A SURVEY OF CHRONIC PATIENTS IN A MENTAL HOSPITAL

By

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INTRODUCTION

A STATISTICAL study of large numbers of chronic mental patients may seem to have no direct bearing on the problem of how to treat the individual patient and prevent chronicity. Yet the collection and analysis of mass data form an essential part of epidemiological studies which have made possible many notable advances in preventive medicine. Much of the statistical information at present available in various official documents such as the annual reports of the Ministry of Health and the Board of Control, the Registrar-General's Statistical Review, are so generalized and fragmentary as to be almost meaningless (Lancet, 1955). A few mental hospitals publish annual reports containing broad statistical information; but the detailed facts needed for proper assessment of the size and nature of the problem and for any rational reform are almost invariably lacking. Throughout the field of psychiatry, particularly in connection with the development and effect of chronicity, the existing vital statistics are incomplete and inconclusive.

Over 40 per cent. of the hospital beds in the United Kingdom are occupied by the mentally ill and a high proportion of these are chronic in terms of length of stay in hospital. A single chronic mental patient may occupy a bed that in a general hospital might serve over a hundred patients during an equivalent period. Many different solutions to the problem of the chronic mental patient have been proposed or adopted, but few have been preceded by adequate ascertainment of the facts.

It seemed, therefore, worth while to carry out a detailed survey of the chronic population of a single mental hospital within a limited period (January to March, 1955). One could hope to get some data indicating the most profitable lines on which to attack the problem of overcrowding which is especially marked in the hospital concerned. It was clear that the patients to be studied were not a representative sample of the total chronic mental hospital population of Great Britain, but one could hope that the data obtained would be of interest to other psychiatrists faced with similar problems and would perhaps stimulate similar surveys elsewhere.

Methodology

The hospital is situated in a closely built-up area near the centre of a large industrial city. It was built over 100 years ago and in spite of modifications remains ill-adapted to modern views on the rehabilitation of long stay patients. In addition to the main block there are three annexes for chronic patients;

https://doi.org/10.1192/bjp.103.430.146 Published online by Cambridge University Press

one for females situated within the curtilage of the main hospital and two for males placed some six miles away. If overcrowding indices are ignored the whole hospital can accommodate some 1,400 patients. Wards accommodating chronic patients vary in size from 20–112 patients.

For the purposes of the enquiry chronic patients were defined as patients who had been in hospital continuously for two or more years at the time of the enquiry. The period of two years was selected as the most suitable dividing line since experience has shown that the chances of discharge fall rapidly after two years' continuous hospitalization. By such a definition some patients may be omitted who have been in hospital for less than two years but are nevertheless bound to become chronic patients. It also misses a number of patients who through the application of modern physical treatments, are discharged and re-admitted repeatedly, thus masking their chronicity by short returns to their families. On the other hand some patients are included who may recover and be discharged after two years in hospital. Nevertheless other criteria, clinical or diagnostic, of chronicity are open to objection on other grounds and lack the simplicity of the definition adopted.

A *proforma* was designed on which the required information about each patient could be rapidly recorded and later transcribed on to punched cards for statistical analysis. Draft proformas were subjected to a pilot survey and modified accordingly. As originally planned the survey was to take place in two parts; part 1 was to be concerned mainly with data concerning the patient in hospital, and part 2 concerned with the patients' current family and social background. Owing to the lack of a psychiatric social worker, part 2, which was to be carried out in a field survey had to be abandoned.

While Part I of the proforma (see Appendix) was based on the case records and administrative records of the hospital, Part II dealing with the patient's behaviour, employment and nursing requirements was ascertained by interviewing the nursing staff and by examination of nurses' notes. The various categories are self-explanatory—except perhaps for 20–23 dealing with the patients' abnormal behaviour. Here special care was taken to explain the meaning of the terms to the nurses. In cases where clinical data were in doubt the patient was seen and examined. Care was taken to ensure that information about individual patients was obtained from nurses who knew the patients well by their long contact with them; in some wards this necessitated interviewing the deputy sister or charge nurse.

The information of Part III of the proforma was obtained from the patients' visiting and parole cards. The former are kept at the Porter's Lodge and each visit to the patient is recorded.

Some errors in assessing a number of various factors are probably inevitable in a large scale survey of this type. Nevertheless it was felt that recording and rating errors were not so large as to have a significant influence on the results.

Findings

Age and Sex Distributions

There were 442 male and 654 female patients who had been in residence at the hospital for over two years at the time of the enquiry. The distribution of these patients by age, sex and length of stay is shown in Table I, using 10-year age-groups and 5-year groups for length of stay. Whereas slightly more than half the male patients are aged between 40 and 59 years, almost half the female patients are aged between 50 and 69. Differences between the two percentage age distributions are apparent from Figure 1.

TABLE I

Distribution of Patients According to Age, Sex and Length of Stay

(*a*) Males

Age Group	Duration of Stay (Years)							
	2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
<30 ..	8	6	2	—	—	—	—	16
30–39 ..	10	26	14	8	—	—	—	58
40–49 ..	15	25	33	21	11	6	—	111
50–59 ..	8	14	12	37	20	19	12	122
60–69 ..	5	11	3	7	15	11	18	70
70–79 ..	5	11	3	12	8	5	15	59
80+ ..	1	1	—	1	1	1	1	6
All ages ..	52	94	67	86	55	42	46	442

(*b*) Females

Age Group	Duration of Stay (Years)							
	2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
<30 ..	6	4	—	—	—	—	—	10
30–39 ..	8	13	12	12	1	—	—	46
40–49 ..	9	29	29	30	19	2	2	120
50–59 ..	10	20	26	29	34	27	9	155
60–69 ..	13	23	16	34	37	26	22	171
70–79 ..	15	13	16	17	21	8	16	106
80+ ..	5	2	2	11	11	2	13	46
All ages ..	66	104	101	133	123	65	62	654

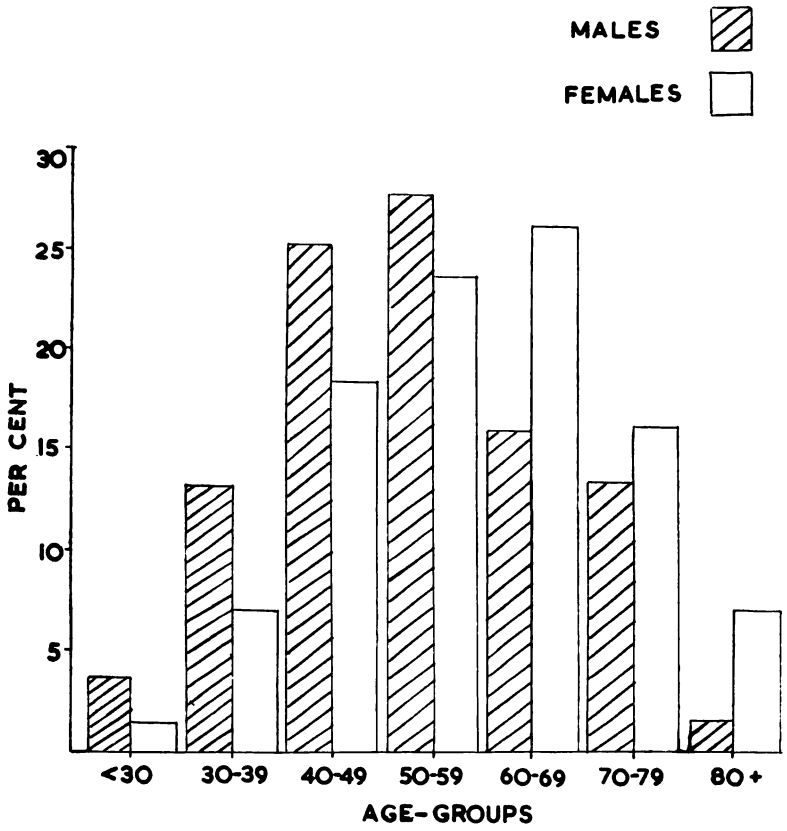

FIG. 1.—Percentage age distribution of all patients.

https://doi.org/10.1192/bjp.103.430.146 Published online by Cambridge University Press

Length of Stay

Examination of length of stay distributions shows that of male patients, 66 per cent. had been in residence for more than ten years; the corresponding female proportion was 74 per cent. Of male patients aged 60 years or over, 75 per cent. had been in residence for more than 10 years and 55 per cent. for more than 20 years. Corresponding proportions for females in this age-group were 79 per cent. and 48 per cent.

Re-admissions

The number of previous admissions was recorded for each patient and 57 per cent. of male and 61 per cent. of female patients had become chronic patients after their first admission. On relating length of stay to the number of previous admissions it was found that of patients who had been in hospital for more than ten years, 65 per cent. had been admitted only once, whereas the corresponding figure for patients who had been in hospital for less than ten years was 47 per cent. (Table II).

TABLE II

Duration of Stay (Years) and Number of Previous Admissions
(Percentage distribution for each group)

Males

No. of Previous Admissions	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
0	36·5	43·6	50·8	70·9	65·5	64·3	78·2	57·4
1	32·7	27·7	28·3	22·0	23·7	28·5	15·2	25·6
2	17·3	19·1	16·4	3·5	7·2	—	2·2	10·4
3 or more	13·5	8·5	4·4	2·4	3·6	—	2·2	5·2
Not known	—	1·1	—	1·2	—	7·2	2·2	1·4
All patients	100·0 (52)	100·0 (94)	100·0 (67)	100·0 (86)	100·0 (55)	100·0 (42)	100·0 (46)	100·0 (442)

Females

No. of Previous Admissions	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
0	54·6	50·9	61·4	63·1	62·6	66·2	72·6	61·2
1	28·8	32·7	26·8	25·6	25·2	24·6	16·1	26·1
2	12·1	9·7	8·9	7·5	7·3	3·0	4·8	7·8
3 or more	3·0	4·8	2·9	2·3	3·2	3·2	3·2	3·4
Not known	1·5	1·9	—	1·5	1·7	3·0	3·3	1·5
All patients	100·0 (66)	100·0 (104)	100·0 (101)	100·0 (133)	100·0 (123)	100·0 (65)	100·0 (62)	100·0 (654)

Re-admission rates were also calculated for each age-group (Table III). Those referable to male patients under 50 years of age were slightly higher than those for subsequent age-groups. The female distributions present a more striking pattern. The proportion of patients with no previous admission

TABLE III
Age and Number of Previous Admissions
(Percentage distribution for each age-group)

Males

No. of Previous Admissions	Age-Group (Years) <40	40–49	50–59	60–69	70+	All Ages
0	54·1	42·3	66·4	68·6	58·5	57·4
1	27·0	32·5	19·6	22·8	26·2	25·6
2	12·2	16·2	10·7	4·3	4·6	10·4
3 or more ..	5·4	9·0	1·6	2·8	7·7	5·2
Not known ..	1·3	—	1·6	1·5	3·0	1·4
All patients ..	100·0 (74)	100·0 (111)	100·0 (122)	100·0 (70)	100·0 (65)	100·0 (442)

Females

No. of Previous Admissions	Age-Group (Years) <40	40–49	50–59	60–69	70+	All Ages
0	41·1	54·1	59·4	65·5	71·1	61·2
1	39·3	35·0	27·0	22·2	17·8	26·1
2	17·9	7·5	9·0	6·5	4·6	7·8
3 or more ..	—	2·5	3·9	3·9	3·9	3·4
Not known ..	1·8	0·8	0·7	1·8	2·6	1·5
All patients ..	100·0 (56)	100·0 (120)	100·0 (155)	100·0 (171)	100·0 (152)	100·0 (654)

increased consistently with age; the converse was true of patients with one previous admission. Of female patients under 40 years of age, 18 per cent. had been admitted twice previously.

Abnormal Behaviour

It was hoped to obtain a behaviour profile of each patient by recourse to the list of emotional states shown on the proforma. In actual practice it was found that many patients could not be clearly rated by the relatively simple scale used. The analysis was therefore confined to identifying those exhibiting offensive tendencies, i.e. those patients who had one or more of the following states: suicidal, aggressive, destructive, restless, irritable or were continually undressing. It was found that 51 per cent. of male and 47 per cent. of female patients fell into this group.

Presence of Physical Diseases

The prevalence of physical disorders was an important feature of this enquiry and is further considered in relation to mobility of patients. Overall proportions for males and females were 28 and 33 per cent. respectively and Table IV gives such proportions by age-group. These increase with age; the

TABLE IV
Patients with Physical Diseases by Sex and Age-Group

Age-Group (Years)	Sex: Males No.	Males Proportion of All Patients	Females No.	Females Proportion of All Patients
Under 40	11	14·9	12	21·4
40–49	22	19·8	20	16·7
50–59	27	22·1	39	25·2
60–69	25	35·7	59	34·5
70 and over	40	61·5	88	57·9
All ages	125	28·3	218	33·3

figure for patients aged 70 years and over is outstandingly high. The relatively high proportion for females under 40 years of age is due to the provision of a female ward for patients with pulmonary tuberculosis.

Conditions which are included in these totals, grouped according to the International Statistical Classification of Diseases, are given in Table V for males and females separately. Some patients have more than one of the

TABLE V

Physical Diseases Present

Diagnostic Category (I.S.C.)	Males	Females
Diseases of Circulatory System	36	90
Hypertension	10	50
Diseases of heart	19	17
Arteriosclerosis	2	17
Other	5	6
Diseases of Digestive System	14	1
Hernia	13	1
Other	1	—
Eye Diseases	11	11
Blindness	7	9
Other	4	2
Neoplasms	2	10
Diseases of Ear and Mastoid Process	11	20
Deafness	11	19
Other	—	1
Diseases of C.N.S.	8	17
Diseases of Bone and Organs of Movement	8	7
Arthritis	3	3
Other	5	4
Injuries	5	9
Diseases of Skin and Cellular Tissue	8	7
Respiratory Diseases	7	26
Bronchitis	7	23
Other	—	3
Diabetes	1	6
Anaemia	1	5
Pulmonary Tuberculosis	—	14
Other	22	30
Total	134	253

categories shown and in such cases are included more than once. Hypertension and heart diseases together account for more than one-fifth of all physical diseases of male patients, and hypertension alone accounts for the same proportion for females; bronchitis contributes 9 per cent. and pulmonary tuberculosis 6 per cent. to the female total.

Employment of Patients

Table VI shows that 40 per cent. of male patients and 54 per cent. of female patients were entirely unemployed. Those shown as working on the ward are mainly engaged on domestic duties and such employment is likely to be nominal and sporadic. A higher proportion of males than females were working elsewhere in the hospital, although the actual numbers were almost identical. Female patients worked mainly in the sewing room, kitchens and laundry, whereas male patients were engaged in the kitchens, on the farm and gardens and on maintenance work. No patients were working outside the hospital grounds. As was to be expected, the proportion of patients unemployed tends

TABLE VI
Employment of Patients by Age
(Percentage distribution for each age-group)

Males

Place of Employment	Age-Group <40	40–49	50–59	60–69	70+	All Ages
Not working	33·8	32·5	42·6	42·9	50·8	39·8
On ward only	45·9	41·4	35·2	38·6	26·2	37·8
On ward and elsewhere	—	3·6	1·7	1·4	1·5	1·8
Elsewhere in hospital	20·3	22·5	20·5	17·1	21·5	20·6
All patients	100·0 (74)	100·0 (111)	100·0 (122)	100·0 (70)	100·0 (65)	100·0 (442)

Females

Place of Employment	Age-Group <40	40–49	50–59	60–69	70+	All Ages
Not working	53·6	49·1	51·6	52·0	63·2	54·1
On ward only	35·7	37·5	32·9	30·4	27·6	32·1
On ward and elsewhere	—	—	0·6	0·6	—	0·3
Elsewhere in hospital	10·7	13·4	14·9	16·9	9·2	13·5
All patients	100·0 (56)	100·0 (120)	100·0 (155)	100·0 (171)	100·0 (152)	100·0 (654)

to increase with age. It was found that duration of stay had little effect upon the employment of patients.

Nursing Care Required

The four-fold classification of nursing care devised by Tait (1948) was used and results are shown in Table VII. The assessment of nursing care

TABLE VII
Nursing Care Required in Relation to Age of Patient
(Percentage distribution for each age-group)

Males

Nursing Care Required	Age-Group (Years) <40	40–49	50–59	60–69	70+	All Ages
None	4·1	14·4	11·5	12·9	12·3	11·3
Routine	71·6	66·7	72·1	68·6	70·8	69·9
Routine plus special attention	18·9	16·2	14·8	15·7	12·3	15·6
More or less constant vigilance	5·4	—	1·6	1·4	4·6	2·3
Constant vigilance plus restriction from violence	—	2·7	—	1·4	—	0·9
All patients	100·0 (74)	100·0 (111)	100·0 (122)	100·0 (70)	100·0 (65)	100·0 (442)

Females

Nursing Care Required	Age-Group (Years) <40	40–49	50–59	60–69	70+	All Ages
None	5·4	9·2	20·0	24·0	25·7	19·1
Routine	62·5	67·5	62·6	60·8	61·2	62·7
Routine plus special attention	26·8	19·2	14·2	14·0	12·5	15·8
More or less constant vigilance	5·4	3·3	2·6	1·2	0·6	2·1
Constant vigilance plus restriction from violence	—	0·8	0·6	—	—	0·3
All patients	100·0 (56)	100·0 (120)	100·0 (155)	100·0 (171)	100·0 (152)	100·0 (654)

required by any group of patients necessarily involves a large subjective element and differing interpretations by ward sisters and charge nurses are likely to occur. This difficulty will chiefly influence the numbers stated as requiring no nursing care and those requiring routine care. Whereas the distinction between these two grades is liable to be subject to error, figures for the other categories will be more reliable.

Only very small proportions required constant vigilance, and about two-thirds of the patients required routine supervision. An examination of proportions for each age-group revealed that, although age does not seem to be an important feature, a greater proportion of patients under 40 years of age required special attention as compared with older age-groups.

Mobility of Patients

Table VIII shows that the large majority of patients (over 90 per cent.) are ambulant for the whole day. As might be expected the proportion of bed-

TABLE VIII
Mobility of Patients According to Age

Males

Mobility	Age-Group (Years) <40	40–49	50–59	60–69	70+	All Ages
Bed-ridden	3	1	1	3	10	18
Ambulant for part of day	—	3	3	2	2	10
Ambulant for whole day	71	107	118	65	53	414
All patients	74	111	122	70	65	442

Females

Mobility	Age-Group (Years) <40	40–49	50–59	60–69	70+	All Ages
Bed-ridden	3	4	9	7	18	41
Ambulant for part of day	2	2	3	1	6	14
Ambulant for whole day	51	114	143	163	128	599
All patients	56	120	155	171	152	654

ridden patients is highest in the older age-groups, and 56 per cent. of the male and 44 per cent. of female bed-ridden patients are over 70 years of age. The excess of female bed-ridden patients in the younger age-groups is partly accounted for by female patients with pulmonary tuberculosis.

About half the bed-ridden patients required only routine nursing care (Table IX). The high proportion of female bed-ridden patients requiring special

TABLE IX

Mobility of Patients and Nursing Care Required

Nursing Care	Sex and Mobility: Males Bed-ridden	Males Ambulant Part of Day	Males Ambulant Whole Day	Males Total	Females Bed-ridden	Females Ambulant Part of Day	Females Ambulant Whole Day	Females Total
None	—	—	50	50	—	1	124	125
Routine	10	6	293	309	19	8	383	410
Routine plus special attention	3	3	63	69	19	3	81	103
More or less constant vigil	3	1	6	10	2	1	11	14
Constant vigil	2	—	2	4	1	1	—	2
Totals	18	10	414	442	41	14	599	654

TABLE X

Degree of Supervision in Relation to Duration of Stay

(Percentage distribution for each group)

Males

Degree of Supervision	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
Confined to ward entirely	32·7	28·7	22·4	23·3	30·9	28·6	30·4	27·6
Confined to ward except for messages, meals, etc.	1·9	1·0	1·4	—	—	—	—	0·7
Allowed outside ward under supervision	32·7	28·7	31·4	15·1	12·7	19·0	13·0	22·4
Allowed outside ward without supervision	32·7	41·6	44·8	61·6	56·4	52·4	56·6	49·3
All patients	100·0	100·0	100·0	100·0	100·0	100·0	100·0	100·0
	(52)	(94)	(67)	(86)	(55)	(42)	(46)	(442)

Females

Degree of Supervision	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
Confined to ward entirely	34·8	30·8	25·7	23·3	17·8	27·7	34·0	26·5
Confined to ward except for messages, meals, etc.	—	0·9	1·0	0·8	0·8	1·5	—	0·8
Allowed outside ward under supervision	42·4	36·5	37·6	48·9	39·8	41·5	37·0	40·9
Allowed outside ward without supervision	22·8	31·8	35·7	27·0	41·6	29·3	29·0	31·8
All patients	100·0	100·0	100·0	100·0	100·0	100·0	100·0	100·0
	(66)	(104)	(101)	(133)	(123)	(65)	(62)	(654)

nursing attention in addition to routine supervision is due to the patients with tuberculosis. Male and female proportions of ambulant patients requiring special attention and more or less constant supervision were almost identical. Differences between male and female proportions of patients requiring no care or routine care are probably artificial and arise because of different subjective interpretations of these classes of care.

Bed-ridden patients therefore need more nursing care than do ambulant patients and 72 per cent. of male and 93 per cent. of female bed-ridden patients had physical diseases as compared with only about one-quarter of ambulant patients.

Degree of Supervision

The four-fold classification used for determining the degree of supervision required is given in Table X. The proportions of males and females confined to the ward were almost the same. Almost half the male and one-third of female patients were allowed outside their wards *without* supervision. There is a complementary sex differential for patients allowed outside the ward *under* supervision. Length of stay in hospital appeared to have little bearing upon the extent of supervision required, although it will be noted that a relatively small proportion of patients who had been in residence for less than 5 years were allowed outside the ward without supervision.

Visiting of Patients by Relatives and Friends

The frequency with which each patient was visited and by whom, was recorded. Some patients were visited by more than one person, usually at different intervals. For the present purpose, the most frequent visit alone is included in the figures given below. As the extent to which patients are visited is likely to be associated with the degree of week-end parole, results are given in Table XI separately for patients who (*i*) did not go out on parole, (*ii*) went out on occasional parole and (*iii*) went out on regular parole. Whereas 9 per cent. of male patients were allowed occasional parole and 11 per cent. regular parole, the corresponding female proportions are only 5 per cent. and 4 per cent. respectively.

TABLE XI

Frequency of Visiting Related to Week-end Parole

Frequency of Visiting	Sex and Week-end Parole							
	Males				Females			
	None	Occasional	Regular	Total	None	Occasional	Regular	Total
Weekly	72	13	4	89	99	8	12	119
Monthly ..	103	12	7	122	141	13	2	156
3-monthly ..	35	3	4	42	78	4	1	83
Annually ..	13	—	2	15	38	1	1	40
Occasionally ..	46	3	7	56	65	3	4	72
Not at all ..	87	7	24	118	175	2	7	184
Total	356	38	48	442	596	31	27	654

Of all male patients, 27 per cent. were never visited and a further 13 per cent. only occasionally. Female proportions were almost the same, so that two out of every five chronic patients had no regular visitors. Roughly the same proportion were visited at either weekly or monthly intervals. Figures for patients who did not go out on parole closely resemble these. Of those patients on occasional parole, two-thirds had regular weekly or monthly visits. As was anticipated, a high proportion of male patients on regular parole were not

TABLE XII

Frequency of Visits by Duration of Stay

Males

Frequency	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
Weekly	17	26	12	19	7	4	4	89
Monthly	13	27	23	18	18	11	12	122
3-monthly	2	11	5	8	9	4	3	42
Annually	1	2	2	4	2	1	3	15
Occasionally	10	12	8	15	2	4	5	56
Not at all	9	16	17	22	17	18	19	118
All patients	52	94	67	86	55	42	46	442

Females

Frequency	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
Weekly	22	30	28	19	10	7	3	119
Monthly	16	34	24	31	26	14	11	156
3-monthly	10	10	10	17	19	8	9	83
Annually	4	7	5	7	4	5	8	40
Occasionally	7	6	7	17	19	7	9	72
Not at all	7	17	27	42	45	24	22	184
All patients	66	104	101	133	123	65	62	654

TABLE XIII

Frequency of Visiting by Age-Group

Males

Frequency	Age-Group (Years)							
	<30	30–39	40–49	50–59	60–69	70–79	80+	Total
Weekly	7	18	21	22	12	8	1	89
Monthly	5	15	33	41	15	13	—	122
3-monthly	1	4	8	9	12	7	1	42
Annually	—	1	4	4	3	2	1	15
Occasionally	3	9	15	14	6	8	1	56
Not at all	—	11	30	32	22	21	2	118
All patients	16	58	111	122	70	59	6	442

Females

Frequency	Age-Group (Years)							
	<30	30–39	40–49	50–59	60–69	70–79	80+	Total
Weekly	3	15	21	18	31	24	7	119
Monthly	2	13	33	31	37	27	13	156
3-monthly	2	4	16	24	25	10	2	83
Annually	1	3	5	14	10	5	2	40
Occasionally	1	2	12	10	27	16	4	72
Not at all	1	9	33	58	41	24	18	184
All patients	10	46	120	155	171	106	46	654

visited regularly; it is surprising that half the females on regular parole were visited at weekly or monthly intervals.

Frequency of visits was then considered in relation to length of stay and age of patient. Table XII shows that 39 per cent of male patients who had been in residence for 20 years or more received either weekly or monthly visits; the corresponding female proportion was 28 per cent. Of those patients who had been in residence for less than 10 years, almost 60 per cent. were regularly visited and the proportion falls off gradually as length of stay increases. A similar relationship exists between age and visiting (Table XIII). Whereas 50 per cent. of male and 41 per cent. of female patients aged 70 years or more were not regularly visited, the corresponding proportions of those under 40 years of age were 31 per cent. for males and 23 per cent. for females.

The principal diagnoses of chronic patients are given in Table XIV together with age and sex distributions. Schizophrenia accounted for 72 per cent. of male and 66 per cent. of female patients; affective disorders accounted

TABLE XIV

Diagnosis by Age

Males

Diagnosis	Age-Group (Years)							
	<30	30–39	40–49	50–59	60–69	70–79	80+	Total
Schizophrenic disorders	14	46	86	96	46	30	—	318
Manic-depressive reaction	—	1	5	4	5	7	1	23
Involutional melancholia	—	—	—	3	3	6	1	13
Paranoia and paranoid states	—	—	—	1	—	1	—	2
Senile psychosis	—	—	—	—	—	4	2	6
Pre-senile psychosis	—	—	—	1	1	1	—	3
Psychosis with cerebral arteriosclerosis	—	—	—	1	4	3	1	9
Alcoholic psychosis	—	—	—	—	—	1	—	1
Psychosis of other demonstrable aetiology	—	6	9	11	2	3	—	31
Other psychoses	—	1	1	1	1	1	1	6
Psychoneurotic disorders	—	1	—	—	—	—	—	1
Pathological personality	—	1	—	—	1	—	—	2
Mental deficiency	2	2	9	4	7	2	—	26
Other	—	—	1	—	—	—	—	1
All patients	16	58	111	122	70	59	6	442

Females

Diagnosis	Age-Group (Years)							
	<30	30–39	40–49	50–59	60–69	70–79	80+	Total
Schizophrenic disorders	7	38	91	112	122	54	12	436
Manic-depressive reaction	—	1	10	10	7	11	6	45
Involutional melancholia	—	—	2	8	12	10	3	35
Paranoia and paranoid states	—	—	1	—	1	—	—	2
Senile psychosis	—	—	—	—	2	21	16	39
Pre-senile psychosis	—	—	2	—	4	1	—	7
Psychosis with cerebral arteriosclerosis	—	—	—	—	2	2	2	6
Alcoholic psychosis	—	—	—	1	—	—	1	2
Psychosis of other demonstrable aetiology	1	2	7	5	6	—	1	22
Other psychoses	—	—	—	1	4	3	4	12
Psychoneurotic disorders	—	—	—	1	—	—	—	1
Pathological personality	1	—	1	—	—	—	—	2
Mental deficiency	1	4	4	13	9	4	—	35
Other	—	1	2	4	2	—	1	10
All patients	10	46	120	155	171	106	46	654

for 8 per cent. and 12 per cent. respectively, and 6 per cent. of male and 5 per cent. of female patients were diagnosed as mentally defective. The large sex differential in proportions of patients with senile psychoses reflects the differences between the age distributions, although it is likely that senile dementia in some cases was superimposed on previous schizophrenia. In what follows, those diagnoses which occur in sufficiently large numbers to merit further analysis are considered in relation to several aspects mentioned above.

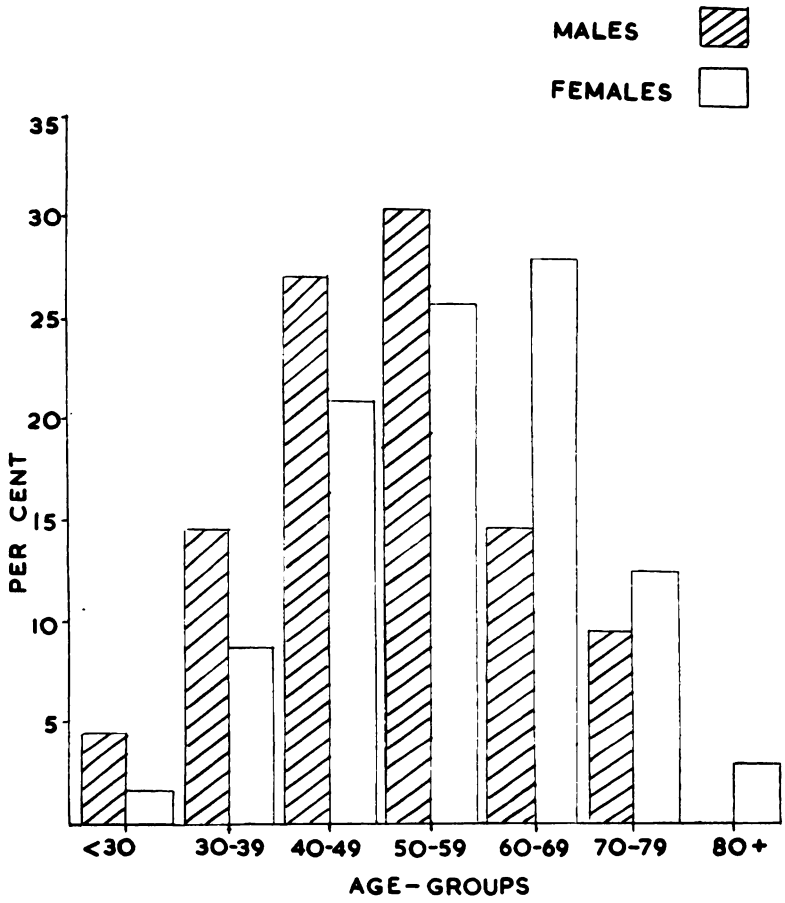

FIG. 2.—Percentage age distribution of schizophrenic patients.

Schizophrenic Disorders

Age distributions for this diagnostic category are depicted in Figure 2 which further emphasizes the sex differences. Table XV gives the results of relating age to length of stay. It will be noted that the large majority of patients had been in residence for 10 years or more; the female proportion exceeds the male. Furthermore, 70 per cent. of male patients aged 60 years or over had been in hospital for more than 20 years; the corresponding proportion for female patients in the age-group was 60 per cent.

Of the male schizophrenic patients, 21 per cent. had accompanying physical disorder of note and 8 per cent. had a mental disorder in addition to schizophrenia; proportions for female patients were roughly the same. For both sexes, over 40 per cent. of patients aged 60 years and over had physical diseases as compared with 15 per cent. of those under 60 years of age.

Table XVI shows the extent of nursing care required by schizophrenic patients. Of all male patients, 16 per cent. required more than routine supervision; the proportion for those under 40 years of age was 25 per cent. Figures for female patients were very similar and show that schizophrenic patients, especially those in the younger age-groups, make considerable demands upon trained nursing staffs.

TABLE XV

Distribution of Patients with Schizophrenic Disorders According to Age, Sex and Length of Stay

Males

Age-Group	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
<30 ..	7	5	2	—	—	—	—	14
30–39 ..	6	21	11	8	—	—	—	46
40–49 ..	7	20	27	19	7	6	—	86
50–59 ..	4	11	9	29	16	18	9	96
60–69 ..	2	5	1	5	13	8	12	46
70–79 ..	—	3	2	4	4	4	13	30
80+ ..	—	—	—	—	—	—	—	—
All ages ..	26	65	52	65	40	36	34	318

Females

Age-Group	Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
<30 ..	5	2	—	—	—	—	—	7
30–39 ..	4	10	11	12	1	—	—	38
40–49 ..	2	21	24	23	18	1	2	91
50–59 ..	2	13	16	20	31	22	8	112
60–69 ..	4	12	10	28	29	20	19	122
70–79 ..	2	4	4	10	18	7	9	54
80+ ..	—	—	—	2	7	—	3	12
All ages ..	19	62	65	95	104	50	41	436

Affective Disorders

Age and sex distributions are given separately for manic-depressive illness and involutional melancholia on Table XIV. For each there was an excess of female to male patients. A combination of these two diagnoses provides sufficient numbers to merit further analysis. Almost two-thirds of these patients were 60 years of age or over. Table XVII gives length of stay distributions and there are some differences between corresponding proportions for males and females. However, for both sexes more than one-third of the male patients and 37 per cent. of females had accompanying physical disorder of note; almost half the patients aged 60 years and over had such diseases. Few patients required more than routine supervision and male and female proportions were almost the same.

TABLE XVII

Duration of Stay Distributions for Certain Diagnosis

Diagnosis and Sex		Duration of Stay (Years) 2–4	5–9	10–14	15–19	20–24	25–29	30+	Total
Affective disorders	M	5	8	2	11	5	2	3	36
	F	14	16	17	16	6	5	6	80
Mental deficiency	M	3	7	1	2	5	3	5	26
	F	6	7	6	5	5	3	3	35
Epilepsy with psychosis	M	2	2	6	1	2	1	2	16
	F	2	1	2	4	2	2	—	13
Senile psychosis	M	3	2	—	—	1	—	—	6
	F	16	7	7	3	1	—	5	39

TABLE XVI

Nursing Care Required by Patients with Schizophrenic Disorders

Males

Care	Age-Group (Years)							
	<30	30–39	40–49	50–59	60–69	70–79	80 and over	Total
None	—	1	11	12	5	6	—	35
Routine	11	33	60	74	34	20	—	232
Routine plus special attention	2	9	12	8	7	4	—	42
More or less constant vigilance	1	3	—	2	—	—	—	6
Constant vigilance plus restriction from violence	—	—	3	—	—	—	—	3
All patients	14	46	86	96	46	30	—	318

Females

Care	Age-Group (Years)							
	<30	30–39	40–49	50–59	60–69	70–79	80 and over	Total
None	—	2	8	20	29	17	5	81
Routine	5	25	62	71	77	34	6	280
Routine plus special attention	2	8	16	19	14	3	1	63
More or less constant vigilance	—	3	4	1	2	—	—	10
Constant vigilance plus restriction from violence	—	—	1	1	—	—	—	2
All patients	7	38	91	112	122	54	12	436

Mental Deficiency

This condition was the principal diagnosis of 26 male and 35 female patients at the time of the survey, and it was a subsidiary diagnosis in the case of 18 male and 17 female patients. From the age distributions given on Table XIV it will be noted that two-thirds of such patients were under 60 years of age; about the same proportion had been in residence for 10 years or more (Table XVII). Of all male mental defectives, 50 per cent. had accompanying physical disorders of note and 58 per cent had a secondary diagnosis of mental disorder. Corresponding female proportions were 34 per cent. and 49 per cent. Few patients required more than routine nursing supervision.

Epilepsy with Psychosis

An age distribution is given for each sex in Table XIV, although it is necessary to combine results for the sexes to give sufficiently large numbers for further analysis. Nearly half the patients with this condition were under 50 years of age. Table XVII shows that almost one-third had been in residence for 20 years or more. With only two exceptions, these patients were ambulant for the whole day and 62 per cent. were working on the wards; the remainder were unemployed. Four patients of each sex had some physical disorder of note and five males and one female had a subsidiary mental disorder. Almost one-third of these patients required more than routine nursing care, although only one needed more or less constant vigilance.

Senile Psychosis

Mention has already been made of the large excess of female patients with such conditions and the following comments refer to all patients. Only two patients were under 70 years of age and 40 per cent. were 80 years of age or over (Table XIV). Almost the same proportion had been in residence for less than 5 years (Table XVII). As was to be expected, a high incidence of physical diseases was recorded (60 per cent.) and 10 patients (23 per cent.) were confined to bed. Almost one-third of these patients required special attention in addition to routine nursing care although none needed constant vigilance.

Discussion

From the total findings of our survey, this paper only presents a selection of facts from which practical conclusions may be drawn. Material, for instance, relating to small diagnostic groups, or data referring to the areas of the city in which the patients had their home, have been omitted. Only those features which seemed to be of clinical and practical significance, have been correlated.

Sex Differences

As in other mental hospitals of the region, the *preponderance of females over males* represents a special problem in chronic patients. The ratio of 1·5/1 female to male is comparable with that found by Cross for the whole region (1954). The difference is partially accounted for by the longer life expectation of females. Ratios female to male increase rapidly with age so that the ratio for the over 70's is 2·3/1. One has also to think of clinical and social factors which may be responsible for this discrepancy. A male patient is probably more readily tolerated at home, particularly if he is able to earn a living even at reduced capacity. The situation is more difficult if the patient is female with

poor ability for household duties and impaired relationships with the family and with the neighbours. There are possibly cultural factors which influence the family and make them more ready to accept the return of mentally handicapped male patients. That these speculations are correct cannot be proven from the survey; but they are put forward as explanations to be confirmed by a more detailed study.

Another factor to be considered in this connection is the established preponderance of *women with affective psychoses* particularly in the higher age groups. Logan (1956) showed that there were nearly double the number of females admitted with these disorders in England and Wales.

Length of Stay and Re-admission

The distribution of *length of stay* shows that this hospital suffers, like many others, from a large number of chronic patients accumulated before the last war, i.e. before the methods of active physical treatments were introduced or fully applied. Of the cases (71 per cent.) who had been in the hospital for 10 years or more, almost two-thirds were never discharged and had become chronics after their first admission; during the last 10 years this proportion has dropped by 18 per cent. This suggests the more active treatments introduced during the last 10–15 years have led to a smaller number of "chronics" being accumulated in spite of an increasing admission rate of the hospital. It also implies a higher rate of discharge and consequently a greater population at risk for later re-admission.

Though not established from the figures of this survey there is general agreement about the rise in *re-admission rates* in recent years. It has been implied by some observers that there is little point in discharging a patient who will almost certainly require re-admission in the near future. Such a view is to be deprecated. A few months outside hospital is better than none and if a patient is not given every chance of life outside hospital one cannot be certain that he will be unable to adapt himself to life in the community. Clinical experience shows that predictions as to whether or not a patient can live outside hospital are not always correct. The best policy, where no contra-indication exists, is to encourage every opportunity of discharge. This applies not only in the affective disorders where the phasic nature of the illness makes repeated discharge and admission inevitable, but also to the much larger groups of schizophrenics where prolonged and repeated efforts to stabilize the patient outside hospital are needed. Critics of the rising re-admission rates should remember that from the purely administrative point of view a single bed which serves only one permanently hospitalized patient may also serve two or three patients who are discharged and re-admitted repeatedly.

It would be rash to conclude that the *modern methods of therapy* are preventing chronicity of mental illness altogether, and especially of schizophrenia; it seems, in fact, probable that neither insulin-coma treatment nor E.C.T. has any long-term influence on the course of this disease. What these and other treatments, such as the newly introduced drugs, achieve is to give the patient in remission an opportunity of getting back into the outside world and of adapting to a life among normal people, even if they still show more or less conspicuous symptoms of their illness.

Manifest Behaviour and the Problem of Discharge

The results of our attempt at *behaviour rating* for each patient were not entirely satisfactory. The traits used did not cover all significant aspects of

behaviour adequately and individual items did not yield much helpful information. The omission of a special item for incontinence was later regretted. It was found in many cases that in the time available it was difficult to rate the manifest behaviour except in negative terms such as affective indifference, apathy and social withdrawal. Patients whose behaviour presented actual difficulties to the nursing staff were more easily assessed. The fact that more than half the patients did not present any marked behaviour problem suggests that retention in hospital depends on social and other aspects unrelated to their behaviour pattern. This is in keeping with the clinical observation that some patients discharged from hospital at the request of their relatives are more disturbed in their behaviour than many who have to remain because their families are unable or unwilling to accept them home.

One difficulty in making any generalization from the behaviour ratings of these patients is that the observed behaviour may be purely *situational.* It is not uncommon in clinical practice to observe patients who behave well in hospital and yet show a totally different picture when allowed to return home on parole; in other cases these phenomena are reversed. Much would seem to depend on the *emotional atmosphere* of the home and the hospital, and the patient's attitude to either. The chronic mental patient is not unresponsive to his environment and the behaviour pattern may vary accordingly.

One strong influence on the patients' behaviour has not been active in the hospital to which this survey refers: there has been almost no treatment by *prefrontal leucotomy* of chronic psychotics, an operation carried out in more than 10,000 patients in the United Kingdom. It would be very interesting to compare our findings with those of a hospital in which neuro-surgical treatment was applied liberally in suitable cases.

The area served by the hospital is an industrial one with a long tradition of full employment for the majority of able-bodied and able-minded members of the family. Many mothers of large families do part-time factory work. To accept back into the family a mentally-handicapped member who, though not showing any really troublesome behaviour, is not a wage earner, appears to be a burden that some families are not prepared to accept. The problem of the return home may be greater than presented by the mere presence of the patient, as a wage-earning relative may have to take time from work to attend to his needs.

Another factor is the housing shortage; patients are not welcomed readily into already overcrowded accommodation. The duty of the family to care for its handicapped members has not been strengthened by the provisions of the welfare state. There are no incentives beyond moral ones for families to accept chronic mentally handicapped patients back again. This is particularly true when family ties have been weakened by prolonged hospitalization. By and large it would seem that the longer a patient is in hospital the more difficult it becomes to discharge him and that this is far more dependent on social factors than the actual condition of the patient.

There is, of course, another side to this problem of the best disposal for the permanently mentally handicapped patient. Some families extend themselves beyond reasonable limits to keep a chronic psychotic out of hospital to the detriment of the whole family and particularly the children. Outside the mental hospital and the family there are very few disposals for the permanently handicapped but relatively stable mental patient. It is unfortunate for this discussion that the social survey of the homes of these patients could not be carried out so that more precise formulation of the social factors involved could be made.

Physical Disorders and Nursing Care

The high incidence of patients with *physical disorders* indicates that many patients have a double handicap which may contribute to the necessity of retention in hospital. This would appear to be of particular importance in the older age groups. The physical factor may prevent gainful employment and make the problem of discharge far more difficult than it would be otherwise. The need to diagnose and treat accompanying physical disease in the chronic mental patient may influence policies of placing chronic mental patients in long-stay annexes with minimal medical and nursing care. In fact, doubly trained nurses may be needed for this type of case.

Our assessment of the *amount of nursing care* was obviously influenced by the attitude of the ward nurses who made the ratings. There seemed to be good agreement about patients who required more than routine attention. On the other hand, it was more difficult to decide whether a patient should be placed in the category of "routine care" or of "no nursing supervision". It was not only the attitude of the nurse to her charges that counted, but also the ward in which the patient happened to be placed. Some wards containing a majority of well conducted patients had a low nurse/patient ratio and in these most patients were expected to care for their own personal needs (toilet, feeding, dressing, etc.). In such wards the rating for patients who did not require nursing care was high. On the other hand, wards containing a high proportion of disturbed patients tended to have higher nurse/patient ratios. Here patients were given "routine care" irrespective of their individual needs. In such wards few patients were rated as needing no nursing care. This statement is not intended to imply criticism of the nursing staff. Except for patients requiring special nursing attention, the nursing need of a particular ward is inevitably determined by the needs of the majority. In large wards with 80 patients or more little heed can be given to the individuals not requiring special care. It is difficult when dealing with large numbers to make exceptions in ward routine so that patients who might care for themselves are given an opportunity to do so. This points to the need for proper classification of chronic patients according to their individual nursing requirements. Much of the trouble caused in chronic wards is due to the resistance against adequate grading. Sometimes this comes from the patient who attaches himself to one ward or one nurse or from the nurses who dislike to see their personal preferences for patients overruled.

The number of patients rated as requiring no nursing care underlines the point already made that retention in hospital depends not only on biological factors in the illness but on social ones as well.

The difference in nursing care required by males and females may be partially accounted for by bias of the raters, but is also probably influenced by cultural factors. Men are not as a rule reared to become highly efficient in caring for their purely domestic needs but to earn a living, whereas in women the opposite generally obtains. These cultural differences are often reflected in the wards themselves; female wards tend to be cleaner, fresher, and savoured with flowers; a less orderly state of affairs permeated with tobacco smoke often exists in male wards.

Employment of Patients

Some inferences can be made from the figures about the *employment of patients*. The large number of patients employed on domestic duties in the ward suggests that such employment cannot be realistic, as similar tasks could be

performed by very much smaller numbers of ward maids. There are good reasons to believe that the employment of patients outside the ward is dependent more on the work available to patients than the capacity of patients to do it. If occupation, beyond handicraft work provided through occupational therapy, is considered to be of therapeutic importance for the chronic patient, then the need for further developments in this field is clear. The idea of preparing the patient for work that he may take up after discharge, in other words, of rehabilitation and preparation for life outside hospital, only slowly takes root in the field of mental illness.

In view of the continuing problem of chronicity and of the striking overcrowding especially in the female wards of our mental hospitals, the attention of psychiatrists should be drawn to imaginative schemes of occupation and rehabilitation, particularly for women. At present, they are for a good part of the day unoccupied after sharing the available household duties in the ward, brooding about their complaints or withdrawn into a delusional world, living in an atmosphere of boredom and hatred which the nurses are unable to improve because of the large numbers under their care.

If there were the possibility of placing suitable cases in hostels and homes run by the Mental After Care Association, whence they could go to work or make themselves useful caring for the other boarders, this would be a step in the right direction. In fact, as a great number of chronic schizophrenics are physically well, all types of intermediary stages of care between hospital on the one end and family life on the other should be tried out and made use of.

Mobility and Degree of Supervision

The findings on the *mobility* of patients are in accordance with expectations. Only a small proportion of patients are bed-ridden and most of these are senile patients with accompanying physical disorders. The vast majority of patients are fully ambulant and it is with these patients that the bulk of the nursing is concerned. For most chronic patients the bed has no more significant role than a place to sleep at night. It seems illogical therefore that many mental hospitals have adopted the tradition of the general hospital in giving the bed pride of place. Day room and other facilities assume far greater importance in the treatment of the ambulant patient and doubts are cast on the usefulness of large bedded wards for the treatment of the chronic mental patients. Like normal people, these people sleep better where there is less noise. The disturbance caused by a noisy and difficult patient may influence the temper and emotional tolerance of several dozen of his co-patients sleeping in the same ward.

The *degree of supervision* accorded to patients suggests that there is more freedom and less supervision for male patients. The availability of work outside the wards for male and female patients and of staff to look after them may have contributed to this difference. The amount of freedom which a patient enjoys does not depend only on his mental state, but on the tradition of the ward in which he is placed. It depends moreover, on the overall administrative policy of the hospital. Since the survey was carried out, a number of wards have been unlocked and an increasing number of patients allowed freedom in the grounds without supervision. This makes it even more important that the patients should be adequately classified or in other words they should be placed in wards where they can be granted the most practicable amount of freedom.

There has been much emphasis of late on the "*open door*" policy in mental hospitals with a maximum of freedom for patients. While the advantages of

such policy have been clearly demonstrated, there seems a danger that this cult of the unlocked door may be overdone and thereby fall into disrepute. It is clear from this survey that some chronic mental patients remain highly aggressive and difficult, and probably dangerous to themselves or others. For such patients the "open door" in its accepted sense would sooner or later prove disastrous, particularly for a hospital situated in a densely populated urban area. The survey confirms the need to keep a *small* number of chronic mental patients confined to the ward or under constant supervision. The value of a more liberal regime for these few patients is doubtful even if it were practicable.

Visiting of Patients

The finding that two out of five chronic patients have no regular *visitors* underlines the isolation from their families and the outside world for many patients. The chance of discharging such patients is dependent on getting them sufficiently well to be able to earn their living and maintain an independent existence without family help and in competition with normal people. Few patients who have been in hospital for more than two years can measure up to such demands.

The other side of the picture is more heartening in that approximately *one-third of patients* who have been in hospital for *more than twenty years* still continue to receive either weekly or monthly visits. The families of such patients who continue to visit regularly and frequently over many years must obviously retain some concern about the patients' welfare. The fact that such patients have not been discharged means that either the patient's mental state does not allow life outside mental hospital or that there is some other obstacle, financial, domestic or housing, to prevent this. It seems highly probable that in some cases where strong family ties remain, discharge would be possible if some realistic and practical aid were available to help the family in dealing with the patient at home. The recent work of Poole and his associates in Oldham (1956) is of particular interest in this respect.

Diagnostic Assessments

The *diagnostic assessments* are of considerable interest, showing that numerically and therapeutically the greatest problems are the *schizophrenic disorders;* these far outweigh all the other diagnostic categories put together. As already pointed out earlier, all scientific and practical effort should be concentrated on these disorders. Although they have so far resisted preventive or therapeutic methods aimed at reducing the prevalence of the illness, enough is now known of the factors influencing behaviour and adaptation of the chronic schizophrenic to deal with his problems in and out of hospital. The large number of passive, indolent and harmless chronic schizophrenics as demonstrated in our survey are always in danger of being forgotten (Bickford, 1955) while the main resources of the hospital are devoted to recent admissions. The survey shows that there is no foundation for regarding the chronic mental patient as essentially different or requiring much less medical or nursing care than the more recent case. On the contrary, to avoid chronicity and utilize every sign of improved behaviour and better adaptation which may lead to discharge, well trained nursing staff and specialized knowledge is as much needed as in the treatment of earlier patients. It is in the nature of schizophrenia that only persistent attempts to adjustment, not easily discouraged by initial failure can lead to a satisfactory result.

The preponderance of females among *affective psychoses* has been mentioned already. The high incidence of accompanying physical disorders in the chronic affective psychoses, which was particularly marked in the aged, is in keeping with the clinical concept that the prognosis in these cases is significantly worse where physical disease is present. The fact that over two-thirds of the affective disorders were 60 years of age or more confirms the adverse factor of age on prognosis stressed by Watts (1956) and others.

The presence of 61 *mental defectives* in a mental hospital reflects on the inadequate provision for their care in mental deficiency institutions. New legislation can be expected for the care of this type of case when the report of the Royal Commission has been published. One can hope it will take account of the defectives' frequent inclination to psychotic episodes, and also of the many cases in which physical handicap is combined with mental subnormality and makes social adaptation a very difficult problem—as in the patients of our survey.

Chronic epileptics with character abnormalities and persistent or transient psychotic features represent a considerable burden for the nursing staff, in spite of their small numbers. It is difficult to see where else they could be cared for because they are unsuited for life in an open epileptic colony, even if such existed in the Region. They would probably be happier and less troublesome in small groups on a farm or in an Occupational Hostel.

The *senile psychoses* do not present a sizeable problem among the chronic patients. This finding is consistent with that of Roth (1955) who showed that 82 per cent. of these patients died within two years of admission. While the senile psychoses may well represent a serious problem among recent admissions they make a very small contribution to the chronic population.

SUMMARY

A comprehensive survey has been made of 442 male and 654 female patients who had been continuously in residence in a mental hospital for two or more years at the time of the enquiry. Details which were recorded are given in the Appendix.

Examination of age and sex distributions showed that the female to male ratio (1·5:1 for all ages) increased with age and the value for the 70 years and over age-group was 2·3:1. Possible explanations of these differences are discussed.

Two-thirds of all male and three-quarters of all female patients had been in residence for 10 years or more. Of these patients, 65 per cent. had been admitted only once as compared with 47 per cent. for those patients who had been in residence for less than 10 years. This suggests that a smaller number of chronic cases have been accumulated during the past ten years in spite of an increasing admission rate. Modern treatments did not prevent chronicity altogether, especially as regards schizophrenia.

Many patients did not show any serious behaviour problems and retention in hospital often depended on social and other factors unrelated to biological factors in the illness.

Almost one-third of the patients had physical diseases of note and the rate for those aged 70 years and over was outstandingly high. Thus many patients have a double handicap which may contribute to their retention in hospital and which may prevent gainful employment.

The need for proper classification of chronic patients according to nursing needs is stressed. From the four-fold classification used it was found that only very small proportions of patients required constant vigilance and about two-thirds required routine care only. It was clear that the degree of supervision accorded patients depends not only on their mental state but on ward tradition and administrative policy.

Nearly half the patients were entirely unemployed and of the remainder many were engaged on domestic duties on the wards; such employment is likely to be nominal and spasmodic. Employment and occupation for chronic patients presents special problems requiring imaginative schemes for their solution.

The large majority of patients were ambulant the whole day and the proportion of bed-ridden patients is highest in the older age-groups. Bed-ridden patients need more nursing care than do ambulant patients and 72 per cent. of male and 93 per cent. of female bed-ridden patients had physical diseases.

A further study of patients with certain diagnoses was made. Chronic schizophrenia accounted for 72 per cent. of male and 66 per cent. of female patients. The large majority of such patients had been in residence for 10 years or more and it is towards this disorder that

scientific and practical efforts should be directed. Schizophrenic patients, especially those in the younger age-groups make considerable demands upon nursing staffs; more than one-fifth had accompanying physical disorders. Almost two-thirds of patients with affective psychoses were 60 years of age and over and more than one-third had physical diseases superimposed upon their mental disorder. More than half the patients with a principal diagnosis of mental deficiency had a secondary diagnosis of mental disorder and half the male and one-third of the female mental defectives had physical diseases. Senile psychoses did not present a sizeable problem in chronic patients.

ACKNOWLEDGMENTS

Thanks are due to Dr. J. J. O'Reilly, Physician Superintendent, All Saints Hospital, for his interest and the permission to carry out the survey.

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APPENDIX

PROFORMA

Survey of Long-stay Patients

PART I

Name of patient.....

1–5 Registration number [ ][ ][ ][ ][ ]

6 Sex 0 Male 1 Female

7–8 Age of patient at time of survey (years) [ ][ ]

Date of last admission to hospital.....

9–11 Duration of present stay in hospital [ ][ ][ ] years months

12 Method of referment (Ring as appropriate.) 1 Voluntary 2 Certified 3 Temporary 4 Other

13 Marital status. (Ring as appropriate.)
1 Single 2 Married 3 Widowed 4 Divorced or apart 9 Not known

14 Number of previous admissions [ ]

Address of patient prior to admission.....

.....

PART II

15 Ward Number [ ]

16 *Mobility of patient*. (Ring as appropriate.)
1 Bed-ridden (persistently).
2 Ambulant for part of day.
3 Ambulant for whole day.

APPENDIX—*continued.*

17 *Degree of supervision.* (Ring as appropriate.)
1 Confined to ward entirely.
2 Confined to ward except for messages, meals, etc.
3 Allowed outside ward under supervision.
4 Allowed outside ward without supervision.

18 *Week-end parole.* (Ring as appropriate.)
0 No parole 1 Occasional parole
2 Regular parole

19 *Employment*
1 Not working.
2 Working on ward (specify type of work) .....
3 Working elsewhere in hospital (specify work).....
.....
4 Working outside hospital (specify work) .....
.....
Specify number of hours worked per day, if applicable.....
.....

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20–23 *Patients abnormal behaviour*
(Ring all appropriate letters.)

A Depressed
B Apathetic and inactive
C Inaccessible
D Alternating state
E Irritable
F Suicidal
L Aggressive and/or destructive
M Restless
N Demented
P Untidy
R Overtalkative
S Continually undressing
T Others (specify) .....
.....

24 *Nursing supervision required*
0 No nursing care of any kind.
1 Routine—supervision at meal times, dressing, washing, etc.
2 Routine plus special attention not to extent of 3 and 4 below.
3 More or less constant vigilance.
4 Constant vigilance plus restriction from violence.

25 *Physical diseases present.* (Ring as appropriate.) 0 No. 1 Yes.
If yes, specify .....
.....

26–29 *Principal diagnosis at time of survey* (*W.H.O. Code*)

Specify.....

30 *Subsidiary diagnoses.* (Ring as appropriate.) 0 No. 1 Yes.
If yes, specify .....
.....

PART III

Name(s) and address(es) of relative(s) and friend(s). Specify each person recorded and code relationship to patient by recourse to code at foot of page.

31 (i).....
.....

32 (ii).....
.....

33 (iii).....
.....

https://doi.org/10.1192/bjp.103.430.146 Published online by Cambridge University Press

APPENDIX—*continued.*

34 *Is patient visited by* (i) *above?* *Date of last visit* .....
(Ring as appropriate.)
0 Not at all 2 Weekly 4 3-monthly
1 Occasionally 3 Monthly 5 Annually

35 *Is patient visited by* (ii) *above?* *Date of last visit* .....
(Ring as appropriate)
0 Not at all 2 Weekly 4 3-monthly
1 Occasionally 3 Monthly 5 Annually

36 *Is patient visited by* (iii) *above?* *Date of last visit* .....
(Ring as appropriate)
0 Not at all 2 Weekly 4 3-monthly
1 Occasionally 3 Monthly 5 Annually

RELATIONSHIP CODE

1 Wife/husband	5 Brother	9 Nephew
2 Mother	6 Daughter	10 Cousin
3 Father	7 Son	11 Other relative
4 Sister	8 Niece	12 Friend

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