whether they would say the same about our innovations and services today.

We can’t put the world – or the specialty – to right in one fell swoop. We have laid spectacular foundations both before and during the past 21 years and need to build on this. Institutional memory in the National Health Service is not good; we need to keep in mind experiences, changes, successes and failures of the past to avoid throwing the baby out with the bath water. Or, as a tsar paraphrased a prime minister, the further we look back, the further we can look forward.

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a. Don’t ask how they all got different surnames; was it foul play or hanky-panky on the part of Miss Trust or Hans Offourservices, or others? Not that such things would go on in the National Health Service.
Party Games

Compiled by Claire Hilton and Dave Jolley, with more than a little help from their friends

This is a birthday party, so we have included some party games, with a prize. The prize is £25, either vouchers or a donation to a charity of your choice, or perhaps into the coffers of your trust or primary care trust or GP commissioners in the hope that they might ring-fence something for your service.

Peter Connelly, Chair of the Faculty, will help us judge the answers, which need qualitative rather than quantitative evaluation.

Your answers please (even if you do not manage all the questions) to claire.hilton@nhs.net by 30 April 2011. Individual, family, friends and team entries will all be welcome.

The name of the winner and the answers will be published in the next Faculty newsletter.

Good luck and we hope you have fun!

1. In 1989, who or what was:
   a. Prime Minister
   b. First Division Football League Champions
   c. Nobel Peace Prize winner
   d. most popular name for a baby boy
   e. most popular name for a baby girl
   f. top of the pop charts January
   g. top of the pop charts December.

2. Which of these were first seen in 1989:
   a. EastEnders
   b. Game Boy
   c. Satanic Verses
   d. World Wide Web
   e. karaoke
   f. Barbie doll
   g. Global Positioning System (GPS)
   h. Human Genome Project.

3. Our cousin: providing services for old people 1950s style. Who is it?

4. Psychiatrist in the chair. Who is it?

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a. Permission to reproduce material in questions 3, 4, 5, 7, 9, 11 and 13 has been obtained. Full acknowledgements for all images and quotations will be given with the quiz answers in the next edition of the newsletter.
5. A geriatrician ally. Who is it?

7. A serious matter: old age psychiatry conferences 1980s style!

Who are they? What might they be thinking?
Please add speech bubbles!

6. Who said what, when and where?

a. ‘Psychogeriatrics … has developed ever more rapidly … and those few of my colleagues who argue that it should not exist are in no stronger a position than Canute holding back the waves.’

b. ‘In an attempt to “convert” the local psychiatrists I was insufficiently charismatic, and got a very frosty response. Fortunately, they couldn’t find the cross, so I survived to write this article.’

c. ‘Perhaps to some of us [psychogeriatricians] the attraction in the work resembles the lives of Norsemen – there is a thrill in sailing up some administrative backwater and creating mayhem. If so, then once a new service becomes accepted and semi-respectable (I doubt if we can ever be totally respectable for our colleagues) life begins to get dull; accordingly one day we return to our longboats – to the heartfelt relief of the locals – and head for new places to conquer. The metaphor is not wholly accurate – life would be easier could we burn down the occasional administrative HQ and out its occupants to the sword!’

d. ‘The care of old people can not wait on Utopias, for many of them will be dead long before even the earliest Utopias arrive, and unless social policy and the training and professional aspirations of health personnel undergo fundamental changes … the elderly and the chronic sick, even in Utopia, are still somehow to be at the end of the queue.’

8. How many years before the National Dementia Strategy was the following written about medicine for old people?

‘This subject is one of the highest importance, and yet has been strangely overlooked during the last half century.’

9. Which influential organisation, and when, would stereotype its data like this:

[Graph showing population projections and percentage of elderly population]
10. Explain the differences between these paired words: please chose five pairs.
   a. Psychogeriatrics – Adult psychiatry
   b. Brain failure – Confusional state
   c. Care management – Case management
   d. SAP – QCF
   e. SCIE – DeNDRoN
   f. Benign senescence – Mild cognitive impairment
   g. Personalisation – Depersonalisation
   h. Palliative care – Supportive care
   i. Cluster analysis – Delphi group
   j. Personal budget – Individual budget
   k. The unfittest – Best fit
   l. Nested estimates – Multicollinearity
   m. 10/66 – 36-hour day
   n. Intermediate care – Long-stay care
   o. Graduates – Lifelong learning
   p. Melancholia – Mega-colon

11. Each of the following appeared in a different year from 1989 to 2010. Please match each to its date.
   a. Seminars in Old Age Psychiatry
   b. Second NICE guidance on the use of anti-dementia drugs
   c. Social Care Institute for Excellence Guide 3: Assessing the Mental Health Needs of Older People
   d. Report of the Inquiry into the Care and Treatment of Christopher Clunis
   e. Promoting Mental Health: Strategy and Action Plan (Northern Ireland)
   f. Principles and Practice of Geriatric Psychiatry (First Edition)
   g. Old age psychiatry recognised as a specialty
   h. NSF Older People (Wales)
   i. NSF Older People (Scotland)
   j. NSF Older People (England)
   k. NSF Mental Health
   l. National Dementia Tsar
   m. National Dementia Strategy
   n. The Health of the Nation
   o. First Admiral Nurse service
   p. Faculty residential meeting in Jersey
   q. Faculty residential meeting in Belfast
   r. Faculty residential meeting in Liverpool
   s. Donepezil licensed in England
   t. Criteria for dementia with Lewy bodies, Newcastle
   u. Cornelius Katona appointed Professor at UCL
   v. Revised Code of Practice: Mental Health Act 1983

12. A map of a psychogeriatric service
   In which newsletter and in what year did this appear?
   Is this a hope impossible for the future? Yes/no – please state your reasons.
13. The Tzar’s cars

One is the real thing (Bentley), the other a cheaper look-alike (Chrysler), and the number plate gives the date of Alzheimer’s paper.

- From where does the number plate originate?
- Is this an automotive Capgras syndrome?
- What is the psychopathology which inspires this scenario? Please explain the psychodynamics.
- The picture was taken on private land; which car would be contravening the Road Traffic Act if it was driven on a public road?
- Many of us remember having suits for Sunday best and others for the working week. Is this the auto-equivalent? What is the name of this phenomenon?
- Who else is renowned for conducting home visits in a real Bentley? Where was this? What was the explanation?

To help you, a sample answer is given below.

I just love the picture and this is because it says so much to me.

I know about big black cars: I learned to drive in Big Bodied 1946 Austin 12. The car came in two versions, with the same engine: Big and Not so big. Our Big belonged to my granddad Cooke. He was smaller than I was and am, lived to be ninety-eight and a half and insisted on climbing the pear tree in his orchard into his nineties. Big was the only car in the family and was driven by my uncle and dad as well as granddad. Weekends were spent cleaning it, painting over the rusty edges and rehearsing journeys I hardly remembered.

Driving it was a nightmare – the end of the bonnet seemed to be in a world removed from my control and the windscreen confirmed this feeling of watching a changing scene, which might be from a penny arcade rather than the real (mean) streets. There was the time when a neighbour’s wooden gates fell before that bonnet, as I underestimated my swing when attempting a turn.

Big’s registration number was GOC 449, which I took to relate to Granddad (George Cooke) and the A449 which is a major road we used on journeys to the seaside. I am sure it was just one of those things.

So, to the owner of the big black cars, I love them because they say so much.
- Not afraid in any company.
- Out of the shadows.
- Proud of what he is about and pleased to share knowledge of it.
- Humble in giving credit to the history (everyone will remember that date now).
- Dedicated to dementia and all its aspects.
- Respectful and cautious, ‘a workday suit and one for Sunday best’ maintaining the image but taking very good care of the real thing between times.

And I know that the owner handles these big cars brilliantly. Driving to a meeting in Bristol in an earlier version Bentley, he parked with no qualms and no problems in a multistorey car park which would have worried me in my Morris Minor.

In safe hands here.

My thesis is, I believe, validated by the whimsy on the other Bentley driver I have known who knew she was safe in such a car even in a scary part of London Town.

Dave Jolley