

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.

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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James Warner is a consultant old age psychiatrist in the Kensington, Chelsea and Westminster Older Adult Psychiatric Liaison Team in London and the medical director of Red & Yellow Care in London. He is Chair of the Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists.

This edition of the *BJPsych* sees the publication of an important article by Abdul-Hamid *et al*, assessing the quality of care of people with mental illness who grow old and transfer to an older adults service *vis à vis* those who remain in general adult services.¹ I cannot overemphasise the importance of this paper. The notion of specialist psychiatry services for older people, who have very different psychological, medical and social needs to adults of working age, is rather like having lifeboats on a cruise ship; intuitively a good idea, but there is little evidence to support the presence. This evidence is becoming increasingly important because, over the past few years in the UK, and indeed around the world, we have seen specialist old age services being dismantled and integrated into 'ageless services'. Before we look at the reasons and consequences of these changes in more detail, it is perhaps worth tracing the development of old age psychiatry as a specialism.

The development and decline of the speciality

The first specialised old age psychiatry services began in the late 1950s.² 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 speciality 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.³

By 1980, the Faculty of the Psychiatry of Old Age had been established at the Royal College of Psychiatrists in the UK, and the speciality gained its own postgraduate training programme and specialist postgraduate qualification. There are nearly 600 old age psychiatrists practising as consultants in the UK currently,

†See pp. 440–443, this issue.

and a recent survey, which represented 95% of National Health Service providers in the UK, found all delivered core old age mental health services. However, this survey revealed some worrying trends.⁴ In total, 11% of respondents identified that whole sections of core services had gone ageless, so an 18-year-old and an 80-year-old would be treated on the same ward or by the same community mental health team. A further 7% of trusts were considering making such a move. These results suggested that the discipline of old age psychiatry was under threat.

Such a threat would have significant consequences. Respondents who had experienced transition to agelessness reported significantly detrimental effects in the quality of care, patient safety, service efficiency and staff morale.⁵ Contemporaneous with the development of ageless services, there was a significant reduction in uptake of training posts in old age psychiatry. Without the next generation of old age psychiatrists being trained, the specialism would soon wither. Finally, since 2010 there were disproportionately more cuts in funding in old age services compared with adult services. The vultures were circling!

There are probably a number of reasons for this shift to ageless services. First, at around this time, both England and Scotland introduced equalities acts. Although careful reading of these acts would reaffirm that specific age-related services were appropriate and lawful, my suspicion is that some providers were shifting to ageless services for fear of falling foul of the legislation. The second reason is that these changes also occurred at the same time as one of the most severe periods of health austerity the UK has witnessed. Combining teams can be seen as an easy way of saving money, although the unintended consequences that may accrue from such changes are usually not factored into these equations. A third factor is a pervasive and pernicious institutionalised ageism still prevalent within the health sector.⁶ One piece of evidence to substantiate this statement is the substantial (over £2 billion annually) relative underfunding of old age psychiatric services relative to adults of working age – a disparity that resulted from the differential introductions of the national service frameworks over a decade ago but continues today.⁷

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

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.¹ 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.⁸ 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.

James Warner, MD, MRCP, FRCPsych, Kensington, Chelsea and Westminster Older Adult Psychiatric Liaison Team, CNWL NHS Foundation Trust, South Kensington and Chelsea Mental Health Centre, 1 Nightingale Place, London SW10 9NG, UK.
Email: j.warner@imperial.ac.uk

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