13 Services

Colin Godber and Henry Rosenvinge

Development of services • Range of services available • Links with other services • Conclusion

Development of services

Psychiatry was slow to respond to the challenge of an ageing population. The growth of specialised services for the elderly was essentially a grass roots response to local problems. From this emerged a generally accepted model of service. The way this operates has been strongly affected by increasing private institutional care during the 1980s, and has changed again with the renewed Government emphasis on community care in the 1990s.

The pre-specialist era – the 1960s

In the 1960s, a handful of major figures in psychiatry put the elderly on the map (Roth, 1955; Macmillan, 1960; Robinson, 1962; Post, 1965). However, the speciality as a whole found old people an encumbrance, particularly if they suffered from dementia (see Box 13.1). Functional illness was undertreated, and the standard response to a presentation of dementia was avoidance, or consideration solely of the option of institutional care. In some districts, geriatric services elected or found themselves obliged to help out from their already overstretched resources. Sometimes they were offered beds and staff by the psychiatrists to run the dementia service for them (Portsmouth, 1973). Generally, the scenario was one of great strain on families, with little support from the psychiatric service.

General practitioners (GPs) saw little point in early referral, often waiting until things were so bad that the psychiatric service was forced to respond, or intercurrent illness justified an acute medical admission. In the latter case the extra leaning power of the physicians often brought the patient rapidly to the top of the psychiatric or geriatric waiting list (whichever was the shorter or least stoutly defended). In the year or two before the establishment of the psychogeriatric unit in which we work, the general psychiatrists had embargoed admission of confused elderly people to their acute beds, leaving an already overstretched and under-resourced geriatric unit to pick up the pieces.

This sort of situation resulted in extra pressure on residential homes, which frequently found themselves admitting people with whom they could not cope, and without recourse to help or admission from the

Box 13.1 Psychogeriatrics in the 1960s

Dementia avoided and sometimes banned from psychiatric wards
Functional illness in the elderly undertreated
GPs saw little point in referring patients; instead patients admitted to medical wards with intercurrent illness
Residential homes admitting patients for whom they could not cope
Well patients 'banned' from homes, and living on long-stay wards
A few key figures such as Roth, MacMillan, Robinson and Post

psychiatric service if they became acutely disturbed. Not surprisingly this undermined trust, and when such patients eventually gained admission, the home would refuse to have them back even if they had considerably improved. As a result, the hospital long-stay beds often housed many patients who required little nursing care, while the homes carried many patients with dependency and behaviour more suited to long-stay hospital care (Clarke *et al*, 1979; Wilkin *et al*, 1985).

Emergence of a 'comprehensive' psychogeriatric service – the 1970s

Joint psychogeriatric assessment units

By the early 1970s, psychiatry was coming under increasing pressure to put its house in order with regard to the elderly. With many geriatric units tackling the needs of the physically disabled elderly in a much more effective manner, the Department of Health began to encourage psychiatrists to learn from them, and establish a partnership in the management of patients with dementia. In two important circulars (Department of Health and Social Security, 1970, 1972) it proposed that at least one psychiatrist in each district should take responsibility for liaising with the geriatric and social services, and that the focus of their collaboration should be a joint psychogeriatric assessment unit (see Box 13.2). Patients admitted to such a unit would have their psychiatric, medical and social needs assessed and treated, after which they would return home, or be placed in long-stay psychiatric, geriatric or residential care, according to guidelines laid down in the circular. The idea was a good one, but the guidelines were too simplistic and too susceptible to different interpretation by the respective agencies, as they attempted to protect their overstretched resources. Joint units would often clog up because one or more party failed to transfer patients when their assessment was complete. Where there was firm adherence to the operational policy,

and the geriatric and psychiatric services worked well, they could prove a valuable asset (Donovan *et al*, 1971; Arie & Dunn, 1973; Godber, 1978).

Pioneers

Although the joint unit was not a panacea, the early 1970s did see an increasing number of psychiatrists electing to focus on the elderly, though widening their brief to include functional illness in a 'comprehensive' psychogeriatric service (as opposed to the 'dementia' service envisaged by the department). A cluster of pioneers (e.g. Arie, 1970; Whitehead, 1972; Pitt, 1974) described the establishment of such services, and demonstrated how much could be achieved therapeutically in the support of caring families, by an enthusiastic community-oriented approach, coupled with more effective use of beds. Many psychiatric trainees were stimulated by these accounts, or by direct exposure to such services, to move into the field themselves. An active peer support and pressure group began to meet at the Royal College of Psychiatrists and was later to metamorphose into the present Old Age Faculty. This group agreed on a number of guidelines and policies, on a range of important service issues, many of which are referenced in Arie & Jolley's article (1983).

Home assessments

In contrast to the Department of Health's model, most psychogeriatricians based their assessment in the patient's home, or secondarily in the clinic or day hospital. This enabled many patients to be treated without recourse to hospital admission. Those needing residential, geriatric or other specialist care could be referred directly to the appropriate service, without interposing what might be an unnecessary or lengthy period in the assessment unit. Those requiring psychogeriatric admission would come in with a specific plan for treatment, and with preparations for discharge already set in train. This reduced pressure on beds, making it easier to admit urgent cases without delay, and to achieve the trust and cooperation of carers with a high rate of acceptance by them for discharge. This capacity for quick response and rescue in a crisis came to be seen as the crucial hallmark of an effective psychogeriatric service, and an essential back-up to its support work in the community.

Against the background of previously severely unmet needs, the novelty of a responsive service inevitably increased referral rates and the demand for short-term care. Likewise, the more optimistic approach to functional illness in the elderly shown by most psychogeriatricians, and the demonstration to GPs that many patients they had previously seen as 'demented' or intractably or 'understandably' depressed could be treated successfully, increased demand on that front too. This change in work pattern usually resulted in a steady shift in bed use from long to short stay, with shorter spells

Box 13.2 Psychogeriatrics in the 1970s

Department of Health and Social Security recommended joint psychogeriatric assessment units
Group meeting regularly at the Royal College of Psychiatrists
Domiciliary-based assessments
Proving to GPs that treating depression was necessary and effective
Pioneers such as Arie, Whitehead and Pitt

in the latter. Eventually there was enough turnover to meet all acute needs, which in turn reduced the demand for long stay further. In our district, the existence of a case register enabled us to monitor this shift in work pattern. This showed much higher admission rates, and lower long-stay occupancy, than in districts without specialised psychogeriatric services (Jennings, 1984).

Fruition of the district psychogeriatric service – the 1980s

The impact of the early services led many districts to follow suit by setting up their own psychogeriatric posts (see Box 13.3). By 1981 the number of consultants working in the field had risen to 106 (Wattis *et al*, 1981) and by 1985 the figure was just under 250 (Wattis, 1988). The spread was most marked in the regions in which the earlier services had been set up. The resources offered with these posts were variable and often quite inadequate. The Old Age Section of the College produced guidelines for the resourcing of new posts, and identified a psychogeriatrician in each region to brief regional advisers and health authorities on new posts as they arose. It also established links with the British Geriatric Society, and jointly agreed a code for collaboration between old age psychiatrists and geriatricians, an interface all too prone to conflict (Royal College of Psychiatrists, 1979; Royal College of Psychiatrists & British Geriatric Society, 1992).

For some years the Department of Health dragged its feet in acknowledging these developments, though the Health Advisory Service publication *The Rising Tide* (1983) laid down some important guidelines for district provision for the elderly, and stimulated the Government to invest money to promote "demonstration services" and examples of good practice. However, it was not until a joint working party of the Royal College of Physicians and Psychiatrists (1989) published its report that the extent and patchiness of the development of old age psychiatry was recognised by the department and the colleges. This report endorsed the comprehensive model of psychogeriatric service, and listed the resources and working relationships necessary to achieve a good district service. It

Box 13.3 Psychogeriatrics in the 1980s

Expansion in consultant numbers
Old Age Section of the Royal College of Psychiatrists links with British Geriatric Society
Health Authority Service, in their report *The Rising Tide* (1983), suggest "demonstration services"
Joint report from the Royal Colleges of Physicians and Psychiatrists recommend a "comprehensive model"

recommended the establishment of old age psychiatry as a speciality with specific higher training requirements. This was accepted by the department. It was estimated that a further 250 consultant posts would be needed by the end of the century to bring every district up to what was currently regarded as an adequate level.

Community care – the 1990s

It was hoped that the purchaser–provider split, introduced by the NHS reforms, would enable health authorities to reduce the extent to which they were constantly having to bale out over expenditure on acute services. This would enable the promised investments in the 'Cinderella services', such as the elderly and mental health. Unfortunately the political imperative to cut waiting lists, and a succession of resultant crises in emergency services, resulted in the black hole of acute care continuing to suck in the greater part of any new investment (see Box 13.4).

Psychogeriatricians have had to fight harder than ever to hang onto the resources for their patients. They have had to second guess their health authorities purchasing plans (because they are seldom nowadays asked to participate in local planning and strategic development) in order to be ready to shape their services accordingly. They have also had to work to contract activity targets that have virtually no relevance to the quality of service being provided. With health authorities generally anxious to reduce their expenditure on such important areas as respite and continuing care, psychogeriatricians have had to make a careful judgement as to how much of these they can afford to stockade. If they aim too high, they invite competitive tendering with a private sector that will invariably undercut them. Those who have kept their continuing care units intact have usually done so on the basis of a much smaller number of beds, focusing on patients requiring very skilled care and multi-disciplinary review of a type seldom achievable by the private sector. Although the old norms of three longer-stay beds per thousand elderly still apply in Scotland, something around one bed per thousand is seen as more realistic in England.

Following National Health Service Executive guidance (Department of Health, 1995), health authorities have had to be much more specific about who qualifies for different aspects of continuing health care. Fortunately, they usually involved local clinicians in drawing up their criteria. This has been effective in stemming the tide of NHS disinvestment in these areas, and has given clinicians a better chance of justifying continuing specialist care for their clients. Nevertheless, it leaves a health–social care divide which is entirely artificial, but very firmly maintained because of the different financial rules that operate on either side. The House of Commons Select Committee on Health (1996) urged the Government to require health authorities to pay for the nursing element of care in nursing homes. An authoritative Joseph Rowntree Foundation working party (1996) went further and supported a European model of social insurance, whereby an earnings-related levy would fund social care in the event of chronic disability or old age. If politicians find the courage to promote such a system, we might get closer to the integrated care management that was implied in the rhetoric with which the Government launched the Community Care Act.

The implementation of the Act was anticipated with trepidation. It was feared that the inadequate funding of social services, the unpreparedness of social workers for the purchasing role and the lack of providers of domiciliary care, would lead to a rapid silting up of hospital beds, such as occurred in the late 1970s. The picture has turned out better, initially at least, than feared. Certainly, social services have not had enough money, a problem exacerbated by the political difficulty of charging more than a nominal rate for domiciliary and day care services (which means that they are subsidising these in a way that they are not with residential and nursing home care). Generally, however, they have managed their budgets well, and care managers have shown increasing skill in putting together imaginative and effective packages of care for their clients, and linking these in with those provided by the NHS. The Government's hopes that the vacuum in domiciliary care would be filled by the entrepreneurial independent sector, have been substantially justified, though the quality of care is certainly variable.

People with dementia living on their own are still prone to require residential care at a rather earlier stage than their physically disabled counterparts. Nevertheless, the use of domiciliary carers to make sure that they are getting meals, medication and attending day centres, has certainly kept many people going much longer in their homes, and within acceptable limits of risk than was feasible in the past. The delay in hospital discharge that was anticipated has taken some years to become apparent; and it has often been related to disputes by reluctant purchasers over who pays for what, at the health–social care boundary. It is certainly pleasing to see many more patients now supported at home who, in the 1980s, were consigned to residential care.

Box 13.4 Old age psychiatry in the 1990s

Acute care continues to take resources
Old age services have to compete for resources
Local guidelines for continuing care
Social services budgets remain restricted
Private sector offering domiciliary care
More patients staying in the community

Range of services available

Psychogeriatric services only deal with a small proportion of mental illness in old people. Our quite busy service is in contact with just over 3.5% of those over 65 in the catchment area. Comparing this with actual prevalence rates for the psychiatric illnesses of old age means that we see under half of those with moderate or severe dementia, and a much smaller proportion of those with major functional illness (although the latter constitute over half of referrals). Clearly it is important to educate those in primary care to identify patients most in need of specialist referral, and to manage the rest.

The introduction of annual screening of the over 75s as part of the GPs contract, has provided an opportunity for dialogue. In our district, many GPs have adopted a screening instrument whose design was shared with geriatricians and psychogeriatricians, who also contributed a set of algorithms for the management of identified 'cases'. Such a partnership may be improved through the Care Programme Approach (CPA), and the participation by community mental health nurses (CMHNs) and primary care nurses in care management. Building links with social services and primary care teams improves their care of mental illness in older people and their selection of which patients to refer on.

Old age psychiatrists

Most psychogeriatricians prefer to assess patients at home, feeling that this gives a clearer picture of the patient's environment and support, better access to the ambivalent patient, and the opportunity to establish a plan of management before the patient, or the service, is otherwise committed (see Chapter 1). It has been suggested that another motivation is the domiciliary visit fee. Clearly, if the policy of the psychogeriatric service is that all patients will be assessed at home, it behoves the consultant only to claim such a fee if the GP specifically requests a home visit. The great variability in the extent to which such fees are claimed, and the increasing insistence by employers that they should only reflect out of hours work, makes it likely that they will be replaced by a more appropriate

Box 13.5 Advantages of home assessments

Offers a clearer picture of environment and support
Better access to the patient
Avoids difficult travel for the patient
Results in a fee (likely to be phased out)
Teaching experience for junior doctors and medical students

way of recognising the extra effort of taking the service to the community. There is certainly a need for proper evaluation of medical home assessment, and of the sharing of this work between members of a multi-disciplinary community team, and closer joint working with GPs through regular visits or clinics in surgeries.

Our service assesses all new cases at the point of referral, and carry out most follow-ups at home. Junior staff are involved in this work, which offers them an insight into the natural history and community impact of their patients' illnesses, an experience which has drawn many into subsequent careers in psychogeriatrics. Extending this to medical students during their psychiatry attachment has greatly enhanced their experience and enjoyment of the placement. Generally, the aim is to follow patients only as frequently and as long as specialist input is required. In the case of patients with dementia where surveillance, carer support, help in managing behaviour problems and liaison with primary care, social and voluntary services are the main requirements, the ongoing involvement of the CMHN is more effective.

Community mental health nurses

The CMHN is the lynch pin of the community psychogeriatric team, with a particular remit in the support of patients with dementia and their carers. Carers rarely take in all that is told to them at the time of the initial assessment, and they usually rely on the CMHN for information and counselling about dementia, and the task that faces them. The CMHN also acts as an advocate, a guide to services and benefits, and as a bridge between the specialist and primary care services. They will monitor the health of the patient and carers, encouraging involvement with support groups (which the CMHNs often help to run), and local organisations such as the Alzheimer's Disease Society. As the illness progresses, CMHNs can offer extra respite and domiciliary services, and alert the GP or psychogeriatrician if reassessment and treatment are needed.

CMHNs can play a similar monitoring and advisory role with residential homes and develop training courses for staff. CMHNs may be aligned to

Box 13.6 Roles of community mental health nurses

Key members of multi-disciplinary teams
Offer information and support to patients and carers
Monitor the health of patient and carer
Offer training to residential and other staff
Offer advice to primary health care teams

particular general practices, acting as a specialist resource within the primary care team, whose members may consult them, without the need for a formal referral to the service. Our community service operates in two teams, one of two consultants, and one of three consultants (also GP linked); each consultant's patch comprises the practices of three to five CMHNs. This offers familiarity with local conditions and resources, and close links with services, such as day centres or social services teams. Another advantage of sectorisation is that it allows the CMHNs and consultants to relate their use of beds and day places to the size of the population they serve.

Other members of the team

There has been a trend for occupational therapists and psychologists to extend their work outside the hospital or day hospital, both to facilitate discharge, and to widen the range of assessment and treatment available to patients referred to the service. In many services, multi-disciplinary teams have been set up to operate solely in the community, sometimes incorporating staff from social services (social workers, home care manager, home carers and occupational therapists) and the primary care team (health visitor, district nurses). While recognising individual specialist skills teams often encourage a generic approach to assessment with keyworkers. Team meetings are used to allocate and review clients, and to make referrals between members of the team when specialised skills are needed (Coles *et al*, 1991; Lindesay *et al*, 1991). This model is felt to work well by most who have adopted it, and it has been favourably evaluated by MacDonald and colleagues (1994). Exponents of the different models tend to support their particular approach with great conviction. Dening (1992) attempted a more dispassionate review in his commentary on a number of services he had visited prior to taking up his own consultant post.

A variety of other methods have been adopted to extend support to psychogeriatric patients and their carers. Some CMHNs have auxiliaries giving direct care in the home. Under the auspices of MIND, in Southampton we have established a sitting service to widen the range of respite offered to

carers, especially when admission or day care was unacceptable (Rosenvinge *et al*, 1986). This service now offers 20 000 hours of care a year, and apart from enhancing the quality of care, it has paid its way financially in terms of reduced demand for long-stay beds. More recently this project has been extended to people with dementia living alone, in a way which dovetails with the home care service, often succeeding where the latter has been refused entry. This has led to an extension of the service to support patients with chronic functional illness.

Day care

Day care is an area in which psychogeriatricians have made the best use of the opportunities and resources they have available, rather than designing to a set plan. Although some have used day hospital as a major part of the assessment process (Bergmann *et al*, 1978) and a few for the treatment of acute illness (Whitehead, 1972), the most usual functions have been longer term support for the most vulnerable and respite for carers.

Our day hospital operates four types of service:

(a) Providing psychotherapy and behavioural intervention to tackle specific problems.
(b) Longer term support to those with relapsing illness or poor response in the first setting.
(c) Assessment, rehabilitation and respite for patients with dementia.
(d) A travelling day hospital taking a mixed clientele from rotating venues in the more distant parts of the catchment area.

Doubts have been expressed as to the specific function and cost-effectiveness of day hospitals in the care of older people (Royal College of Physicians, 1994). A debate in the *International Journal of Geriatric Psychiatry* (Fasey, 1994; Howard, 1994) concluded that there was need for further evaluation. It is important to see the role of the day hospital as potentially very different from a day centre. It can be the focus for assessment and treatment, as well as providing respite for the most dependent patients (Rosenvinge, 1994). The influence of day hospital treatment on the long-term use of the psychogeriatric service needs to be evaluated. One difficult to measure group are chronic functionally ill patients who comply poorly with treatment, and have a high risk of relapse. This group are only manageable with the high level of nursing and medical supervision that the day hospital provides.

Our own unpublished audit of day hospital care showed benefit to patients, as perceived by their carers, referrers and GPs, as well as by themselves. GPs, if they are fundholders, are now in a position to purchase day hospital care for their patients. It is important that they appreciate what an active day hospital can offer. By having special links with the community, the day hospital is well placed as a flexible resource centre, a liaison facility

Box 13.7 Roles of day hospitals
Long-term support for patients and carers including respite Assessment Treatment of acute illness Psychotherapy and behavioural interventions Rehabilitation Opportunity for teaching professionals and volunteers

with primary care and social service departments. It therefore makes an excellent venue for teaching professionals and volunteers (see Box 13.7).

In-patient care

The more positive approach to functional illness and the relatively high rate of use of electroconvulsive therapy in the elderly has created the need for more acute beds than recognised in the old Department of Health and Social Security norms (Department of Health and Social Security, 1975). In our service, functional illness beds comprise about a third of the 90 short-stay beds operating for the catchment area population of 60 000 people over 65. Although seasonal peaks of affective illness sometimes result in an overflow to the organic wards, it is much better to separate the two, whose nursing and therapeutic needs are very different.

The acute organic ward is undoubtedly the most demanding on staff, and requires close integration of nursing, remedial therapy and medical skills. Department of Health and Social Security norms for so called 'assessment' beds generally underestimated the need for such acute care in an active psychogeriatric service. Beds are needed for respite care in an environment that is gently rehabilitative and avoids disruption to the patient as much as possible. Despite undue alarm raised by Rai *et al* (1986) on the basis of so called 'social admissions' to their geriatric unit, others have found no increase in mortality from planned respite care (Selley & Campbell, 1989), and clear benefit to carers (Pearson, 1988; Levin, 1991) (see Chapter 18). It is important to be able to admit patients without delay, and to honour planned respite admissions. Equally important is careful preparation for discharge, with involvement of the CMHNs, carers and those responsible for the social care at home.This includes follow-up at home within a day or two by a designated member of the team. Preparatory home visits are used with increasing frequency.

One way of responding to the demand for more extensive and flexible day care (with the capacity for longer hours and availability seven days a week), is to make the day hospital the main focus of non-domiciliary care (Baldwin, personal communication). Taken to its logical conclusion this

would enable patients to be cared for through crises or episodes of illness as day patients, with overnight stay as an optional extra (e.g. at the height of the episode or perhaps the night before electroconvulsive therapy). This would undoubtedly reduce the number of nights spent in hospital and help to avoid the disruption and dependency that tends to occur with spells of in-patient care. It would require closer day-to-day review of the progress of in-patients and day patients than is customary. It would also need to be backed up by a more flexible transport system, enhanced CMHN input and the availability of 'getting up' and 'tucking in' services.

There is still a definite role for the psychogeriatric service in the continuing in-patient care of a hard core of disturbed patients. At the same time there is a need to replace the old warehousing model with a more homely environment in which the patients' choice and dignity is respected. Placing responsibility for the longer stay patients in a unit with a highly respected nursing officer committed to this approach can achieve a remarkably changed 'nursing home unit' (Norman, 1987; Hargreaves, 1989; Murphy, 1989; Lindesay *et al*, 1991). A major task in the future will be to impress on health authorities, the need to maintain such provision within the NHS, but ensure that its cost is not seen as too prohibitive.

Links with other services

Geriatric services

Efforts have been made with geriatric medicine to achieve joint working and planning at national and local levels (Royal College of Psychiatrists & British Geriatrics Society, 1992). Joint clinics are frequent, and in many districts one specialist will visit the other's unit on a regular basis, or joint assessment units have been established. Collaboration can be enhanced if consultant catchment areas are the same, or both units have beds on the same site. Overlapping needs of many patients receiving day, respite and long-term care justifies the extension of joint care to these areas, especially for poorly mobile patients with functional or organic illness. In some centres the logical step has been taken of merging the two services, such as the joint department of Health Care of the Elderly in Nottingham (Arie, 1983). In many districts the merging of units, following the NHS reforms, has brought the two services closer managerially.

Social services

Another important interface is with the providers of social care (see Box 13.8). The importance of support to residential homes and day centres has already been mentioned, and probably reaches its closest level in the context of specialised homes for the elderly mentally ill where psychogeriatricians have often been involved in both selection and

ongoing review of residents. A close working relationship with social services is essential and is facilitated if they have their own 'elderly' teams.

The principles of the CPA were well established in old age psychiatry before it became a formalised process. For patients at risk, or requiring mixed health and social care input, the CPA assessments and reviews can be helpful in coordinating support, and clarifying responsibilities, as well as making contingency plans to cope with crises or the breakdown of care at home. The meetings are time-consuming, but are helpful to families and other grass roots carers and serve to forge links between the CMHNs and their other community colleagues. It is important for consultants to participate when needed, and can be a useful exposure for trainees; the infrequency of attendance by GPs is regrettable. Use of supervision orders and supervised discharge tends to be much less in old age than general psychiatry. We, at the time of writing, have used these procedures only seven times and once respectively (see Chapter 19).

Domiciliary care agencies

The proliferation of the independent provision of domiciliary care since the implementation of community care has increased the complexity of monitoring patients and their carers in the community. Responsibility for care management usually lies with a social worker, but it is often the CMHNs who have the skills to guide carers confronted with, sometimes difficult, patients with dementia. CMHNs often act as care managers, in all but name. An increasing proportion of domiciliary care is now provided by private agencies (some diversifying from residential care) whose staff selection and training may be far from rigorous. This is obviously an area of risk for vulnerable people with dementia, particularly if they live alone and have little family contact. This underlines the need for vigilance by CMHNs.

Voluntary services

The Alzheimer's Disease Society plays an invaluable role as a self-help organisation, and a source of information to patients and their carers, when first confronted by a dementing illness. At both local and national levels it has been very effective as a pressure group, and as a fundraiser for research or local service projects. Like Age Concern, it also provides some domiciliary and day care services (see Appendix for a list of useful addresses).

Conclusion

Services for the elderly mentally ill have evolved rapidly since the 1960s. They have often been developed at a local level by committed individuals. They have had to reflect changes in Government policy, and have been

Box 13.8 Links with other services

Geriatric medicine, nationally (British Geriatrics Society) and locally
Social services, including care programme approach meetings
General practitioners
Community psychiatric nurses
Private sector, including residential home staff
Voluntary agencies, including the Alzheimer Disease Society

consistently underfunded. Present services are based around the multidisciplinary team, where community psychiatric nurses play a central role. Day care and in-patient care can complement each other. Better links with other agencies are important for future development.

References

Arie, T. (1970) The first year of the Goodmayes psychiatric service for old people. *Lancet, ii*, 1179–1182.

Arie, T. (1983) Organisation of services for the elderly: implications for education and patient care – experience in Nottingham. In *Geropsychiatric Diagnosis and Treatment* (ed. M. Bergener), pp. 189–195. New York: Springer.

––– & Dunn, T. (1973) A 'do-it-yourself' psychiatric-geriatric joint patient unit. *Lancet, ii*, 1313–1316.

––– & Jolley, D. (1983) Making services work: organisation and style of psychogeriatric services. In *Psychiatry of Late Life* (eds R. Levy & F. Post), pp. 222–251. Oxford: Blackwell.

Bergmann, K., Foster, E. M., Justin, A. W., *et al* (1978) Management of the demented elderly patient in the community. *British Journal of Psychiatry*, **132**, 441–447.

Clarke, M. G., Hughes, A. & Dodd, K. (1979) The elderly in residential care: patterns of disability. *Health Trends,* **2**, 17–20.

Coles, R. G., von Abendorff, R. & Herzberg, J. L. (1991) The impact of a new community mental health team on an inner city psychogeriatric service. *International Journal of Geriatric Psychiatry*, **6**, 31–39.

Dening, T. (1992) The community psychiatry of old age: a UK perspective. *International Journal of Geriatric Psychiatry,* **7,** 757–766.

Department of Health (1995) *NHS Responsibilities for Meeting Continuing Health Care Needs*, HSG(95)8 LAC(95)5. London: Department of Health.

Department of Health and Social Security (1970) *Psychogeriatric Assessment Units*, circular HM 70 (II). London: HMSO.

––– (1972) *Service for Mental Disorder Related to Old Age*, Circular HM 72 (71). London: HMSO.

––– (1975) *Better Services for the Mentally Ill*. London: HMSO.

Donovan, J. F., Williams, I. E. L. & Wilson, T. S. (1971) A fully integrated psychogeriatric service. In *Recent Developments in Psychogeriatrics* (eds D. W. K. Kay & A. Walk), pp. 113–123. Ashford: RMPA.

Fasey, C. (1994) The day hospital in old age psychiatry: the case against. *International Journal of Geriatric Psychiatry*, **9**, 519–523.

Godber, C. (1978) Conflict and collaboration between geriatric medicine and psychiatry. In *Recent Advances in Geriatric Medicine* (ed. B. Isaacs), pp. 131–142. London: Churchill Livingstone.

Hargreaves, S. (1989) A model for long term care – assessment at 2 years. *Geriatric Medicine,* **19** (5), 55.

Health Advisory Service (1982) *The Rising Tide: Developing Services for Mental Illness in Old Age*. London: HMSO.

House of Commons Select Committee on Health (1996) *Long Term Care: Future Provision and Funding, Third Report,* HCP 59/95/96. London: HMSO.

Howard, R. (1994) Day hospitals: the case in favour. *International Journal of Geriatric Psychiatry*, **9**, 525–529.

Jennings, C. (1984) *Psychiatric Care in Eight Register Areas: Statistics from Eight Psychiatric Case Registers in Great Britain 1976–1981.* Southampton: University of Southampton.

Joseph Rowntree Foundation (1996) *Meeting the Costs of Continuing Care: Recommendations*. York: Joseph Rowntree Foundation.

Levin, E. (1991) Carers – problems, strains and services. In *Psychiatry in the Elderly* (eds R. Jacoby and C. Oppenheimer), pp. 301–312. Oxford: Oxford University Press.

Lindesay, J. (ed.) (1991) *Working Out: Setting Up and Running Community Psychogeriatric Teams*. London: Research and Development for Psychiatry.

–––, Briggs, K., Lawes, M., *et al* (1991) The Domus philosophy: a comparative evaluation of a new approach to residential care for the elderly. *International Journal of Geriatric Psychiatry,* **6**, 727–736.

Macdonald, A., Goddard, C. & Poynton, A. (1994) The impact of 'Open Access' to specialist services – the case of community psychogeriatrics. *International Journal of Geriatric Psychiatry,* **9**, 709–714.

Macmillan, D. (1960) Preventive geriatrics. *Lancet*, *ii*, 1439–1440.

Murphy, E. (1989) *Home or Away?* London: National Unit for Psychiatric Research.

Norman, A. (1987) *Severe Dementia: The Provision of Long-Stay Care*. London: Centre for Policy on Ageing.

Pearson, N. D. (1988) An assessment of relief hospital admission for elderly people with dementia. *Health Trends*, **20**, 120–121.

Pitt, B. (1974) *Psychogeriatrics* (1st edn). Edinburgh: Churchill Livingstone.

––– (1992) Damning evidence. *British Medical Journal,* **304,** 323.

Portsmouth, O. H. D. (1973) The organisation of psychogeriatric care. *Modern Geriatrics,* **3**, 553–556.

Post, F. (1965) *Clinical Psychiatry of Late Life*. Oxford: Pergamon.

Rai, G. S., Bielawska, C., Murphy, P. J., *et al* (1986) Hazards for elderly people admitted for respite ('holiday admissions') and social care ('social admissions'). *British Medical Journal,* **292**, 240.

Robinson, R. A. (1962) The practice of a psychiatric geriatric unit. *Gerontologia Clinica,* **1,** 1–19.

Rosenvinge, H. P. (1994) The role of the psychogeriatric day hospital. *Psychiatric Bulletin,* **18**, 733–736.

–––, Dawson, J. & Guion, J. (1986) Sitting service for the elderly confused. *Health Trends,* **18**, 47.

Roth, M. (1955) The natural history of mental disorder in old age. *Journal of Mental Science,* **101**, 281–301.
Royal College of Physicians (1994) *Geriatric Day Hospital: Their Role and Guidelines for Good Practice. Report of the Research Unit of the Royal College of Physicians and the British Geriatrics Society.* London: Royal College of Physicians.
––– & Royal College of Psychiatrists (1989) *Care of Elderly People with Mental Illness: Specialist Service and Medical Training*. London: Royal College of Physicians.
Royal College of Psychiatrists (1979) Guidelines for collaboration between geriatric physicians and psychiatrists in the care of the elderly. *Bulletin of the Royal College of Psychiatrists,* **3**, 168.
Royal College of Psychiatrists & British Geriatrics Society (1992) Revised guidelines for collaboration between physicians in geriatric medicine and psychiatrists of old age. *Psychiatric Bulletin,* **16**, 583–584.
Selley, C. & Campbell, M. (1989) Relief care and risk of death in psychogeriatric patients. *British Medical Journal,* **298**, 1223.
Wattis, J. P. (1988) Geographical variations in the provision of psychogeriatric services for old people. *Age and Ageing*, **17**, 171–180.
––– (1989) A comparison of 'specialised' and 'non-specialised' psychiatric services for old people in the United Kingdom. *International Journal of Geriatric Psychiatry*, **4**, 59–62.
–––, Wattis, L. & Arie, T. (1981) Psychogeriatrics: a national survey of a new branch of psychiatry. *British Medical Journal,* **282**, 1529–1533.
Whitehead, J. A. (1972) Services for older people with mental symptoms. *Community Health,* **4**, 83–86.
Wilkin, D., Hughes, B. & Jolley, D. J. (1985) Quality of care in institutions. In *Recent Advances in Psychogeriatrics* (ed. T. Arie), pp. 103–118. Edinburgh: Churchill Livingstone.

Additional reading

Age Concern (1991) *Issues in Financing Residential and Nursing Home Care*. London: Age Concern.
Department of Health and Social Security (1989) *Caring for People: Community Care into the Next Decade and Beyond*. London: HMSO.
Levin, D. (1991) Psychiatric services for the elderly carers – problems, strains and services. In *Psychiatry in the Elderly* (eds R. Jacoby & C. Oppenheimer), pp. 301–312. Oxford: Oxford University Press.
Murphy, E. (1997) Dementia care in the UK: loking towards the millenium. In *Advances in Old Age Psychiatry* (eds C. Holmes & R. Howard), pp. 128–134. Bristol, PA: Wrightson Biomedical Publishing.
Norman, A. (1982) *Mental Illness in Old Age: Meeting the Challenge*. Policy Studies in Ageing No. 1. London: CPA.