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A/Prof Gerard Byrne (Chair SATPOA)
A/Prof Stephen MacFarlane (Secretary and Victorian rep)
Dr David Lie (Treasurer and Qld rep)
Dr Sires Bharathan (NZ rep)
Dr Gary Cheung (NZ rep)
Dr Janine Stevenson (NSW rep)
Dr Sally Rischbieth (SA rep)
Dr Elizabeth Stirling (WA rep)
Dr Helen McGowan (Co-opted Member)
A/Prof Carmelle Peisah (observer)

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Disclaimer:
Views expressed in articles in this newsletter are those of the author and do not necessarily reflect the views of the Committee or the College.

From the Editor

As the year rushes towards a close, I hope that you have had the opportunity to attend some of the many celebrations that have honoured the 50th anniversary of the formation of the RANZCP.

To mark this year of celebration and reflection we have published, in full, a richly detailed account from Prof John Snowden, of the development of the Faculty of Psychiatry of Old Age. There has been marked growth and I thank John for documenting the story of these remarkable characters and processes.

We warmly welcome the new members of the FPOA binational committee and especially Dr Jane Casey as the binational Chair. Jane brings extensive clinical and managerial experience to the role and is ably supported by the Rod Mackay (Past Chair) and the rest of committee. They are keen to meet up with you and represent your views, so please take the opportunity when you can.

Jane reports on a number of key projects that she and other FPOA committee members are involved in. In addition, many of our colleagues from FPOA and RANZCP have been involved in the National Mental Health Services Planning Framework, which promises to provide relative benchmarks for service development based on population and need. Some states are already using the framework draft for service planning, so it is hoped that this will drive some significant reform when endorsed and released. A cohesive and informed collegiate can be influential in these processes and your involvement and support for your representatives is appreciated.

I hoped to have this newsletter circulated before the FPOA congress in Auckland, but technical and process issues defeated us. Unfortunately, I was not able to attend, but the program looked great and I understand that the Kiwis delivered their usual balance of excellence and hospitality."

The RANZCP Congress will be in Perth in May 2014 and I know that Jane and others have been working to ensure that there will be some highlights for POA to tempt you across the Nullabor.

"With best wishes to you, your family, friends and colleagues in POA for a relaxing and rejuvenating Christmas holiday"

Helen McGowan
From the Chair

A warm welcome to all our members and readers. Thank you to those who have encouraged and supported me in taking on this role of the Faculty Chair. It is with some apprehension, as I follow on from Rod McKay, who has contributed an enormous amount of time and energy whilst he served his term, and he has laid the foundations for consolidating our Faculty in its purpose. I am bolstered by Rod’s ongoing interest and wisdom and his representation on the Community Collaboration Committee. I am also grateful to Stephen MacFarlane continuing his role as Secretary and representation on the Committee for Research and for Gerard Byrne’s continued contribution and his leadership as the Chair of SATPOA.

David Lie has jumped right in as the new Queensland representative and the Treasurer for the Faculty. Bean counting should come naturally from this region. Sally Rischbieth continues in her role as SA rep and I welcome Dr Liz Stirling as the WA representative, Janine Stevenson representing NSW and Dr Sires Bharathan who has joined us as the NZ rep from the South Island. I further welcome Dr Gary Cheung who has recently joined us as the NZ North Island counterpart and further has taken on the role of faculty representative to the Australasian Psychiatry Journal. Carmelle Peisah remains our invited observer and given her enthusiastic input over the past term I am delighted she has continued in this role. And this newsletter would not exist if it were not for the patience and perseverance of Helen McGowan who continues in her co-opted role and our Editor.

Our first teleconference as the newly formed committee was held in July. The current work plan and risk register has been revised and updated. Branches are reporting pockets of activity in particular with respect to clinical pathways, dementia care and advisory services. The recently revised budget will hopefully allow for increased collaboration at the branch level with equitable funding available for regional meetings for our faculty members. It is encouraging to see the increasing numbers of new members and advanced trainees. Securing opportunities in the public health system is the next challenge. A subsequent teleconference has also been had and we are continuing to streamline our focus and priorities.

Position Statements are being revised with “The Use of Anti-Depressants in Dementia” ready for input from the CTIEBP in October. The use of anti-psychotics in BPSD in Dementia has received media and political attention over the last year and both Australian and New Zealand colleagues have been active in their responses to the controversies. Work is also underway in a number of regions in collaboration with Alzheimers Society. I anticipate that the College Position Statement will be revised by early next year which is timely.

Our Australian members remain poised to respond to the political climate. A recent example was the response to the implementation of Activity Based Funding. The grind of rolling changes in health care systems and the fiscal environment renders some to feel behind the 8 ball. I imagine that the regions that seem to be less politically vocal are just trying to get on with what is in front of them. But I think New Zealand members and other smaller branches need to echo those with a more prominent political voice. Vehicles such as the Older Persons Mental Health Network (Australia) and the National Dementia Cooperative (NZ) are new developments that could also harness the multi-disciplinary promotion of mental health for older people.

I represented the Faculty at the first Members Advisory Council Meeting in early August in Melbourne. This meeting seemed to be one for finding its feet and a subsequent meeting was more focused. There was much debate about the proposal for a Faculty of Psychotherapy. I was able to present a succinct report on our Faculty which thanks to our founding members is well-established in its principles. How the Faculty can better serve its purpose both for its members and ultimately our patients is the question that I would like all members to consider.
From the Chair continued

The Bi-National FPOA Scientific Meeting on November 14-16 has occupied much of my time in its organisation and preparation in the last several months. We were fortunate to have secured an impressive line-up of speakers of both academic prowess and clinical expertise. I have received much positive feedback and the atmosphere of the meeting was warm and optimistic. It was wonderful to put faces to names, meet many new members, be able to learn and share ideas and indeed take part in our Faculty.

I originally penned this letter on the night on the conjunction of the waxing crescent moon and the planet Venus. The brilliant phenomenon of "earthshine" with sunlight reflected from the earth to the moon has imparted a three dimensional quality to the moon. As to the significance of this, according to astrology, I could enjoy numerous social contacts and appreciate a diversity of sincere and straight forward communication. In the meantime I was guided by my Maori lunar calendar which tells me Hoata is a good time for eeling, crayfishing and planting kumara.

Have a safe and happy Christmas, see you in the New Year and I look forward to our next Bi-national Meeting in NSW in 2014
Ka kite ano

Jane Casey

From the Secretary

The 14th International Congress of the International Psychogeriatric Association was held in Seoul, South Korea, between October 1st-4th 2013, and featured a wealth of local and international speakers, amongst them a healthy representation from Australia and New Zealand. Having attended a number of IPA conferences by this stage, I feel that their value lies not so much in the presentation of new developments and groundbreaking research (after all, ours is a field that changes slowly) but in their ability to draw together quality speakers who are expert within their areas and who can summarise the current state of knowledge in an expert fashion. I found the Seoul meeting to be no exception in this regard, with a range of plenary sessions providing much stimulating content. Concurrent sessions were streamed so as to allow participants with particular areas of interest to never be left wanting.

Some of the plenary highlights included sessions from Ronald Petersen from the Mayo Clinic, who discussed the challenges of early diagnosis in Alzheimer's disease, an overview of the reclassification of cognitive disorders within DSM-V presented by Bill Narrow from the DSM taskforce, and a fascinating an entertaining session from John Morley from the University of Texas, who summarised the current state of play in the area of hormonal anti-ageing therapies. It was certainly informative to note the demographic profile of those who attended that session, in particular, though some of the attendees might have been disappointed to hear the conclusion that no particular hormonal therapy has a great deal of evidence behind it in terms of specific anti-ageing outcome. Some hope was provided to the more vain members of the audience, however, regarding data on human growth hormone. This substance does, it seems, make us look younger by reducing wrinkles, although the effect is mediated by its effect on increasing skin thickness!

Professor Claude Wischik, from the University of Aberdeen (and Chairman of Alzheimer's disease therapeutics company TauRx) gave a fascinating overview of the role of tau pathology in AD, an area that is often neglected in a world dominated by the amyloid hypothesis, whilst symposia on topics
From the Secretary continued

ranging from BPSD to late-life depression. Depression and neuroimaging provided a wealth of options to a multidisciplinary audience within a magnificent venue attended by our gracious South Korean hosts.

The mission of IPA is to improve the mental health of older people everywhere through education, research, professional development, advocacy, health promotion, and service development. The FPOA is an IPA affiliate, and works closely with the organisation to further its initiatives at a binational, regional and global level.

Significantly, Australians are the largest single national group that contributes to IPA membership numbers. I would urge those of you who are not yet members to join this organisation, whose role is vital for our specialty, and our patients! Membership costs are very reasonable (a two-year membership can be attained for USD$245) and entitle members to a range of benefits from access to online educational resources through to complementary subscription to the online version of International Psychogeriatrics. Membership of the IPA can be obtained online, via http://www.ipa-online.net/ipaonlinev4/main/join/join_application.html

Editorial Note:

A highlight of the IPA conference for Australian and New Zealand colleagues was the “changing of the guard” as Prof Henry Brodaty took over the role as President from Jacobo Mintzer. Please note, of course, that this is not the official photo, but does capture the spirit of the occasion. Henry and the IPA Board have announced changes in the way IPA will function and plans more frequent, smaller conferences to optimise cost-effective opportunities for attendance.

Treasurer’s Report

With much trepidation I write my first Treasurer’s Report for FPOA. In this initial instalment I will give a basic recitation of facts with little analysis other than to say we have a fairly simple cashflow and a significant strategic reserve. I’m not yet familiar enough with the role to say more. Our current account balance is $A 196189 having been reinvested some months back. We ran a large surplus last year due to conference activity and we’re currently running a positive variance for this Financial Year (we’re in the black). I’m happy to take any queries at david.lie@health.qld.gov.au and to forward a copy of the balance sheet if you are interested.

David Lie
Initial Developments in Old Age Psychiatry

By John Snowden

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.
## Development of Geriatric and Psychogeriatric Services

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<table>
<thead>
<tr>
<th>Year</th>
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<tr>
<td>1948</td>
<td>Marjory Warren pioneered development of UK geriatrics</td>
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<td>1955</td>
<td>Martin Roth’s differentiating studies: 2-year outcome</td>
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<tr>
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<td>Research at NIMH on human ageing commenced</td>
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<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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<td>1969</td>
<td>Tom Arie led development of Goodmayes service</td>
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<td>1971</td>
<td>European Association for Geriatric Psychiatry</td>
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<td>1978</td>
<td>RCPsych formed its Section of Psychiatry of Old Age</td>
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<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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<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>1992</td>
<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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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.”

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. 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.
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.

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 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, 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


Conference news

DElirium CLinical And REsearch Day DECLARED

One day multidisciplinary symposium for all who want to do better with delirium.

Save the Date
Tue 27 May 2014
Venue
Ian Potter Auditorium,
Melbourne Brain Centre,
Parkville, Melbourne

Call for Abstracts

The Australian Delirium Society symposium gives a unique opportunity to present your research and clinical work in the field of delirium and reach a multidisciplinary audience. Both oral and poster presentations are considered. Submissions close 17 February 2014. Please note presenters should also be registered for the meeting. You will be notified by early March 2014.

Please email our organisers for further information: declared2014@gmail.com

FPOA Prizes - applications now open

In 2012, the Faculty of Psychiatry of Old Age introduced three prizes to promote excellence in advancing the Quality of Life in Older People with Mental Illness.

Submissions for the Faculty of Psychiatry of Old Age prizes to promote excellence in advancing the quality of life in older people with mental illness are now open and will close January 31, 2014.

The three prizes of the Faculty are:

- The RANZCP Faculty of Psychiatry of Old Age Basic Psychiatric Trainee Prize
- The RANZCP Faculty of Psychiatry of Old Age Psychiatric Trainee Prize for Scholarly Project
- The RANZCP Faculty of Psychiatry of Old Age Prize for the Best Mental Health Service Improvement

Specifically, the Prizes aim to:

- Encourage and promote the highest clinical and ethical standards in the delivery of Psychiatry of Old Age services amongst psychiatry trainees in Australia and New Zealand.
- Encourage and promote training in Psychiatry of Old Age of the highest standard for psychiatrists, trainee psychiatrists, medical students, related health professionals, students of related health professions and other medical practitioners.
FPOA Prizes - applications now open  

More detailed information on all RANZCP awards can be accessed by visiting the 'Awards and Prizes' pages within the 'Membership' menu of the RANZCP web site, www.ranzcp.org. Please contact the Membership Services team on awards@ranzcp.org or +61 (0)3 9601 4968 for any assistance or to discuss any of the RANZCP awards.

The RANZCP’s Faculty of Psychiatry of Old Age Basic Psychiatric Trainee Prize:

The Prize is open to basic psychiatry trainees, that is, a Stage 1 or 2 Trainee under the Competency Based Fellowship program

The Prize will be awarded for an essay which demonstrates a focus on engagement with the person, the impact of their illness, and how treatment and other interventions may impact upon this and applications will be reviewed on the basis of:

- Originality
- Scientific Merit
- Contribution to the knowledge base of psychiatry of old age.

For more information, please click here

The RANZCP’s Faculty of Psychiatry of Old Age Psychiatric Trainee Prize for Scholarly Project:

The Award is open to Advanced Trainees in Psychiatry of Old Age, or Fellows who have achieved the Advanced Certificate in Psychiatry of Old Age within the 24 months prior to the deadline.

Applicants shall have completed meritorious research in the field of psychiatry of old age, either conducted within the Advanced Training program in Psychiatry of Old Age or the subsequent two years after the granting of an Advanced Certificate. Research should have been performed at least partly in Australasia, within the 2 years prior to application for the Award

For more information, please click here

The RANZCP’s Faculty of Psychiatry of Old Age Prize for the Best Mental Health Service Improvement:

The Prize is open to all mental health services, and whilst not having to be within a formal Psychiatry of Old Age service, the improvement must be:

- Focused upon the needs of people with mental illness who are older.
- Within a public or private mental health service with accreditation against the national mental health standards, or New Zealand equivalent.

Submissions will be reviewed for their contribution to the quality of life in older people with a mental illness.

For more information, please click here

Bianca Mathews
Letter from New Zealand

Dr Sires Bharathan is warmly welcomed as the new NZ representative on the binational FPOA. He was born in Sri Lanka a Tamil, Hindu by birth and early upbringing. In 1982, Bharathan’s parents immigrated to the Republic of Transkei – that was recognised only by the South African Government of the time, as secondary school teachers. Bharathan attended a school for whites (being a foreigner) with a Christian background and completed school before going onto study medicine in a predominantly African university. He first started working with the older person in 1997.

His interests in the physical and intellectual health of the older person was piqued then. His final immigration was in 1999 when he moved to Blenheim, New Zealand. He then did his Fellowship, working in Christchurch where he also completed his POA training. He now works in a provincial town - Timaru, South Canterbury. Having had children in the South Island of New Zealand, it adds to his belief of being an ardent New Zealander. He has a wide range of interests in Psychiatry of Old Age including teaching, with a firm belief of getting the most out of life.

Letter from Western Australia

Hello from WA. My name is Liz Stirling, and I recently took over the position of Chair from Dr Mathew Samuel, with Dr Prakriti Gopinathan as Secretary. We have an active local faculty, with monthly meetings in which local and binational FPOA and general old age psychiatry matters are discussed, followed by a journal club presentation. Educational sessions are organised regularly, usually as evening meetings, and the two most recent presentations were by new Fellows who spoke about their advanced training research projects, both extremely interesting and informative. Dr Fiona Krantz is the Director of Advanced Training in POA with one advanced trainee and five consultants working towards their certificates of advanced training currently.

We look forward to seeing you all at Congress in Perth next year!

Letter from New South Wales

The NSW branch of the Faculty for the Psychiatry of Old Age (FPOA) consists of Dr Carmelo Aquilina, as chair, Dr David Burke, Secretary and Dr Janine Stevenson as the bi-national committee representative. The NSW branch held a successful Annual meeting in Parramatta in September. This meeting was organized in conjunction with the Psychogeriatric Nurses’ Association (PGNA) and attracted 155 attendees. The meeting also included a historical tour of Cumberland Hospital and a dinner lecture on the turbulent early years of this oldest active psychiatric institution in the country, meetings of the Sydney Psychogeriatric Trainers led by Professor John Snowden and the Advanced Trainees Trainers meeting led by Dr Douglas Subau. A commemorative booklet was produced and sent out to all members.

The Faculty annual meeting considered the perennial question of how to invigorate the Faculty meetings and involve members. Ideas included fixed date meetings, collaboration with other partners (like the PGNA, Australian and New Zealand Society for Geriatric Medicine (ANZSGM)) and picking up topics that are relevant to members. It is hoped that we can revive quarterly meetings and make them interesting and well attended. A more active public and college profile would be another way to engage and enthuse members.

Carmelo Aquilina Chair
State News

Janine Stevenson is warmly welcomed as the new NSW representative on the binational FPOA committee and is consultant psychiatrist and psychogeriatrician and Clinical Associate Professor with Sydney University. She is the Medical Clinical lead of the NSW Dementia Behaviour Management Advisory Service And Medical Director of the Riverglen Old Age Psychiatry Unit. She also supervises and lectures for the Master of Medicine in Psychotherapy With Sydney University. Research interests include personality disorders in old age, psychotherapy in older adults, psychotherapy outcome and treatment of BPSD in dementia

Letter from Queensland

Well I’m not sure what’s happening in your part of the world but in the public sector at least our only constant here is change The current swing is to decentralisation of healthcare responsibility (older colleagues have seen this before) from the State government to regional structures. It remains to be seen what implications (if any) there are for the training and the provision of subspecialist mental health services generally as there is much variation in cuts to government programs.

For those who have helped to advocate for better specialist MH service provision for older adults (e.g. that they exist at all in some towns and cities), the next test will be achieving a uniformly good standard of care across the State.

With the devolution of the old monolithic “Queensland Health” there are 16 of these “Hospital & Health Services” to negotiate with and they are much more autonomous entities than before.

For example there is less central monitoring of equity of access to psychogeriatrics. The promise is fewer hoops to jump if the CEO wants to support you but the risk is less oversight if the CEO thinks you’re not a priority and you’re already behind other centres.

Further afield we should look with interest at the “ageless” mental health service debate in the UK which has significant implications more broadly. One of my bosses asked me about this the other day. I haven’t worked in the UK but the promise might include better access to programmes like community rehabilitation and rapid assessment. The risks to clients seem to include ageist denial of service and a dumbing down of interventions delivered by clinicians less used to working with older adults.

It has been difficult to attract crowds here to FPOA CME events but to compensate there has been a significant expansion in local research, meetings and conferences relating to geriatrics and dementia.

Interest in POA Advanced Training continues albeit in fits and starts. We have few opportunities to work as a specialist psychogeriatrician so there is no workforce crisis yet. Demand is greater than supply at least in the public sector.

Interesting times ahead I’m sure.