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LONG STAY PATIENTS IN A STATE MENTAL HOSPITAL

O. SOMASUNDARAM[1], M.B.B.S., D.P.M., M.R.C. Psych. (London)
P. JAYACHANDRAN[2], M.A.
R. KUMAR[3], B. Sc.

SUMMARY

A study of the long stay patients in a state mental hospital on 30th June 1980 revealed that 70 per cent of the total 1,434, i.e. 1015 had spent more than two years continuously; most of them are chronic schizophrenics, admitted by the police, lacking social support. The need for rehabilitating them both within and outside the hospital is stressed.

The popularity of the mental hospitals was waxing and waning in the history of psychiatry. Asylums were built to 'wrest' the patients from the community and protect them from neglect and cruelty. But in course of time the asylums were accused of practising the same on their patients ; Pinel had to carry the revolutionary fire of liberty and humanism into the dark corners of the asylums. Tuke and Dix had to bring to the notice of the pubilc and the authorities the sad and the dehumanising conditions in the public asylums. In the early years of this century Kreepelin, Bleuler, Jung and Meyer, while working in the mental hospitals made contributions which are a part of history now. As an aftermath of the tranquillizer era hopes ran high and predictions were made, that the days of the mental hospitals were over and their end was in sight. Tooth and Brooke (1961) forecast that the mental hospital beds in the United Kingdom could be reduced from 3.3 to 1.8 per thousand of the population in the next fifteen years. The hospital plan of the Ministry of Health (1962) was also based on this assumption. The community mental health movement in the U.S.A. resulted in the rapid and unplanned exodus of half the inhabitants of the State hospitals between 1963 and 1973 eupheumistically termed 'deinstitutionalization'. The unpreparedness of the community to accept these mental patients stressed once again the importance of the role of the mental hospitals in their custodial care.

W.H.O. as early as 1953 had recommended the provision of five psychiatric beds per ten thousand in the Asiatic countries to accommodate patients who are, because of their behaviour, a danger to themselves and to others or who otherwise create a grave social problem in the community in which they live (W.H.O., 1953). The position of India is far from satisfactory, even when this modest recommendation is considered. In 1946, we had just over ten thousand beds in mental hospitals in the undivided India (Singh, 1969). The position improved and reached a figure of 12,685 in 1961 (Prasad, 1961). Latest available figures for the 33 mental hospitals are 21,000 (Sethi, 1976 ; Sharma, 1976). The gap between the need and the availability of psychiatric beds in our country is evident from these figures. Many of our mental hospitals are not only crowded but contain a high proportion of chronic patients. Very few systematic studies on chronicity are available ; Bhaskaran (1970) has referred to 'the unwanted patient' in the Hospital for Mental Diseases at Ranchi. The other reports are Gupta *et al.* (1968),

1. Professor of Psychiatry
2. Psychiatric Social Worker
3. Statistician

Institute of Mental Health, Madras-10.

Bhaskaran *et al.* (1972) and Gupta *et al.* (1980).

The Government Mental Hospital at Madras (presently the Institute of Mental Health, Madras) is one of the oldest and largest in the country. The hospital was built by the then British Government in 1871 and served the erstwhile Madras Presidency of British India, comprising of the entire Tamil Nadu, parts of Andhra Pradesh, Karnataka, Kerala and a small part of Orissa. Only in 1957 when Tamil Nadu attained the present unilingual status some of the patients were returned to the Mental Hospitals at Bangalore, Waltair, Hyderabad and Calicut. The present strength of the Institute is 1800.

MATERIAL AND METHOD

The list of patients with their names, dates of admission, type of admission, diagnosis and particulars about social support (as determined by the visits of relatives and friends and letters addressed to the patient) were obtained on the mid-day of 30th June 1980, age as mentioned by the relatives or the police was grossly approximate and hence is not included in the present study. There were 1434 patients and the break-up is as follows :

Civil admissions : ..	Men ..	902
	Women ..	394
	Children	79
Criminal admissions :	Men ..	54
	Women ..	5

All patients continuously hospitalised for a period of two years or more were considered as long-stay patients. This definition of 'long-stay patient' is in conformity with the Indian studies already mentioned.

There were 1015 long-stay patients and they were studied in greater detail. When the diagnostic labels were in order, such as chronic mania, toxic psychosis etc., the patients were subjected to a fresh psychiatric interview and given the appropriate diagnosis.

The results are tabulated as follows :

TABLE-I. *Composition of the* 1015 *patients by duration of stay and sex*

Period of stay	Men	Women	Total
2 years	48	19	67
3 years	50	15	65
4 years	43	23	66
5 years	40	20	60
6—15 years	275	144	419
16—25 years	154	69	223
26—35 years	56	17	73
36 years	33	9	42
Total	699	316	1015
Average Stay	13.9 years	12.9 years	

There is no significant difference in the duration of the stay for the two sexes.

TABLE-II. *Diagnosis of Long Stay Patients*

	Men(%)	Women(%)	Total (%)
Schizophrenia.	430 (61.4)	195 (61.4)	625 (61.4)
Mental Retardation	175 (25.0)	81 (25.6)	256 (25.2)
Epilepsy	77 (11.0)	33 (10.4)	110 (10.8)
Affective Disorder	6 (0.9)	3 (1.3)	9 (0.9)
Organic Brain Syndrome.	11 (1.7)	4 (1.3)	15 (1.7)
	699(100)	316(100)	1015(100)

TABLE-III. *Admission Status*

	Men	Women	Total
Voluntary patients	208	126	334
Certified cases from Madras City.	191	105	296
Certified cases from districts.	162	45	207
Certified on petition	80	34	114
Criminal	56	6	62
Not clear	2	0	2
Total	699	316	1015

TABLE-IV. *Marital Status*

	Men	Women	Total
Single	512 (79.5%)	163 (56.8%)	675
Married	122 (18.9%)	106 (36.9%)	228
Divorced	10 (1.6%)	18 (6.3%)	28
	644	287	931

$X^2=54.052$, d.f.=2, $P<.001$

There were significantly more single men than single women.

DISCUSSION

It should be noted that the sanctioned strength of the hospital was only 800 until 1957, when the State Government raised the bed strength to 1800 and sanctioned more personnel and funds. The hospital continues to function in the same campus built in 1871. So the Madras Hospital is no exception to the other Indian mental hospitals in experiencing overcrowding.

The long stay patients formed about 70 per cent as compared to 60 per cent of the Ranchi Hospital and 50 per cent of the Agra Hospital. This higher proportion of the chronic patients is probably due to historical reasons. This hospital served the erstwhile Madras Presidency of the British India and the Madras State of the independent India till 1957 when the patients of newer states of Kerala, Karnataka and Andhra Pradesh were returned to their respective States. Patients whose correct addresses could not be ascertained or who were admitted by the Madras City Police (but who actually belonged to other linguistic states) were retained in the hospital and contribute much to the number of long-stay patients.

Patients with mental retardation form 25 per cent of our sample ; most of them are admitted by the police or by the relatives who do not visit their wards subsequently.

TABLE-V. *Social support by sex by type of admission*

	Continuing support		Ceased support		Never had any		Total
	Men	Women	Men	Women	Men	Women	
	N=206	N=91	N=83	N=29	N=108	N=196	
Voluntary patients	89	46	21	18	98	62	334
Certified patients	108	43	56	11	269	130	617
Criminal	9	2	6	0	41	4	62
Total	206	91	83	29	408	196	1013

The corresponding figure for the Ranchi Hospital is only 7 per cent.

It could be seen from the Table II that the average stay of male population is 13.9 years and for the female population is 12.9 years. The corresponding figures for the Ranchi Hospital are 12.5 years and 17.25 years respectively. 34 per cent of the long stay patients stayed in the hospital continuously for more than 16 years (35 per cent of the males and 31 per cent of the females). 33 per cent of males and 63 per cent of the females of the Ranchi Hospital, stayed for more than 10 years.

In 21 per cent of the long stay patients, addresses of the relatives are not known. All of them are certified cases. Many of the patients could have been discharged to the care of the relatives only if the police had made an attempt to get the addresses at the time of admission. This could be done if social workers of type 'Mental Welfare Officers' as mentioned in the Mental Health Acts of the United Kingdom work in close collaboration with the police at the district headquarters.

Three per cent of the patients belong to the adjoining states of Andhra Pradesh, Karnataka and Kerala. Most of them belong to the border districts like Nellore (Andhra Pradesh) etc. There should be reciprocal arrangements between the various states of the Indian Union to look after the psychiatric patients so that hardships in their care could be reduced. For instance, it is much easier for the Andhra patient residing in the Nellore District to come to Madras City rather than go to Hyderabad or Vishakapatnam much far away.

About half of the patients (384) who are brought to the hospital by the police with Madras City address are taken charge of in the city. Actually they do not belong to the city ; some have stayed into the city ; some are brought and abandoned in the city by their relatives who know that the patients could ultimately find their way into the hospital. As mentioned earlier, the services of a mental welfare officer is essential for the metropolitan cities even if this facility could not be extended to the districts.

About 100 patients belong to the southern districts of Madurai, Ramanathapuram, Pudukkottai, Tirunelveli and Kanyakumari. A Mental Hospital situated in one of these districts should serve these districts more efficiently.

DIAGONISTIC CATEGORIES

Schizophrenia forms 61 per cent of our sample in both sexes. The corresponding figures for Ranchi are 76 per cent and for Agra are 93 per cent. Most of these patients have stayed for more than 15 years. These figures confirm that the problem of the chronic mental patient is that of the schizophrenics as in other parts of India and the rest of the world. 25 per cent of the chronic patients are mentally retarded and many of them are hospitalised since their childhood. Organic brain syndromes form only a small part of the chronic population ; 2 per cent (Cf. 11 per cent of Ranchi and 8 per cent of the Camberwell sample). The contribution of the organic cases to the chronic mental hospital population is rather small in our country at the moment ; but the tilt in favour of this group by the aging population is likely to change soon.

ADMISSION STATUS

Table III shows the admission status of the long-stay patients. It could be seen that only about 30% of the chronic patients belong to the category of voluntary patients. (Cf. 22 per cent of Ranchi and 1 per cent of Agra samples). The higher percentage of the Madras sample reflects the admission policy of the hospital. From 1939 to 1948 voluntary admission received momentum by the efforts of the then Superintendent (Subramaniam, 1971). Presently the voluntary admissions form about 70 per cent of the total admissions of roughly

2000 per annum. Majority of our chronic patients belong to the certified groups 'the wandering and/or dangerous lunatics who need care according to the Indian Lunacy Act. Most of these patients are abandoned by their relatives and are 'unwanted' (Bhaskaran, 1970).

MARITAL STATUS AND SOCIAL SUPPORT

TABLE VI. *Marital Status of Long Stay Patients in India*

		Present Study	Ranchi	Agra
Men :	Single	73.0%	84.5%	50.0%
	Married	17.0%	12.8%	37.5%
Women :	Single	54.0%	43.0%	26.7%
	Married	35.0%	43.0%	63.3%

(Status like 'widowed' and separated are omitted in this table).

Amongst the chronic patients the male unmarried outnumber the married males enormously (though to a much less extent in the Agra sample) the married females are almost equal to the unmarried females. The reasons are clinical and social as pointed by the Ranchi workers. The first attack occurs usually between the age range of 15 and 25 years in both the sexes. Among women, the age of marriage being lower, it is possible that some are already married by the time they had the first breakdown, thus accounting for the proportionately larger number of married women in our sample. The age of marriage being higher in men which in turn may act as a stigma and lessen the chances of a subsequent marriage as well.

The other possibility is social. Being single, male patients have no family of their own. On the death of their parents, especially the father, they become anchorless and may be slowly forgotten. On the other hand, married men are likely to be taken back into the family even though they may be non-productive. On the other hand, in case of the female patients, because of cultural compulsions and the possibility of remarriage of the husband, even married women are likely to be forgotten and allowed to be chronic as often as single women.

SOCIAL SUPPORT TO THE LONG STAY PATIENTS :

It is shown in the Table V. Only 30 per cent of the patients receive support from their families. Combining Table I with this Table, it could be seen that in either sex it works out to be 30 per cent. The patients who never had any support from their families since the time of their admission into the hospital or lost this support after some time is 70. Combining Table III showing the type of admission with Table V it could be calculated that about 60 per cent of the voluntary patients and 73 per cent of the certified patients lack social support. The high figure for the certified patients is not surprising as most of them lack homes and are picked up by the police. The comparatively high figure for the voluntary patients is probably due to the fact that they were admitted in the previous decades and the family support is lost due to death of the relatives or migration of the relatives to the neighbouring states. Another very important reason is that the relatives deliberately mislead the hospital authorities by giving wrong address. Now-a-days the relatives of the new patients, are screened by fairly senior psychiatrists and psychiatric social workers (unlike previously when this information was collected by a member of the clerical staff). The periodic home visits by the psychiatric social workers after admission (at least in the city) increases the changes of continuing family support.

By increasing the number of voluntary patients to a very high percentage, screening the relatives and continuing contacts with the families through home visits in

TABLE VII

Year	Census on 1st Jan.	Voluntary admission	Certified admission	Total admission	Total Discharge	(Admission —Discharge)
1974	1700	819	543	1362	1393	—31
1975	1669	759	625	1384	1329	+55
1976	1724	969	468	1437	1509	—72
1977	1652	1043	565	1608	1588	+20
1978	1672	1148	636	1784	1754	+30
1979	1702	1254	634	1888	2049	—161
1980	1541	1410	525	1935	2012	—77
1981	1464	1361	448	1809	1835	—26

the city and through letters to the families from the districts the inpatient strength of the Institute of Mental Health at Madras has been maintained at a comfortable level, as shown in the table.

CONCLUSION

In spite of the spectacular therapeutic advances in psychiatry in the last few decades the problem of the chronic mental patients (mostly chronic schizophrenics) has not been effectively solved in any part of the world. A developing country like ours can ill afford its mental hospital beds to be clogged with these patients, remembering at the same time that many of them lack social support outside the health services. As pointed out by Bhaskaran (1970) the rehabilitation of these patients both inside the hospital and outside the hospital should be attempted. A lively and dedicated endeavour in this direction is urgently needed.

REFERENCES

BHASKARAN, K. (1970). The unwanted patients. Indian J. Psychiat., 13, 1.

BHASKARAN, K., NEENA DHAWAN AND MOHAN, Y. (1972). A study of the effect of prolonged hospitalisation on schizophrenics. Indian J. Psychiat., 14, 106.

GUPTA, P., PRABHU, M. AND PRABHU G. G. (1968). Rehabilitation of the chronic psychiatric patient. Indian J. Psychiat., 157.

GUPTA, S. P., YADAV, B. S., BHARADWAJ, R. C. AND SHARMA, R. P. (1980). Psycho-social problems of long stay mental patients. Indian J. Psychait., 22, 251.

HAILEY, A. M. (1971). Long stay psychiatric inpatients—A study based on the Camberwell Register. Psychological Medicine, 1, 128.

JOHN, A. TALBOTT, (Ed.). (1978). The chronic mental patient. The American Psychaitric Association, Washington D. C.

SINGH, KRIPAL. (1969). Psychatry and the nation. Indian J. Psychiat., 1, 99.

MATHROOBOOTHAM, N., GEETHA KRISHNAN AND NARASIMHA RAO (1982). Chronic schizophrenics in Sheltere Workshop, Unpublished.

PRASAD, B. G. (1961). Some thoughts on mental health in India. Ind. J. Psychiat., III, 110.

SETHI, B. B. (1976). Burning and neglected psychiatric problems in India. In : 'The New Psychiatric Hospital', Lucknow.

SHARMA, S.D. (1976). Psychiatric facilities in India. In : Souvenir of the 28th Annual Conference of the Indian Psychiatric Society, Nagpur.

SUBRAMANIAM, N. (1971). The Government Mental Hospital, Madras-A short history in Government Mental Hospital 1871-1971. Souvenir, Madras.

TOOTH G. C. AND EILEEN BROOKE. (1961). Trends in the Mental Hospital population and their effect on future planning. Lancet, 1710.

WORLD HEALTH ORGANIZATION. (1953). Technical Report Services No. 73. The Community Mental Hospital, World Health Organisation, Geneva.