

### OPENING ADDRESS - A J Foster

I am accorded a signal honour and privilege in opening the Twelfth Annual Conference of the Australian Association of Gerontology.

As you are aware, the Honourable Douglas Lowe, Deputy Premier and Minister for Industrial Relations and Health, is faced with an industrial matter this morning of sufficient difficulty to prevent his officiating at this opening ceremony. He has sent the following message: "I sincerely regret that due to a serious industrial dispute, my services are required at Royal Derwent Hospital this morning. Among other important considerations, urgent action on this dispute will ensure heating for your sessions at Royal Derwent Hospital on Sunday. Best wishes to the delegates from other States".

I must pay tribute to the Minister for his energy in regard to the care of the aged. Seven years ago, he became involved in a development in Claremont which now represents one of the most complete cottage development concepts yet constructed in Tasmania. He showed deep concern, in his previous portfolio of Housing, for the proper care of the aged and I am sure that he will continue to act in the interests of the elderly and of those who care for them.

I also pay tribute to the former Minister for Health, the Honourable Hedley Farquhar, who gave the Tasmanian Branch of the Association both strong moral support and substantial financial assistance in order to advance the standard of geriatric services.

We in Tasmania do not feel that we lag behind the mainland in those services, but we welcome this opportunity for the input of new ideas for us to put to the test and to learn from.

Twenty-five years ago, Launceston had one of the worst examples of Victorian Poor Law institutions in Australia, yet it was the only place where the elderly could find shelter. The beds were ancient prison cots and one toilet served thirty people.

A young hospital administrator, Bruce Griffiths, who is here today, saw the vision splendid and with untiring effort steered through to the halls of power the campaign for something better. Cosgrove Park was the result, but it almost failed in its early days, not from neglect but from too much care. The new institution, with its chrome, stainless steel, glass and tiles, was clean, warm and comfortable, and yet it abounded with unhappiness within. I suppose that we were all trying to convince ourselves that one can never have too much of a good thing. When it became clear that this was not true, Bruce Griffiths, with the assistance of Apex, Rotary and other voluntary bodies, harnessed all the available community energy and transformed life for many people by promoting a flow of people through the institution and establishing an appropriate integration of the aged residents with younger members of the community. Putting new ideas to the test in this way is, to me, the hallmark of proper scientific evaluation of any phenomenon.

Many changes have occurred in Tasmania in the organisation of services for the aged; we have seen the establishment of retirement cottages, of joint nursing of sick elderly couples, of rehabilitation programmes in day hospital and day care centres, and of domiciliary nursing and household help. These are now accepted as standard functions of a health care system, whereas a decade ago their existence was minimal and only a few pioneering bodies were advocating their use. Perhaps there is no greater pioneer in this field than our President, Dr Dick Gibson, whose influence has been strong in Tasmania and no doubt all over Australia.

Whilst one can look with justifiable pride at past achievements in services for the aged, there is still much to be done in all three areas of health, welfare and housing. Governments must increasingly look to organisations such as our Association to provide information on how our national resources may be used to provide the greatest good for the greatest number of aged people.

The Social Welfare Commission's report on the care of the aged to the previous Australian Government contained many valuable recommendations. However, ideas concerning social welfare evolve so quickly that any recommendations are soon out of date. I therefore question whether it is proper for any government to resort to "one-off" inquiries every time there is a need to make an analysis of a system. There seems ample evidence to justify the establishment in Australia of a Foundation of Gerontology

which could undertake continuous research into and review of the various exercises in social engineering initiated by legislation.

It is now my pleasure to declare the Twelfth Annual Conference open, and to express the hope that you will not only further your knowledge but also enjoy our Tasmanian hospitality.

## **THE AGED SICK: A MENTAL HOSPITAL STUDY**

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### **SUMMARY**

A sample of 55 patients aged 60 years and over in the Royal Derwent Hospital, Hobart (Tasmania's only mental hospital), was examined for presence of mental and physical disorders, prognosis, treatment and care of any disorder present, probable life expectancy, length of stay in the hospital, appropriateness of placement in a mental hospital, source of referral to the hospital, and family support. The study also examined the use of the hospital by Tasmania's three major geographical regions and the hospital's admission and discharge policies. The paper presents the findings of the examination.

The study suggested that 50% of the hospital's elderly patients were inappropriately placed in the hospital. The study also revealed significant presence of combined mental and physical disorders in the patients. The reasons for and ramifications of these findings were discussed.

### **Introduction**

Tasmania has 400,000 population spread evenly in three geographic regions, north and north-east, north-west, and south. The Royal Derwent Hospital in Hobart is the sole mental hospital in Tasmania. It contains more than 1,000 beds and has a daily average of more than 900 patients. Approximately one-third of the patients are over 60 years.

A study was commissioned by the Tasmanian Mental Health Services Commission in 1974 to survey the elderly inmates of the hospital and to report on admission policies, discharge policies, mental and physical morbidity profiles of the patients and any matters considered important in the care and management of psychogeriatric patients.

This paper describes a study of the modes of admission into the hospital, the length of patient stay, discharge patterns and the retention of community supports after admission.

### **Methodology**

A systematic sample of patients aged 60 years and over was selected by examining every fifth patient in the subject age group in six wards occupied predominantly by aged people. Fifty-five patients were selected, 28 males and 27 females.

Each patient was subjected to an extensive physical examination and a psychiatric profile was recorded. A distinction was drawn between the presenting disorder at the time of admission and the disorder present at the time of the survey. A judgement was made as to whether the predominant disability at the time of survey was medical or mental or a significant combination of both. Other indices sought were:

1. The prognosis of the mental and/or physical disorder(s) of each subject.
2. The probable life expectancy of each subject.
3. The length of stay, appropriateness of placement within a mental hospital, and any suitable alternative for each subject.
4. The use of the hospital by the three major regions of the State.
5. The source of referral of each subject.
6. The social support available from each subject's family and relatives.

### **Results**

The mean age of patients was 72.4 years and there was no significant sex difference. The longest period of stay was 59 years and the shortest one month. The mean period of stay was 17.3 years — 25.9 years

for male patients and 8.4 years for females. Twenty-eight per cent of males and 20% of females suffered only the social disabilities of isolation and no alternative accommodation.

The dominant disorder at the time of the survey was medical in 16.4% and mental in 43% of the sample. Two significant medical disorders co-existed with mental disorders. Ischaemic heart disease was present in 36% and peripheral vascular disease in 33%. Twenty-two per cent of females suffered from osteoporosis and osteoarthritis and 4% were diabetic. Twenty-eight per cent of males had prostatomegaly and 14% had cataracts.

An assessment was made of each subject's ability to manage personal activities of daily living and 60% of males and 41 % of females were found fully independent in those activities, which included control of bladder and bowel. Females were more dependent than males in all aspects of daily living.

### ***Prognosis***

More than 50% of subjects of both sexes had a good prognosis in regard to general physical health and 36% in regard to mental health.

### ***Life Expectancy***

A largely intuitive and subjective judgement was made on life expectancy of the subjects. It appeared that about 15% would not survive one year but that the remainder would survive more than one year and in many instances more than five years

### ***Appropriateness of Placement***

It appeared that 50% of subjects were inappropriately placed in the hospital. It was thought that even proportions of these could have been suitably placed in hostels or nursing homes.

Of the subjects considered appropriately placed in a mental hospital, 12% could have been suitably managed in a special unit nursing home where the subject's tendency to wander and occasional psychotic outbursts could be controlled by the physical structure of the building and an ordinarily competent staff.

Of the patients inappropriately placed, 19% were considered suitable for home care with the support of relatives and full use of existing domiciliary services. Because of the geographical spread of former domicile of the subjects it was impractical to interview their relatives, but information available in hospital records suggested general family rejection of subjects even when home care was theoretically possible. The information was abstracted from a close study of nursing notes recording the frequency of family visitors and family interest in the subject's welfare as shown by letters, parcels of clothing and Christmas and birthday remembrances and from personal discussions with those subjects sufficiently competent to discuss their family position.

### ***Regional Use of the Hospital***

In spite of the hospital's location in the southern region of Tasmania, its use by all three regions closely followed the distribution of the population.

### ***Drug Use***

Medication for both mental and medical disorders correlated well with the morbidity profile of mental illness in both sexes and seemed appropriate in each subject.

An attempted analysis of the medication lists for purely medical conditions proved impossible since the need for some medicines could not be established while others were being used in homoeopathic dosage. It should be noted that whereas medication for mental illness is prescribed by persons with wide psychiatric experience such is not always the case with medication for physical illness.

### ***Discussion***

The subject population did not reflect morbidity in the population as a whole but could be used in the construction of a profile of social, medical and mental morbidity in the total aged population. The study crystallised some of the problems facing mental hospital administrators and allowed new conclusions to be reached on effective disposition of scarce and expensive resources.

### ***Absence of Mental Illness***

There was no demonstrable mental illness in approximately 25% of the sample population. This group suffered instead from the twin disabilities of prolonged social isolation and lack of appropriate alternative accommodation. A subjective prognosis of life expectancy of the subjects indicated that many beds would be used by their present occupants for five years or more.

### ***Period of Residence***

Male subjects had abnormally long periods of stay in the hospital. The mean age at presentation was 34 years and the average length of stay was 25.9 years. Many subjects of long-standing residence had been free of serious mental symptoms from some months up to five years after admission. One reason for the length of stay would seem to be the fact that case review of chronically ill inpatients has been extremely limited in the hospital. The absence of full case review has precluded serious efforts to keep patients in social contact with the outside world or to pursue any active programmes of resocialisation. A recent study of adult psychiatric services in the south of Tasmania by W. V. Younger (personal communication) indicated a lack of serious endeavour at outpatient level at Royal Hobart Hospital and at John Edis Hospital to deal with psychogeriatric problems, which confirms a national trend. Younger also demonstrated that the time spent in the care of geriatric inpatients was a small fraction of 1% of the total hours expended by medical practitioners on all mental health services in the southern region of Tasmania. Time spent with chronic psychiatric patients was 3% of the total. Therefore it would seem that mentally disturbed old people receive less psychiatric attention than other age groups and that time spent with chronic psychiatric patients generally is also extremely low and may well lead to a replication of the current high percentage of institutionalised but symptom-free old people.

Another reason for the lengthy residence of males may be the former practice of "employing" reliable inpatients in kitchens, gardens and laundries with the ready approval of relatives and probably with the compliance of the patients themselves. A third reason may be the fact that society in general has a fear of males who have suffered from a mental illness and this fear may militate against the male patient's re-entry into society.

Female subjects were evenly represented with males in the hospital population. The mean age at presentation was 60 years and the average length of stay was 8.4 years. Females showed a marked preponderance of mental disorders associated with other cerebral conditions in comparison with males. The predominant causes for male admission were schizophrenia, paranoid states and alcoholism. It is probable that families are more tolerant to mental disorders in females and that presentations occur as a result of crisis. Society may well be less afraid of emotionally disturbed females.

### ***Incidence of Medical Disorders***

The study showed a high proportion of medical disorders — an average of two disorders per patient. In 25% of males and 7% of females the medical problem was the dominant disorder. Mental illness unassociated with any disorder was present in only 39% of males and 48% of females. Combined disorders were present in 36% of males and 45% of females. The figures confirm the common finding that old age is a time of multiple pathologies. The study pointed to a sometimes irrational and homoeopathic use of drugs for medical conditions, indicating that the hospital should exercise greater supervision of the medical management of its inmates. It would also seem a necessary prerequisite to admission that all but acutely disturbed patients be medically assessed before leaving their referring hospital, regional clinic or family practice. Preadmission evaluation is especially relevant to assessment of cardiovascular function where the probability of the exhibition of tricyclic antidepressants is high. It is equally important to assess renal and hepatic function where either may be suspect and so contra-indicate the use of drugs excreted by these organs. I believe that the establishment of community health centres working in concert with regional psychiatric and other consultant services would readily permit a shift in emphasis for mental illness from the asylum to the community.

### ***Social Competence***

Subjects exhibiting little or no medical or psychiatric illness were asked whether they wished to leave the hospital. The replies showed intense ambivalence. Subjects of long-standing residence did not object to the idea of discharge but did not know what they would do outside the hospital. It was concluded that 20% of the sample should have been resocialised long before since they were competent in activities of daily living and had no significant medical or mental disorder. However, the closed community of the mental hospital, the high proportion of single, widowed and divorced persons and the high rejection rate by residual families

all combine to make any dramatic discharge programme fraught with risk of breakdown and possible recrudescence of dormant emotional disorder. A pilot study of resocialisation using appropriate supporting services seems indicated.

### ***Misplacement and Alternatives***

It is indefensible to keep a person who no longer needs highly specialised and extremely expensive services in a mental hospital simply for the sake of shelter.

Hostels and nursing homes offer suitable alternatives. A realistic attitude to placement in either place is necessary to ensure that a sudden transition does not precipitate an emotional crisis or recrudescence of a pre-existing illness.

### ***Admissions from the Community***

Any practitioner reasonably believing a person to be acutely and severely disturbed should have professional right of access to a mental hospital for the patient. However, in less urgent situations it seems that admission is far more readily accomplished than discharge. In Tasmania, it is suggested that regional psychiatrists could be responsible for admission decisions and could maintain contact with a patient's family through field officers. Continuing family contacts should create a foundation for realistic discharge policies. It is also suggested that any nursing home which tends to encourage the admission of socially difficult but only mildly demented old people to hospital should be asked to give the vacated bed to a hospital patient ready for discharge. Whenever possible a patient should be admitted with psychiatric assessment and complete medical assessment. The role of Tasmania's major hospitals in providing the necessary clinical and special investigatory skills has been ignored for far too long and should be seriously considered in programmes aimed at proper primary diagnosis and management.

### ***Regional Use of the Hospital***

Since the hospital is used equally by Tasmania's three major regions it can be inferred that mental illness is evenly spread through the whole population and that the shortfall in community mental health facilities is state wide.

### ***Nursing Care***

The study made a subjective judgement on the nursing management of the subject population. The nurses appeared competent, compassionate and knowledgeable about the psychiatric history and progress of each patient. The nursing staff were concerned at their own lack of medical knowledge and expressed a keen desire to learn at least the common medical disorders. A senior medical officer to give formal lectures and practical demonstrations would seem invaluable in this situation. The nursing staff experienced communication difficulties caused by "days-off" which occurred during the normal working week. It is suggested that the administration explore the possibility of charge staff working Monday to Friday in order to maintain essential liaison with the remainder of the health team.

### ***Additional Observations***

While not appearing as a significant statistic, it was evident that subjects admitted prior to the antibiotic era suffered a high incidence of tuberculosis. Breakdown in old age and outbreak among staff and Mantoux negative patients must be considered distinct possibilities. There was a high incidence of unrecognised cataracts in aged males which could be explained by the long periods of stay of males coupled with incomplete case reviews. It is probable that sensory deprivation consequent on cataracts could add to confusional episodes.

### ***Conclusions***

Admission policies have permitted entry into Royal Derwent Hospital of people who could have been managed in the community or in community-based institutions. Approximately 25% of the subject population had no demonstrable mental illness and a further 25% were not ill enough to need mental hospital care. Discharged patients run the risk of social breakdown and need appropriate community services for support during the resocialisation process.

Male subjects were admitted at an earlier age and stayed longer than females and investigation is needed of the medical and social dynamics involved. There is a compelling need for constant review of all long-standing patients in the expectation that therapy combined with the natural history of the disease will

permit realistic discharges to occur. For success in this respect the hospital and supporting regional services must make every effort to preserve contact between a patient and his/her family, since maintenance of social contacts is an important factor in successful resocialisation, even if a patient enters a hostel or halfway house. A realistic programme for discharge of mental hospital patients would reduce the overall cost of institutional care. If there is no change in discharge policy at Royal Derwent Hospital at least 80% of inmates aged 60 years and over will remain resident for up to five years and more. Supporting medical services in the pre-admission and post-admission phases are essential.

Tasmania's major hospitals must involve themselves in a dynamic programme of diagnosis and assessment. Where neither formal nor informal links exist between psychiatric and medical services for the aged, efforts should be made to establish and formalise a cooperating relationship.

A profile of medical, psychiatric and social disability within the community would establish: whether community health care reaches the elderly sick; the frequency and consequences of misapplication of resources; why people are institutionalised unnecessarily for years; how best to make discharge policies realistic; the effect of changing patterns of therapy and care on demand for current methods of care.

There is need to establish a proper nexus between primary preventive medicine and therapeutic medicine. Proper medical and social assessment would allow realistic medical and social programmes to be undertaken. The study described in this paper indicated widespread misuse of available accommodation in one mental hospital. It can be assumed that a study of the full range of health care services in Tasmania (and elsewhere) would indicate vast misuse of resources. The social and financial significance of current weak management models is evident from facts already obtained and from known methods of management. There is an urgent need for discussion with government housing authorities concerning the provision of elderly persons' accommodation within the community, serviced where necessary by well-developed community health services.

The study indicated a need for investigation of nursing education. The study showed psychiatric nursing staff to lack knowledge of common medical disorders and it is certain that this situation exists in reverse in medically oriented geriatric institutions. Nursing staff in general hospitals likewise lack general knowledge of chronic disability and mental illness. It would seem that basic nursing education should be restructured to follow a common course content to a determined level of competence, after which specialised education could follow.

I believe that those people who are out of contact with the world present the ultimate challenge to the healing professions. A modern St Matthew may well have added to the 35th verse of his 25th chapter, I was without comprehension and ye made me feel the tenderness of care. And we like the righteous of old may say, Lord, when did we do these things for you? To which the answer may well be, Verily I say unto you inasmuch as ye have done it unto one of the least of these my brethren ye have done it unto me.

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