COMMUNITY NEEDS OF ELDERLY PSYCHIATRIC PATIENTS*

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Treatment and care of psychiatric patients within the community rather than in the overcrowded wards of mental hospitals have been recommended by a Royal Commission (Report, 1957) and are about to become one of the corner-stones of the new Act of Parliament governing the legal aspects of mental illness. Recent accounts of out-patient, day-hospital, and domiciliary psychiatric treatments have gained so much attention that it is unnecessary to summarize them here.

Few people would deny that these movements are in the right direction and are likely to benefit a large proportion of patients. But, to avoid imposing undue strain on their families, treatment of psychiatric patients within the community will have to be conducted in a spirit of flexibility and co-operation between hospital and community. We cannot overstate the paramount need for rapid and, if necessary, repeated interchanges between specialist treatment under the aegis of the hospital, and aftercare and support by the family, the general practitioner, and the services of the local authorities. Co-operation in passing the ball rather than the buck is a *conditio sine qua non* if patients who are both mentally disordered and elderly are to be treated outside hospitals; and workers like Macmillan (1957) and DeLargy (1957) have pointed the way in which rapid changes between specialist treatment and community care can be achieved. Hospital costs can no doubt be greatly reduced by cutting down the time spent by people occupying hospital beds, but the public should be warned that adequate community services for the discharged patient are likely to be very expensive in terms of man-power (general practitioner and specialist time, home nursing, occupational and social therapy, etc.), of buildings, and of transport from home to treatment and occupation centres.

We would like to submit the results of an investigation designed to assess the amount of further help needed by a group of discharged elderly psychiatric patients.

Design of Investigation

All 131 patients discharged from the geriatric unit of our hospital during 1955 were followed up over the 24 months after leaving in-patient care. In some cases we were in possession of all relevant facts by reason of continued personal contact over this period; in others information was obtained by psychiatric social work or correspondence with hospitals. No patient was lost from this inquiry, but six cases were omitted from the analysis of our data because information was incomplete. We were able to assess the amount of further treatment our patients had received, and also to pick up cases who, though showing psychiatric symptoms, had not received further attention from psychiatry during the whole or part of the two years under review, and who therefore

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might be deemed to have been in need of help from the community. Implicit in this line of reasoning is the assumption that the community could have done one of two things for these old people: (1) supported them in such a way as to make specialist treatment unnecessary, or (2) guided them towards early resumption of psychiatric treatment.

In this study we were concerned only with finding out the proportion of patients requiring further treatment, the numbers needing community care, and the length of time during which community action was needed. We have not attempted a critical evaluation of the assistance our patients received or failed to receive, but, before coming down to an analysis of our data in a statistical fashion, it might be of interest to have a short account of the impressions we have gained during our follow-up study.

Impressions of Community Aftercare

In many areas south of the Thames, from which most of our patients came, the usual services for the elderly, such as home helps, Meals on Wheels, old people's clubs, etc., are provided. But they are limited by lack of money and man-power. Meals on Wheels service, for example, is a valuable aid; but it often functions only three times a week, or dinners for two days are left at one time. Probably this works well with old people interested in food, but it is well known that many old people with residual mental symptoms need to be coaxed to eat, and the mere fact that someone comes to the door every day, plate in hand, says an encouraging word, and perhaps helps to find a knife and fork, may mean the difference between a meal eaten and one left to congeal on the table.

Another service of which far more is needed is the Incontinent Laundry Collection. We recall, from our group, one old man enabled to keep his demented wife out of hospital for much longer than had been anticipated with the help of this service. In fact, two hospital beds were kept free in this case, because it was not long after the wife had to be removed to hospital that the husband, possibly because he had been deprived of having to minister to his wife's needs, followed her there.

Home-help services seem to be of more use to women than to old men living alone, who often have an aversion to letting strange women into their abodes. Even so, there were several men who stayed out of hospital or Part III accommodation for lengthy periods because they were provided with a varied range of domestic services by the local authority or voluntary bodies.

Friendly visiting is particularly valuable in the after-care of elderly patients, provided it is done regularly. Unfortunately, this appears to be available in only few areas. One woman in our group seemed to need the stimulus of almost daily visiting to maintain contact with the outside world of reality. This we could not obtain for her, and she withdrew into herself, failed to go out to buy food, and very soon relapsed into the persecuted behaviour which had led to her admission; long-term care in a mental hospital finally became necessary. In addition to stimulating and encouraging the ex-patients, there are some chores which can easily be done for them by a regular visitor. He or she will not only bring life into the home, but can also become an ally for shopping expeditions or changing of library books, and so prevent the old person from becoming house-bound for

psychological reasons. On the other hand, we must not overlook the fact that some of our patients remained unresponsive to efforts of socializing them in this fashion.

Quite a number of our patients successfully returned to their pre-illness occupations, and it has been our experience that if a patient was really fit on discharge he would, if he so desired, find employment by himself; if he did not much wish to work the combined efforts of disablement resettlement officer and psychiatric social worker tended to fail. In times of partial unemployment more strenuous efforts will have to be directed towards making the public realize that part-time work may result in a significant contribution to the mental health of our increasing elderly population.

It may be impossible to ascertain whether a patient, while he is living in hospital, is fit for the stresses of the outside world, including employment. We have felt the lack of halfway-houses where the patient's ability to tolerate the outside world might have been assessed, and from whence the elderly person, in order to gain the independence which a salary gives, might be launched into a job suited to his present capabilities. Halfway-houses would have been useful also to housewives and retired people whose adjustment to the outside world still seemed precarious. We discovered that several of the patients, who had left us for various homes, eventually improved enough to face returning to their own abodes.

We were often discouraged by the small amount of aftercare likely to be available in some of the areas to which our patients were discharged on account of the inadequate establishment of trained social workers. In this connexion it is of great interest that only one of a number of our ex-patients with whom the P.S.W. had been able to keep up regular contact had to be readmitted during the period under review. One severely persecuted patient was kept out of hospital largely through the persevering care of her local old people's welfare secretary, who often consulted the P.S.W. On the other hand, there were, unfortunately, patients who were unable to use services that were offered to them; they tended to fall into two groups. There were those who remained too ill to benefit from P.S.W. contact, though not so severely disordered in behaviour to require in-patient care—for example, one elderly man whom the P.S.W., in spite of active support from the patient's wife, herself an ex-mental nurse, was unable to mobilize towards a club and other facilities only a stone's throw from his house. Secondly, there were the people who "always kept themselves to themselves," and who resisted attempts at socialization. But frequently in these cases, and in others, members of the patients' families appeared to benefit from occasional opportunities of blowing off steam and of having a sympathetic listener in the social worker.

We have been unable to assess the amount of help our patients had been receiving from their family doctors, though many patients had consulted them. But without putting the G.P.s to great trouble it would not have been possible to find out what proportion of these contacts had been for psychiatric complaints. There were a number of instances where we had evidence for much active support from the family doctor, but it was rare for him to establish contact on his own initiative with a patient of whose discharge he had been notified by letter. Patients often alleged—and one should perhaps not put too much trust in these statements—that their G.P.s had said that they were now "under the hospital."

Characteristics of Sample

All patients had been admitted on a voluntary basis and had reached the unit via the out-patient department of the hospital, its domiciliary service, a mental observation ward, or after recommendation by psychiatrists not on the hospital staff. Only patients suffering from deterioration over long periods and finally requiring long-term care were not accepted. We are therefore dealing with a sample from which cases with the worst prognosis had been excluded.

There were 49 men and 76 women, between the ages of 60 and 84, with the majority over 70 years old. A diagnostic breakdown is given in Table I, and the predominance of affective (mainly depressive and anxious-agitated) symptomatology in this sample emerges clearly.

TABLE I.—*Diagnostic Breakdown of the 125 Patients*

Psychoses due to cerebral causes	..	..	..	36
Affective psychoses	..	..	..	56
" illnesses with neurotic admixtures	..	..	..	20
"Paraphrenic" illnesses	..	..	..	13

An attempt has been made to separate off patients with severe affective disturbances and delusional elaborations of guilt or hypochondriacal thought content from those with milder affective illnesses of neurotic severity. "Paraphrenic" was used as a provisional label for patients whose persecutory or schizophreniform symptoms were not associated with obvious affective or psycho-organic features.

Community Needs of Members of Sample

Early Treatment Aspects

Hospital services as constituted at present are limited to the treatment of actual illness. Prevention and aftercare are in the hands of family doctors and the medical services of local authorities. Prevention of psychological disorders in old age has not yet become a practical possibility, but much suffering of both patients and their families can be prevented by instituting treatment early in the illness.

In 93 of our patients admission to the unit had been the first attempt at treating the present illness, but in 74 cases symptoms had already been present for more than six months; 31 had been ill for more than two years. In view of the relatively poor response to specialist treatment of the paranoid illnesses and the neurotic depressions of the elderly, the long time-lag between inception of symptoms and hospital admission which we found in these groups may not be of much practical importance, but it is surely disquieting that of the 41 patients with affective psychoses—conditions which are well known to respond promptly to modern forms of treatment in a large proportion of cases—only 8 were referred for treatment during the first six months of their illnesses, while 17 had been ill for well over one year before receiving psychiatric attention.

These figures need not be interpreted as signifying that patients and their families were slow in seeking medical advice, or that the family doctors had been dilatory in referring elderly patients to psychiatrists. It is generally accepted that the management of affective illnesses presents a large item of the G.P.'s work (Watts, 1957), and it may well be that the patients who reached us so late in their illness represented the small proportion of cases in which his treatment had failed. On the other hand, there were several instances where the true nature of the illness had not been recognized for some time.

It has been shown (Cosin *et al.*, 1958) that treatment of established dementing disorders in old people produces only very modest responses, and that in these conditions therapeutic results are unlikely to improve unless early treatment can be instituted. In our present material there had been a long time-lag between the date around which the appearance of organic mental symptoms was retrospectively recalled by relatives and admission. Of 33 cases, 24 had been deteriorating for at least one year, and 18 for over two years. This is yet another reminder to those responsible for the elderly of the community that they will have to consider urgently efficient ways of discovering early cases of senile mental decline and methods to attempt prevention of further deterioration.

Aftercare Needs

Aftercare needs have to be assessed against the background of the patients' clinical state during the two years following discharge from hospital, which is given in Table II. Two patients with organic mental disorders had been discharged by death, and our number has therefore been reduced to 123. Our patients had been in hospital for periods averaging three and a half months, and all but the few who left against advice had been sent out only after it was felt that no further psychological, physical, or environmental therapy was likely to produce further improvement. It will be seen that in spite of thorough treatment only 15% made complete and lasting recoveries, while a further 22% recovered

These findings underline the fact that psychiatric disorders, like most illnesses in old age, tend to become chronic or recurrent, and, in keeping with this, our follow-up investigation showed that only 29% of patients did not receive any further psychiatric attention apart from one or two routine follow-up checks in the out-patient department or by P.S.W. visit; 20% had received further out-patient department support from our clinic; 31% had both in- and out-patient treatment at our or other psychiatric hospitals; and 20% had required further in-patient treatment (Table III). This outcome was particularly common in the organic group, where it usually meant long-term care. Further in- and out-patient treatment was given most often in the "psychotic" affective group, in keeping with the high recurrence rate of this disorder.

TABLE III.—Treatment Given During the Two Years Following Discharge

	Organic Psychotics	"Psychotic" Affectives	"Neurotic" Affectives	"Paraphrenics"	All Diagnoses
No treatment apart from follow-up attendances	9	12	11	4	36
Out-patient support only	5	13	3	3	24
Further out-patient and in-patient treatment	7	25	5	2	39
Further in-patient treatment only	13	6	1	4	24
	34	56	20	13	123

TABLE II.—Clinical State During the Two Years Following Discharge

	Organic Psychotics	"Psychotic" Affectives	"Neurotic" Affectives	"Paraphrenics"	All Diagnoses
Completely symptom-free throughout ..	2	12	4	1	19
Intermittent or continuous mild symptoms	5	11	8	5	29
Intermittently disabled ..	2	19	4	2	27
Continuously disabled ..	25	14	4	5	48
Total ..	34	56	20	13	123

but had early recurrences: 24% of ex-patients continued to be subject to mild symptoms, and 39% remained continuously disabled by severe symptoms. As one might expect, results of treatment had been most disappointing in patients with mental symptoms due to cerebral deterioration or disease, but failure to recover from affective disorders and the high incidence of early recurrences in these conditions also emerge very clearly.

Thirty patients had further treatment for more than 18 months, 39 for 6 to 18 months, and 18 for less than 6 of the 24 months under review. The amounts of time spent under specialist care would have been even greater had it not been for the fact that 23 of the 123 ex-patients died during the follow-up period. All but one had had continuously severe symptoms—in the majority, of the organic mental reaction type.

We have at last reached the point where we may attempt to assess the amount of community care which our sample of elderly psychiatric patients required after discharge. Though we have just seen that these patients had received a good deal of further specialist attention at our hospital and at other centres, scrutiny of our data showed clearly that many of them had received no psychiatric treatment at all in spite of continued mental ill-health, or that they were left without specialist help for prolonged periods. By subtracting the number of months during which patients had been receiving psychiatric care from the number of months throughout

TABLE IV.—Number of Months During Which Patients Needed Community Help (That is, During Which They were Ill, but not Receiving Psychiatric Treatment)

	Organic Psychotics					" Psychotic " Affectives					" Neurotic " Affectives					" Para- phrenics "					All Diagnoses					Total		
	Mths. Ill Without Psychiatric Treatment					Mths. Ill Without Psychiatric Treatment					Mths. Ill Without Psychiatric Treatment					Mths. Ill Without Psychiatric Treatment					Mths. Ill Without Psychiatric Treatment							
	0	<6	6	12	18	0	<6	6	12	18	0	<6	6	12	18	<6	<	6	12	18	24	0	<6	6	12		18	24
Completely symptom-free throughout	2					12					4					1						19						19
Intermittent or continuous mild symptoms	1	1	2	1		6	1		1	3	2		2	4		3				2		12	2	2	4		9	29
Intermittently disabled	1		1			17		1	1	1	3					2						23		3	1			27
Continuously	14	1	2	4	4	10		2	1	1	1		1	2	1	3		1	1			28	1	5	8	6		48
	18	2	5	5	4	45	1	3	3	4	10		1	4	5	9		1	1	2		82	3	10	13	15		
	34					56					20					13					123							

which they were suffering from symptoms, we were able to obtain, as the difference, the periods of time during which some help from the community, including the family doctor, had been desirable. Many of these patients had, in fact, been supported by agencies of the community or had finally been referred back for psychiatric treatment, as discussed in an earlier section of this paper. Here we are concerned only with showing the number of months during which patients had been in need of some form of community action, because on the one hand they had been unwell, but, on the other, had not been receiving psychiatric help. As we are dealing here with the main subject of this communication our complete data are presented in Table IV.

Subjects have been tabulated by (1) original diagnosis and (2) clinical status during the follow-up period independently of diagnosis, against the number of months during which they were suffering from psychiatric symptoms, but not under specialist care, and thus presumably in need of community action. For the sake of completeness we have included those ex-patients who had remained mentally well and had needed no help. Taking a superficial view, there were 82 people in whose cases community agencies would not have contributed towards better care, because they had remained well throughout the two years under review, or because they had been receiving treatment promptly on recurrence of symptoms or had been safely in hospital for long periods. But we have been unable to assess what proportion of these long-term hospital patients did in fact have unsatisfied needs of community care, in that they should have been transferred from mental hospitals to residential accommodation or domiciliary care provided by voluntary organizations or local authorities.

Forty-one patients, exactly one-third of all cases, without any doubt went through periods during which action by the community might either have been therapeutic or should have brought people back into psychiatric treatment at an earlier date; in 15, community needs had been present throughout the whole of the two years under review, and in 26 during shorter periods. We may also see from Table IV that the needs of the patients with recurrent attacks and intervening periods of reasonably good mental health were minimal, but that 20 of the 48 continuously disabled patients may not have been under any form of psychiatric treatment or supervision for lengthy periods while they and their families were clearly in need of help. The majority of old people with mild symptoms were in the same position for many months, which is an even more important finding, because these mild disorders should respond to community care so much better than severe illnesses or dementias.

Looking at openings for community action in terms of the various diagnostic categories, we found that the needs of the organic psychotics were greatest; next came people with affective disorders on a neurotic background. But even the needs of patients with psychotic affective illnesses arising more often in stabler personalities were by no means negligible in our age group (11 of the 44 not continuously well). We know from clinical experience that paranoid old people often respond, at any rate for a time, to simple common-sense measures without psychiatric advice.

Summary and Conclusions

Our findings demonstrate that, in the fields of prevention and early treatment as well as that of after-

care, the scope for community action in the case of elderly psychiatric patients is frighteningly large. In our experience with one year's discharges from a unit for recoverable cases over the age of 60, only 15% of patients remained completely well over the next two years, and 71% received further psychiatric treatment. Of the 104 patients with recurrent or continuous symptoms, at least 41 (39%) had been in need of community action coming from the family doctor, voluntary organizations, or services run by the local authority. We also recorded our impressions of the community care which was in fact given to this sample of patients, but obviously failures had come to our attention more often than successes.

Both general impressions and our statistics point to the same conclusion: any worth-while community service for elderly people with psychological illnesses or difficulties will have to cater for very large numbers, and will turn out to be very expensive in terms of manpower and money. At the same time, beyond vague impressions, very little is known about the therapeutic effectiveness of community care in this group of psychiatric conditions, and we venture to suggest that any future community programmes for elderly people be introduced step by step and in accordance with plans which will allow of scientifically conducted and controlled assessments of the value of community care of elderly psychiatric patients.

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LONG-TERM ANTICOAGULANT TREATMENT OF CORONARY THROMBOSIS IN GENERAL PRACTICE

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Anticoagulant therapy in the early stages of coronary thrombosis is now generally acknowledged to be beneficial and is widely practised. Long-term treatment with anticoagulants is much less extensively used, though Tulloch and Wright (1954) started giving it in 1940, and up to 1952 had treated 227 patients for periods of up to eight years.

Short-term anticoagulant therapy is the use of anticoagulants during the first three to four weeks of the illness. Long-term therapy is treatment carried on for longer than four weeks, either immediately after the onset of the illness or at any subsequent time.

The literature is liberally studded with articles on long-term anticoagulant treatment in hospital out-patient departments and in consultant private practice (Foley and Wright, 1949; Hines and Barker, 1949; Cosgriff, 1950; Bay *et al.*, 1954; Borg, 1956; Breddin, 1957; Estes, 1957; to name but a few). In sharp contrast I have been able to find only one article (Putnam, 1957) which describes the experience of a general practitioner