Further developments in psychogeriatrics in Britain

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In 1981 we reported the rapid recent growth of psychogeriatric services, a major new development in the National Health Service.¹ Recent publications such as *The Rising Tide*,² *Care in Action*,³ and *Mental Illness in Old Age: meeting the challenge*⁴ emphasise the increasing needs of the elderly mentally ill and the efforts required to meet them. Two new chairs in old age psychiatry have been created, at Guy's Hospital and at the Institute of Psychiatry. We now report further developments in this field with special reference to numbers of consultants and opportunities for higher training. Our earlier survey described the position at the end of 1980; reported here is the position as surveyed at the end of 1983.

Over 200 consultant psychiatrists were identified as being likely to be working specifically in old age psychiatry. One hundred and fifty eight of these replied to a questionnaire, from which a "core group" was identified of 126 psychiatrists providing well defined special services for old people ("psychogeriatricians"). Forty of these had started to work as consultants in this specialty since the previous survey. Allowing for others known to be doing this work but who did not respond in 1983, we estimate that at the time of the survey there were 150 consultant psychogeriatricians in the United Kingdom, an increase of 25% on our 1980 estimate of 120.

In 1983 one third of the services concerned more than one consultant, compared with only one quarter in 1980. The proportion of consultants giving the whole of their time to this work had increased, from just over a third to almost one half. In addition to the increase in consultants, respondents who replied to both surveys showed a net gain of 67 sessions devoted to psychogeriatrics (equivalent to six more full time posts). Over 100 districts (or their equivalents in Scotland and Northern Ireland), however, were without an identified psychogeriatrician. The age distribution of consultant psychogeriatricians is shown in the figure.

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Ages of consultant psychogeriatricians at 31 December 1983 (118 valid observations; mean age 44.1 years).

Senior registrars

The Joint Committee on Higher Psychiatric Training requires senior registrars training for special responsibility posts in psychogeriatrics to spend between one year and 18 months in higher training posts in which psychogeriatrics forms the main part of the work. Although we identified 28 established senior registrar placements, only 14 of them met the joint committee's criteria and were available at least two years in every three. This is equivalent to 12% of the number of current consultant posts, which compares with ratios in general psychiatry and in the other major medical specialties of between 19% and 26%.⁵ Seven senior registrar posts temporarily established for training in this subject in 1979 account for one half of the satisfactory posts available. This shortfall has only partly been offset by a small number of determined senior registrars who obtained elective posts in psychogeriatrics; but the development of higher training clearly is not keeping pace with the rapid expansion of consultant posts. Between 1979 and 1982 the Royal College of Psychiatrists provided assessors for an average of 26 consultant psychogeriatrician appointment committees a year, and in 1983 for 33 (personal communication). Although direct information is not available, our inquiries suggest that about two thirds of these committees made an appointment.

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gives the best value for the money spent: they must be managed efficiently. Policies must be based on a long term, consistent, and coherent strategy, albeit one that is flexible enough to take account both of changing demands and of scientific advances. The NHS should be a patient oriented service. All the different professions, disciplines, and other groups involved in it must give first priority to agreed objectives for improving health care.

Good management does not absolve the government from ensuring that its policies and priorities for developing the health service are well conceived and are adequately funded through wise economic and fiscal policies. As politics are nothing more, according to Virchow, than medicine on a large scale, politicians may have something to learn from the physician about the rehabilitation of the body politic when it becomes sick. In emergencies or crises in which there is no alternative treatment radical and hazardous measures may be justified; but, even in such circumstances, the wellbeing of the whole patient is paramount. The physician must judge how much of his treatment the patient can endure.

Over the next few years we can expect many new posts to be advertised as health districts without a psychogeriatrician strive to obtain one, and as larger districts create further posts. Our earlier survey showed that although most posts were filled by senior registrars, some were filled by established general consultant psychiatrists "converting" to old age psychiatry; there is thus a wide age range among existing consultants.¹ Although flexible retirement options for psychiatrists make prediction difficult, it is likely that, in addition to expansion, there will be four to five consultant vacancies a year from retirement.

At present there are not enough senior registrar posts to meet the combined needs of new posts and retirement vacancies. A doubling of the number of satisfactory training posts should help to provide sufficient properly trained candidates for the new posts. In the absence of official manpower statistics on "psychogeriatrics," which is not distinguished from general psychiatry, further surveys such as ours will be needed to monitor developments and to measure continuing needs.

We thank Lorna Rowden, who has undertaken extra work to make this survey possible, and Jane Manley and Jane Boyce at the Royal College of Psychiatrists, who provided data on appointment committees and consultants' ages.

References

- Wattis JP, Wattis L, Arie T. Psychogeriatrics: a national survey of a new branch of psychiatry. *Br Med J* 1981;282:1529-33.
- National Health Service Health Advisory Service. *The rising tide*. National Health Service, Sutton, Surrey, 1982.
- Department of Health and Social Security. *Care in action*. London: HMSO, 1981.
- Norman A. *Mental illness in old age: meeting the challenge*. Centre for Policy on Ageing: London, 1982.
- Department of Health and Social Security Medical Manpower Section. *Medical and dental staffing prospects in the NHS in England and Wales, 1982*. *Health Trends* 1983;15:35-9.

(Accepted 8 June 1984)

No matter how promising it may be in theory, its side effects in practice must not be so adverse that existence for the patient becomes intolerable. Sensitivity, judgment, and compassion are all important. In the prescription of its remedies for the body politic including those measures directed at the NHS, the government requires to exhibit similar sensitivity, judgment, and compassion.

I should like to thank Mr T D Hunter and other members of the secretariat of the Scottish Health Service Planning Council for their advice and help.

References

- Scottish Home and Health Department. *Scottish health authorities priorities for the eighties*. Edinburgh: HMSO, 1980. (Shape report.)
- Scottish Home and Health Department. *Scottish health authorities revenue equalisation*. Edinburgh: HMSO, 1977. (Share report.)
- Department of Health and Social Security. *Sharing resources for health in England: report of the resource allocation working party*. London: HMSO, 1976.
- NHS Management Inquiry. *Report*. London: DHSS, 1983. (Griffiths report.)

(Accepted 23 May 1984)