Planning against neglect

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Before the National Health Service came into being, large numbers of old people ended their lives in the dismal wards of poor law institutions or in grim local authority mental asylums. They were recruited from the poor, the isolated and the rejected.

Since 1948 there has been a steady increase in the number of old people requiring help because of ill health or social difficulties. There has been some improvement on the situation that existed before the creation of a National Health Service but these improvements have not kept pace with the ever-increasing demand.

The specialty of geriatric medicine arose more because the Ministry of Health did not know what to do with the elderly institutionalised it inherited than from any strong, positive desire to provide an effective service for old people. Fortunately geriatricians appointed to deal with this problem and their successors have made impressive efforts to provide a sensible, hopeful and humane service for the elderly sick and disabled. Geriatric services have not only coped with so-called medical and social problems, but have also tried to cater for a proportion of the elderly mentally ill.

Until fairly recently the psychiatric services did little for the elderly. Old people with functional mental disorders, such as depression, paraphrenia and neurotic reactions, were treated (with varying degrees of success) in the same way as younger people, but if the patient suffered from dementia, or was labelled as suffering from dementia, the chances were that either no help was offered, or the patient was condemned to a long-stay ward with the minimum of care or treatment.

One result of this non-provision of active treatment was that old people from the community joined the ranks of those who had grown old within the mental hospital and together they started to make up an increasing proportion of psychiatric hospital residents. This 'flooding' of the mental hospitals, coupled with the desire of some psychiatrists and other specialists to provide a better service for the elderly, led to a few hospitals developing special units for the elderly mentally ill.

During the past 10 years, a number of special units have been created and developed, but the majority of area psychiatric services failed to do anything until very recently. Now the Department of Health and Social Security has produced a Memorandum, 'Services for mental illness related to old age', (HM (72)71, October 1972).

The problem

The statistics of our increasing elderly population are often set out, but they are worth emphasising. At present there are nearly 6½ million people over the age of 65 in our society; more than 2½ million of them are over 75. The estimates suggest that, within 20 years, there will be an extra million people over the age of 65, with 942,000 more old people over 75, and 522,000 more over 80. At present there are approximately 116,000 patients in mental illness hospitals – 52,000 of them over the age of 65, and 27,000 over 75.

The incidence of mental illness within the elderly population is difficult to assess. Surveys in a number of areas have shown that some degree of dementia is prevalent in about 10% of people over 65, the majority of whom live at home. Other surveys have suggested that between 41% and 55% of elderly people at home have some kind of psychiatric disorder. Another survey concluded that nearly a quarter of its sample of apparently healthy elderly people suffered from serious emotional stress which could respond to help and treatment.

These studies indicate that there are very large numbers of old people who need (or may need) the kind of help that psychiatry, in co-operation with other services for the elderly, should provide.

A suggested solution

There is little doubt that old people not only prefer to remain in their own homes until they die, but also tend to react rather badly when admitted to hospital or any other type of institution. For this reason it is important for any service for old people to be community orientated. This does not mean that in-patient or residential facilities should be neglected, but it does mean that these facilities should be only a part of a much more comprehensive service.

It can be argued that any modern, effective psychiatric service that provides the necessary range of facilities for younger patients could deal adequately with the demands of the elderly as well. This is an ideal solution which is unlikely to be achieved. The combination of general lack of staff interest in the elderly and their special medical and nursing needs make it necessary for special services to be established for them. These special services should be staffed by personnel interested in the problems of old people and able to co-operate with (and become an integral part of) other facilities for the old, including those
provided by geriatric units and local authority health and social service departments.

An essential part of a special service for the elderly is a day hospital, or several – depending upon the population and geographical size of the area served. A day hospital should and can provide all the facilities of a good in-patient unit except for night accommodation. This means that patients can be assessed, investigated, treated, rehabilitated and supported without the trauma of admission to hospital, and can continue to be supported whilst still living in the comforting familiarity of their own homes. Staff from the day hospital should be available to go out into the community to help and treat those patients who, for one reason or another, are temporarily or permanently unable to come to the day hospital.

Many old people are admitted to hospital because of some crisis which may be an acute illness – or some social mishap. If the immediate crisis can be dealt with at home, subsequent admission to hospital is not likely to be necessary yet, once admitted, it may be very difficult ever to re-establish the patient in the community.

To deal with this aspect of the problem an emergency team should be available to go out at any time, 24 hours a day, 7 days a week. This team must be able to deal with most emergencies, including the provision of a night sitter if necessary. The experience accumulated by such a team has shown that the vast majority of crises can be dealt with successfully without admitting the patient to hospital, though day hospital attendance is often necessary after the crisis has passed.

In many cases old people need the company and activity of a day hospital, but do not need its medical and nursing facilities. For them, day centres, run either by local authorities or voluntary organisations, are essential and no day hospital can function successfully unless there are good day-centre facilities in its area.

Obviously the special service for the elderly also needs in-patient units which should be run on active, patient-participatory lines with enough activity and entertainment for the patients to be able to live as normal a life as possible. Some patients need only a short period in hospital, others need recurrent hospital admission, either because of their own needs or the needs of their relatives. A relatively small number of old people need permanent institutional care, either in hospital or a local authority home or hostel.

As well as providing these in-patient facilities, the
special service should concern itself with the patients who have grown old within institutions. For them there should be active rehabilitation programmes and schemes to re-establish within the community those who are able. Boarding-out schemes, group homes, and resettlement with members of their own families are some of the ways of providing positive alternatives for these forgotten, and largely neglected, people.

The kind of service which I have described very briefly should be run very closely with other services for the elderly. This can only be the case if the various personnel actively involved in this area of work are allowed and encouraged to work together. The aim should be to establish such a degree of integration that no one ever says 'This is your problem'.

The Memorandum

Sir Keith Joseph's policy document, 'Service for mental illness related to old age', looks at the issues, and makes suggestions similar to those I have aired here. But the official document does have some elements of vagueness. Itoptimistically suggests that old people with functional mental illnesses can and will be treated by the normal services for younger patients. This may happen in some places, but in many, the old person admitted to the psychiatric hospital or unit at the moment is treated very much as a second, if not third or fourth-class citizen.

In its consideration of patients who have grown old in hospital the Department's memorandum makes no mention of boarding-out schemes, group homes, and so on – the inference is that these patients should remain where they are. A quick look at the elderly 'graduates' in most psychiatric hospitals would show that an appreciable proportion could be re-established in the community if the necessary efforts were made.

Little mention is made in the memorandum of the gross inadequacies of present community facilities for the elderly. The total number of day hospitals and day centres in the country is pitifully small. Meals on wheels and home help services are totally inadequate, and most hospitals and local authorities seem more concerned about their residential accommodation than with providing services to support old people in the community.

I suspect that most hospital authorities will look at this DHSS document and continue to do what they are doing now. Since it is primarily intended for the hospital service, local authorities will also be able to ignore what it infers but does not spell out.
The need

Every area in the country requires a comprehensive service for the elderly mentally ill. This service must be adequately staffed with people of the right calibre and motivation, and should fit in to an overall plan of services and support for the elderly in general. Not only must the hospital service be pressurised into doing this but, since the vast majority of patients treated by any speciality in the hospital service, (except for obstetrics and paediatrics) are elderly, medical and nursing education must also be radically changed so that all personnel know what to do for old people who are ill.

Geriatric and specialised psychiatric services cannot and should not be expected to deal with all old people, and the other social and medical specialists who have to deal with the elderly should be able to do so effectively themselves except when special circumstances indicate the need for the expertise of a geriatrician or a psychiatrist with a special concern for the elderly. Every doctor should be able to recognise the simple psychiatric and social syndromes associated with old age and know how to treat them.

Our increasing elderly population is a problem for all of us. The problems presented can be solved provided we try. Failure to make the effort could lead to a problem of crisis proportions, and will mean that most of us can look forward to only misery when we become old.