THE PROBLEM OF THE AGED PATIENT IN THE PUBLIC PSYCHIATRIC HOSPITAL

Formulated by the Committee on Hospitals of the Group for the Advancement of Psychiatry


1. Our Aging Population

The population of the United States is aging. Improved public health measures and medical care have increased the average life span from 47 to 68 years during the last half century. By 1970 it is estimated that there will be sixteen and one-half million persons 65 years of age or over. At present the average life expectancy, at the age of 65, is nearly 13 years.\(^1\)

The healthy old person has capacities for productive activity which should not be ignored. Even more serious than the enforced retirement of the still vigorous and productive elderly worker is the social isolation and inactivity to which it often leads. There is imperative need for social recognition of the problems presented by our older population if unnecessarily widespread and demoralizing hardship is to be avoided, and if society is not to be saddled with the care of an aging group arbitrarily separated from productive activity by the arrival of a particular birthday. There is need for prompt social planning, wisely directed, to aid our aged in a healthy transition to an occupied, if not a productive, old age.

Elderly people need to be useful and to be allowed to earn their own living as long as possible. They need shelter, companionship and guidance. They need freedom, dignity, and respect. The aged are entitled to as full a life as they are capable of enjoying.

It is inevitable that a larger population of aged will be reflected in increased demands upon public psychiatric hospitals, but the size of these demands may be reduced by intelligent planning. Malzberg\(^2\) found that the average annual rate of first admissions for senile psychoses, to all hospitals in New York State, increased from 7 per 100,000 population in 1920, to 8 in 1930, and to 12 in 1940. The rate for psychoses with cerebral arteriosclerosis, in turn, increased from 5 in 1920 to 11 in 1930, and to 21 in 1940. About 38% of present admissions to mental hospitals are diagnosed as Senile Psychoses or Psychoses with Cerebral Arteriosclerosis. It can be expected, from present trends, that this percentage will increase considerably in the years to come.

There is need for research to determine more accurately the percentage of senile patients in our communities who will eventually require institutional care, and in particular, care in the public psychiatric hospital.

Searns has said that "The rate of admission of older persons to hospitals for mental disease is merely part of a universal sociologic phenomena by which sick persons are being cared for in hospitals rather than in their homes."\(^3\) Whether this be true or not, it is a fact that the few hospitals at present available for chronic diseases, are filled to overflowing with elderly patients. It may be said that whenever an aged patient cannot care for himself and has no one to care for him, he eventually goes to the state hospital. Although many of the aged presently admitted for care in a mental hospital show nothing more important than memory impairment, confusion, and physical infirmity. It seems evident that many who come to the mental hospital, come primarily for sociologic reasons. This situation needs correction.\(^4\)

II. Public and Community Responsibility in the Care of the Aged

The present lack of adequate public provision for care of the aged results in the commitment to state hospitals of elderly persons who, although legally eligible in most cases for such hospitalization, might be better, more happily and more economically cared for by less drastic measures.

Some people are old merely in a chronological sense. They may still possess a measure of vigor and a keen mind. Some show moderate to severe loss of memory or of intellectual capacity; others become frustrated, depressed, irritable or excited. Some have as their predominant problem the physical infirmities of the aging process with loss of function of extremities, heart disease or general enfeeblement. Many such persons will be unable to care for themselves and will have no one to care for them.

It is understood that public intervention in the management of the affairs of the aged begins when relatives or friends are lacking or are unable to assume, in whole or in part, the necessary responsibilities. For such individuals three levels of community service are proposed. Flexibility of movement by the elderly person between the three areas is a fundamental requirement of the plan. Some states will need to re-examine outdated commitment laws and the legal codes under which nursing homes and hospitals operate in order to separate clearly the group of aged patients requiring enforced institutional care from those whose need is for guidance, home services or infirmary assistance. The three types of care which are proposed (in guidance centers, infirmaries and hospitals) will be discussed in turn:

\(^1\)U. S. Bureau of Census, Social Security Administration and Institute of Life Insurance.


1. Old Age Guidance Centers

It is suggested that mental hygiene clinics in hospitals or in existing social agencies which are easily accessible to clients be designated as guidance centers for the aged. Such clinics would provide medical, social case work, and psychological evaluation, as well as the necessary X-ray and laboratory studies to facilitate treatment. The centers might supply information and helpful guidance to the aged patient in an independent solution of his problems. Other services might include placement in.convenient homes or in special housing, built and planned exclusively for the aged, or in housekeeping facilities designed to keep couples together with the help of public assistance in the fields of nursing, medicine and social service. Referrals to Old Folks' Clubs and community centers for the aged could also be made by the Center.

A number of different approaches to this problem are already under trial in many parts of the country. An example of how one such organization handles its aged is illustrated by the work of the Benjamin Rose Institute in Cleveland, planned for the benefit of "cultured and educated elderly people." When needed, the Institute offers pensions which average $52.00 per month. In a case load of 290 over 65% live independently, and the rest in nursing or boarding homes. They are supervised by seven social case workers. Each individual accepted for care is given a thorough physical examination. Medical care is continued through treatment in the doctor's office or at home when necessary. Hospitalization under the agency is available, if needed. Model boarding homes are used, caring for 10 persons, each of whom has his own room and may carry on his own business if he is capable of doing so. The incidence of psychiatric illness has been very low. Within the past 10 years, only two or three patients have required commitment to a public mental hospital. The average case load ranges from 250 to 300. Intensive case work keeps the patients working, active and out of the hospital. Several psychiatrists attend case conferences in an advisory capacity. The Institute is building a 60-bed hospital in connection with the University for research purposes.

Another example of community planning for the aged of a different type is illustrated by the William Hodson Community Center in Old Burrow Hall, Bronx 57, New York.

Many old people living alone in rooming houses or living with children who have families of their own, often have little to do. The creation of community centers with activities for elderly people is desirable.

It is believed that the Old Age Guidance Center could solve many problems at this level and materially reduce the need for hospital care. In addition, the clinic would be the logical agency to which both the Infirmary for the Aged and the Public Hospital could turn when the patient was ready for discharge and reintegration into the community.

2. Infirmaries for the Aged

It is suggested that each community of sufficient size establish an infirmary unit available for the care of aged persons who are physically infirm. These units are easier to operate when they do not exceed 500 beds or are constructed in multiples of 500 beds. To prevent the disruption of long established family ties, housing should be available for elderly couples. The infirmary would provide bed or semi-ambulant care of high medical calibre for the helpless, aged patient who cannot attend to his own needs and who has no one to help him. An optimistic and hopeful atmosphere is of the utmost importance. A sheltered workshop should be provided for infirmary patients and referrals from the Old Age Guidance Centers.

Confusion, memory impairment, restlessness or irritability should not in themselves result in transfer to the public psychiatric hospital unless they result in behavior which is too disturbing for the infirmary to handle readily.

More serious illnesses and major surgical conditions will not, of course, be treated in the infirmary, but will be referred to nearby general hospitals. As stated above, one of the major principles of the plan must be fluidity of interchange so that the hospital patient may be returned to the infirmary or to the guidance center just as easily as he was transferred from it.

3. Geriatric Units in Public Hospitals

Hospitals are, as a rule, not properly designed or equipped for efficient, comfortable treatment of the aged. The elderly patient is often feeble, moves about with difficulty, sometimes has paralyses of the legs or arms, oftentimes is unsteady in gait or is prone to falls and injuries. His eyesight is frequently bad and there is commonly some memory impairment and confusion which may make it difficult for him to find his way about the hospital.

Because of his unsteadiness and enfeeblement, the high wax polish common to hospital floors is undesirable. Stairways, always difficult for the aged to climb, may also prove to be a hazard when badly lighted. The elderly patient finds it easier to get to the toilet areas and the out-of-doors when they are close at hand.

His care is easier if bathing suites are not centralized and are planned for more individual attention, with supports upon which he can lean to steady himself. Instead of eating in centralized cafeterias, he fares better if he can take his meals seated at a table and if the food can be brought to him. The aged have only a limited capacity to help themselves and to help others and, as a result, need attentive and prompt nursing service.

On those several accounts and because it is quite evident that the problem of the aged patient in the public hospital will become greater, there is need for the establishment of special geriatric units, both in the mental institution and in the general hospital. When the public hospital cares for the aged, society has a right to expect that the
care given will be adequate and not of the "concentration camp" variety which all too often has resulted from public indifference.

a. Geriatric Unit in the General Medical and Surgical Hospital

A specially designed unit in the general hospital providing the safeguards and conveniences necessary for the highest standard of geriatric care in cases of acute medical or surgical illness is desirable in all sizeable communities. Where budgetary limitations prevent the development of a separate acute geriatric service, adequate medical care can still be assured the elderly patient, if the infirmary previously described is located within easy ambulance distance of a general hospital offering definitive treatment in the various medical specialties. Major surgical procedures, deep X-ray and radium therapy, the management of severe fractures with their constant hazard of hypostatic pneumonia are best carried out by the skilled professional teams and in the alert medical atmosphere of the progressive general hospital. No attempt, however, should be made to retain the elderly patient in the general hospital beyond the time necessary for management of the acute condition. He then would be returned to the infirmary and his convalescence supervised there by consultants drawn from the general hospital who are familiar with the acute phase of his illness.

b. The Geriatric Unit in the Public Mental Hospital

All public psychiatric hospitals should also have especially constructed and planned geriatric units for the care of those patients referred from the infirmary or directly from the Old Age Guidance Center.

The aging process affects patients differently. Instead of showing bodily enfeeblement, simple loss of memory or mild confusion, there may be other symptoms that are more socially disturbing. Some elderly patients become agitated and depressed, others become suspicious and react to delusions, still others become overactive, excited, or irritable, noisy and disturbing to their associates. Such cases are often dangerous to themselves and create a problem too great to be cared for at home or in the infirmary. Transfer to the geriatric unit of the public hospital for psychiatric care becomes necessary.

As these patients improve, they may be returned either to the infirmary or to the Guidance Center for community placement in Old Age assistance homes or in Family Care, etc., as their condition dictates.

The geriatric unit preferably should be constructed as a one-story building with easy ramps to the out-of-doors. If a multi-story building is used, there must be adequate elevator service. Floors should be rough and not slippery. There must be handrails in the corridors and lavatories. Toilets adequate to the patients' needs should be located only short distances from living rooms and from bedrooms so that they may be easy of access. Nurses' stations should provide for unobstructed observation. Living rooms should be cheerful and homelike and patients should eat close to the place where they live. Many beds will require sideboards to prevent the patients from falling to the floor. There must be barber shops, beauty parlors, and facilities for occupational therapy. Outdoor gardens should be reached by short, easy ramps. Security features are desirable to prevent some patients from wandering. The medical wards of the hospital, and the clinic and laboratory services must be readily accessible.

Many different approaches to this problem have been developed in various sections of the country. An example of multi-story construction is that of the Colorado State Hospital, where a specially designed building for senile patients has been erected. This building provides cheerful surroundings for the patients, while retaining necessary detention and supervisory features.

Bedrooms have maximum fenestration in order to provide light and sunshine, and to eliminate the usual dreariness found in this type of building. The walls between bedrooms are carried to the ceiling and are soundproof. Corridor partitions are only high enough to insure privacy, so that both light and ventilation are improved. The usual heavy doors have been omitted to minimize the sense of confinement. Walls are finished in glazed tile so that maintenance costs are reduced to a minimum. Tiles are of cheerful colors which vary in different locations to provide fresh atmosphere as patients move from one unit to another.

Visiting areas in the building are open and pleasant so that visitors as well as patients have no impression of detention, although the rooms are readily supervised.

Nurses' stations contain all necessary utilities, including refrigerators for the storage of patients' casual food items. Each station is equipped with private lavatory rooms for the convenience of the staff.

Each ward unit has ample toilet facilities for patients, including showers and tubs, as well as laundry trays so that patients can do such laundry work as they desire. Toilet stalls are separated by glazed tile partitions to eliminate the hazards of metal fixtures which were formerly used.

Single rooms are equipped with fluorescent lighting elements built into the ceilings, as well as with floor outlets for the possible installation of bedside lamps, radios and other electrical equipment. Outlets are individually "switched" from the main electrical panel so

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Zimmerman, F. H., M.D., Sup't., Colorado State Hospital, Pueblo, Colo. Personal Communication.
that they may be readily disconnected in any room.

"Although the building is a six-story structure, all floors are served by ample and spacious elevators. Provision is made for movies, theatrical entertainments and musical programs in a small theatre having a stage, theatrical lighting equipment and a projection booth. There is also a large canteen for the sale of candies, sandwiches and various small articles used by the patients. Ample space is provided for occupational therapy, and there is a completely equipped beauty salon for the women and a barber shop for the men.

"Each ward has an open porch, directly off the lounge room, which is readily supervised from the nurses' station.

"There is a generous provision for the comfort of the staff, including showers, toilet rooms, laundry and lounge rooms."

(1) Personnel

Psychiatric hospitals have usually been planned for ambulatory patients of the continued treatment type, some of whom are expected to do a great deal of work. Staffing patterns may, therefore, be markedly below those required for the proper nursing care of the elderly psychotic.

The staffing of the Geriatric Unit should be at least equal to the standards of the American Psychiatric Association until a much needed and carefully conducted study reveals a more accurate measure.

It is suggested that a psychiatrist be available for every 100 patients. The mental and physical health of the patients would be his responsibility. A broad treatment program including psychotherapy, shock therapy, occupational therapy and social case work would be planned by him in association with qualified members of his staff and would be effected in part by the psychiatrist and in part by trained assistants under his direction.

Since disease does not take summer vacations and ignores the 40-hour work week, personnel-patient ratios for attendants as well as for graduate nurses require more explanation than is ordinarily given in order to be meaningful. Variation in the experience and practice of public mental hospitals as to the rate of absenteeism, the length of vacations, the amount of authorized sick leave, the number of recognized legal holidays and the length both of the work-day and of the work-week point to the desirability of establishing standards in terms of actual ward coverage, 24 hours a day, 365 days a year. Hospitals are then afforded a usable basis for the calculation of their own overall personnel requirements and may distribute the attendant and nursing staffs between the various on-duty shifts in whatever manner meets their peculiar needs.

A graduate nurse is recommended for every 20 patients as an average 24-hour standard. Translated into a daily staffing pattern for a 100-bed building, this would permit the assignment of 7 nurses on the morning shift, 6 on the afternoon and 2 on the night. The nurse would administer bedside care, supervise the attendants, be responsible for carrying out the physician's orders and would endeavor to insure healthy staff and patient attitudes through the application of her psychiatric training.

Much of the actual daily care would be in the hands of attendants of whom there should be one for every 12 patients. Translated into a daily staffing pattern for a 100-bed building, this would permit the assignment of 10 attendants on the morning shift, 9 on the afternoon and 6 on the night.

An occupational therapist should be provided for every 100 patients in order to plan some constructive activity which is within the patient's physical limitations and yet will give him satisfaction and make him feel important again. Personnel should also be available for social work, physical therapy, and for research into the special problems of the aged.

The Infirmary for the Aged, referred to in sec. II-2, should have similar types of personnel but will require a smaller resident medical staff than the geriatric unit and a larger visiting staff of psychiatrists, neurologists, orthopedic surgeons, internists and general surgeons.

(2) Patient Care

The aged patient often feels that he has outlived his usefulness, that there is nothing left that is important in life for him to do and that people don't want him. It is for this reason that the nursing care of the aged should be particularly concerned with personal relationships. Reassurance, kindness and fostering of companionship can be cultivated to bring love and warmth into the important relationships. At the same time, the staff must avoid infantilization and, in its place, foster the development of as much independence as the patient can assume.

Regularity in management is desirable, for the older patient gains security from a fixed schedule and meets change with difficulty. He appreciates knowing what is coming next. Patients need to be encouraged in self-care and urged to help others if they are able to do so.
As much ambulation or as much movement should be encouraged as the patient can tolerate without fatigue. No patient should be kept in bed who can sit up, or be allowed merely to sit if he can also walk. It is important to recognize that the aged move and think at a slower tempo. All treatment must be gentle and over-treatment avoided. The dosage of drugs should usually be reduced and sedatives avoided whenever possible. Regular toileting should be practiced. Special attention must be given to nutritional needs. There is some indication that the senile patient has special dietary requirements. The diet should be smooth, with an increased amount of Vitamin C and calcium. At least one pint of milk per day is advisable, with supplementary protein provided by the addition of skimmed milk powder to appropriate foods.

(3) Activities

It is highly desirable to develop within the institution an environment that approximates the community life from which the patient came.

Every patient who is capable of it should have a job to perform. No matter how simple the task, he should realize that everyone is dependent upon him to do it. The aged need to consider themselves useful. The formation of patient-directed committees is useful; one, for example, on admissions, to receive new patients and introduce them to others; a committee to properly celebrate birthdays: a holiday committee to plan special events and parties. Retired teachers may be the nucleus for discussion groups on current events, political and social topics. Interest in religion should be encouraged and an opportunity for worship given. Facilities for checkers, cards, billiards, horseshoes, shuffleboard, darts, quoits and other mildly active games should be available. There must be an opportunity for the growing of plants indoors or for gardening out-of-doors. Sewing, knitting, quilting and other hobbies should be provided for. Some of the men may be able to paint and refinish furniture. The aged enjoy movies and radio and television. There should be walks out-of-doors and trips or excursions for those who are able to leave the grounds. The aged also find much satisfaction in animal pets and when the patients can care for them, these should be provided.

III. Research

Reasonable solutions for the problems of the aged require skilled and coordinated effort. Many cooperating agencies must share in the responsibility for devising plans. The American Geriatric Society and other special groups may be expected to assist in this work.

It would seem important to study the following areas in the care and management of the aged:

1. The elements which assist healthy transition from the vigorous period of life to a happy and adjusted old age:—preparation for retirement, the development, exercise and preservation of interests, the importance of hobbies and of social life, emotional acceptance of the decline in vigor.
2. The price paid by the younger generation when a mentally ill aged person is kept in the home.
3. The adjustment of older patients in nursing homes.
4. The effectiveness of occupational therapy and recreational programs.
5. The present facts concerning the adjustment of the aged in the community.
6. The nutritional needs of the aged.
7. The types of economically productive activity, in and out of sheltered workshops suitable for elderly people after retirement.
8. The place of programs for the aged in community recreational centers.

SUMMARY

There is imperative need for social recognition of the problems presented by our rapidly growing older population and for prompt and wise planning to aid our aged in the healthy transition to an occupied if not a productive old age. Too many old people are entering mental hospitals for sociologic reasons who could be better, more happily and more economically cared for by less drastic measures.

Public intervention in the management of the affairs of the aged should begin when relatives or friends are lacking or are unable to assume the necessary responsibilities. For such individuals three types of care are proposed:

1. Old Age Guidance Centers as in the case of the Benjamin Rose Institute in Cleveland would provide both medical and psychological evaluation and assistance. Services would include counselling, placement and public assistance in the fields of nursing, medicine and social services. Every effort should be made to allow elderly couples to be together.
2. Infirmaries for the Aged with capacities up to 500 would provide bed or semi-ambulant care for the helpless, aged patient unable to care for himself and with no one to help him. There should be provisions for elderly couples to remain together as long as possible.
3. Geriatric Units in Public Hospitals would be particularly designed for the efficient, comfortable care of the aged. Bathing suites and toilets would be planned for more individual care and located within short distances of living rooms and bedrooms; floors would not be made slippery with wax; convenient table service at meals would be available and an adequate nursing and attendant staff assured.
Specially designed Geriatric Units in General Hospitals for the treatment of acute medical or surgical illnesses in the elderly patient, although warranted in all sizeable communities, may not be possible because of budgetary limitations. In such instances, the Infirmary for the Aged should be located within easy ambulance distance of a progressive general hospital offering definitive treatment in the various medical specialties. Following such hospitalization, elderly patients would be returned to the Infirmary for convalescence supervised by consultants preferably drawn from the general hospital and familiar with the acute phase of the illness.

Geriatric Units in Public Mental Hospitals should receive only patients whose behaviour becomes too disturbing for the community or for the infirmary to handle readily. The Geriatric Unit, preferably constructed as a one-story building with easy ramps to the out-of-doors, would contain those conveniences and safeguards already described, along with additional facilities for long term treatment and care, barber shops, beauty shops, occupational therapy rooms and outdoor gardens. Patients must have ready access to the medical wards, clinics and laboratories of the mental hospital as well as to the theatre, recreation areas and canteen. The appearance of detention should be minimized and the surroundings made as cheerful and homelike as possible.

Recommended personnel-patient staffing ratios for psychiatrists and occupational therapists are 1 to 100. Ratios for nurses and attendants, based on actual ward coverage, 24 hours a day, 365 days a year, are 1 to 20 and 1 to 12 respectively. Personnel should also be available for social work, physical therapy and research.

Nursing care of the aged should be particularly concerned with personal relationships, fostering companionship and minimizing infantilism. Regularity in management, maximum ambulation, gentleness in treatment and special attention to nutritional needs are to be stressed. Much effort should be made to approximate, within the institution, the familiar and friendly features of community life. Every patient who is capable should have a job to perform, no matter how simple. Patient-directed committees and discussion groups are helpful. Interest in religion, participant amusements, hobbies and the keeping of pets should be encouraged.

Active, coordinated research into many aspects of the care and management of the aged is necessary.

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2. To re-evaluate old concepts and to develop and test new ones;
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