Old age psychiatry in Britain was born in the 1960s and 1970s, and came of age at its recognition by the government as a distinct specialty in 1989. Yet the need for it had been recognized as far back as the 1940s. Why was the gestation so long, and how has it developed in the last twenty years since its recognition? What can we learn from this history?

**THE EARLIEST DAYS**

The likelihood that older people would become major users of psychiatric services was identified during the Second World War. Increasing longevity meant there were more, and even older, old people. Falling birth rates increased the proportion of old people and since more women were in employment it was harder for them to take on traditional caring roles. Some of the more frail older people were cared for in ‘chronic sick’ and mental hospitals, which might be needed for war casualties.

Until the 1940s mental and physical ill health in old age had been considered largely irremediable. In the 1940s Marjory Warren, the pioneering geriatrician, demonstrated the scope for rehabilitating old people, psychiatrist Felix Post wrote on psychiatric differential diagnosis and multidisciplinary approaches to treatment, and Willi Mayer-Gross described how severely depressed old people could improve with electroconvulsive therapy (ECT). Despite the evidence of successful treatment, older people were not given priority in health policy. In 1942 the Beveridge Report laid the foundations of the ‘welfare state’ and a National Health Service (NHS). However, it stated, ‘It is dangerous to be in any way lavish to old age, until adequate provision has been assured for all other vital needs.’

After the war, at the instigation of Professor Aubrey Lewis, a psychiatric ‘geriatric unit’ was opened at the Bethlem Hospital in South London, part of the Bethlem-Maudsley postgraduate psychiatric teaching hospital (see Chapter 03). This unit was for functionally ill patients regarded as treatable. Patients with dementia, especially those requiring long stay care, were excluded, in part because of opposition from academic psychiatrists who did not see their care as being worthy of study and investigation.

We shall touch on matters relating to these early influences, since all run throughout the development of the specialty. In addition, each generation rediscovers the demography of ageing as if it were a new phenomenon. Yet unlike, say, trends in fertility, or in transportation, which cannot be predicted with certainty, we always know the size of prospective populations of older people and the epidemiology of the crucial illnesses. Repeatedly, the government has laid plans and failed adequately to implement or fund them, and then has ‘discovered’ afresh the scale of need. In 1950 we hear, ‘It is recognised that the present conditions of financial stringency limit opportunities for action at this time.’ In 2001, a national service ‘framework’ for older people had no allocated new funding for mental health, whereas a parallel framework for mental health for younger people was substantially funded.

Another initiative in 2007 to improve access to psychological therapies has followed an economic model and has been targeted towards getting unemployed younger people into work, although this may well be changing to become more inclusive across all ages. A contrast exists even within Britain: since 2002, Scotland provides both free personal and nursing care, if deemed appropriate after assessment, while England and Wales do not.

**WORKING WITH GERIATRICIANS**

Working with geriatricians is crucial in view of the multiple and interlinked disorders of old people, yet at times this has been erratic. Although active treatment, both physical and mental, was being advocated by the 1940s, geriatrics developed much earlier than psychogeriatrics. This was in part because many early geriatricians saw themselves as holistic practitioners for older people, therefore requesting little psychiatric assistance. The advocacy of Lord Amulree, a civil servant and geriatrician, and the other founders of geriatrics drew the successes of rehabilitation, including emptying hospital beds, to the attention of the government. Such a phenomenon did not occur in old age psychiatry until around 1970 when new local services, such as that established at Goodmayes Hospital in 1969, were drawn to the attention of the Department of Health and Social Security: only then it was recognized that a modern approach could reduce bed occupancy, improve outcomes and save money. Until the 1970s old age psychiatry in the UK was
characterized by research in clinical treatment, nosology, pathology and epidemiology, with only small pockets of local service innovation.

In 1970 there were 200 geriatric medicine consultants\textsuperscript{13} but only a handful of psychogeriatricians\textsuperscript{14,15}. By 2006 there were 700 psychogeriatricians\textsuperscript{16}. Where enthusiastic geriatricians and psychiatrists existed in a particular locality they collaborated. In addition, collaboration between the Royal College of Psychiatrists and the British Geriatrics Society\textsuperscript{17} since the 1970s has led to the development of guidelines for good practice and working collaboratively\textsuperscript{18}. Moving services away from isolated mental and ‘chronic sick’ hospitals and their coming together in district general hospitals has given better access to each other’s services. Sometimes this facilitated joint working, but formal joint services were rare. In 1977, a department of Health Care of the Elderly, comprising both medicine and psychiatry working together, along with other relevant disciplines and professions was set up in Nottingham. There was an orthopaedic-geriatric unit, a stroke unit and a continence service, and joint research, along with extensive teaching of medical students and postgraduate trainees of relevant disciplines, and of overseas workers\textsuperscript{19–21}.

‘Memory clinics’ are another development, now widespread, with their roots in both psychogeriatric and geriatric practice in the mid-1980s\textsuperscript{22}. More recent developments include psychiatric liaison services for patients with acute physical illness in district general hospitals\textsuperscript{23}. Jointly run ‘intermediate care’ or ‘convalescent’ rehabilitation units for confused older people, especially those recovering from both delirium and physical illness, are also new. Geriatricians and psychiatrists still have much to learn from each other, and ‘seamless’ services remain the ideal. ‘Guidelines for collaboration’ have recently been updated\textsuperscript{24}.

WORKING WITH PSYCHIATRISTS CARING FOR YOUNGER PEOPLE

Before the establishment of the specialty, mentally ill old people requiring secondary care were the responsibility of general psychiatrists, but they rarely showed interest in actually working with them, especially those with dementia. However, some of the pioneering psychogeriatric services, such as Sam Robinson’s in Dumfries (1958)\textsuperscript{25}, or Brice Pitt’s at Claybury, Essex (1966)\textsuperscript{26}, emerged in part due to the far sightedness and encouragement of general psychiatrists who were medical superintendents of mental hospitals. Despite such early developments, it took until 1989 for the Royal College of Psychiatrists and the government to agree officially to the creation of the new specialty of old age psychiatry. Until then, lack of recognition meant that it had often been impossible to extract from official statistics adequate data on older people’s use of services, and hence to establish the scale of need for services and for training.

Competition for resources is inevitable, so long as resources are limited. The low status of the aged, the perceived needs of people of working age, and the common misperception that young severely mentally ill people are frequently dangerous have generally resulted in funding for services for younger people disproportionately exceeding that for older people.

A CENTRAL BODY FOR COORDINATING DEVELOPMENT

A powerful national focus for securing improved recognition and better resources has been the flourishing Faculty of the Psychiatry of Old Age at the Royal College of Psychiatrists (since 1988), and its predecessor bodies (from 1973). It has, among other things, encouraged research, innovation, multidisciplinary working, and links with voluntary and statutory organizations and with the government, and has taken an interest in architecture and design for elderly confused people\textsuperscript{27}. A first series of newsletters in the 1980s served as a constructive means of communication among clinicians. A second series since 1996, available online since 2000 (www.rcpsych.ac.uk/college/faculties/oldage/newsletter.aspx), often expresses thoughtful comment related to current clinical and policy dilemmas. Faculty meetings have remained a source of debate, education, inspiration and problem solving. The Faculty’s website is a mine of information (www.rcpsych.ac.uk/college/faculties/oldage.aspx).

RESEARCH AND ACADEMIC DEVELOPMENT

Research on older people’s mental health has flourished and has helped the development of evidence-based practice. Sir Martin Roth in the 1950s defined the major diagnostic categories in older people\textsuperscript{28}, rather as Emil Kraepelin had done 50 years earlier for younger people. Felix Post undertook follow-up studies of treatment of depression and psychotic disorders. Nick Corsellis\textsuperscript{29} followed by Bernard Tomlinson, Martin Roth\textsuperscript{30} and Elaine and Robert Perry unpicked the neurological and neuropathological features of Alzheimer’s disease\textsuperscript{31}. Early research by Raymond Levy into lecithin and later tacrine was a forerunner of today’s evidence-based antidementia drugs\textsuperscript{32}.

Difficulty in obtaining funding for research has been characteristic\textsuperscript{15}. But the growth of the neurosciences, along with the influence of bodies such as the Alzheimer’s Society, has enhanced the scale of funding for research into the dementias, and has attracted able workers.

Research has also grown through the development of academic departments of old age psychiatry. The first old age psychiatrist to be appointed professor became head of the joint department of Health Care of the Elderly in Nottingham in 1977. The first professor of old age psychiatry, at Guy’s Hospital, London, was appointed in 1983. The International Journal of Geriatric Psychiatry was started in 1986. In 1989 there were half a dozen professorial departments\textsuperscript{33}; now most medical schools have an academic presence for old age psychiatry, and many NHS consultants are involved in teaching medical students and postgraduates. Many other departments in universities are now conducting relevant research, and there are further thriving journals.

TEACHING AND TRAINING

Biographical information reveals that many colleagues did not envisage becoming old age psychiatrists, but were inspired by others to do so; they saw and experienced what could be done to help old people. Such effective teaching is crucial\textsuperscript{15}.

Sharing our knowledge with other specialties and disciplines can change the way colleagues respond to elderly mentally ill people – in primary care, in management, in palliative care, social services, learning disability services, voluntary organizations, Citizens Advice Bureaux, and within the multidisciplinary teams within which we work. Other groups that have sought teaching include architects, designers, lawyers and the police.

Structured training for old age psychiatrists has also evolved over the years. The earliest psychogeriatricians in the 1960s and 1970s had little or no specific training. Six months’ experience in old age psychiatry is considered valuable for trainees in psychiatry and in
general practice. Specialized training for career old age psychiatrists is during the last three years of a six-year psychiatry training scheme. There is a competency-based curriculum, and at least two years (full-time equivalent) old age psychiatry in recognized training posts are usually required.

CLINICAL INNOVATION

The demise of the vast Victorian mental hospitals, the coming of community care, more liberal mental health legislation and new effective psychopharmacology have all helped to shape the progress of psychiatry since the 1950s. The psychogeriatricians have consistently fought to prevent older people being left behind younger people in new developments. Important classic texts of innovation in old age psychiatry such as In the Service of Old Age by Tony Whitehead (1971) deserve particular mention, as do the reports in the 1960s and 1970s of abuses in the unfashionable sectors of care. The Ely Hospital Report (1969) was also instrumental in bringing about the Hospital (later Health) Advisory Service (HAS), which advised on the neglected areas of the health service. The HAS was a valuable ally of the early old age psychiatrists, encouraging and spreading good practice. Its first director became an old age psychiatrist upon demitting office.

Home assessment and support by consultants and other team members was the norm: in some services this is still the usual first point of contact. Initial assessment at home was introduced in the 1960s, in order to evaluate, in the light of knowledge of the home setting, who could be helped without hospital admission, or who might need a medical or a surgical bed rather than psychiatric help. Often the entire management of the patient could be undertaken in the patient’s home. Home assessment and treatment is valued by patients, carers and staff, and it helps to build a close working relationship with the local community, and is popular with medical students.

The importance of support for carers of people with dementia has long been recognized. Respite admissions, social services day care, help with personal care at home and the Admiral Nurse service established in 1994 (www.fordementia.org.uk/admiral.htm) are important in delivering such support.

Psychotherapy, including family therapy with old people and their adult children, dates from the 1960s but is still not widespread, despite pockets of enthusiasm. In a very few places psychiatric intensive care units, in particular providing care for elderly men with dementia and disruptive behaviours, have evolved, such older people being excluded from similar services for younger people. Elsewhere, intensive home treatment teams are appearing for even those with severe mental illness such as would traditionally require admission.

Old age psychiatry day hospitals date from the 1950s onwards. They were often a substitute for long stay care for people with chronic mental illness living at home or with their family. More recently they have developed to offer assessment, treatment, rehabilitation and support such as might be beyond the capacity of a social care day centre. They enable some with particularly disruptive behaviours unmanageable by a social care day centre to remain in the community.

More recently as ‘ethnic minority’ populations have aged, understanding cultural and religious customs and attitudes to mental illness and ageing has become important in many local communities.

Other disciplines have developed in parallel to old age psychiatry. The British Psychological Society, for example, established a special interest group for psychologists working with older people in 1980 (www.psige.org/index.php).

Without evaluated creativity, we would not have the rich array of services that, despite constraints of limited funding, serve our patients, their relatives and carers. But by no means every service for older people yet has all the components described above (see Table 2.1).

LONG STAY CARE

Up to the 1980s, most long stay care for dementia, along with that of aged people with chronic psychosis, took place in hospitals. Local authority residential homes were intended to care for frail old people, but with the passage of time they too increasingly became facilities for demented people, but lacking nursing skills and facilities appropriate to their residents’ needs. During the Thatcher era of the 1980s, long stay care in hospitals was replaced by care in commercial, or, less often, charitable homes. Surveillance of standards in multiple dispersed units became very difficult. Third party inspection and definition of ‘minimum standards’ was instituted by the Blair government. Education and training of care home staff, long virtually absent, is now becoming more prevalent. But ‘scandals’ in the care of old people continue, and although they often achieve publicity, they generally evoke less indignation and less remedial action than similar scandals in child care. Fortunately, architects and designers often now devote special skills to the needs of old people.

THE FUTURE

Old age psychiatrists, like workers in other health specialties, practise within the context of the structure and culture of society. At the time of writing we enter a recession, with uncertainty about the future, but with ever more evidence of the effectiveness of our interventions.

There are more government initiatives. The National Dementia Strategy, emphasizes raising awareness, early diagnosis and intervention, and improving quality of care in dementia, and is welcome on that account. However, the government’s initial financial backing for the strategy amounts to less than 1% of the total annual cost of dementia care. It is hard to believe that this will make any significant impact. In addition it states, ‘Decisions on funding for subsequent years will only be made once we have had the opportunity to consider

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<td><strong>Core features are likely to include:</strong></td>
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<td>Community: assessment, diagnosis, treatment, rehabilitation</td>
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<td>Inpatients: acute assessment and continuing care</td>
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<td>Memory service</td>
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<td>Support for carers</td>
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<td>Liaison service to geriatric, medical and surgical wards</td>
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<td><strong>Other:</strong></td>
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<td>planning</td>
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the results from the initial demonstrator sites and evaluation work. There is no expectation therefore that all areas will necessarily be able to implement the Strategy within five years. This resonates with previous policies advocating good practice, which are neither mandatory nor adequately funded.

A new Mental Capacity Act seeks to provide a statutory framework to protect vulnerable people who are not able to make their own decisions. There is also new legislation relating to ‘deprivation of liberty’, significantly affecting people with dementia who lack capacity to decide on their place of care, to determine whether and how they can be confined to a care home or hospital in their best interests. The new Equality Bill should prevent discrimination in services on the basis of chronological age. However, it also carries the paradoxical risk that a separate service for old people may be regarded as discriminatory. Challenges to our special services have long arisen from this viewpoint, and we must continue to show that special services for an inherently low status and thus usually neglected group make for better care, and to point to the reasons why.

Legal and medical changes, and changes in society, will raise new questions, but the 1970s adage for an old age psychiatrist will continue to be ‘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’.

REFERENCES