# *Interim Guidelines for Regional Advisers on Consultant Posts in Psychiatry of Old Age**

The development of an effective psychiatric service for the elderly is dependent upon the allocation of adequate resources. A good candidate, trained in psychiatry for the elderly, is unlikely to consider a post where the provision is inadequate.

The population to be served should be clearly defined as: (a) total—all ages; (b) number over 65 and (c) number over 75. There should be a description of the type of catchment area in terms of geography and social structure and there should be comment on any aspects of the catchment population which will make the service different from average.

There should be a clear understanding of what facilities are to be allocated to the psychiatrist for the elderly for functional illness service and dementia service respectively. The DHSS formulae are:

*1. Functional illness service for the elderly* (from within the provision for general psychiatry)

| | |
|---|---|
| (i) Acute beds | 0.5 per 1000 population |
| (ii) Long-stay beds | 0.17 per population |
| (iii) Day places | 0.65 per 1000 population |

(to be shared by the in-patient group)

*2. Dementia service for the elderly*

(i) *Psychogeriatric assessment unit:* 12-20 beds per 250,000 population.

This figure is now inadequate because practice has changed from assessment to assessment, treatment and rehabilitation *in situ*, and because the proportion of very old people in the population has increased since 1970 (the date of the DHSS recommendation). A reasonable figure for a psychogeriatric unit would be 1 bed per 1000 population over 65 years—to be on a DGH site.

(ii) *Psychogeriatric long-stay:* 2.5-3.0 beds per 1000 population over 65 years.

The equivalent number of long-stay patients in a mental hospital, even though they are over 65 years, will not provide vacancies at the necessary rate. The population should be one of genuine elderly, severely mentally infirm patients, i.e. severe dementia.

(iii) *Psychogeriatric day hospital:* 3 beds per 1000 population over 65 years.

**Consultant time**

The sessions allocated to old age psychiatry should be seen in the context of the total number of consultant sessions in psychiatry. At present, at least 25 per cent of all psychiatric admissions are over the age of 65. Where an active psychiatric service for the elderly develops, this proportion is likely to increase. For every 10,000 old people in an average community there will be demand for approximately 100 acute psychiatric admissions annually. Because of this high rate of demand and because of the heavy committment to work in the community, the maximum number of old people for whom one full-time consultant can provide a service will be approximately 22,000. A part-time commitment can be calculated on the basis of 2,000 old people per session.

If an inadequate number of sessions is available to serve the whole of a district's elderly population, inevitably some of the work will remain the responsibility of the general psychiatrists. If this is the case the separate areas of responsibility should be clearly defined by sectorization. A nebulous commitment to old age psychiatry is easily used by the general psychiatrist as an excuse for refusing to give the psychiatrists for the elderly a fair share of the acute psychiatric facilities.

**Non-consultant medical staff**

(a) *Trainees:* The consultant psychiatrist for the elderly should attract 25 per cent of the psychiatric trainees and these posts should be included in a rotational training scheme. The experience available in this field would be useful for GP trainees who might also be attached to the service.

(b) *Senior registrar:* Experience in psychiatry of the elderly should be available to all senior registrars on a rotational basis. The rapid expansion of consultant posts in psychiatry of the elderly means that training consultants in this field is a primary task and therefore attempts should be made to obtain a senior registrar post specifically for this purpose.

(c) *Clinical assistant:* The service should attract a share of clinical assistant sessions which will reflect the availability of these and the way in which they are used within the psychiatric service.

**Other staff**

(a) *Secretarial:* The secretary attached to a consultant psychiatrist for the elderly will have considerable responsibility for management and liaison. If possible she should be employed as a personal secretary with higher clerical grading. 0.5 to 1 full-time secretary will be needed for every 10,000 old people served. A day hospital will need additional receptionist/clerk-typist staffing if it is to work effectively.

(b) *Community psychiatric nurses:* 1 to 2 nurses per 10,000 population over the age of 65.

(c) *Special areas:* A 50 per cent increase in consultant time will be needed in a teaching area. There will need to be an increase in all staff if facilities are on several sites.

*The Section for the Psychiatry of Old Age prepared these Guidelines for Regional Psychiatric Advisers to comment on consultant job descriptions at the end of 1979. The Court of Electors approved their use on an interim basis at the beginning of 1980.

**Other necessary details of the service**

*1. The psychiatric service*

(a) The catchment area (whether or not coterminous with the old age psychiatry catchment area); (b) number of acute and long-stay beds; (c) number of sessions of consultant time; (d) number of trainees; (e) number of clinical assistant sessions; (f) number of day hospital places and (g) number of community psychiatric nurses.

*2. The geriatric service*

(a) The catchment area (whether or not coterminous with the psychiatric service for the elderly); (b) total number of consultant sessions; (c) consultant sessions available to the psychiatric service for the elderly; (d) total number of geriatric beds; (e) number of geriatric beds on an acute hospital site and (f) number of geriatric day hospital places.

*3. Social services*

(a) The area served (whether or not coterminous with the health services and the size of the population over 65); (b) number of Part 3 residential places and day centre places; (c) number of EMI home places and EMI day places; (d) whether or not any personnel are available with special expertise relating to the elderly and the proposed social work input into the pyschiatric service for the elderly; (e) number of places available in private nursing homes and (f) details of sheltered housing.

*4. Administration*

(a) Details of the local cogwheel organization and (b) is there a regional adviser or advisory group in psychiatry of the elderly?

**Summary**

For a district service with a total population of 200,000 and 30,000 over the age of 65 the following are required:

*Functional illness:* (i) 15 acute beds; (ii) 5 new long-stay beds; (iii) 20 day places.

*Dementia service:* (i) psychogeriatric unit—30 beds; (ii) long-stay—75 to 90 beds; (iii) day places—90.

*Consultant time:* 15 sessions. In a teaching area there should be 50 per cent increase in consultant time.

*Non-consultant medical staff:* (i) trainees 25 per cent share of total in psychiatry; (ii) senior registrar 25 per cent share of total in psychiatry; (iii) clinical assistant according to availability and deployment.

*Other staff:* 1.5 to 3 secretaries for the functional illness service and the psychogeriatric unit. Additional secretarial time for the dementia day hospital. Two to 6 community psychiatric nurses.

The facilities described above are not ideal but are those required to establish a credible psychiatric service for the elderly. Shortage of money at the present time means that promises made in job descriptions are unlikely to be fulfilled in short term, and therefore a post should not be approved unless facilities are to be immediately available. Health authorities would be unlikely to create posts for surgeons without beds and operating and anaesthetic facilities. They must be made aware that a psychiatric service likewise cannot operate without a basic provision.

# *Overseas Trainees in Psychiatry**

By Surya Bhate, Chairman, Overseas Trainees Committee

For decades doctors have been migrating from developing to developed countries. Principal beneficiaries of this trend have been the USA and UK, though similar trends have been evident in France (Algerian doctors) and to a smaller extent in Germany. Few doctors from developed countries go to developing ones for training (or to train), so the flow of migration is virtually one way. In the UK concern has been expressed about the competence (technical as well as the ability to converse in English) of immigrant doctors, leading to rather confused and at times acrimonious exchange of views. Until recently there has not been any attempt by governmental agencies or professional bodies to look at various aspects of the immigration of physicians and its effects.

*The views expressed are the author's own and do not necessarily reflect those of the Committee.

Overseas doctors have been coming to the UK for several decades. Many trainees have overcome enormous obstacles to come to this country for further training. It has become apparent that few doctors return to their country of origin after further training, most preferring to stay in the UK and some going to the USA. This has led to a complex situation, often contributed to by a lack of clear-cut policies on the part of successive governments.

Often immigrant doctors have arrived and stayed in response to employment opportunities and to the extent to which overall demand is or is not met by British graduates. Thus, the immigrant doctors may be seen as responding, in market terms, to demand and supply. Jobs are offered, doctors are available, and migration follows. The effect of this policy has been to employ overseas doctors predominantly in shortage, undersubscribed and unpopular



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