

GUEST EDITORIAL

Wither old age psychiatry?

I think it is fair to say that the UK was one of the first countries to develop dedicated old age psychiatry services. The first such documented service was set up in the Crichton Royal Hospital in Dumfries in 1958 (Robinson, 1965). This arose after decades of recognition that older people with mental illness get a raw deal if they are managed in adult services (Hilton, 2012). Following a slow start, specific old age services began to burgeon. The discipline got recognition as a separate faculty in the Royal College of Psychiatrists in 1988, and throughout the eighties and nineties, virtually all areas of the UK developed their own specialist old age psychiatry services; multi-disciplinary teams working with people over the age of 65 generally providing community-based services with input to people's homes as the norm.

There are a number of benefits to having dedicated old age services. First, the needs of older people would tend to be eclipsed by adults of working age who often present in more dramatic fashion, and with a very different psychopathology, epidemiology and social needs. Older people tend to have far more physical health issues, particularly physical health issues that either cause or complicate the management of mental illness; old age psychiatrists *par excellence* understand the interfaces between physical medicine and psychiatry. Old age psychiatrists are also very skilled in dealing with social and psychological issues related to aging, such as bereavements, isolation, and existential concerns, and psychological issues relating to end of life. Traditionally, old age psychiatry has advocated home-based services, which overcomes the problems of frailty and cognitive impairment impeding access.

This happy situation pertained in the UK until the middle of the first decade of the 21st century. Since this time, there have been a number of significant structural changes in the health services in the UK. This includes a very different way of commissioning healthcare, devolvement of power (and accountability) from the government down to local commissioning groups, and the introduction of a competitive healthcare market where private healthcare providers are enabled to tender for services that were traditionally the realm of the National Health Service (NHS). A number of other issues have occurred which have probably

impacted on how services are commissioned and run. This includes the introduction of Equalities Act across the component countries of the UK, which essentially means that individuals cannot be discriminated against in terms of service provision by virtue of their age. A further, highly significant issue is that we have had a period of austerity, unparalleled since the inception of the NHS in 1948, and for the first time, health funding in the UK is being cut in real terms.

Development of ageless services

The concatenation of austerity, Equalities Act, and changes in commissioning have, I believe, led to a situation that has fostered the erosion of old age psychiatry as a specialty. Over the last few years, anecdotal reports of “ageless” services have emerged from various quarters, but there was little evidence to suggest to what extent this was happening. The Old Age faculty of the Royal College of Psychiatrists therefore conducted a national survey of service provision in the autumn of 2012. We received responses from 97% of NHS healthcare providers (trusts) in the UK, including Scotland, Wales, and Northern Ireland, and a rather dismal picture emerged. Approximately 11% of trusts had moved substantially to ageless services where people of all ages were treated by the same service (Warner and Jenkinson, 2013). This predominately affected people with functional disorders, which account for about two-thirds of psychiatric morbidity in this age group. Some health providers had reduced old age psychiatric services into dementia-only services, which disregards the strong and complex association between dementia and functional illness. Worryingly, nearly 10% of health providers were planning such a move. Therefore, the current picture in the UK is that around a fifth of mental health service providers had either already created services where a 19-year-old and a 90-year-old may be treated by the same community mental health team or admitted to the same ward, or were planning such services.

We followed this with a more in-depth study of the impacts of the move to agelessness by sampling only those individuals who had identified that they had experienced such a switch

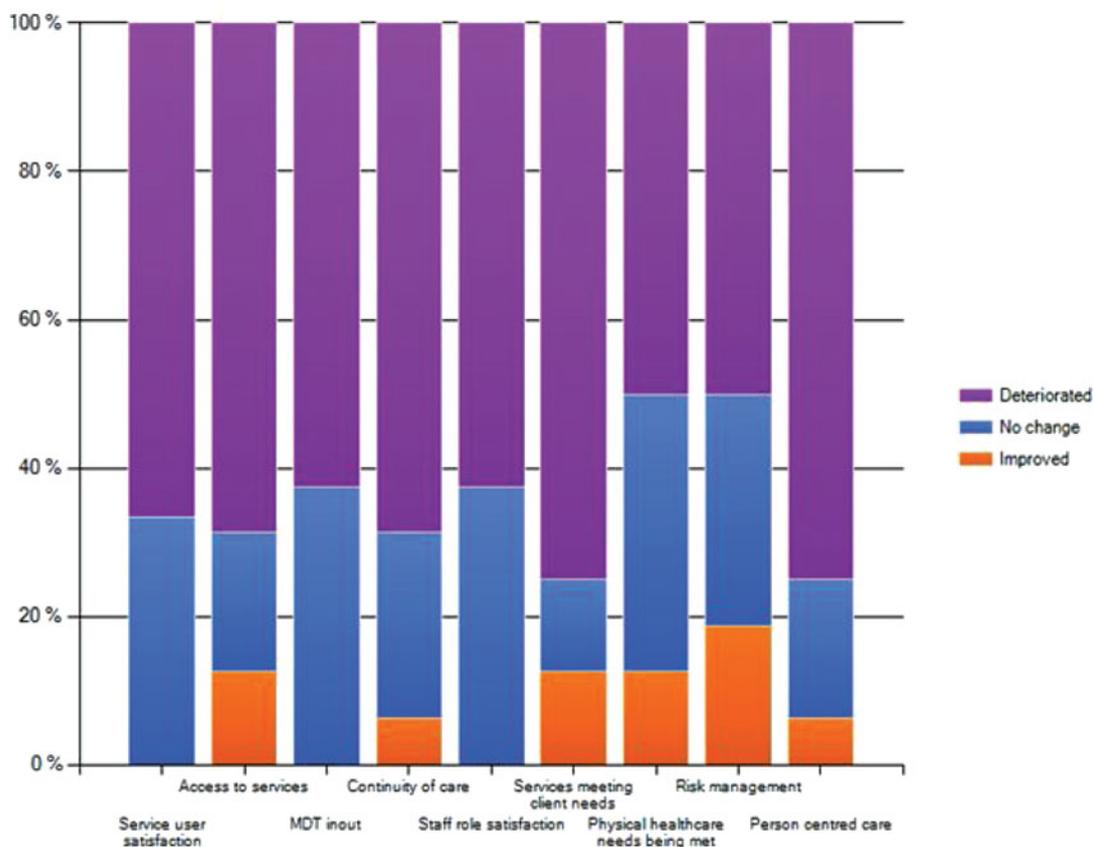


Figure 1. Impact of ageless services showing most respondents reported deterioration of outcomes.

(38 respondents). We enquired about 19 different outcomes, including patient satisfaction, patient safety, and service utilization. In every domain assessed, the move to agelessness was associated with more negative outcomes (see [Figures 1 and 2](#)).

Over three quarters of old age psychiatrists in the second survey believed that the switch to ageless services was bad news. This stance was supported by a large number of external stakeholders who were co-signatories to a letter sent to all of the chief executives and medical directors of mental health trusts in the spring of 2013. Stakeholders including the Royal College of Nursing, the British Geriatric Society, British Psychological Society, Royal College of Psychiatrists, and NHS Confederation all oppose the move to agelessness.

What are the consequences of ageless services? First and most important is that recruitment to old age psychiatry training in the UK has fallen dramatically. Without talented and enthusiastic trainees to replace the current generation of old age psychiatrists, it does not matter how services are configured, the discipline will wither and die. Another consequence is poor outcomes for older patients using generic adult services. But, perhaps most importantly, the philosophy that older people

are a unique group, with a unique set of needs and requirements, is being eroded.

The way forward

Given that in the UK it may now be unlawful (and it remains illogical) to define access to old age services as passing your 65th birthday, and the lack of an alternative service criterion may have contributed to ageless services, the Old Age Faculty of the Royal College of Psychiatrists set out to develop needs-based service criteria. These were designed after extensive stakeholder consultation and ratified at our last executive. The hope is that they may help to overcome the definitional issues that have contributed to the erosion of the discipline ([Rajenthiran et al., 2013](#)). The new criteria are:

1. People of any age with a *primary* dementia.
2. People with mental disorder and physical illness or frailty which contributes to, or complicates the management of their mental illness. This may include people under 60.
3. People with psychological or social difficulties related to the aging process, or end of life issues, or who feel their needs may be best met by a service for

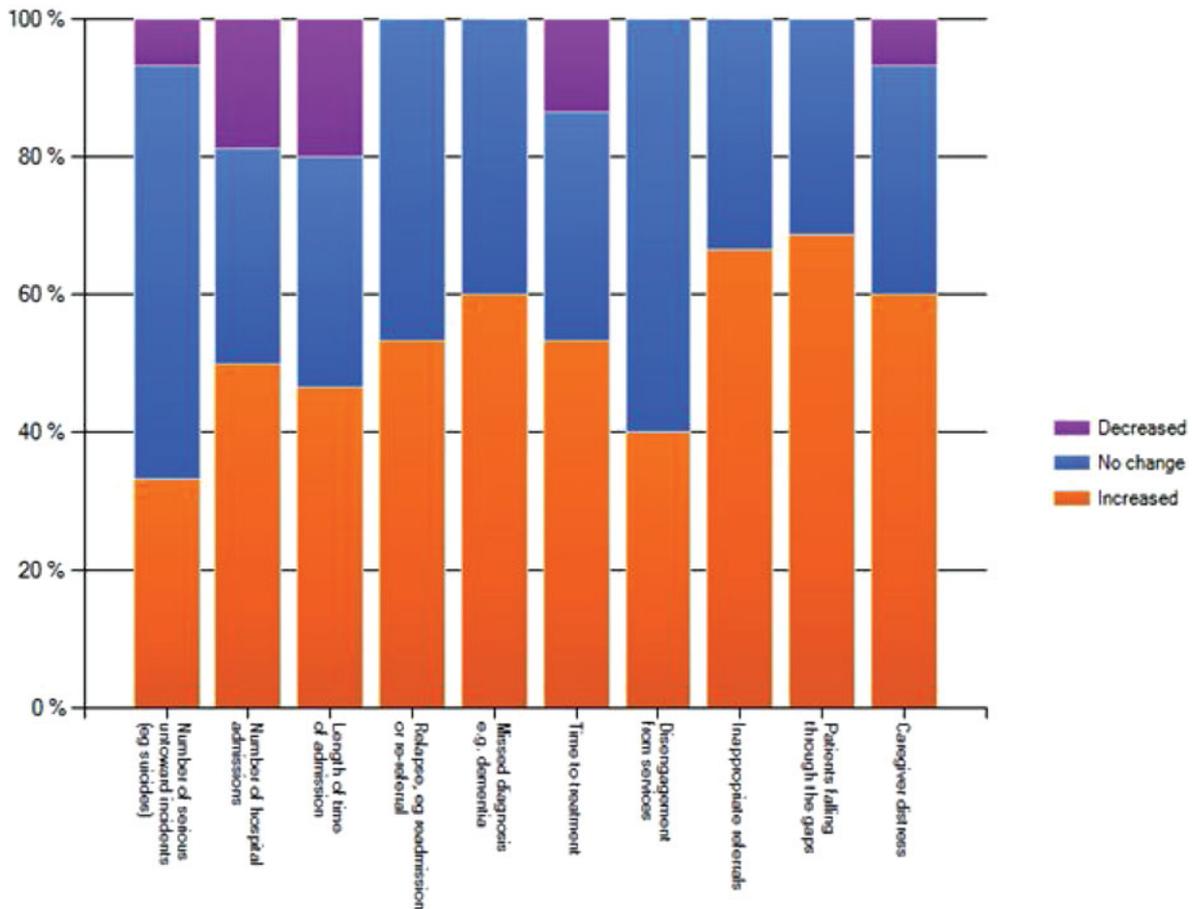


Figure 2. Transition to ageless services showing impact on outcomes.

older people. This would normally include people over the age of 70.

Another problem that has hampered our cause is a lack of robust evidence to support the notion that specialist old age services are better for older people than general adult services. The mantra repeated by commissioners and local managers is, “there is no evidence to say that old age services are better,” and this has been difficult to challenge. We are garnering some evidence, now we are on the back foot, but it is a shame the discipline has not developed an evidence base in the halcyon years.

A major concern is that, just as many countries around the world joined the UK in the development of old age psychiatry as a specialty, these countries may now begin to dismantle the services they have created. A letter recently published in *The Times* newspaper signed by 29 old age specialists from around the world demonstrates the significant international support for the cause of retaining dedicated old age services (Warner *et al.*, 2014). This alone is not enough. What is needed is vigilance in every country that provides such services, close collaboration in helping to assemble

an evidence base to defend our specialty, and a clearly articulated international vision that older people should get the services they deserve. Without this the specialty will wither on the vine.

Conflict of interest

None.

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