Editorial

Old age psychiatry in the modern age†

James P. Warner

Summary
Old age psychiatry services globally are under threat. The discipline enjoyed its heyday in the two decades bridging the millennium. More recently there has been a move to integrate old age services with those of working age adults, to create ‘ageless’ services. Evidence is beginning to accumulate that this is a bad idea.

The development and decline of the specialty
The first specialised old age psychiatry services began in the late 1950s. They were much needed! Prior to that, there had been scant regard for the mental health needs of older people. Those who had necessitated admission to hospital were often cared for on ‘back-wards’ with little regard to their mental health, physical needs or social welfare. Notwithstanding these pioneering services, the development of the specialty was slow, despite the fact that there had been a number of policy reports identifying the gap, and recommending solutions. However, during the 1970s and 80s, the specialism gained ground with the development of dedicated, consultant-lead, multidisciplinary teams serving both community patients and providing in-patient and day hospital facilities. More recently there has been a move to integrate old age services with those of working age adults, to create ‘ageless’ services. Evidence is beginning to accumulate that this is a bad idea.

Action to protect old age services
In response to this, the Faculty of the Psychiatry of Old Age of the Royal College of Psychiatrists set about trying to protect remaining old age services and restore those that have gone ageless. After extensive stakeholder consultation new service criteria defined around the needs of the older people that the old age

Declaration of interest
J.W. is Chair of the Faculty of Old Age Psychiatry at the Royal College of Psychiatrists. He hopes to grow old and, if he needs mental health services wants to be looked after by appropriately skilled professionals.

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†See pp. 440–443, this issue.
teams serve, rather than a criterion based on a patient passing a specific birthday, were developed. The new needs-lead criteria are as follows.

(a) People of any age with a primary dementia.
(b) People with mental disorder and physical illness or frailty that contribute(s) to, or complicate(s) the management of their mental illness. This may include people under 65.
(c) People with psychological or social difficulties related to the ageing process, or end of life issues, or who feel their needs may be best met by a service for older people. This would normally include people over the age of 70.

The Faculty also undertook a broad publicity campaign, writing to politicians, publishing a joint commissioning guide that was sent to all healthcare commissioners in the UK. We also sent a letter, co-signed by several national organisations including the Royal College of Nursing and British Geriatrics Society, to all chief executives and medical directors of mental health trusts, advising against moves to ageless services.

One difficulty we faced in this task is a lack of sufficient evidence that old age services do confer benefits for older people. The paper by Abdul-Hamid et al provides such evidence. They found that older people who had graduated (a horrible word in this context) from working age adult services to specialist old age services had significantly fewer unmet needs than those who continue to be looked after in adult psychiatry, despite the total needs not being significantly different between the two groups. Particularly when service planning is so devoid of any robust evidence, and so many service changes are made based on intuition and heuristics rather than any evidence, this paper is very welcome in supporting old age services going forward.

Conclusions

The erosion of old age services in the UK has been watched closely by our colleagues around the world, who, it seems, are beginning to face similar difficulties. The good news is, at least anecdotally, some mental health trusts that have converted to ageless services are now reintroducing specific old age services. In the coming year the Faculty will repeat its national survey to better map the current service provision and future trends. In the meantime, it is imperative that we garner more evidence in the form of research like the paper by Abdul-Hamid and colleagues to support our arguments with commissioners and healthcare providers.

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