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The provision of mental health services in England for people over 65 years of age, 1970–78

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The twentieth century saw an increasing number of people living into old age, and consequently a higher prevalence of age-related chronic degenerative brain disorders. By 1971 the mental hospitals were almost half full with people over 65 years of age. Thus plans to close the mental hospitals meant that the development of community mental health services for older people was a necessity. Although there was a multi-disciplinary focus on the care of older people, the lead in service development was largely taken by psychiatrists, both individually and through the Group for the Psychiatry of Old Age at the Royal College of Psychiatrists.

Keywords: closure of mental hospitals; community care; dementia; psychogeriatrics; Royal College of Psychiatrists

Introduction

Major changes took place in the provision of mental health services in the 1970s. However, historians of psychiatry such as Andrew Scull (1984) and Edward Shorter (1997) have largely ignored the impact of these changes on older people. This paper aims to fill this gap.

The study falls into four parts: psychiatrists and psychogeriatricians; new policies; multi-disciplinary working; and providing alternatives to the mental hospitals. Many of the sources referred to were in a bulging lever-arch file belonging to the secretary of the Group for the Psychiatry of Old Age (1973–78). This file remained with his successor until 2004 when it came into my
possession. Other primary sources include textbooks, journals, oral history interviews, and archives from the Bethlem Royal Hospital, King’s Fund and Wellcome Library.

**Background**

Mental illnesses such as depression, schizophrenia and neuroses (functional disorders) affect older as much as younger adults. Dementia (organic degenerative brain disorders) and acute delirious states are more common in old age. These disorders can co-exist, and be further complicated by physical illness and frailty, plus psychological and social factors such as bereavement. Such complex clinical scenarios were clearly noted in the 1940s (Lewis and Goldschmidt, 1943; Post 1944).

Mental health care for older people in England had been developing slowly in a piecemeal and sporadic fashion before 1970 (Hilton, 2005a, 2005b). Felix Post, the first old age psychiatrist at the Bethlem Royal Hospital, was appointed in 1947 and pioneered treatment of psychiatric disorders in older people (Post, 1962, 1966). Martin Roth classified the major psychiatric disorders in old age (Roth, 1955). The first international conference on the subject took place in London in 1965 (Anon., 1965). England was not alone in overlooking older people’s mental welfare. In 1972 the World Health Organisation (WHO) noted this was an international phenomenon. In particular, ‘Progress made towards implementation of the recommendations made in the [1959] report has been disappointing’ (WHO, 1959, 1972).

In 1970 the memorandum *Psycho-geriatric Assessment Units* (DHSS) suggested a revival of Government interest in older people. A report in *The Lancet* of the older people’s psychiatric unit at Goodmayes Hospital, Ilford (Arie, 1970), as well as considerable correspondence relating to psycho-geriatric assessment units suggested a medical interest (Andrews, 1970; Burrowes; 1970, Exton-Smith and Robinson, 1970; Hurst and Morton, 1970; Wilson, 1970). Whitehead’s book *In the Service of Old Age* (1970) ‘to inform public opinion of what can be done, and to stimulate self-scrutiny by authorities who should be doing more’ was published by Penguin, suggesting a wider interest in the mental wellbeing of older people. Again pivoting around 1970, scientific papers from the 1969 symposium *Recent Developments in Psychogeriatrics* were published in 1971 (Kay and Walk). Also in 1970 the Hospital (later Health) Advisory Service (HAS) began to inspect long-stay hospitals (Baker, 1973), giving new insights into the care of elderly mentally infirm (EMI) people.

While Ministry of Health and Department of Health and Social Security (DHSS) directives usually related to England and Wales, the Royal College of Psychiatrists, which had a major influence on service development, drew its membership from the entire British Isles and beyond. However, because of travelling distances, most of those attending the College Group for the Psychiatry of Old Age in London were from England. Thus this paper necessarily focuses on the provision of mental health services for older people in England only.
Psychogeriatrics: what is it?

Rather like ‘community care’, the term ‘psychogeriatrics’ emerged without a clear definition or origin (Arie and Isaacs, 1978). Consequently it had different meanings to different people. When hyphenated as ‘psycho-geriatric’ in 1950 it implied geriatricians and psychiatrists working together to assess older people.3 Hardly used for nearly two decades, it then became a bone of contention: ‘part of the problem of the acquired respectability of the term is that people are beginning to believe that it really has a meaning’ (White, 1972). In 1971 the Society of Clinical Psychiatrists said psychogeriatrics included ‘the whole range of psychiatric conditions in the aged’ (Enoch and Howells, 1971), while a group of geriatricians and psychiatrists concluded that since general psychiatrists should care for patients of all ages with functional disorders, there was no need for a separate specialty of psychogeriatrics (Andrews et al., 1972). It remained unclear whether geriatricians or psychiatrists should care for people with dementia. However, with the recognition that ‘behavioural disturbance is the real “nitty gritty” of psychogeriatrics’,4 it was highly unlikely that division of labour by diagnosis rather than need was appropriate. Others considered that ‘Psychogeriatrics … was largely a social problem’.5 Whitehead (1976) commented:

not only is psychogeriatrics an ugly word … but means different things to different people … Brice Pitt … defines it as ‘that branch of psychiatry which is concerned with the whole range of psychological disorders developing in the senium’. Let us hope that this definition will become universally accepted.

Psychiatrists are medical doctors, in contrast to psychotherapists, psychoanalysts and psychologists who are usually not medically trained. Those working with older people in 1973 tended to identify themselves as general psychiatrists with a special interest in old age. The term ‘psychogeriatrician’, a psychiatrist working with older people, only gradually emerged. The early 1970s saw the embryonic development of psychogeriatrics within psychiatry. It remained somewhat nebulous in its identification, with its roles open to negotiation.

Policy and organization

The Hospital Plan (Ministry of Health, 1962) proposed a comprehensive system of District General Hospitals (DGHs). Although both geriatrics and mental illness were included, there was no reference to the elderly mentally ill. Plans to close the mental hospitals predicted a reduction in mental hospital beds from 150,000 to 75,000 over 15 years, while integrating services for ‘mental disease’ into the community and DGH (Ministry of Health, 1962; Powell, 1961).

Community care was an important concept traced back to a loosening of statutory restraints on care for the mentally ill, such as the Maudsley Hospital admitting voluntary patients in the 1920s, the Mental Treatment
Act (1930) allowing psychiatric out-patient clinics, and some experimentation in community approaches before World War II (Welshman, 1999). Further community development was promoted by the availability of new psycho-active medications in the early 1950s, the Mental Health Act (1959), an emphasis in the 1960s on personal autonomy and the emergence of the anti-psychiatry movement, although they showed little specific interest in older people (Tantam, 1991). In 1963 the Ministry of Health urged local authorities to develop community care.

The 1974 reorganization of the National Health Service (NHS) theoretically supported these earlier objectives, aiming to provide locally organized health care tailored to population needs. In England, strategic Regional Health Authorities emerged with Area Health Authorities directing District Management Teams and Family Practitioner Committees, which organized care coterminous with local authorities (DHSS, 1972a). However, the medical profession appeared to view reorganization with some scepticism, for example, referring to the forthcoming 1 April changes: ‘All Fools Day next year will see a tragi-comedy of epic proportions’ (McKie, 1973), and will ‘sacrifice both health workers and patients on the altar of “managerial efficiency”’ (Robson, Iliffe and Le Fanu, 1972). Psychiatrists in 1976 suggested ‘re-introduction of a body of educated people to whom one could turn at hospital level rather than the present situation of dealing with faceless voices’.6

Other contemporaneous reports affected mental health services. For example, the 1966 Salmon report reorganizing senior nursing staff structure was criticized in that ‘too many qualified people have become desk bound’.7 The Seebohm report (1968) organized social services into local area teams, making social workers more family orientated, but reducing the provision of specific mental health social workers.

The relative contributions of social ideology and economic forces are hard to ascertain. Secretary of State Barbara Castle wrote that psychiatric services would continue to be based in the mental hospitals for some years until the economic situation improved (DHSS, 1975). Community care may have been proposed as a cheaper alternative to institutional care, due to concerns over ever-rising costs of healthcare within a capitalist welfare system (Scull, 1984). However, smaller units were pro rata more expensive to run (Ross, 1976; Royal College of Psychiatrists, 1976). Despite optimistic policies, financial constraints were a significant limiting factor8 (Anon., 1974a; Enoch and Howells, 1971).

The dilemma: would more old people fill the mental hospitals?

In 1971, of 116,000 patients in mental hospitals 52,000 were over 65 years. Whereas numbers of long-stay patients were overall decreasing, the previous 15 years had seen an increase of 34% in those over 75 (National Association for Mental Health, 1972). The same year, in England and Wales, 13.3% (6,865,000) of the population were over 65 years and 4.7% (2,318,000) were over 75 compared with 4.7% and 1.4%, respectively, in 1901 (Arie and Isaacs, 1978).
In part, this demographic change explains why Emil Kraepelin in his early twentieth-century classifications of mental illness hardly mentioned the degenerative brain diseases of old age. He did, however, refer to ‘senile’ and ‘involutional’ psychoses, but his patients ‘of considerable age’ were mostly aged under 60 (Kraepelin, 1904). Even the original description of ‘Alzheimer’s disease’ related to a 55-year-old woman (Alzheimer, 1907), thus setting up the inaccurate paradigm of ‘senile dementia’ being different from Alzheimer’s in younger people. In 1946 Aubrey Lewis predicted that older people might eventually entirely fill the mental hospitals as age-related disorders became more commonplace. However, dementia was frequently missed in local statistical returns and under-diagnosed in primary care (Williamson et al., 1964) so data tended to underestimate prevalence and need, and hence resources. Although desegregation of the mentally ill was a moral issue for younger people, it was an essential medical one for older people with complex health needs. Despite this, older people were not prioritized.

Psychiatrists and psychogeriatricians: the Royal College of Psychiatrists and Group for the Psychiatry of Old Age

Many psychogeriatricians making the greatest impact like Tom Arie (Goodmayes 1969–77, then Nottingham), Anthony (Tony) Whitehead (Severalls, Colchester 1960s, then Brighton) and David Jolley (Manchester 1976) did this both through developing local clinical services and their involvement with the Royal College of Psychiatrists Group for the Psychiatry of Old Age (GPOA).

In 1971 a ‘coffee house’ group of psychiatrists working with older people was meeting to exchange views and consider ways of improving psychogeriatric services. They included Tom Arie, Carrick McDonald (Warlingham Park, Surrey), Loic Hems and James Cockburn (Long Grove, Epsom), Brice Pitt (Claybury 1966–69, then Harlow, then the London Hospital 1971–84) and Klaus Bergmann and Garry Blessed from Newcastle-upon-Tyne (Arie, 1989). They realized that in order to make any impact, they would both have to increase their numbers and have to acquire a body through which they could find a voice. Having written to some 50 members and fellows of the Royal College of Psychiatrists, they achieved a quorum of potential participants to form an official College Group, inaugurated on 9 February 1973. As a support and discussion group there were no terms of reference; these evolved later. Felix Post was elected chairman, and Brice Pitt secretary. Martin Roth, president of the College, declined to participate despite his extensive research into older people’s mental health.

The pioneering psychogeriatricians were noted for their enthusiasm (Baker, 1974), and Arie (1971) wrote about psychogeriatrics: ‘I have never before been in a professional setting where intellectual and emotional satisfaction go more closely hand in hand’. In 1975 the Group had about 100 members and enquired about becoming a more prestigious Section of the College. They were told that
at least 500 members were required. One advantage of Section status was representation on College Council, viewed as vital since ‘The Group can not rely on the College putting matters concerning the psychiatry in old age before members’. This, however, was temporarily resolved when Post was elected to Council (Anon., 1975). Despite inadequate membership for Section status, the College indicated that the Group was too big for their current structure and they should form an executive committee. The Group expressed some resentment at being told how to organize themselves. However, one of the reasons given was that as a pressure group they were not making enough impact, since quarterly meetings were insufficient to prepare comments for submission to Council. An executive committee acting between meetings could do this. If the College’s perception was correct, it is regrettable that it took three years for this important point to be made since the Group was the only national organization solely dedicated to advocating for elderly mentally ill people.

Psychiatrists’ attitudes to older people were ambivalent, with a degree of tension between the established College hierarchy and the new psychogeriatricians. Whitehead (1972) commented that psychiatrists should stop ‘pretending that the old were not their concern’, and Pitt recollected:

General psychiatrists were dead keen to get us to take their old schizophrenics ... it was quite absurd because there were a great many of them, so we said no, it has got to be mental illness which starts after the age of 65, which is arbitrary although makes a bit of sense ... We were pretty paranoid about general psychiatrists ... who were more likely to exploit than support us.

With this ambivalence, coupled with the DHSS’s habit of planning for younger before older mentally ill people, psychogeriatrics risked being neglected. For example, the College and DHSS proposed increasing the number of consultants in general psychiatry without a proportional increase in psychogeriatricians, despite population trends. Eventually this was amended.

The care of ‘graduates’, chronically ill patients admitted before modern treatment who had grown old in hospital, was also on the interface with general psychiatry. Rehabilitation required overcoming numerous behavioural problems of institutionalization (Goffman, 1961). McDonald argued passionately for psychogeriatricians to be involved with rehabilitating older graduates, reporting in 1975 of his success, and: ‘If we, the interested psychogeriatricians, turn our backs ... they will be condemned to live out their lives in our mental hospitals for no better reason than that they have already spent many years incarcerated therein.’ Psychogeriatricians acknowledged an ethical obligation towards this work, but staffing levels were such that it would be ‘impossibly burdensome’.

The College appeared to being doing little to improve awareness of trainee psychiatrists about older people. Psychotherapy, child and forensic psychiatry were on the syllabus while psychogeriatrics was noticeable by its absence
(Royal College of Psychiatrists, 1973b). With respect to training psychogeriatricians, in 1973 consultant posts were being advertised, but there were inadequate numbers of senior registrars training. The Group therefore wrote to the DHSS to create six training posts. This letter probably sparked an invitation for Group representatives to attend the College’s manpower sub-committee which, although expressing ‘some opposition’ to psychogeriatrics, nevertheless supported the creation of these additional posts. By 1975, however, there were still only three training posts, at Goodmayes, the Bethlem and Maudsley, and Tindal General, Aylesbury (Pitt, 1975). An unsupportive letter to the Group from Thomas Bewley (College sub-dean) emphasized that each individual would need to negotiate funding for training locally. However, not to be thwarted, the Group established its own old age training sub-committee, and the British Post Graduate Medical Federation approved several ‘advanced secondment’ training units. The benefits of this scheme were reported by Jolley (1976).

Both training and appointing new consultant psychogeriatricians progressed inconsistently. When in 1977 it was reported that the Yorkshire Regional Manpower Committee had refused funding for consultant and senior registrar posts, it became apparent that neither psychiatrists nor geriatricians sat on that committee. The objectives of the posts were probably not understood, emphasizing the need for those working with older people to be involved in medical management. The fact that the Group commented ‘it is ill advised for a new consultant to be expected to manage with half an office and a third share in an inferior typist’ suggests that this sort of scenario actually occurred. Arie’s opinion (quoted in Anon., 1978) was that care for elderly mentally ill people was a ‘political emergency’, estimating that, based on existing recommendations, there were 200 psychogeriatric consultant vacancies, but still only six senior registrars training. Contrary to previous advice, in order to appoint a second consultant in some districts he even advocated appointments to relatively unresourced posts, as resources would not be allocated until someone was there to fight for them. Indeed, an important role for the psychogeriatrician was ‘to organise services to meet the community’s need … occasional militancy required to gain for the elderly a fair share of scant resources to put them to best use, to make do with too little while wheeling, dealing, and fighting for more.’

It was also considered that chronic dementia services were unlikely to attract enthusiastic applicants, and any post of less than 25 hours a week was probably unworkable, indicating that the health authority had little idea of the nature and extent of the work.

The Group’s relationship with the College hierarchy was sometimes difficult, but Pitt (1974) argued that opponents to psychogeriatrics ‘are in no stronger a position than Canute holding back the waves’. There were other hiccoughs, such as when the influential HAS suggested that only one consultant psychogeriatrician was required for a population of 700,000, leading to the director Dr Woodford-Williams being invited to explain such a ‘wholly
inadequate’ proposal to the Group.\textsuperscript{33} However, from the handful of psychiatrists with a special interest in older people in 1970, there were 120 psychogeriatricians by 1980, each dedicating on average 25 hours a week to older patients (Arie and Jolley, 1999). That itself was a huge achievement.

**A new policy: Services for Mental Illness Related to Old Age.**

*HM(72)71*

*Services for Mental Illness Related to Old Age* (DHSS, 1972b) – originally *Hospital Services for Mental Illness Related to old Age* – followed *Hospital Services for the Mentally Ill* (DHSS, 1971), which hardly mentioned older people. Developed by the ‘coffee house’ group working closely with the DHSS,\textsuperscript{34} ‘HM(72)71’, as it became known, was the blueprint for developing psychogeriatric services. It identified three groups of elderly patients: graduates who were to be rehabilitated and discharged if possible; those with functional illness who were to be treated along with younger patients in the DGH; and those with dementia who should be cared for either by psychiatrists or by geriatricians, depending on their physical health needs. While beds and ‘places’ were numerically specified, staffing levels were not defined, and appointing a psychiatrist in each area with special responsibility for the aged was only tentatively proposed.

In response to HM(72)71, MIND, with Age Concern, surveyed psychogeriatric services. Problems identified included a lack of assessment facilities, understaffed wards, staff discouraging visitors, and only 19\% of psychiatric hospitals having a geriatrician or psychiatrist for older people. Concern remained that ‘much more specific and realistic targets can and should be set’ (National Association for Mental Health, 1973). Bergmann (1973) noted MIND’s attack on DHSS policy, adding that clinicians ‘may forget that their own attitudes may also have contributed to the present unsatisfactory situation’.

The merits or otherwise of the memorandum were immediately on the Group’s agenda, a major question being ‘Is the DHSS aware of, and prepared to condone the inadequacy of services?’, and it requested an official meeting with the DHSS.\textsuperscript{35} Although an informal discussion took place, an official conference was postponed until after *Better Services for the Mentally Ill* (DHSS, 1975) which also largely prioritized younger people.\textsuperscript{36}

Assessing the impact of policies and obtaining resources was in part difficult because of inadequate data. Lack of recognition of psychogeriatrics by the DHSS as a specialty until 1989 guaranteed a dearth of relevant data. Data about older people with mental illness were sometimes subsumed under the title ‘For the elderly (including the elderly mentally infirm)’ (Ministry of Health, 1964). Statistics on day hospital usage did state numbers of people over 65, but were unreliable. In this instance, recording attendances on the last full working day of the year between Christmas and New Year risked showing an under-utilization of available places (DHSS, 1973a). Both the lack of data and the difficulties in interpreting it encouraged the Group to collect its own data.
In 1974 service-related research was undoubtedly led by Kay and Roth in Newcastle. However, the Group distributed a questionnaire to members about resources and working practices. Importantly, this indicated that none of the areas surveyed had all the facilities deemed to constitute a comprehensive service by the DHSS, making it impossible to give meaningful statements on the adequacy of DHSS proposals. Pitt’s notes commented ‘DHSS still dragging feet over specialty?’, while Arie, in the presence of Dr Brothwood from the DHSS, suggested that lack of data on older people was hampering progress. However, the DHSS appeared to listen to the Group, which was important for making progress.

The Group challenged itself to ascertain the real numbers of psychogeriatricians. The secretary wrote to 117 Area medical officers to find out which psychiatrists had responsibility for psychogeriatrics. Replies indicated that 61 Areas had psychiatrists with a special interest in older people, but ‘8 of these claims seem highly dubious’. The secretary planned to write to those nominated who were not Group members ‘asking if indeed they had an interest and would like to join’. This scenario again emphasized the difficulty in both obtaining and interpreting data for the specialty.

Other Group members, such as Langley working in conjunction with Exeter University’s Institute of Biometry, shared their research on service development. Promoting such research became an important objective of the Group, probably contributing to England’s lead in service development ‘well ahead of the North American scene’ (Shulman, 1994).

Multi-disciplinary work

Collaboration and dissent: working with geriatricians

In the mid-1940s, Dr Marjory Warren reported on the successful rehabilitation of older physically ill people (Warren, 1943, 1946). She set the foundations of geriatric medicine which developed far more rapidly than psychogeriatrics. Collaboration between psychiatrists and geriatricians was crucial for providing care to older mentally ill people, although the physicians clearly placed the onus for service development on the psychiatrists.

Prior to 1970 there had been some successful joint ventures between psychiatrists and geriatricians, such as in Edinburgh (Fish and Williamson, 1964), Nottingham (Morton, Barker and Macmillan, 1968) and Cornwall (Donovan, Williams and Wilson, 1971), frequently influenced by the ideals of individual innovators (Arie and Dunn, 1973). Psycho-geriatric assessment units, initially proposed in 1950 had largely failed to become widespread. Nor did they flourish after their reiteration in 1970 (DHSS), a response to WHO’s suggestions (1959) and an influential paper by Kay, Roth and Hall (1966) and Kidd’s study (1962) – later shown to be flawed (Copeland et al., 1975) – stressing poorer prognosis for older people placed in the wrong type of unit. Thus psycho-geriatric units aimed to ensure accurate assessment of
elderly patients with complex problems, but were never of proven value (Pitt, 1974). The demise of the units may have been for several reasons, including the huge discrepancy in consultant numbers: 293 geriatricians in Great Britain and Northern Ireland (Brocklehurst 1970) but only a handful of psychogeriatricians. At times geriatricians regarded the joint units as an imposition, suspicious that the new psychiatric units proposed for the DGHs would never meet the needs of older people (Andrews et al., 1972), while psychiatrists may have resented the directive that geriatricians should be in overall charge of the unit (DHSS, 1970). Geriatricians were appointed specifically to work in mental hospitals, but some preferred the lure of the new DGHs.48

The HAS highlighted that disagreements not infrequently occurred over who should care for individual patients, ‘Such lack of joint responsibility can only be deplored’, and on these grounds they also advocated joint assessment units (NHS, 1974). Although there was some move to create entire integrated psychiatric-geriatric services such as the Department of Health Care of the Elderly in Nottingham with Tom Arie appointed professor in 1977, this model did not become widespread.

The Society of Clinical Psychiatrists organized a geriatric-psychiatric liaison committee aiming to promote widespread clinical services (Enoch and Howells, 1971). This pre-dated the BGS and Royal College of Psychiatrists discussions (1973). The latter led to agreements on managing patients with dementia based on their behaviour rather than diagnosis, on training and recruitment of nurses and doctors into psychogeriatrics, and on the need for specialist consultant psychogeriatricians in each area, with geriatricians on appointment committees for psychogeriatricians and vice versa. However, cooperation between geriatricians and psychiatrists on policy development fluctuated.49 In 1975, only after a joint BGS and DHSS report was written critical of the organization of psychogeriatrics, did they request consultation with psychiatrists.50 This disconcerting report led to the reconvening of a liaison group.51 Further collaborative guidelines in 197752 set out important principles: that services for the elderly should be a unity for consumers; that there should be reciprocal training schemes for psychiatry and geriatrics; that responsibility for treatment should be determined by needs not resources or ‘quirks of referral’; and that no one should be labelled a psychiatric patient by virtue of some previous psychiatric episode (Norman, 1982). Such important principles continued to influence practice at least into the 1980s.

The multi-disciplinary team: nursing, psychology and occupational therapy

Even in the 1970s, some nurses perceived older people stereotypically: ‘Loss of weight is now more definite, and as the body dries up and the subcutaneous fat disappears, the skin becomes dry and wrinkled and the eyes sunken and lustreless … And ... their memory fails ...’ (Roberts, 1971). The body drying up reflected the classical Greek medical theory of marasmus (Theoharides 1971); implying that memory failure is inevitable was false. Perhaps the weight loss
reflected inadequate diet in long-stay hospitals. However, such attitudes of hopelessness in ageing may have had nihilistic effects on staff. Negative stereotypes of older people were not confined to nurses but also pervaded society at large, especially in the era of youth culture developing as the ideal. Simone de Beauvoir wrote *Old Age* in 1970 to challenge and explain such negative stereotypes, and the term ‘ageism’ was a new addition to the English language in 1969 (Oxford English Dictionary, 1980).

Unfortunately, in places with wards of over 70 beds it was ‘virtually impossible to provide a satisfactory standard of nursing care’ (Ministry of Health and CHSC, 1968). Nursing care became even more difficult when people with chronic functional illness were discharged and the wards filled with demented people requiring more intensive nursing. Although special training was advocated for nursing elderly mentally ill people (Ministry of Health and CHSC, 1968), it was unclear if this meant a physical or a psychological approach.

In 1975 the Group expressed concerns over training nurses to care for the ‘difficult dements’ to be placed in the proposed community hospitals. In 1976 there was unease about new DHSS proposals for residential homes, in that trends away from medical and nursing models might not meet the needs of more dependent residents. The Group (GPOA, 1978) emphasized in a memorandum that standards in mental hospitals were unacceptably low, largely due to staff shortages, under-financing and a ‘serious lack of central guidance’ on nursing requirements. Based on BGS recommendations for geriatric ward nursing and other reports, a ratio of 1 nurse to 1.2 patients was recommended for older peoples’ assessment wards, considerably more than the 1 to 3 for younger people. It is unlikely that nurses were involved in developing this recommendation. However, shortly after the memorandum was published (GPOA, 1978), the nursing advisor to the DHSS was invited to discuss the subject with the Group. Whether that was due to any disgruntlement from the nurses about doctors producing a memorandum about their work is unstated.

A BGS and Royal College of Nursing (1975) report on improving geriatric care stressed the importance of dignity, independence and mobility. However, mental health nursing appeared less progressive. Professor of Nursing Annie Altschul (Edinburgh) with Ruth Simpson (c.1977) wrote that the nurse can ‘exploit the phase when the patient accepts dependence, use it to build up prestige and will be grateful for the patient’s non-critical submission to treatment’. Such institutionalizing of nursing attitudes may have developed secondary to inadequate staffing, but was also likely to have contributed to a patient’s sense of powerlessness and may have been related to the hospital scandals of the previous decade (Robb, 1967). Altschul and Simpson (c.1977) emphasized that in dementia ‘Nursing care is concerned primarily with the preservation of physical health’. However, such advice was being questioned by other nurses such as Molly Clarke (Southampton) who commented that traditional acute nursing had little to offer the elderly and although sound principles for geriatric and psychogeriatric nursing were emerging they had not
yet been incorporated into training (Clarke, 1977). Nurses on long-stay wards still regarded themselves as working in a ‘dumping ground’ where ‘failures’ accumulated, while the very different goals of ‘cure’ and ‘care and maximisation of function’ still needed to be negotiated (Arie and Isaacs, 1978). However, things were changing. For example, Baker and Clark (1976) were advocating active, non-custodial roles for nurses, a wider range of skills than traditionally acquired in training, and the importance of community psychogeriatric nurses for elderly confused people.

**Psychology and occupational therapy**

Although developing both before and during the 1970s, psychology was a slightly later addition to the old age team, with the establishment of the British Psychological Society Faculty for Old Age Psychology in 1980 (British Psychological Society, 2007). Meanwhile, occupational therapy was well established but yet to take on its modern assessment and therapeutic role, concentrating instead on diversional tasks (Altschul and Simpson, c.1977).

**Closing the mental hospitals: the options**

Long term plans were to close the large mental hospitals, often far from where patients lived, and to consolidate local services. Calculation of bed numbers for community EMI services was based on a series of hospital censuses, with a final recommendation of 2.5 per 1000 elderly people (Eason and Grimes, 1976), a figure incorporated into *Services for Mental Illness Related to Old Age* (DHSS, 1972b).

But all was not straightforward. Whitehead stated in 1972 that ‘mental hospitals are becoming under-staffed, neglected dumps for the elderly’, reiterating this in 1983. It is likely that recognition of the unsuitability of mental hospitals for older people with dementia was itself responsible for a fall in the number of admissions in the early 1970s (Shulman and Arie, 1978). Yet some people were as vehemently against hospital closure as others were for it. For example, Tucker (1972) commented ‘we must keep the socially disruptive mentally sick people in the mental hospitals where they belong’. Although less applicable to the elderly, they could undoubtedly be very disruptive. Among older people with identified mental illnesses, behavioural difficulties caused significant distress in over half the families caring for them (Bergmann, Foster, Justice and Matthews, 1978).

Anxiety that hospitals would close without the provision of adequate suitable alternative accommodation (BGS and Royal College of Psychiatrists, 1973) was reiterated in 1977 in DHSS rhetoric: ‘in some areas bed-closures programmes are out of phase with the development of alternatives’. Most long stay beds still remained in mental hospitals. Although Powell’s ‘Water Tower speech’ (1961) had specifically mentioned ‘the old’ requiring various levels of community care, the tendency to prioritize the young persisted. For example the Worcester
Development Project feasibility study of community services failed to take into account older frail disoriented people when designing accommodation (Rooney and Matthews, 1982).  

Epidemiological studies and knowledge of disease processes were used to estimate need (Kay, Bergman, Foster, McKechnie and Roth, 1970), but little account was taken of other factors such as expectations of older people themselves (White, 1975), working patterns of carers, or improved treatment. Innovative care schemes were not new, but nor were they widely practised (De Largy, 1957; Whitehead, 1970). However, multi-agency cooperation and innovation was essential to develop services such as day hospitals, residential homes and community hospitals. A pragmatic summary in 1971 also suggested boarding-out services, day centres and clubs, sheltered workshops, meals-on-wheels, home helps, ‘sitters’, laundry services, a ‘good neighbour policy’ and financial support both for families caring for older people and for voluntary organizations as key to supporting mentally frail older people in the community (Enoch and Howells, 1971).

The day hospital

For older people, the day hospital developed conceptually as an alternative to long-stay care. There was less focus on the possibility of psychiatric day assessment, such units existing in only a few places such as at Exminster in Devon (DHSS, 1971; Kay et al., 1966; Langley, Wright, Sowden and Cobby, 1975). Older people were unlikely to be admitted to general psychiatry day hospitals, and many geriatric day hospitals seemed also to exclude the demented. In only very few places was anything like the DHSS’s recommended 2–3 places per 1000 population over 65 achieved (Arie, 1979). Whitehead (1970) noted that: ‘Some patients enjoy the ambulance journey more than the session in the day hospital’. In 1975, Arie humorously suggested ‘Transport therapy’, whereby the bus journey and activities on board were the focus of therapy. For many, the journey to the day hospital was the only glimpse of real life in an otherwise home-hospital bound world. However, not infrequently insufficient suitable transport effectively limited the availability of day places (Godber, quoted by Anon., 1978).

Residential homes

With the objectives of discharge from mental hospitals and preventing admission, residential placements were needed, and these were suggested in Services for Mental Illness Related to Old Age. Residential homes were to be provided at ‘an overall ratio’ of 25 places per 1000 elderly people, but numbers specifically for people with dementia remained unstated. Many elderly demented people needed residential homes not chronic psychiatric wards (Arie, 1971), but there was doubt whether Local Authorities would find the money for adequate quality and quantity of places within a reasonable time frame (Arie, 1973a).
In 1965 the Ministry of Health recognized that some people were so disturbed that they could not live amicably with mentally well residents. In the 1970s the moral debate on integration versus segregation questioned if older confused people should be cared for in homes giving various levels of care, or in specialist facilities. The Group took up this issue following the imprisonment of the warden of a specialized EMI residential home, Orchard House in Oxford, with the Group expressing the feeling that ‘there but for the grace of God’ went many of the homes in their own areas. Social workers preferred the integration model, but this did not necessarily work. It was reported that pressure to remove a confused resident from a home was more likely to come from residents than staff, but staff also had preferences about the sort of residents with whom they wanted to work (GPOA, 1976). Specialized homes for behaviourally disturbed people could be designed to maximize independence and could develop supportive links with local psychogeriatric departments. But residential care home staff required training to care for confused people, in particular, as ‘They do not know how to approach or handle them. Trial and error methods sometimes aggravate the condition’, and training required money.

Other issues were raised by the Group in order to ensure flawless coordination of care. For example, if a person in a residential home required psychiatric admission, should it be to the hospital in the area from which the patient originated or the one close to the home? Emotive discussion on this led to far-from-unanimous agreement. Various colleagues had other, sometimes controversial, care schemes to propose, notably Langley, with ‘yet another knotty dissertation’ undoubtedly stimulating debate within the Group.

Community hospitals
Whereas EMI homes were for people with dementia and behavioural problems, long-term hospital care was for those ‘requiring heavy nursing and “mindless” i.e. unable to appreciate their surroundings’. With the closure of mental hospitals, this group and some ‘difficult dementes’ would be placed in the proposed community hospitals.

Community hospitals were alluded to in Services for Mental Illness Related to Old Age (DHSS, 1972b), and the Hospital Plan (Ministry of Health, 1962) vaguely referred to ‘many small hospitals’ in addition to DGHs. Cottage hospitals had existed for many years, and in some places there was public protest at threats to close them. Community hospitals probably in part emerged from such protests. New proposals were outlined in a memorandum (DHSS, c.1973b) obtained by the Group that was disconcertingly stamped ‘For information only’. Although some psychogeriatricians in rural locations welcomed community hospitals to help to provide local services (Langley, 1974), others greeted them with consternation: ‘the community hospital, whatever that may be. Is it perhaps the old workhouse? The half-empty tuberculosis hospital?’ (Bergmann, 1973); Arie (1973a) commented:
[M]any of us would have been happier if more consultation and public debate had taken place beforehand with an official announcement afterwards, rather than the other way round, for if community hospitals become largely aggregations of patients who do not merit the services of the DGH we can expect to see in them something very similar to the institutions we have come to know so well.

This fear was also shared by geriatricians (BGS and Royal College of Psychiatrists, 1973).

Community hospitals were unlikely to meet pioneering architectural designs to promote independence and quality of life for confused people. Concerns also related to an absence of defined staffing levels, plus the proposal of medical staffing largely by general practitioners in cooperation with consultants, a new relationship for hospital work which would require considerable negotiation (DHSS, c. 1973b). A statement that ‘the use of existing buildings may enable some community hospitals to be established early’ (DHSS, c. 1973b) provoked the response that ‘someone is trying to run this on the cheap’. In addition, beds for younger patients would be in the more prestigious DGHs (DHSS, c. 1973b), compounding fears that elderly people would be placed in the lower part of a two-tier hospital system. Even Dr Brothwood (DHSS) appeared uncertain of the benefits of community hospitals, stating that policy had outstripped experience. The widespread implementation of new styles of service without adequate evaluation was apparently not uncommon (Jolley and Arie, 1978). However, community hospitals never became as widespread as planned. In their absence, older people continued to accumulate in the mental hospitals (DHSS, 1980).

The interface with social services

The importance of social difficulties leading to admission for older mentally ill people was well recognized, with implications that manipulating the social environment could be beneficial (Lewis and Goldschmidt, 1943). A social worker was attached to Post’s team from its inception and Severalls Hospital also had specific social workers for older people from the 1960s (Whitehead, 1970). Health and Welfare (Ministry of Health, 1963) proposed developing social care but failed to be specific or to provide adequate costings and therefore a credible framework for progress. In addition, ‘the Ministry did not seem willing to coerce those whose services were of poor standard’ (Welshman, 1999). Philosophy of social care, as with nursing and psychiatry, needed to undergo a major shift to improve mental health care for older people.

Both the roles of social workers and their management structure changed, moving from hospital to local authority employment at the same time as the 1974 NHS reorganization. Although the DHSS had considered bringing together health and social services under a single administration, this had not happened (DHSS, 1972a). Such unification would have had immense potential
to benefit older people. Woodford-Williams commented: ‘The weakening of links with social services … is keenly felt by consultant geriatricians and psychiatrists, particularly in relation to community support where the shortage of psychiatric social workers is having repercussions on the “new” long-stay problem.’ (NHS, 1974). These weakened links were accompanied by requests from the College for reintegration of mental health social workers into the health service (Royal College of Psychiatrists, 1971).

In 1977, however, there appeared to be increased interest towards older people by social work organizations such as the British Association of Social Workers (BASW).75 Perhaps interest occurred later than in some other professions, which were already moving to ward specialization, because of the Seebohm genericization of social work. Social work speakers were invited to address the Group in 1977,76 and they in turn requested more education on psychogeriatrics.77 A multi-agency conference proposed in 1975 on psychogeriatric services also finally materialized in 1977.78

Following Better Services for the Mentally Ill (DHSS, 1975) which briefly mentioned older people and the treatability of some of their illnesses, Priorities for Health and Personal Social Services was published the next year (DHSS, 1976). However, with services for mental illness in one section and services for the elderly in another, older mentally ill people risked falling precariously between the two priority areas. Priorities for Health emphasized alternatives to hospital care, aiming to support elderly people in the community for as long as possible. Ideas were certainly constructive, but funding was not necessarily evident. Indeed, the section on personal care stated that expansion would not continue at ‘anything like the recent rate’ (DHSS, 1976). It appeared unlikely that measures would be adequate79 (Anon., 1977). Concern remained about difficulties in coordinating care, insufficient mental health social workers, and that guidelines for developing community facilities for the mentally ill were not mandatory (Royal College of Psychiatrists, 1977). A Happier Old Age (1978), a DHSS discussion document, considered older people making choices about their own lives, while re-emphasizing the need for collaboration to make the best use of resources.

Arie (1973b) commented that many doctors and social workers:

 cannot formulate a ‘psychogeriatric problem’ in any other terms but as to the need to get it instantly off their hands … Few patients are so taxing to doctors as the confused and the demented. No other condition generates so much crisis, irritability, and interprofessional friction.

Although social workers and doctors did not always see eye to eye, directors of social services and doctors collaborated on strategic planning for community care (Anon., 1976), such meetings being indeed vital (GPOA, 1976). However, service provision was in part undermined by the removal of mental health social workers from the health service, and there appeared to be little, if any,


extra resources to pay for community care which remained ‘more apparent in rhetoric than reality’ (Welshman, 1999).

**Limitations and conclusions**

The subject of this study began in 1970, the year Whitehead published *In the Service of Old Age*, and concluded in 1978 with the Group achieving the status of a Section of the Royal College of Psychiatrists. But were Whitehead’s aims of informing public opinion of what can be done and stimulating self-scrutiny by the authorities achieved? There appeared to be little response from the public. It seems unlikely that self-scrutiny by the authorities would have been achieved without persistent and considerable pressure from the Group for the Psychiatry of Old Age.

The 1970s saw developments in provision of community care for the elderly mentally ill, coordinated nationally rather than in the earlier piecemeal fashion. In part this was due to *Services for Mental Illness Related to Old Age*, despite the drawbacks that it was not obligatory and that it was often taken as gold standard, rather than being a bare minimum on which further improvements should be built.

The 1970s also saw the entrenchment of some unfortunate developments, in particular the prioritization of younger over older people. The demarcation of age 65 years as a cut-off for older people’s care was probably necessary to establish distinct specialist services, but was not ideal in that chronological age has no precise relationship to physical health, care needs or social activity. In addition, the unenviable position of psychogeriatrics being neither psychiatry nor geriatrics but part of both placed it precariously between its two older and more powerful siblings.

This account has been very medically focussed, but since the subject is the management of illness, this is not unreasonable. Clearly various organizations were concerned such as MIND, the HAS and BGS. The Group frequently engaged with other specialties and agencies – from architects to geriatricians to social workers and policy makers (DHSS, 1980). Group members also generated ideas, supported peers, debated best practice and pursued implementation, all crucial to the development of the specialty. Yet their influence was moderated by resource issues, both financial and manpower, throughout the 1970s. Resource allocation and ideology were not always reconcilable.

The year 1978 was by no means an end-point to developing services, and perhaps was only another beginning. Without doubt, the philosophy of care, active treatment in appropriate environments and respect for older people with mental illness clearly established by the Group was a vital cornerstone for further developments. It was not until 1989 that psychogeriatrics was recognized as a specialty by the DHSS, and having a consultant in each district with responsibility for older people’s mental health services only materialized close
to the millennium (Arie and Jolley, 1999). When the mental hospitals finally closed in the mid-1990s, older people were often the last to leave. The developments after 1978 would be an area worthy of future historical investigation.

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7. Ibid.
18. GPOA 13 May 1976 (5a).
24. GPOA 30 Jan 1975 (5e).
27. GPOA 30 Oct. 1975 (6h).
29. GPOA 6 Oct. 1977 (77/77i).
32. Ibid.
42. GPOA 30 Oct. 1975 (5d) draft minutes.
43. GPOA 29 Jan. 1976 (5c).
45. GPOA, ‘Group into Section?’ (unpublished document).
47. Ministry of Health, ‘Care of the aged’ (see Note 3).
50. BGS, ‘Preliminary report of the working group on mental health in old age’ (draft), with letter from DHSS to Pitt, 27 Jan. 1975, GPOA archives.
51. GPOA 16 Sept. 1976 (5c).
52. GPOA 19 Jan. 1978 (16/78).
54. GPOA 30 Jan. 1975 (5g) draft of minutes.
55. GPOA 16 Sept. 1976 (7).
56. GPOA 20 Apr. 1978 (29/78).
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60. GPOA 28 Mar. 1974 (4).
61. GPOA 24 April 1975 (5c), quoting Dr Thompson.
62. Pitt, ‘Comments on Royal Commission’ (see Note 53).
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75. GPOA 14 Apr. 1977 (25/77).
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77. GPOA 23 June 1977 (40/77).
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