The Problem of the Aged in Mental Hospitals

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THE problem of the aged in Mental Hospitals is universal, and is becoming more acute as time goes by. Mental disease is a tragedy at any time of life, but coming on in the later years it presents a particularly saddening picture. The majority of these patients have led a busy and useful existence, and those who were once the props and pillars of their age and generation are now a burden on the backs of their younger brethren. The aged patient is considerably different from the average inmate of a mental hospital. No other type of patient, with the exception of the acutely ill, requires so prolonged and continuous supervision. Uncontrollable factors, such as incontinence, confusion, and memory impairment, make it impossible for the aged to get along without considerable physical help from the nursing staff. Occupational therapy is limited, especially for those suffering from senile and arteriosclerotic dementia, and the useful output from such a department is so small that it presents a serious drain on the resources of the mental hospital. Looking after such patients constitutes the most monotonous and least glamorous type of nursing, and a year of care of the aged patient is probably equivalent to at least two years care of any other—the acutely mentally ill excepted.

This communication deals briefly with patients of 60 years and over in the six mental hospitals of Northern Ireland in general, and Purdysburn Hospital in particular. The basic age of 60 years rather than 65 years was taken to conform with the statistical requirements of the Geriatric Service. To give some idea of the amount of accommodation required for these patients, the following table gives the return from each of the mental hospitals.

TABLE I

	Total No. of Patients	60 Years and Over	Percentage	Number Fit for Transfer	Percentage of Over Sixties
Antrim	694	236	34	99	42
Armagh	562	223	39.7	82	36.8
Down	909	305	33.5	81	26.5
Londonderry	570	182	31.9	96	52.7
Omagh	839	302	36	106	35.1
Purdysburn	1563	468	30	154	32.9
TOTAL	5137	1716	33.4	618	36

It was of interest to find in this survey that if alternative accommodation could be obtained, either in a psychiatric long-stay annexe with simple supervision, resident homes, frail ambulent long-stay annexe, or bed-fast long-stay annexe, 618 patients

in all could be discharged from these six mental hospitals, thereby reducing the number to 998, or 24.3 per cent. of the total resident population.

TABLE II

	Total Number in Residence				Sixty Years and Over			
	Males	%	Females	%	Males	%	Females	%
Antrim - -	369	53.2	325	46.8	100	42.4	136	57.6
Armagh - -	300	53.4	262	46.6	106	47.5	117	52.5
Down - -	456	50.0	453	50.0	134	43.9	171	56.1
Derry - -	335	58.8	235	41.2	85	46.7	97	53.3
Omagh - -	466	55.5	373	44.5	172	57.0	130	43.0
Purdysburn -	829	53.0	734	47.0	204	43.6	264	56.4
TOTAL	2755	53.6	2382	46.4	801	46.7	915	53.4

In all the hospitals in Northern Ireland the total number of male patients exceeds the number of female, the proportion being 53.6 per cent. males to 46.4 per cent. females. Despite this over-all male superiority the scene changes when only those over 60 years are considered—it is then found that the females outnumber the males, the proportion being 46.7 per cent. males to 53.4 per cent. females. In Omagh mental hospital only do the male patients keep a majority, the proportion being 57 per cent. males to 43 per cent. females.

TABLE III—PURDYSBURN HOSPITAL

	Total Number in Residence			Sixty Years and Over					% of
	Males	Females	Total	Males	%	Females	%	Total	Total Pop.
1/ 1/38 -	910	779	1689	146	38.4	234	61.6	380	22.5
1/ 1/39 -	926	815	1741	169	40.0	251	60.0	420	24.1
1/ 1/40 -	928	794	1722	156	39.0	244	61.0	400	23.2
1/ 1/41 -	913	772	1685	170	41.6	239	58.4	409	24.3
*									
1/ 1/46 -	802	680	1482	155	40.3	230	59.7	385	26.0
1/ 1/47 -	802	681	1483	161	41.1	231	58.9	392	26.4
1/ 1/48 -	817	684	1501	164	40.0	246	60.0	410	27.3
1/ 1/49 -	836	713	1549	184	41.7	257	58.3	441	28.5
15/10/49 -	845	748	1593	195	41.2	278	58.8	473	29.8

* Figures for 1942-45, inclusive, are not given, as over 500 patients of all ages were temporarily transferred to other hospitals during these war years.

The number of older patients in mental hospitals is rising and, unfortunately, is rising quickly. On 1st January, 1938, the proportion of the over sixties to the total number of patients in this hospital was approximately 22.5 per cent. On 1st January, 1941—24.3 per cent., 1st January, 1946—26 per cent., and 1st January, 1949—28.5 per cent. There has been a further increase since the beginning of this year, and the figure now stands at 29.8 per cent., despite a rise of 44 in the total number of patients. If consideration is given to the actual number of over sixties, it will be

found that on 1st January, 1938, there were 380. This figure remained fairly constant up to 1st January, 1947, when there were 392, or an increase of 12 in 9 years, despite a drop in the total number of patients, but since then there has been a sharper rise, the total on the 1st January, 1949 being 441, an increase of 49 in 2 years, and at the present time is 473. It is interesting to note that the proportion of males to females over 60 in this hospital has remained almost constant since 1939, the proportion being at present 41.2 per cent. males to 58.8 per cent. females. This is certainly not the findings of some of the American hospitals who note an increase in the proportion of females. The outlook is not promising, and the time may come shortly when the chronic schizophrenics will lose their long-held honoured position as the biggest single group in the mental hospitals.

Various factors, mainly beyond control, have combined to bring this about. During the present century there has been a steady rise in the number of persons over sixty years of age, and this is still increasing. In Great Britain in the three years 1944-47 the number rose from 6,300,000 to 7,400,000, an increase of over one million. At the beginning of the century the ratio of over sixties to the total population was 1 to 18, but in 1947 it was 1 to 5.5. The figure for the Northern Ireland Mental Hospitals at present is 1 to 3, but if the Geriatric Service could find accommodation for the 618 individuals already mentioned who are fit for discharge to their care, the figure would become 1 to 4.7.

The advance of medical science and the progress of preventive medicine have played a large part in reducing the havoc wrought by physical disease in later life, but this has left the way open for an increase in the mental disorders of old age. As repair of physical injury is slowed down by advancing years, so also is recovery from mental breakdown retarded, especially where organic illnesses, such as arteriosclerosis, have an influence on the condition. Two thousand years ago the average span of life was 25 years, in 1900 it was 49, but to-day it is 66.5.

The mobilization of women during the war years for the services and for work in the factories has greatly reduced the number available to look after the aged sick as, having once tasted independence, they are loath to return to their homes to care for aged relatives. Families are smaller, and it is becoming more difficult to find the dutiful daughter, who, willingly or unwillingly, was expected to stay at home to look after the parents from their retirement from active work until their death, anytime within the next twenty to thirty years. Through pension schemes, many old people have become more or less financially independent and live alone, so that when they fall ill, either mentally or physically, they require to be nursed in hospital. Domestic and nursing help have been more difficult to find of recent years, at least at reasonable prices, and difficulties in housing conditions, as well as the lessening of filial responsibility, have all played their part in adding to the problem.

A comprehensive health service which is to look after everyone from the cradle to the grave has provided an excuse for those who wish to shelve any responsibility in this matter, and who expect the State to step in and provide the necessary accommodation and care. In addition to a more enlightened public attitude towards earlier use of the mental hospitals, many other factors have played their part, but

the net result has been to put an unprecedented demand for care and treatment of the old people on the existing hospitals and institutions.

The general hospitals in their turn, have their own problems, especially since July 1948, and they are extremely reluctant to receive any but acute cases whose stay in their beds will be of short duration.

This is the age of specialisation, and it has been carried further than could have been foreseen many years ago. As well as general hospitals there are now chest, fever, children's, neuro-surgical, and orthopædic hospitals, to name but a few, and each of these has no place in it for anyone who falls into a different category. The medical wards of the general hospitals have no place in them for the aged chronic sick, so again specialisation has been resorted to, and the geriatric service has come into being. Here the new broom is desirous of making a very clean sweep, and any long-term sick patient who shows outward manifestation of being a little odd, of being troublesome at times, or even shows mild resentment at being firmly handled by the nurses, is promptly despatched to the nearest mental hospital. Some Poor Law Institutions have been converted into hospitals by a stroke of the pen, and are now anxious to shift all patients to mental hospitals who show signs of mental derangement, irrespective of the bodily condition from which they may be suffering —this factor is causing intense concern to some of the county mental hospitals in particular. The result has been to increase the numbers of the over sixties in the mental hospitals during the past year. It is interesting to point out, in passing, that in 1941, owing to the great upheaval caused by the air raids on Belfast, 156 over sixties were admitted to Purdysburn as against 114 for 1940 and 79 for 1942. In 1947, 168 were admitted, 203 in 1948, and 117 *in the first six months alone* of 1949. It has been our experience that the female admissions over sixty have always outnumbered the males, sometimes by as much as 2 : 1. In some places in England and America the contrary has been found. A survey was carried out in this hospital to see the fate of those patients of sixty and over.

TABLE IV—PURDYSBURN HOSPITAL

	Admissions over Sixty	Discharged	Death within 6 Months	Death within 1 Month	Remaining After 6 Months
1928 -	111 ...	24 ...	40 ...	16 ...	47
1933 -	148 ...	58 ...	61 ...	29 ...	29
1938 -	143 ...	53 ...	50 ...	25 ...	40
1943 -	74 ...	27 ...	16 ...	6 ...	31
1948 -	203 ...	64 ...	71 ...	38 ...	68
1949 -	117 ...	31 ...	42 ...	30 ...	44

(First six months only)

Some of these patients lived for a few days only, and in one case this year death occurred within 12 hours of admission. In the majority of cases of early death the underlying cause was arteriosclerosis. After studying the case records of these patients, one is forced to the conclusion that some of them could have been dealt with best by being allowed to remain in the hospital from which they came, rather than transfer them to die in a mental hospital.

TABLE V—PURDYSBURN HOSPITAL

	Admitted when Sixty +	Arterio-sclerosis	Senile	Other	Long-standing Mental Disease	Total
Males -	57	13	26	18	138	195
Females -	128	27	76	25	150	278
TOTAL	185	40	102	43	288	473

Of the 473 (195 males, 278 females) patients at present resident in this hospital 288 are cases of long standing mental disease and of the remaining 185 admitted at the age of sixty or over 21.6 per cent. are arteriosclerotics, 55.1 per cent. are seniles, and 23.3 per cent. are other types of mental disorder.

The age distribution of the 473 patients is as follows :—

TABLE VI—PURDYSBURN HOSPITAL

	60-64	65-69	70-74	75-79	80-84	85 +
Males -	57	50	52	22	9	5
(Per Cent.)	29.2	25.7	26.6	11.3	4.6	2.6
Females -	67	54	67	45	30	15
(Per Cent.)	24.0	19.1	24.1	16.3	10.9	5.5

It is obvious from these figures that the average mean age of the females over 60 is much greater than that of the males.

The use of penicillin and the sulphonamides has helped to prolong the lives of many of these patients who would otherwise have succumbed to acute lung conditions, and it is obvious that this will give rise to the need of more nursing care from an already overworked and understaffed personnel.

What then can be done to help towards a solution to this grave problem? The exclusion of the aged from the medical wards of the teaching hospitals has resulted in a gross defect in the training of both doctors and nurses. In general practice the care of such patients constitutes a considerable proportion of the work so that newly qualified doctors have seen little or nothing of the special problems which arise in dealing with these patients, and, consequently, the only solution they have to offer is to call for help from the geriatric service. Here again, the doctors and nurses require training in mental abnormalities which may occur in the aged. Unless such training is given the eccentricities and behaviour disorders of older people are taken far too seriously, as they are not properly understood and no allowance is made for them, with the inevitable result that there will be confinement in a mental hospital for the majority.

It would be retrograde in these days to suggest that admission to mental hospitals should be made more difficult, but, in the case of the over sixties, with the exception of the acutely mentally ill, some screening appears to be necessary. This could be brought about by greater co-operation between psychiatrists and physicians in charge of the geriatric wards, when each case should be approached as a problem to be worked out together with equal responsibility. At present the number of

psychiatrists available is not adequate for much time to be given in this direction, but when this defect has been remedied, it should be part of the extra-mural duties of the local mental hospital staff to give their advice in the border-line cases, thereby establishing a much-needed liaison between the mental and general hospitals.

A suggestion has been made that a geriatric unit should be established at the mental hospital, as there already exists in each hospital a great number of these unfortunates who, for the most part, lead a vegetative existence. There is no doubt that such a unit, comprising occupational therapy and specialised services for the aged, would be of great benefit, but there are many factors against such a solution. Economics, difficulty in staffing, and, above all, the situation of the unit, would be immense handicaps. It has been found that psychiatric out-patient clinics are more successful when run in conjunction with general hospitals, and the same factors apply in this case.

Another suggestion has been the establishment of a special hospital, with out-patient clinic and social services, where all patients of 60 and over would be admitted when ill. After admission, disposal would be made to the medical, surgical, geriatric or psychiatric divisions with full co-operation and facility of transfer between the various units. The psychiatric division would be under the control of the local mental hospital, whose staff would be responsible for running it. One advantage of this would be that it would give rise to easy inter-change of patients from the mental hospital who no longer needed such control, and from this special hospital disposal could be made to a suitable position in the outside world without the stigma of the mental hospital resting upon them.

In conclusion, I would like to emphasise the following points :—

1. This is an urgent problem requiring solution at an early date to avoid the mental hospitals becoming the dumping ground for any of the aged chronic sick who are not quite up to standard from a mental point of view.
2. Nothing much can be done for the apathetic type of senile already in the mental hospital, in view of overcrowding, shortage of staff and lack of equipment—for this type of patient the solution appears to be the reduction of further admissions by the provision of some organisation prepared to take an interest in these old people.
3. The setting up of a geriatric unit away from the mental hospital is probably the best way of dealing with new cases, where the psychiatric division would be under the supervision of the local mental hospital medical staff.
4. The more efficient screening of the chronic sick showing evidence of mental disorder seems necessary, and this could be brought about by more co-operation between the psychiatrists and the geriatric service.
5. In view of the short duration of life of some of the patients admitted from general hospitals, a few beds should be available there for treatment of cases who break down owing to their physical illness.
6. The Mental Health Service has long been regarded as the Cinderella of medicine, but the time has now come for it to take a lead in dealing with this problem. This can only be done by active co-operation with our colleagues in

other branches of medicine. We can no longer afford to lead an isolated existence, but must recognise that there is as great a job to be done extra-murally, by publicity and by action, as well as within the walls of the mental hospitals.

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REVIEWS

THE POCKET PRESCRIBER AND GUIDE TO PRESCRIPTION WRITING. By D. M. Macdonald, M.D., D.P.H., F.R.C.P.E. Revised by A. G. Cruikshank, F.R.C.P.E. Pp. 275. Edinburgh: E. & S. Livingstone Ltd. 4s. 6d.

THIS is one of the most useful little reference books that the G.P. could carry with him. It is truly pocket size, measuring $4\frac{1}{8}$ inches by $2\frac{7}{8}$ inches.

The fourteenth edition of this book, which was first published in 1882, is brought well up to date with information on penicillin, sulphonamides, thiouracil, and proprietary medicines, as well as many of the old, well-tried prescriptions. The book is eminently practical and gives concise alternative treatments for the different diseases under separate indexed headings, e.g., Alimentary, Respiratory, Blood, etc. There are also notes on prescription writing, dosage tables (adults and children), diets, average heights and weights, incubation periods, D.D.A. regulations, etc.

The Pocket Prescriber should be of service to the recently qualified doctor, as well as a memory refresher to the older doctor. R. G. K.

A PSYCHIATRIST LOOKS AT TUBERCULOSIS. By Eric Wittkower, M.D. The National Association for the Prevention of Tuberculosis, Tavistock Square, London, W.C.1.

IN this well-written book the author gives a psychopathological hypothesis of tuberculosis and a description of the various reactions between the illness and the different types of personalities.

Every chronic condition constitutes a psychological problem for the patient, and we may as well admit, for the doctor too. The physical factors, like the toxæmia, which lowers the threshold of inhibition, and the lack of muscular activity, which leads to tension and anxiety, are mentioned and very well described.

A need for affection as an outstanding common feature of the premorbid personality of the tuberculous patient is demonstrated in this book.

External events as precipitating or "reactivating" factors are discussed.

The masterly description of the psychological state of a tuberculous patient in Thomas Mann's "Magic Mountain" is not mentioned.

Before concluding the review of this very interesting and readable book, the reviewer wants to quote another writer, G. B. Shaw, who says in "Doctor's Dilemma," "Now-a-days the troubles of consumptive patients are greatly increased by the growing disposition to treat them as lepers." K. S.