

The Psychogeriatric Panel: A Health and Social Services Partnership

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Any service designed to meet the needs of the elderly must necessarily embrace a wide diversity of personnel and facilities. Not only is a multiprofessional team imperative, but such resources as are available—whether in the Health Service or personal Social Services—must be used in the full.

A flexibility in approach, the willingness to experiment, to cut across red tape and even administrative barriers, and to accept a blurring of roles (rather than a rigid adherence to the job description) becomes as essential a part of the service philosophy as the free interchange of information and ideas.

Following the Seebohm Report (Seebohm Committee, 1968) Social Services and Health Services seemed to pursue parallel courses with little liaison towards joint planning and a real integrated working relationship. More recently this unhappy and inefficient relationship has been recognized and guidelines issued (Care in the Community, 1981; Report of the Royal College of Physicians, 1981).

The formation in the Medway District of a Psychogeriatric Panel is an attempt to remedy this hitherto unsatisfactory state of affairs by a team from both services working together in the care of the elderly. It was set up as part of the developing Psychogeriatric Service and was seen as the means whereby both services could pool and thus share such scant provisions as each had to offer.

The panel first met in October, 1980, and was convened by the consultant psychiatrist (BWD), who had assumed responsibility for developing a Psychogeriatric Service in the District. The panel comprises six members; the consultant psychiatrist, a senior member of the Community Physician's Department (himself closely involved with the Local Authority Housing Department), a senior social worker, who is also chairman of the Medway Towns long-term residential care panel, and chairman, Social Services Multifaceted Residential Care (not long-stay) Committee, the matron of a large Part III old folks home in the Medway District, and one psychiatric community nurse, who was also especially appointed to the service in a liaison capacity. The community nurse has to liaise between four other colleagues, the panel and, of course, members of the primary care team. Observers—students, nurses, trainees in psychiatry—are welcome to sit in and see the panel in operation.

Relevant organization of Health District

The Medway Health District from the point of view of the psychiatric services, is divided into two. Its south-eastern sector (Swale) is part of the catchment area of Kent and Canterbury Health District, and the patients in this sector are admitted to St Augustine's Hospital, at Canterbury,

under the care of a consultant psychiatrist appointed to both Health Districts.

The south-western sector (Medway Towns) has its own district general hospital psychiatric unit (56 beds), of which ten are for acute functional psychoses in patients aged 65 or over, whilst longer-term beds, and all beds for high-dependency nursing care (severely demented) are at Oakwood Hospital in the Maidstone Health District ten miles away.

Oakwood Hospital also aims to offer two beds for male and female patients for short-term 'holiday care', particularly to give caring relatives or neighbours some respite and breathing space from their responsibilities. In addition, the Medway Health District Psychogeriatric Service needs to relate to three Social Services Divisions, each with its own Divisional Director, one of whom (Gillingham) is responsible for social workers working within the hospital setting.

As part of the endeavour to unite the complementary roles of the differing facilities in each Health District, the Psychogeriatric Panel meets alternately at Oakwood Hospital and in Part III accommodation in the Medway Towns. It deals with the clinical and social problems brought by each discipline represented within the panel, and not only are new cases discussed and appropriate management plans decided but existing, ongoing situations and previously determined treatments are reviewed.

The panel case load experiences over twelve months

The panel has now met weekly over the past fifteen months, and this paper presents the cohort of 251 new patients (61 male and 190 female) discussed during the first year. By the pooling of resources available to each service, a number of options have been made open to the panel. According to the consultant's clinical judgement acute disorders of seemingly short-term stay are admitted to the district general hospital psychiatric unit, whilst severely demented patients with behavioural problems and those for longer-term assessment and rehabilitation are admitted to Oakwood Hospital.

Apart from scarce in-patient beds and Part III accommodation, however, the panel are able to call upon several community resources. These include a newly opened day centre, in a Part III home recreational hall, staffed entirely by volunteers, and a twenty-place day centre, opened some eight years ago and operating four days a week in a local church hall (with very limited facilities, wanderers and incontinent patients are unfortunately excluded).

A number of active voluntary organizations operate facilities, ranging from Darby and Joan clubs, to day

centres, and even short-term concentrated domestic support as an emergency holding operation, but both Oakwood Hospital and two other Part III establishments operate a 'phased care', i.e., 'one month in, two months out' policy.

One member of the Community Physician's Department holds regular clinics for residents of sheltered housing and the consultant geriatrician not only offers his own facilities for patients deemed to be predominantly physically incapacitated, but also joins the psychiatrist in a joint clinic held at present on a monthly basis, where both clinicians can together assess the patient and formulate a treatment programme (the consultant psychiatrist has out-patient clinics always attended by other members of the clinical team, i.e., psychiatric community nurse, psychologist and social worker).

Lastly, the psychiatric community nurses, each holding a case load of approximately thirty patients, aged 65 and over, offer an invaluable support and advisory system which unquestionably has contributed towards retaining patients in their own environment. Each of the four psychiatric community nurses, allocated to the clinical area in question relates to the psychogeriatric panel through the psychogeriatric liaison nursing sister.

All patients in this study were exhibiting behaviour disorders such as to jeopardize their own or their relatives' physical health or equanimity. The acute functional disorders seen at a clinic or by the consultant in the home were admitted direct to a hospital bed without discussion by the panel. By far the greatest number of all patients were seen on domiciliary visits (44 per cent), and this accords well with earlier recommendations and opinions (Hemsi, 1980) as being the best means to adequately assess patients and decide on their future needs.

Fifty-five (21.5 per cent) of the total cohort were referred through Social Services Departments and 37 (14.7 per cent) through the community physician. The relatively high number of referrals to the community physician reflects the increasing age and morbidity of residents in sheltered accommodation (Clarke *et al*, 1981). Referrals from 'other' sources (11 per cent) included patients in other consultants' beds (medical, casualty departments or orthopaedic wards), domiciliary visits by consultant colleagues, and rarely from the matron of the Part III homes direct.

With regard to disposal and after-care of these patients, 41 (14.7 per cent) were placed in Part III accommodation and 61 (24.3 per cent) admitted to hospital. By far the greatest number however, 99 (39.4 per cent), were sustained in the community, again, as has been recommended in guidelines (Report of the Royal College of Physicians, 1981) and as proves inevitable anyway through lack of alternative facilities. This highlights one role of the panel in assessing priorities of need and the great advantage of all 'arms' of the service communicating freely in a jointly decided plan to place and sustain such patients within their own homes.

Very few (4.3 per cent) patients proved disabled by

physical disease as their primary pathology and required referral to the geriatrician, but 28 (11.1 per cent) needed assessment and treatment in hospital before being replaced in the community.

Discussion and conclusion

Before the inception of this multiprofessional and mixed services panel, patient disposal and management was particularly laborious and slow. The geographical distances involved often militated against prompt action, and communications were far too limited. No member of the Health or Social Services ever seemed available when the other called or telephoned. The misinterpretation of intent or needs, and failure to understand the other's problems, led to difficulties in negotiation between parties; and a rigid adherence to established procedures, with a fear of departing from them unless blessed by a more senior officer, inevitably led to procrastination while the patient continued in misery and at risk. This panel has overcome all these difficulties, and only the scant resources themselves make the panel's decisions at times difficult and its management programmes limited. The movement of human beings, as in a game of living chess, may not sound ideal, yet the shared knowledge of existing and forthcoming vacancies, of the clinical needs of individual patients and of the settings where these needs can best be met does allow free interchange between hospital and Part III accommodation, and this joint willingness to meet patients' requirements interchangeably has rendered the professionals' job easier and the patients' future much happier.

The Psychogeriatric Panel here discussed has proved invaluable. It has dispelled suspicion and mistrust between the personal Social Services and the Health Service by the frank discussion of individual problems and thus an understanding of each others difficulties. It has engendered a total team spirit, each working with the other in the patient's best interests and has certainly bettered the final programme offered to the patient by this pooling of expertise and resources.

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