NEWS AND NOTES

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THE ROYAL COLLEGE OF PSYCHIATRISTS

Recent Activities

A permanent home for the College has yet to be found. A number of possibilities are currently being explored, in particular buildings which have had restrictions placed on their site development, or whose price has been lowered for other reasons. The College is especially fortunate to have the group of sponsors that it has, headed by Lord Goodman, C.H., acting on its behalf. When buildings of suitable character become available the sponsors are, as was demonstrated recently when a home was almost within our grasp, prepared to act with speed and determination.

The Research Committee is beginning to shape the role of the College in the field of scientific research. In framing proposals for future activities, preliminary and informal discussions have been taking place between the President, and senior officers of the Department of Health and Social Security and members of the Medical Research Council. These exploratory talks will be widened in the near future as concrete proposals begin to take shape. Suggestions from the Regional Divisions and the membership as to how the College could best function in this area would be warmly welcomed.

The College entertained an EEC medical delegation consisting of national representatives of the European Union of Medical Specialists (UEMS) to a dinner and reception on 5 April. This occasion marked the first opportunity to link with the European Community in a medical sphere.

The President, Dr. A. Shapiro (Sub-Dean) and Professor L. G. Kiloh attended a meeting of the Société Médico-Psychologique in Paris on 28 May. The need was strongly felt on both sides for closer links between psychiatrists in the two countries. Where practice and research have such different styles and traditions it seems certain that mutual benefit will ensue from more frequent contact. It is hoped that it will be possible to organize a joint meeting on the practice of psychiatry in the relatively near future.

Informal contacts are being established along similar lines with West Germany, where interest

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in the College is considerable and the *British Journal of Psychiatry* is widely read. Here too there is a strongly felt need for closer contact. And in early September the President will be visiting Sweden in order to strengthen ties with Scandinavian psychiatry, which already has close affinities with psychiatric practice and research in this country.

Joint Report of the British Geriatrics Society and the Royal College of Psychiatrists on Matters Relating to the Care of Psycho-Geriatric Patients

This Report was prepared by a joint Working Party convened following a request from the Executive Committee of the British Geriatrics Society to the President of the Royal College of Psychiatrists to discuss matters relating to the care of psycho-geriatric patients, and has been approved by the Executive Committee of the Society and the Council of the College.

A number of reports and papers were considered, among them the June 1972 draft of a D.H.S.S. circular entitled 'Hospital Services for Mental Illness Related to Old Age'. Observations made did not result in changes in this circular, which appeared (HM(72)71) under the title 'Services for Mental Illness Related to Old Age' in October 1972. The D.H.S.S. document is regarded as the blue-print for the near future, and it is acceptable in broad outline, as well as in many of its parts. Those areas have been examined in which there might arise disagreement between geriatricians and psychiatrists.

The following recommendations are made:

(1) The terms 'Mild Dementia' and 'Severe Dementia' were thought to be unhelpful. In practice, the clinician's assessment of behaviour rather than of precisely defined cognitive status of old persons should determine the kind of setting in which they are best cared for.

(2) In relation to Sections 13 and 14 of the Circular (HM(72)71), old people supposedly needing institutional care, in the presence of apparent mental alertness or only slight intellectual impairment and without marked physical disease or invalidism, are usually accepted, following their general medical practitioner's report, into local authority (and often into private or voluntary) residential homes through the action of social workers alone. It is desirable that the suitability of such persons for a permanent placement should be determined only after specialist assessment. The old person's family doctor should decide whether in a given case assessment by the geriatrician or by the psychiatrist responsible for the district hospital service seems appropriate. In this way early disorders might be detected and suitable preventive treatment or management instituted. Routine specialist assessment may not be practical at the present time, because of the present numbers of geriatricians and psychiatrists concerned with the elderly, but specialist assessment is deemed imperative in the case of persons admitted to homes for the Elderly Mentally Infirm. In the case of all types of patient, consultations with the appropriate specialist should be strongly encouraged.

(3) Old persons with severe behavioural disorders suspected to be due to acute mental changes, or mentally impaired persons suddenly deprived of their social support, are much more likely to present considerable urgency. The family doctor or social worker is likely to think that some form of hospital rather than local authority care is required. The family doctor should call in whom he regards as the most suitable specialist, geriatrician or psychiatrist. Even if the referral turns out to have been to the less appropriate specialist, the subsequent arrangements should be the responsibility of whichever specialist is called in, according to the clinical findings and along the lines suggested in 'Services for Mental Illness Related to Old Age'. Continued home care might remain possible, at least until a vacancy in a community home became available. Often the patient would require admission to hospital, into the geriatrician's care or into the psychiatrist's care as appropriate. Where genuine doubts on diagnosis exist, or when the care of both specialists is needed, the patient should be admitted to a Joint Assessment Unit (HM(70)11). Where such facility does not exist it is especially important that both geriatrician and psychiatrist should have at least the recommended number of beds per 1,000 of population aged 65 and over at their disposal, enabling them to transfer patients speedily who on fuller study are found to have been admitted to the wrong facility. It is highly desirable to avoid multiple consultations in these urgent situations. Geriatricians and psychiatrists should work according to the principles laid down in (HM(72)71), and normally each would accept his colleague's decision. The mechanisms involved in these emergency procedures should be worked out

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