Contemporary Themes

The elderly mentally ill—whose responsibility?

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Summary

The elderly mentally ill make considerable demands on health and social services. To evaluate the need for these services a one-day census of all people aged 65 and over was carried out in an area containing 220 000 people (40 000 over 65). Data were obtained on the nursing needs and psychiatric state of the 2162 elderly people in hospital or local authority residential homes for the elderly, or living at home receiving care from the community nursing service. One-third were classified as having psychiatric problems, more than half of them being outside hospital. Residential homes and community nurses play a significant part in caring for the elderly mentally ill, and an integrated but flexible manpower policy is important.

Introduction

The needs of the elderly are a major consideration in planning health and social services. People over 65 use these services more than other age groups and their use is rising both steadily¹ and apparently inexorably.² Many elderly are mentally ill, with the proportion of psychiatric inpatients over 65 rising from 31% in 1954 to 44% in 1971.³ There is continuing anxiety about mentally disturbed patients occupying geriatric beds⁴⁻⁶ and the problems of the elderly mentally ill in the community are also causing concern.⁷

General estimates of the extent of psychiatric illness among the elderly living at home have been obtained by using screening methods.⁸⁻⁹ These are costly and may yield information which, in a period of economic restraint, is only of academic interest. It is of greater practical importance to know how well a particular area is coping with local problems now.¹⁰ It is equally relevant to determine whether the specific needs of the elderly currently in touch with health and social services are being adequately met. For example, are the community and institutional services overburdened or, alternatively, underused? The availability of local information enables need to be seen in perspective and thus helps planners to provide more effective and efficient services. Such data are particularly pertinent in those districts with the highest proportion of elderly in their population or where resources are unequally distributed.

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The study

We were invited to ascertain the needs of the elderly mentally ill in an area in North-east Essex that has a population of 220 000, with 40 000 aged over 65. This area now comprises two county districts and forms the greater part of a health district. There had been a pronounced increase in the numbers of elderly residents during the previous decade, mainly attributable to the growing attraction of Clacton-on-Sea and Frinton and Walton as retirement areas. There was a large psychiatric hospital in the area, but there was believed to be insufficient local authority residential accommodation for the elderly—particularly that suitable for the mentally infirm.

An initial step was to define precisely what is meant by the "elderly mentally ill." The DHSS circular¹¹ distinguished between a series of clinical groups based on diagnostic criteria. We have adopted a less complicated operational definition derived from an earlier Scottish planning document¹² which included "all persons aged 65 and over suffering with mental disorder with or without physical disability." Although the term "psychogeriatrics" is debatable, we have used it because it has the advantage of international recognition.¹³

There is a widespread belief that the care of the elderly mentally ill falls within the orbit of psychiatry, but it has been suggested¹⁴ that generally this results from too many psychiatric beds. As we did not wish to neglect any section in which psychogeriatric patients might be found and wanted to relate the psychiatric and physical needs of the elderly, we preferred to accept the strong arguments for considering the mentally ill in relation to the problems of the elderly in general. These arguments take account of the known extent of psychiatric illness among those of the elderly who are neither in psychiatric care nor receiving any psychiatric treatment.^{8-9, 15-19}

Method

All health and social service workers in the study area completed a questionnaire about all their elderly patients/clients/residents, but we have restricted the analysis to data obtained from ward sisters, wardens of residential homes, and community nurses. The study was carried out as a one-day census in October 1971. Data indicating the presence or absence of various psychiatric symptoms during the previous six months were recorded for everyone and were used as a basis for identifying those with psychiatric problems. Despite some initial reservations about the validity of psychiatric data provided by non-psychiatric staff—for example, community nurses or wardens of residential homes—such data appeared to have been well recorded. There is also encouraging evidence²⁰ that supports the ability of community nurses to indicate accurately psychiatric problems in patients whom they see frequently.

As psychiatric symptoms are rarely the sole reason for care, we also obtained a record of the nursing needs and the care being received by these elderly people. To measure such nursing needs, we employed the nursing dependency measure initially developed by Barr²¹ but modified in the light of experience in its use across institutional and community case loads.²² It is the time devoted to the simple help or supervision of frail and sick people during their daily activities rather than the extent of technical nursing which is the major burden on those responsible for their care. So our measure divided the population into three groups according to their need for supportive nursing care.

(1) The "minimum" group, who were entirely capable of self care, To qualify for this group a person had to be able to walk around

without supervision or help, or both, from another person; wash themselves daily; use the lavatory; dress and change their clothes; eat their food independently; and be free from any incontinence.

(2) The "maximum" group comprised (a) the totally bedfast (that is, never physically separated from the bed), (b) the immobile chair-fast, and (c) those whose frailty rendered them incapable of moving around without help or supervision from another person and who therefore needed help with their most important daily activities.

(3) The "intermediate" group included all persons who did not qualify for either of the other two groups.

In addition to data on psychiatric state and nursing need, we recorded elementary demographic information on all individuals and their use of services.

Results

The one-day census yielded information on 2162 old people, 5% of the total population aged 65 and over in the study area. Over two-thirds of the enumerated cases were aged 75 or over, in contrast to 36% among all the elderly in the population (table I). Women accounted for 70% of all cases, compared with 60% in the study population as a whole. Almost half (1027) of all those surveyed could care for themselves in their basic daily activities. The remainder were almost evenly allocated between the maximum group needing substantial care and the intermediate group. Additionally, a third (735) of the whole group were reported with one or more psychiatric symptom and have accordingly been classified as psychogeriatric; the remaining 1427 people have been classified as geriatric.

TABLE I—Age and sex of patients in the survey

Age	Men	Women	Total
65-74	245	400	645
75-84	256	648	904
85	147	466	613
Total	648	1514	2162

PSYCHOGERIATRIC POPULATION

Table II shows the location of the 735 (18.2 per 1000 elderly population) people who form the psychogeriatric population. Local authority residential homes and the community nurses were the most important in caring for these patients, being responsible for 26% and 25% of them, respectively. The remaining patients were equally divided between geriatric (21%) and psychiatric hospitals (21%); 7% were in acute beds.

TABLE II—Location and nursing needs of psychogeriatric population

Nursing requirements	Geriatric hospital	Acute hospital	Psychiatric hospital	Residential homes	Community nurses	Total
Maximum	123	43	33	38	63	300
Intermediate	27	8	50	70	64	219
Minimum	7	3	71	81	54	216
Total	157	54	154	189	181	735

Overall, 40% required maximum nursing care and hence placed the heaviest burden on services. The important question was where were the needs for care and support of these particularly vulnerable people being met. Not surprisingly, the burden carried by geriatric hospitals far exceeded that of any other service, and the psychogeriatric maximum-care patients represented just over 41% of the total case load of the geriatric beds in the survey. In contrast, only 11% of such cases were found in the psychiatric hospital, where they formed only a fifth of the case load. Surprisingly, residential homes played as great a part as the psychiatric hospital in caring for such people, but community nurses played a notable part for this group, being responsible for 21%, second only to geriatric hospitals, where 41% of psychogeriatric patients were located.

Cases in the intermediate group accounted for about a third of the total psychogeriatric case load and were principally distributed among

residential homes (32%), psychiatric hospitals (23%), and community nurses (29%). This suggests that residential homes and psychiatric hospitals play a more active part in caring for those psychogeriatric cases whose needs for nursing care are marginal rather than extensive. Very few of those who could look after themselves (that is, minimum care cases) were found in geriatric or acute hospitals, confirming that most psychogeriatric cases in acute or geriatric hospitals did need some degree of supportive nursing care.

GERIATRIC POPULATION

The geriatric population (those reported as not having any psychiatric symptoms during the previous six months) were widely distributed among the services (table III). Over half these people required only minimum supportive nursing care. This compared very favourably with the psychogeriatric population, where 70% fell into the maximum and intermediate care categories. The few maximum care cases in psychiatric hospitals and residential homes was not surprising, since the former were unlikely to cater for those cases without psychiatric symptoms and the latter for those needing help with all self-care tasks. This meant that geriatric patients who had extensive nursing needs were in a similar position to their psychogeriatric counterparts, being cared for principally at home or in a geriatric hospital.

TABLE III—Location and nursing needs of geriatric population

Nursing requirements	Geriatric hospital	Acute hospital	Psychiatric hospital	Residential homes	Community nurses	Total
Maximum	74	57	5	14	106	256
Intermediate	46	47	4	71	192	360
Minimum	22	34	27	288	440	811
Total	142	138	36	373	738	1427

Discussion

This study measures the important part played by the community nurses in caring for the elderly. Over a quarter of all the elderly in the survey who required maximum nursing care were on the case loads of these nurses. More surprisingly, the community nurses were responsible for a fifth of those who had both psychiatric symptoms as well as maximum nursing requirements. A plausible explanation for these findings is that even the most dependent can be cared for at home, but further investment in community services may well not affect the proportion of high care elderly looked after in this way. By themselves, community nurses cannot provide all the care and attention required, and much more will depend on the attitudes, willingness, and ability of families and relatives to continue to accept much of the responsibility. This raises important issues about the social, economic, and psychological cost, both to individuals and to the community of maintaining in their own homes people with extensive nursing needs.²³

The major task of caring often devolves on other family members who are themselves elderly and suffer considerable and prolonged strain.^{24 25} The next generation of potential carers, with a lifetime experience of the welfare State, may not so readily nurse their sick relatives. A further urgent consideration is the chronic shortage of housing suitable for the needs of the elderly—and the reality is that inadequate and unsuitable housing is often a precipitating factor in moving this group into institutions.

Our findings reflect the pattern of care which had evolved up to the time of the study. In hospitals there is generally a rational use of available resources, but there are also instances of apparent "misplacement" in the locations of patients. Misplacement here refers to those patients whose nursing care is not being provided in the most appropriate environment. This may result from inappropriate initial placement due either to expediency or inadequate assessment; alternatively, patients are often retained in care longer than necessary. The obvious solution is to agree

and apply admission and discharge criteria more effectively than at present. Such a criteria-based system, however, might necessitate the frequent transfer of patients in order to function efficiently, and this is not considered to be a reasonable or acceptable policy.

As our findings indicate, the range of nursing needs of the elderly is basically similar regardless of their place of care. Thus a preferable solution to the problems of misplacement would be to provide the elderly with the type of care they need, wherever they are placed. This would not necessarily mean an increase in overall manpower requirements; merely a more flexible and integrated approach to their allocation and use.

As the nursing needs for the elderly in residential homes will vary at different times the community nursing service should provide care rather than the home. This agrees with the recommendations of the working party on collaboration between the NHS and local government.²⁶ Much can be gained from closer integration of the services²⁷ and more flexibility rather than further specialisation in deploying those in the health and social services who care for the elderly.

The total number of elderly people needing maximum care at home, however, was small in proportion to the large majority who required little or no nursing help. Some low and medium care patients may well have benefited from day-care facilities, with which the area is well provided. Unfortunately, in this study we could not examine this increasingly important facility. Most of the patients at home needing nursing care did not need clinical or technical services, but only basic nursing care at differing levels of intensity or social support, or both. Measures such as providing advice and help to caring relatives must be a fundamental consideration.²⁸

We have drawn attention to these needs and facilities in an area with a high proportion of residents over retirement age. In many similar places elsewhere in the country the needs of the elderly are already high or likely to rise substantially as the "young old" become older, with consequent increasing pressure on all services. This increased demand will primarily affect the community nursing service, which already encompasses many of the elderly and is often the first to provide help for an elderly person. Nevertheless, clearly the increased demand will have substantial implications for all the other health and social services.

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Statistics at Square One

IX—Percentages

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Standard error of difference between percentages

Just as a mean and a difference between two means can have standard errors so can a percentage and a difference between two

percentages. Again both the size of the sample and the amount of variation in the population from which it is drawn affect the size of the standard error.

For example, Mr Black is a senior surgical registrar in a large hospital in Edinburgh. He is investigating acute appendicitis in people aged 65 and over. As a preliminary study he examines the hospital case notes over the previous ten years and finds that of 120 patients in this age group, with a diagnosis confirmed at operation, 73 were women and 47 were men. The percentages are: women 60.8%, men 39.2%.

If p represents one percentage, 100 - p represents the other. Then the standard error of each of these percentages is obtained

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