Mental Health of the Aging

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An increase in the numbers of elderly patients with mental disorders may be expected when there is an increase in the proportion of older people in a population. Mental hospitals in industrialized countries are becoming embarrassingly overburdened with elderly patients, and the peak in the age trend of their populations has yet to be reached. The numbers are even greater than would be explained by this trend alone. Because older people in general now have a better chance of physical survival, long-term mental hospital inpatients are accumulating. In addition, the overall rate of admissions of the elderly, and the rate of first admissions in old age, are both rising sharply. This does not necessarily indicate a disproportionate increase in the incidence of mental disorders. Present day social factors make the care of mentally frail old people at home increasingly difficult. These same factors, together with the inferior financial status of old people, may well be forming a pool of lonely, unhappy and deprived individuals especially liable to serious mental disease – though this has still to be proved. Meanwhile mental hospitals are receiving more new patients in the older age groups, because the stigma of mental hospital admission is lessening. Requests for admission may increase still further as interest in the subject awakens, diagnosis becomes more accurate, and there is a greater realization that the prognosis, generally, is not so unfavourable as was once thought, provided that disease is treated early. Departments of geriatric medicine are bearing their share of the problem of mental frailty in the elderly. Directors of some of these departments estimate that 40 per cent or more of their newly admitted patients exhibit some mental abnormality. The justification

5 Gerontologia Clinica, Vol. 2, No. 2, 1960

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for the admission of such patients to geriatric wards lies in the frequency with which the mental symptoms are found to be only one facet of a more general nutritional, metabolic, cardiorespiratory or cerebral vascular disorder, which often responds to efficient treatment with immediate general and mental improvement. This fact is well-known to all who actively practise geriatrics and psychiatry, and it deserves wider recognition by those who do not, whether physicians, surgeons, or family doctors. Both the patients and the hospital staffs would be the losers if patients who required admission were strictly segregated into “mental” cases on the one hand and “geriatric” cases on the other. A geriatric physician can scarcely afford to be without some interest in mental problems, and he must have specialist psychiatric advice to hand. Similarly, the elderly patient in a mental hospital requires just as much as any other to be handled according to the principles of progressive geriatric medicine, and the psychiatrist can benefit equally from a close liaison with his colleague.

The acceptance by a geriatric physician of cases with a mental aspect nevertheless must be dependent on his having the fullest possible diagnostic facilities available, a generous

establishment of staff, the means of separating mentally abnormal from mentally normal patients, and the means of transferring to mental hospitals those who are thoroughly intractable, those whose treatment has to be principally psychiatric, or whose mental abnormality in the longer view is persistent and an embarrassment to his other work. Geriatric departments cannot undertake the care of all mental patients simply because they are old or irremediable. If they adopt a liberal policy with regard to new admissions in whom there is known to be some mental abnormality, they must have real safeguards against being brought to a standstill by an accumulation of untreatable mental disease. In this connection there is much to be said for establishing long-stay annexes for psychiatric geriatric patients who cannot be discharged and yet are beyond the active treatment provided in general or mental hospitals. Such annexes should be as home-like as possible, and managed jointly by geriatric physician and psychiatrist, to whose departments the patients could have easy access in time of need. Notwithstanding, the solution of the mental and physical health problems of the elderly lies mainly in a wide extension of facilities for care within the community. In addition there must be a com-

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p. prehensive policy of adult education so that the community can come to appreciate the needs and limitations as well as the potential worth of the elderly

and so that those who are approaching it can learn how to prepare for the social and physical limitations of old age

and so preserve themselves in good health. The World Health Organization's Expert Committee on Mental Health in their report [Wld. Hlth. Org. techn. Rep. Ser. 171 (1959)] on "Mental Health Problems on Aging and the Aged" make these particular points after reviewing the sources of mental ill-health

its pattern in old age

and its prevention. As one of the means of maintaining the elderly person in the community the Committee suggests the setting up of geriatric guidance centres connected with general or mental hospitals

with outpatient and day-hospital facilities

adequately staffed with social workers

and with appropriate senior medical direction. Where mental breakdown has taken place

it is suggested that short term admission units having no formalities for entry

and utilizing the closest cooperation between physician and psychiatrist

would best be able to aid the patient and return him to the community again. If these units were fully equipped for their task and had laboratories and research facilities

this previously neglected kind of work would acquire stimulus and prestige and thus be able to attract doctors and nurses of the right calibre. These proposals should be welcome to those who are concerned daily with the mental frailties of old age.