DECREASE IN ADMISSIONS TO MENTAL OBSERVATION WARDS DURING WAR

BY

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Much has been thought and written about the effect of war conditions on the neuroses, and it is generally agreed that there has been little or no increase even among populations who have been subjected to the heaviest enemy action. Less attention has been given to the influence of war conditions on the incidence of the more grave mental disturbances of psychotic nature. The facts regarding this subject are not easily ascertained, but it has seemed to me that it might be worth while to consider some statistical details relating to a particular area, and that these, taken together with similar details from other areas, might have a general implication.

It is impossible to state the actual incidence of mental disturbance in any given community, but it can be said that the great majority of persons whose mental condition or behaviour demands restraint and/or supervision must be admitted to suitable institutional care. In this area, except with those individuals—a small proportion—whose means allow of private care, or in cases in which voluntary admission to county mental hospitals is arranged direct, such persons must in the first place go into a mental observation ward. The variation in the number of admissions and of types of disorder should therefore have some significance in relation to the population as a whole.

Yearly Figures for Liverpool

The mental observation wards, male and female, for the whole of the administrative and "user" area of the City of Liverpool, supplying a population of upwards of a million, are confined to a section of one large municipal general hospital. It was therefore decided to note the yearly total of admissions to these wards for each of the first three years of the war and for the three years preceding it, calculating each year from Sept. 1 to Aug. 31. It would have been interesting to make a diagnostic classification, but to do this accurately is quite out of the question in view of its inherent difficulty and of the often short period of stay in hospital. There are, however, several conditions in which a definite diagnosis is available, and three fairly common reasons for admission for observation are those of attempted suicide, epilepsy, and G.P.I.

Cases in Female Wards

	1936-7	1937-8	1938-9	1939-40	1940-1	1941-2
Admissions	603	631	570	465	395	357
Attempted suicide	64	66	66	39	27	34
Epilepsy	35	40	33	37	21	26
G.P.I.	11	11	13	4	3	7
Discharges	631	623	581	464	402	383
To mental hospitals	183	160	142	108	105	112

Cases in Male Wards

	1936-7	1937-8	1938-9	1939-40	1940-1	1941-2
Admissions	530	547	484	493	374	338
Attempted suicide	65	68	82	61	38	31
Epilepsy	44	35	28	18	15	21
G.P.I.	21	26	22	17	12	14
Discharges	529	551	485	519	404	340
To mental hospitals	110	107	122	138	135	131

The yearly total of admissions for mental observation, both male and female, is given, and the yearly number of those who were transferred to mental hospitals. The difference between the latter figures and the total discharges for each year is accounted for by the number of patients who were discharged to their friends or relatives and to other wards or hospitals (no longer requiring mental supervision), or who died. It will be seen that a steady fall in the number of admissions began from the year preceding the outbreak of war, and that there was a very pronounced drop from 1936-7 to 1941-2. The numbers of cases transferred to mental hospitals show

some variation, but this has no immediate significance as regards the incidence of mental disorder, patients being transferred only when vacancies at mental hospitals are available.

Commentary

Is the great reduction in the admissions indicative of a decrease in the incidence of mental disorder? The figures may have been influenced by several factors, such as a lowering of the population of the area, admission of psychopathic individuals into the Services, an increase in the number entering county mental hospitals directly as voluntary or temporary patients, the evacuation of the more unstable types of individual to "safe" areas, and possibly increased admissions into hospitals from safe areas. Though these factors may have played a part, it is to be observed that the number of transfers to mental hospitals on certificate from this hospital has shown no notable change and that there is a fairly constant hard core of the more intractable, more severe, or chronic cases which require longer institutional care. It would appear, then, that the reduction in admissions applies mostly to the less severe, less urgent, and more transient cases; and it would seem reasonable to assume either that such cases remain at home or that they occur less frequently. The former explanation is unlikely, because it seems that in families in wartime there is less willingness or ability to give the care and supervision necessary for mentally handicapped members. Indeed, a relative increase of old people and of mentally defective individuals is noticeable among the admissions, patients coming into hospital who show disabilities of long standing but who previously had been cared for in their own homes. Diagnostic classification of all the admissions might have thrown some light on this question, but as it has been impossible to do this with any reliability the investigations have been confined to the three conditions shown in the tables. The figures for epilepsy and G.P.I. show a downward trend during the war years, but the significance of this can only be a matter for speculation. The marked decrease in suicidal attempts, however, is striking, and may have some relation to the general decrease in admissions.

Conclusion

It seems to me that the above figures point to a decrease during the war in the incidence of mental disturbance, and that this decrease is the result of wartime conditions. Of these conditions the chief factors appear to be the increased opportunities of employment, the strengthening of the community spirit, and a lessening of that consciousness of mental isolation which is so favourable to the development of psychological abnormality.

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THE EMPIRE RHEUMATISM COUNCIL

The sixth annual report of the Empire Rheumatism Council announces that an agreement on joint policy has been reached with the British Orthopaedic Association, one of the items being that orthopaedic hospitals or orthopaedic departments of general hospitals shall include on their medical staffs a physician with a special knowledge of rheumatic diseases, and rheumatism centres shall include an orthopaedic surgeon. To put the policy into effect a standing advisory committee has been constituted, with Lord Horder as its chairman and Mr. G. R. Girdlestone as vice-chairman. The report mentions increased pressure on the very few treatment centres in industrial areas. It is true that some of the spa institutions are not fully utilized, but, valuable as is the part which they can take in rheumatism treatment, obviously they cannot meet the needs of the many thousands of sufferers who require facilities near their homes. Clinics in London—the Red Cross Clinic, the clinic of the Order of St. John, and the clinic at the West London Hospital—are working to capacity or beyond it, and other treatment centres in England and Scotland report that their services are fully utilized. The statistics of the clinics show that about 60% of the patients obtain cure or substantial relief if they receive the right treatment at an early stage, and this without serious disturbance of their industrial and domestic life. The fact remains, however, that the number of centres is so inadequate that for the majority of sufferers no facilities for appropriate treatment are available. By careful husbanding, the total funds at the disposal of the Council have increased to nearly £9,000.