ESTABLISHING THE RANZCP’s FACULTY OF PSYCHIATRY OF OLD AGE

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Fifty years ago there were no local comprehensive old age psychiatry services anywhere in the world. Most older psychiatric inpatients in the US, UK, Australia and elsewhere were in long-stay wards and had little contact with psychiatrists; elderly mentally ill people were accorded low priority within psychiatry. Management tended to be custodial rather than assertive. Mental disorders in old age were commonly attributed to senility, and chances of recovery were usually predicted as poor.

The beginning of a change in attitude can be traced to 1955, when Martin Roth published outcome studies relating to elderly inpatients at a mental hospital in England called Graylingwell. I quote from Gene Paykel’s (2007) obituary of Sir Martin: “he established the modern nosology in what had earlier been viewed as a single unitary degenerative illness, showing that five types of disorder with different features and prognoses could be separated: senile psychosis (Alzheimer’s disease), arteriosclerotic dementia, paraphrenia, depression and confusional states.”

Follow-up of these inpatients after 2 years showed that 20% of the depressive sub-group had died but 65% had been discharged from hospital. 80% in the dementia groups had died. 80% of the paraphrenia subgroup were alive but most were still in hospital.

Also in 1955, research on human ageing commenced at the NIMH, and in 1959 the WHO convened the first meeting of its Expert Committee on Mental Health Problems of Aging and Aged. In 1959 in the BMJ, Felix Post co-authored a paper calling for scientifically conducted assessments of the value of community care for elderly psychiatric patients.

In 1961, Herbert Bower (whom Ed Chiu has called the father of Australian old age psychiatry) undertook a worldwide survey of psychogeriatric services, and when he gave the Beattie Smith lecture at Melbourne University in 1963, he referred to a revolution in geriatric care in England and commented that domiciliary visiting, carried out by a social worker and senior psychiatrist, had proved to be vastly superior to outpatient treatment of older people with mental health problems. He was alluding to work by Duncan Macmillan and colleagues. Bower’s initiative and far-sightedness led to creation of the first psychogeriatric day-centre in Victoria in 1965. He went on to work as a consultant psychogeriatrician at Mount Royal and later at the Melbourne Clinic.

The pioneer of ‘geriatrics’ in Britain was Dr Marjory Warren, following the establishment of the NHS in the late 1940s. The way geriatrics developed both inspired and informed development, 20 years later, of the first old age psychiatry services in Britain in the 1960s. Note, though, that the scant involvement of psychiatrists in relation to dementia at that time led some geriatricians to develop physician-run dementia services. Prinsley, a geriatrician who later came to work in Melbourne, described the ‘psychogeriatric unit’ that he ran, which catered for the whole range of old age mental disorders with minimal cross-consultation with psychiatrists.

Some details about how those first old age psychiatry services were initiated were provided in an interview with Tom Arie by Elaine Murphy (1996) published in the orange journal: “A job was advertised at a place I had never heard of, Goodmayes Hospital, to set up a psychiatric service for old people. I thought, this is really back to what I’m after, going to an un-posh place in the outer East End of London, seeing if one could make a service for old people tick. So that’s...
what I did. Most people thought I had taken leave of my senses. I started work on January 1, 1969. Up the road at Claybury Hospital there was Brice Pitt, who was about two years ahead of me in setting up an old age service – I think his work had given the idea to the Goodmayes people. The people at Goodmayes had been puzzled – who could this chap be who had opted to come out of the teaching hospital to look after old people whom nobody wanted? It somewhat rocked my confidence, everybody being so negative about it.”

[SLIDE 2: photo of Tom Arie and his daughter after he was awarded the CBE] Tom went on to say, in the interview, that they developed “principles that most people subscribe to – that the service, based wherever possible in the general hospital, looks outwards, and most of its activity is in people’s homes and in community facilities. The task is to keep people functioning at home as long as they can, and that means initial contacts, reviews and support are in the setting in which patients need to function. It involves working in a team in which all the members have a sense that they are valued.”

A cluster of pioneers published details of their services. An informal Group within the British Royal College of Psychiatry started meeting in 1973, and in 1978 the College formed a Section of Psychiatry of Old Age – in the same year that the American Association for Geriatric Psychiatry was founded. Interestingly, the Czech Psychogeriatric Association dates back to 1968, and the European Association for Geriatric Psychiatry first met in 1971. The Dutch equivalent was founded in 1981, and the Japan Psychogeriatric Society in 1983.

By 1980, some 120 consultant psychiatrists in the UK had psychiatry of old age as their main activity, and government policy was firmly endorsing the establishment of specialised comprehensive local psychiatric services for old people, the underlying principles being flexibility, responsiveness, availability, unhierarchical use of staff, domiciliary assessment, and willingness to collaborate with other services and agencies (Arie and Jolley, 1982).

Australia and New Zealand

So what was happening in aged care services in Australia and New Zealand in the 1970s and 1980s while these various initiatives were being taken elsewhere in the world? Well, in the 1970s geriatric medicine was developing as a specialty in our two countries, with an emphasis on provision of community services for elderly people. Sid Williams was teaching about old age psychiatry at Lidcombe Hospital in Sydney, and in the mid-1970s, Miriam Merlin in Sydney and Arthur Harrison from Larundel Hospital in Melbourne pioneered development of comprehensive catchment area old age psychiatry services linked to inpatient facilities.

[SLIDE 3: photo of Kingsley Mortimer] It was also in the mid-1970s that Kingsley Mortimer in New Zealand, a former medical missionary, turned to a career in psychiatry of old age in his mid-sixties. He took charge of the psychogeriatric wards at Carrington Hospital in Auckland. The wards had a purely institutional focus. He soon established the first domiciliary and community liaison psychogeriatric service in Auckland, and wrote various articles in the public press that highlighted the needs and problems of elderly people with psychiatric disorders. After Mortimer’s death in 1982, old age psychiatry service development in New Zealand stalled for a few years, but was rejuvenated in the late 1980s after formation of the binational SPOA (Draper, Melding and Brodaty, 2005, page 156) and following visits by old age psychiatrists who had trained with Tom Arie.
In 1984, Tom Arie visited Victoria and Sydney to advise on how best to develop old age psychiatry services. He gave strong support to proposals to establish a coordinated geriatric and psychiatric service for older people in the catchment area of Sydney’s Prince of Wales and Prince Henry Hospitals – a service that accorded with recommendations of the Richmond Report in NSW and would primarily be community-based, but with appropriate inpatient facilities within that group of hospitals. He also talked to members of ADARDS, then newly formed as the NSW precursor of Alzheimer’s Australia.

During the 1980s a number of our College members attended the British Council courses in Nottingham run by Tom Arie – on “Psychogeriatrics: the clinical and organisational psychiatry of the elderly.” Undoubtedly, Tom Arie had a strong formative influence on Antipodean mental health services for older people.

However, at that time there were divergent views about who (psychiatry or geriatric medicine) should take prime responsibility for dementia services. New South Wales policy in 1985 was for geriatrics to assess and treat people with dementia, with availability of psychiatric consultation as required. Some eminent Australian psychiatrists argued that psychiatric resources need not be allocated for elderly person with behavioural or psychiatric disorders because (they said) geriatricians were just as capable of doing the work (Andrews, 1990). Members of our College expressed concern that the discipline of psychiatry of old age was being relegated, in the policies of the NSW Department of Health, to a minor role in care of old age psychiatric problems. In contrast, the health commissions of Victoria and South Australia appeared to be following the British model.

Clearly there was a need for the College to formulate its views and to provide input to State governments in Australia concerning old age psychiatry services. A draft position statement was developed and was presented to the 1986 meeting of the Social and Cultural Psychiatry section of the College. At that time, Australian and New Zealand psychogeriatricians didn’t have opportunities to get together as a group, and there was little discussion in relation to binational issues concerning services for older people. Nevertheless, the binational Council of our College adopted Position Statement 22 in May 1987, giving support for nine principles concerning old age psychiatry services in our countries. With minor amendments, the College has retained the position statement as its declaration of current policy in this field.

In 1986 at a meeting of the Australian Society for Psychiatric Research, there were discussions concerning the establishment of a network of old age psychiatrists. With encouragement from Joan Lawrence, the then President of the College, a meeting was held in Sydney in December 1987, attended by Tom Arie [SLIDE 4: photo of attendees at the 1987 meeting]. Draft terms of reference for a Section in Psychiatry of Old Age were considered and referred to the College Council for approval. Ed Chiu was appointed as the first chairman, and the first AGM was held in Adelaide in November 1988. In due course, David Ames became secretary. In 1995, together with the International Psychogeriatric Association (IPA), the Section hosted a large international congress in Sydney. Subsequently, joint IPA and College regional meetings have been held in Lorne in Victoria, Rotorua in New Zealand and Cairns.

In 1992, a questionnaire identified 34 psychiatrists in Australia who were working full-time in psychiatry of old age, and another 26 full-time equivalents in private practice or only part-time in old age psychiatry (Snowdon et al, 1995). The ratio of psychiatrists to elderly people in Australia was 1 : 30,000. This was similar to the ratio in the UK at that time, but the numbers per elderly population of social workers, nurses, psychologists and occupational therapists working in old age psychiatry teams were far lower (half to one third) than in the UK. How best to serve older
people in rural areas in Australia was then and is still a subject for discussion: what do we do about widely scattered populations who mostly live far away from whichever town is seen as the most appropriate base from which to provide inpatient and non-inpatient psychogeriatric services?

Even more worrying, back in 1998, was the lack of knowledge among administrators in the New Zealand health system about available and needed resources. The New Zealand Mental Health Commission published in 1998 a Blueprint for Mental Health Services in New Zealand – but the authors erroneously assumed that old age psychiatry services didn’t treat organic or age-related disorders (Melding, 2005)! The New Zealand branch of the SPOA surveyed its members and found that 26% of all patients seen in the survey month had an age-related organic brain disorder such as dementia, and up to half of all patients were cognitively impaired in addition to having other psychiatric diagnoses. The Blueprint underestimated the required acute bed resources for the case mix by at least one third. A re-survey in 2003 showed little improvement between 1998 and 2003.

More resources are needed in Australia and New Zealand old age psychiatry, but advocates for other age-groups and sub-specialties within psychiatry are also keen to obtain more. This is a major reason why Psychiatry of Old Age is keen to have representation in meetings where we can argue for appropriate distribution of resources.

At its first AGM, SPOA set itself priorities for attention, one being to lobby for appropriate ways of responding to the needs and psychiatric problems of older people. Others included education of clinicians, research, relationships with geriatrics and community services, and developing treatment guidelines. There were binational meetings of members of the Section in varying capital cities in Australia and in New Zealand, with New Zealand holding its inaugural scientific meeting in 1997. A review of progress after 10 years suggested that most of the Section’s aims had been fulfilled, though worries that the College had not adequately recognised Section concerns (for example, about teaching and about flawed data available to the New Zealand Department of Health regarding resources, and in the Mental Health and Wellbeing study) led to a keenness to have a place on the College Council. To do this, the Section needed to become a Faculty.

In order to justify recognition as a Faculty, the Section needed to show, firstly, that psychiatry of old age is identifiable as a sub-specialty within psychiatry, and that there are advantages in examining the needs and problems of mentally ill older people separately from those of other adults. Secondly, the Section needed to show that old age psychiatrists in Australia and New Zealand have developed sufficient skills and understanding to organise and take responsibility for educating others to become expert in the psychiatry of old age. Thirdly, the Section needed to show that members have a special awareness of the needs and difficulties of older people who have mental health problems, and of how best to treat them, and can advocate on their behalf.

Advanced training in Psychiatry of Old Age (a College-accredited training scheme devised by Brian Draper and the new FPOA’s Committee for Advanced Training in Psychiatry of Old Age) commenced in 1999. Generic advanced training by-laws had been approved by the College’s General Council in 1998.

The Section became a Faculty on 1 January, 1999, the first day of the International Year of Older Persons. This was celebrated in Parliament House, Sydney, with the New South Wales Health Minister launching a NSW policy document concerning old age psychiatry services. Beverley Raphael was NSW Director of Mental Health at the time.
In late 1999, the new Faculty had its first binational clinical meeting [SLIDE 5] at Coogee, with Trey Sunderland as visiting professor, and with our Federal Health Minister, Bronwyn Bishop, opening the meeting.

The Faculty can be proud of the international recognition given to Australian and New Zealand psychiatry of old age. The fact that the old age psychiatry’s peak body, the IPA, had as its President an Australian, Ed Chiu, [SLIDE 6] two decades ago is cause for celebration, but the fact that the IPA’s current President-Elect (Henry Brodaty) will be the second Australian out of less than twenty Presidents says even more about our world leadership in old age psychiatry. We had Daniel O’Connor as IPA secretary, and a number of Australians (Gerard Byrne, Brian Draper, etc) and a New Zealander (Pam Melding) have served as Board members – and David Ames and Nicola Lautenschlager have been successive Editors of ‘International Psychogeriatrics’, the prestigious journal produced by the IPA. Faculty members have also been active in the WPA and of course in Alzheimer’s Disease International. We can be proud of the research record and clinical achievements of our Faculty members and honours bestowed on them. But most of all, I think we can be proud of the difference that the Faculty and its members have made to people’s lives. We need to continue to advocate for interest in, attention to, and comprehensive services for older people in Australia and New Zealand who have mental illnesses – and for their carers.

References


Slides:

1. Herbert Bower
2. Tom Arie and his daughter
3. Kingsley Mortimer
4. Attendees at the 1987 meeting that led to creation of the Section of Psychiatry of Old Age
5. The opening of the first Faculty of Psychiatry of Old Age binational clinical meeting in 1999
6. Ed Chiu
### Figure 1: DEVELOPMENT OF GERIATRIC AND PSYCHOGERIATRIC SERVICES

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>1948</td>
<td>Marjory Warren pioneered development of UK geriatrics</td>
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<tr>
<td>1955</td>
<td>Martin Roth’s differentiating studies: 2-year outcome</td>
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<tr>
<td>1955</td>
<td>Research at NIMH on human ageing commenced</td>
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<td>1959</td>
<td>Felix Post called for studies of community care for elderly psychiatric inpatients</td>
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<tr>
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<td>Herbert Bower gave the Beattie Smith lecture in Melbourne and reported that domiciliary assessment and care had proved vastly superior to outpatient treatment of older psychogeriatric patients</td>
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<tr>
<td>1965</td>
<td>Bower ensured creation of the first psychogeriatric day-centre in Victoria</td>
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<td>1967</td>
<td>Brice Pitt led a new service at Claybury (UK)</td>
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<tr>
<td>1969</td>
<td>Tom Arie led development of Goodmayes service</td>
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<tr>
<td>1971</td>
<td>European Association for Geriatric Psychiatry</td>
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<tr>
<td>1978</td>
<td>RCPsych formed its Section of Psychiatry of Old Age</td>
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<tr>
<td>1978</td>
<td>American Association of Geriatric Psychiatry formed</td>
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<tr>
<td>1981</td>
<td>Dutch equivalent; 1983 Japan Psychogeriatric Society formed</td>
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<tr>
<td>1987</td>
<td>RANZCP Section of Psychiatry of Old Age (SPOA) formed and the College adopted Position Statement 22 supporting 9 principles for old age psychiatry services</td>
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<td>1989</td>
<td>Old age psychiatry became a specialty within the UK’s NHS</td>
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<td>A survey showed there were 34 psychiatrists in Australia working full-time in old age psychiatry and there were another 26 full-time equivalents either part-time or in private practice (= 1 per 30,000 elderly)</td>
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<td>1993</td>
<td>Geriatric psychiatry approved as specialty in the US</td>
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<tr>
<td>1999</td>
<td>RANZCP Faculty of Psychiatry of Old Age (FPOA)</td>
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Prof Tom Arie
(1995)
Associate Professor
Charles Kingsley Mortimer, O.B.E
1909-1982
Associate Professor Edmond Chiu,

1999 FPOA Meeting