A SERVICE FOR THE ELDERLY MENTALLY ILL IN BRIGHTON

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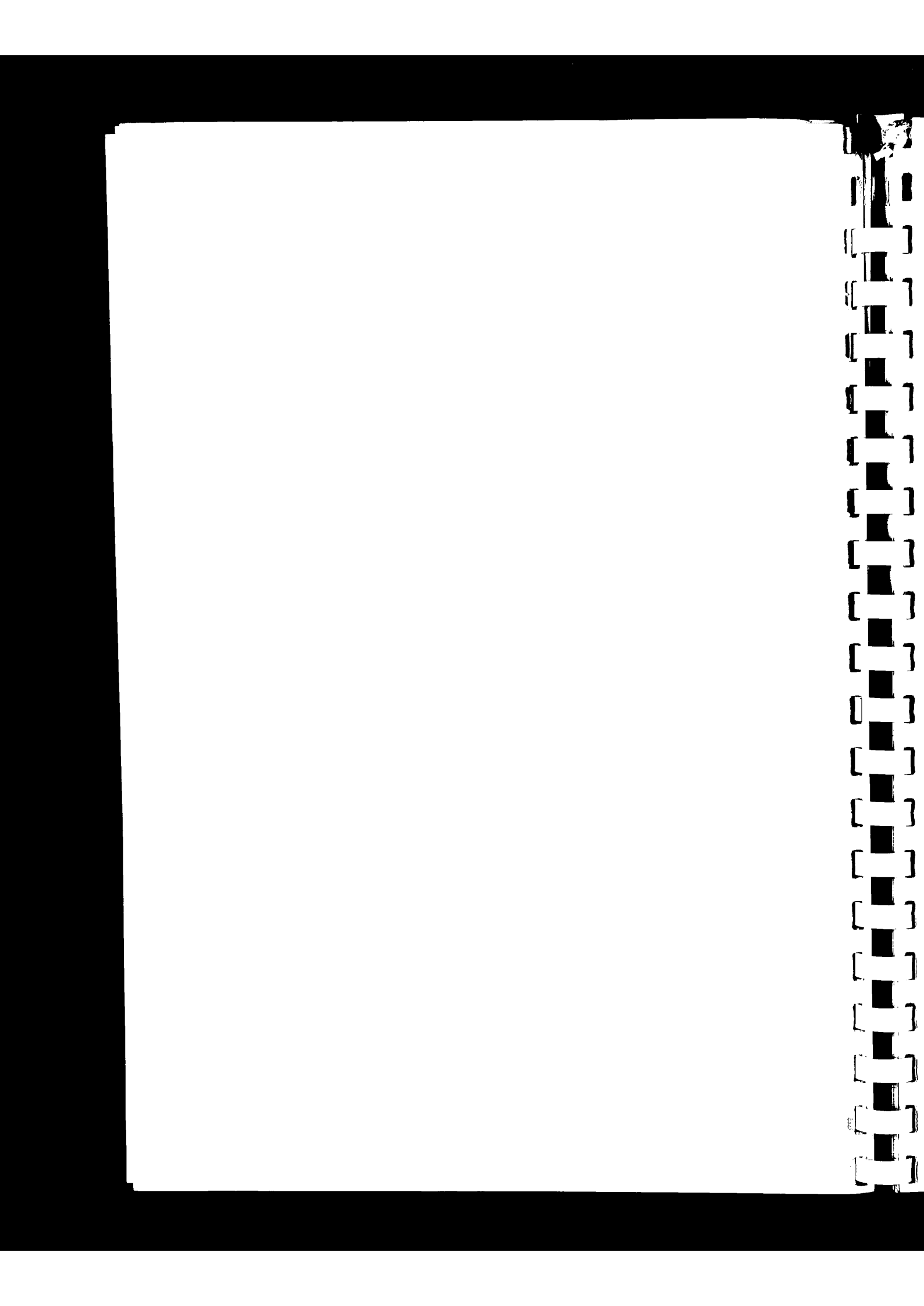
INTRODUCTION

A service for the elderly mentally ill was started at St. Francis Hospital, Haywards Heath, in 1967. The following Papers give some account of what has happened since then, the type of service now provided, and future plans for its development.

Most disciplines involved in the service have contributed, and each Paper is on the whole self-contained. Because of this there is some inevitable repetition.

No psychiatric service can hope to succeed unless there is a team approach, and this is what has been attempted here.

Tony Whitehead



PLANNING SERVICES FOR THE ELDERLY MENTALLY ILL

Tony Whitehead

There are many cogent arguments which support the view that there is too much specialisation in medicine. There are also equally strong arguments against any form of segregation. Unfortunately the realities of our society and of health services are such that both specialisation and some degree of segregation are necessary when considering the special problems presented by disease and disability in the elderly. Geriatric medicine is now a well established speciality, and in the past few years geriatric psychiatry has also emerged as a sub-speciality of psychiatry. There has been opposition to both these developments, and the opponents have had a lot of right on their side. Many old people have enough problems without the additional ones associated with being separated from other age groups. Clusters of old people's bungalows, blocks of old people's flats, and special residential establishments for the elderly are well established ways of herding the old together. This herding together continues when the ageing individual becomes a hospital patient, with an increasing chance of being admitted to either a geriatric medical ward or a so-called psychogeriatric ward.

If society's attitude to the elderly was changed and medical, nursing and social work training significantly modified, it would be possible to counter this movement towards specialisation and segregation, but without this, experience has tragically demonstrated the consequences of not developing special services for the elderly. Psychiatric hospitals that have not developed special units and services for the elderly are

becoming progressively more crowded with old people, few of whom leave except as corpses. It is extremely difficult to provide adequate help, treatment and support for old people in a general psychiatric service. The pressing needs of younger patients tend to force the old into the background, and the final greyness of a long-stay ward. Experience in Essex and Brighton, plus a more superficial acquaintanceship with other special units for the elderly mentally ill, has shown that the development of such services significantly reduces the number of old people in psychiatric institutional care, and at the same time provides help for an increasing number of old people in the community. For example, the average proportion of patients over 65 in psychiatric hospitals is over 50%, yet in the psychiatric establishments serving the Brighton and Hove district, which has a disproportionate number of elderly residents, the proportion of patients over 65 is only a third of the total in-patient population.

Psychogeriatrics

The term 'psychogeriatrics' was coined some years ago, and tends to be used in a confusing manner. Special units for the elderly mentally ill are described as psychogeriatric units, and at the same time psychogeriatric is used as a synonym for the old person with organic brain disease. Old people are subject to the same range of mental illness and disability as other age groups, though obviously the incidence of organic brain disease is higher in the old, thus special services for the elderly mentally ill must cater for the whole range of mental illness. This is important to the patient and the staff of the service. Some mental illnesses, particularly depression in all its forms, and paranoid psychoses, do present differently in old age, with the constant risk of the sufferer being labelled demented when in fact this is not the case.

Staff need to develop special expertise and equally need the variety presented by the whole spectrum of mental illness. Helping and supporting patients with organic brain disease is both satisfying and interesting but the interest tends to wane if this is the only condition treated.

Much has recently been made of the concept of combined assessment units. These are small 10 to 20 bed units jointly used by the psychiatric, geriatric and social services. The idea originated as a method of preventing old people being misplaced and is based on the pioneer work carried out in Nottingham. The Department of Health and Social Security now recommend that each district has a unit. Experience in Brighton suggests that there is no need for such a special facility, provided a close liaison is developed between psychiatry, geriatrics and the social service department. The elderly are subject to multiple pathologies encompassing social, medical and psychiatric distress. It is possible to assess the major and most demanding trouble at a specific time but later the emphasis can change so that the sufferer from severe congestive heart failure with associated mental confusion improves, but becomes depressed, which again may improve so that the immediate need becomes accommodation and social support. No person can be assessed and categorized once and for all. The combined assessment unit does help if there is not a close and ongoing relationship between psychiatric, geriatric and social services department, but this is only a second best. When the psychiatric service for the elderly mentally ill is run closely with the geriatric service, with combined rounds and a mutual understanding of each other's problems, coupled with a close relationship at a worker level between hospital and social service personnel a combined assessment unit is totally unnecessary.

The Hospital Facility.

Hospital provisions for the elderly mentally ill are completely dependent upon what is provided in the community. Community provisions include adequate numbers of home helps who, perhaps, do more than any other group to support old people in their own homes, social work help, day centres and a range of accommodation from old people's bungalows and flatlets by way of warden supervised accommodation to residential homes and a boarding-out service that places old people with families, in group homes and rest homes.

If the community provisions are reasonably good, an adequate service can be provided by the hospital with less than 3 in-patient beds per 1,000 population over 65, but at least 3 day places per 1,000 population over 65. The day hospital is the centrepiece of any service for the elderly mentally ill, since it can provide most treatment and support normally available in a hospital without the trauma of admission. Admission to hospital can be the final catastrophe that afflicts the old person in difficulties. A day hospital provision of 3 places per 1,000 population over 65 is adequate, provided there are day centres run either by the local authority or voluntary organisations in the area served. If there are no such day centres, the number of day hospital places may need to be as high as 4 or 5 per 1,000 population over 65. Both the in-patient and day hospital facilities need to be in the community served and should also be as close as possible to the Department of Geriatric Medicine. It may be necessary to develop psychogeriatric units in mental hospitals many miles away from the population served, but there should be immediate attempts to at least start establishing psychogeriatric facilities within the general hospital complex which is usually close to the population served. Close proximity to the geriatric department makes

a good liaison between the two specialities easier and more effective. In the Brighton area at the present time the day hospital and in-patient unit for the elderly mentally ill is close to the Department of Geriatric Medicine. Day patients and in-patients can be seen by the geriatric physician if they are in the psychiatric unit, or by the psychiatrist if they are in the geriatric unit, at any time and treated appropriately without having to be moved from one service to the other. Experience of working this system has been described in "Geriatric Psychiatry in the General Hospital" (Tony Whitehead and Ganesh Mankikar. Lancet, June 15th 1974, pp 1213/1215).

There is a lot of realistic anxiety about the possibility that mental hospitals will become geriatric ghettos. This can only be prevented if special services for the elderly mentally ill are developed and placed within the general hospital complex.

It is possible to develop special services for old people with mental illness without too much segregation. This can be done by encouraging younger people to come into the day hospital and wards as helpers and visitors. Free and unrestricted visiting is obviously important. There is no place for the bizarre bans on children visiting their elderly relatives when in hospital. Local schoolchildren can be encouraged to interest themselves in the in-patient unit while younger psychiatric patients often enjoy and benefit from working on wards for the elderly.

The staff of the unit should be people who have taken on the work because that is what they want to do. The only exception to this would, of course, be learners who have to be moved around according to the G.N.C. rules.

The multi-disciplinary therapeutic team is usually headed by a psychiatrist but this need not necessarily be the pattern. I have seen an excellent psychogeriatric unit in the United Kingdom administered by a senior nurse and an equally good unit in the United States administered by a social worker.

There are many ways of developing special hospital facilities for the elderly mentally ill, all are effective provided they are community-orientated and are run closely with other services for this age group. Failure to develop special services adds to the misery of growing old and is potentially damaging to the hospital service in general.

A SHORT HISTORY OF SERVICES FOR THE ELDERLY MENTALLY ILL IN BRIGHTON, HOVE AND NEIGHBOURHOOD

A service for the elderly mentally ill was first established in 1966. In that year Dr. Klaus Bergmann was appointed as a psychiatrist with a special interest in the elderly. He developed a service based on St. Francis Hospital, Haywards Heath, which served that hospital's catchment area. The area served was a triangular piece of East Sussex, the base of which extended from Portslade to Peacehaven, with an apex at Peas Pottage. The population was 368,200, with 74,750 over the age of 65.

The service was to provide facilities that would ensure the support of as many people in the community as possible, while still offering help and support in humane surroundings for those that needed long-term care. In the beginning there were only in-patient facilities which consisted of approximately 8 beds for women and 4 to 5 beds for men in the acute psychiatric unit at Brighton General Hospital and 6 female wards at St. Francis Hospital, (Chailey, Firle, Warninglid, Burgess Hill, Rottingdean and Stoneham). These wards and Brighton General Hospital provided 166 beds. The absence of medium and long-stay male in-patient facilities meant that any man who could not be treated and discharged from the unit at Brighton General Hospital had to be transferred to the care of another consultant at St. Francis Hospital. There was no day hospital facility.

After considerable effort Dr. Bergmann obtained a day hospital unit at Bevendean Hospital, Brighton. This consisted of a converted fever ward and was opened in the autumn of 1968, providing approximately 40 places for patients of either sex per day.

During Dr. Bergmann's period in office, close links with community workers were established and the unit management moved towards the ideal of a multi-disciplinary team approach.

Dr. Bergmann left the unit in 1969. He was temporarily replaced by a locum consultant, Dr. Toke, until the appointment of Dr. Whitehead on 1st August, 1970.

Expansion and Division.

During 1970 and 1971 a number of changes occurred. In-patient wards at St. Francis Hospital became mixed sex wards, and this meant that elderly men need no longer be transferred to the care of other consultants. Ovingdean ward (29 beds) was taken over by the unit, increasing the total number of beds to 195. A day hospital was started on Warninglid Ward at St. Francis Hospital to serve Hove, Portslade and the rural piece of East Sussex served by St. Francis Hospital. Warninglid Ward was turned into a day hospital by first taking day patients on the ward while it still provided in-patient care. As the development of day care made admission less necessary, the number of beds on the ward was finally reduced to zero, so leaving it as a day care ward only. This means that the beds were now reduced to 172.

The establishment of Warninglid Day Hospital meant that Bevendean Day Hospital confined its activities to providing day care for the elderly people from Brighton. Close links were established with the Department of Geriatric Medicine in Brighton, and mutually devised plans put forward for future developments. It was also possible to carry out an investigation into the use of senior nurses in place of doctors. The result of this investigation is described in a Paper by Whitehead

and Fannon entitled "A clinical role for senior nurses", published in the Lancet.

The unit also took over the responsibility for two male wards (Peacehaven, with 14 patients and Scaynes Hill with 20 patients), increasing the total beds to 206. Later, three upgraded wards in the west wing of the hospital were taken over by the unit, so making it compact. (Kingston including Plumpton with 54 places and New Stoneham with 12 places.)

Patients were transferred from Peacehaven, Scaynes Hill and Stoneham wards to the new complex and these wards given over to other units. All the wards now became mixed sex wards. The situation was now:

Psychiatric Unit, Brighton General Hospital ..	13 beds
Rottingdean	26 beds
Kingston/Plumpton	54 beds
Chailey	30 beds
Stoneham	12 beds
Firle	11 beds
Ovingdean	29 beds
Burgess Hill	6 beds
Warninglid Day Hospital	30 places

This gave a total of 181 beds and 30 day places. The number of patients on Kingston Ward was fairly quickly reduced to 40.

During this period it was decided that there was a need for two consultant psychiatrists with a special interest in the elderly, and in October 1971 Dr. Robin George was appointed to fill the second post.

Prior to his appointment, the St. Francis Hospital catchment area had been divided into two equal parts as far as population of old people was concerned. One part consisted of Brighton and the other of Hove, Portslade, Peacehaven and the rest of the area. Dr. Whitehead became the consultant responsible for the Brighton area and Dr. George for the other area. Dr. Whitehead established his headquarters in the Day Hospital at Bevendean (Willow Day Hospital), while Dr. George took over the headquarters accommodation available at St. Francis Hospital. In the Spring of 1973, a mixed admission unit of 20 beds was established at Bevendean Hospital (Cedar Ward) adjacent to the existing Day Hospital. Beds at Brighton General Hospital were no longer used. The Wards at St. Francis Hospital were divided up as follows:

<u>The Brighton Unit</u>
<u>(Dr. Whitehead's Unit)</u>

Rottingdean Ward	26 beds
New Stoneham Ward	12 beds
Kingston/Plumpton Ward	40 beds

With a total of 78 beds.

<u>Dr. George's Unit</u>

Chailey (Admission) Ward	30 beds
Firle Ward	17 beds
Ovingdean Ward	29 beds
Warninglid Day Hospital	30 places

This gave a total of 76 beds and 30 day places.

Later the Brighton unit took over responsibility for the Peacehaven district, since this seemed a more rational distribution of

work, particularly since the original reason for dividing the area had been local authority boundaries, which became no longer significant after the re-organisation of local government.

In 1976, the old Sanatorium (Old Stoneham and Scaynes Hill Wards) at St. Francis Hospital was finally converted into an elegant day hospital to replace the rather makeshift Warninglid Ward development.

As early as 1971, it was decided that the whole service for the elderly mentally ill should be accommodated within the general hospital complex. Plans were made to develop an additional in-patient unit at Brighton General Hospital. The plan was to provide sufficient accommodation for old people who became mentally ill in old age. Some patients grow old within the mental hospital. For these, it was considered best that a special unit be developed at St. Francis Hospital that would provide a homely environment but, at the same time, have facilities for rehabilitation, so that those who could be resettled in the community could be prepared for this and finally discharged from hospital.

In 1978 Fletching Block at Brighton General Hospital was partially opened, making the Brighton Unit self-contained and self-sufficient within the general hospital complex. Fletching Block provides 35 places which, with 20 places at Bevendean Hospital, is sufficient in-patient accommodation for the elderly mentally ill, excluding those who have grown old within St. Francis Hospital. The vacant places at St. Francis Hospital are now being used for elderly people from other parts of the hospital who belong to this latter category.

Plans are now being made to make the Hove and Portslade Unit equally self-sufficient, while other plans have been made to deal with

the problem of Lewes and Newhaven. These are parts of the district at present served by Hellingly Hospital, near Hailsham.

In due course a day hospital will be established at the Lady Chichester Hospital in Hove, and a further 35 places will become available in Fletching Block to provide in-patient care for patients from either Hove and Portslade or Lewes and Newhaven. This will be the first stage in the plan to make the rest of the district independent of a psychiatric hospital.

The present situation.

The service for Hove, Portslade and Mid-Sussex is still provided from a base of in-patient wards and a day hospital at St. Francis Hospital. The Brighton Unit now consists of Willow Day Hospital at Bevendean Hospital providing 40 places per day, Cedar Ward at Bevendean Hospital with 20 in-patient places, Fletching Block at Brighton General Hospital providing 35 in-patient places.

Both Cedar Ward and Fletching Block are mixed sex facilities catering for the whole range of patients, from those who are in for a short period to those requiring longer term care.

ORGANISATION OF THE UNIT.

There is little doubt that large organisations and large institutions have many problems that are the direct consequence of their largeness. When that organisation or institution tries to provide a service for people, further problems occur. Large hospitals are frightening places and large mental hospitals are perhaps the most frightening. Most people find little hospitals much better places to go to, than large ones, but sadly little hospitals are usually unable to provide the sort of facilities that are necessary for the help and treatment of individuals. One well tried and effective solution to the problem of the large hospital is to divide it up into a number of small units, or mini hospitals, so that it is then possible to combine the advantages of the large hospital, with the advantages of the small hospital. It is important that these mini hospitals in the big hospital are truly mini hospitals and not simply impersonal units of the impersonal whole. Thus a unit must have its own focus of administration, with its own staff and, if possible, be compact with all its facilities together in one area of the bigger building or building complex. The unit must have its own nurses, doctors, social workers, psychologists, occupational therapists and other ancillary staff. It must also have its own secretary or secretaries. Its headquarters should be a meeting place for all workers involved on the unit and provide offices for the various senior staff, such as the consultant, senior nurse, social worker and what other disciplines that have workers fully committed to the unit.

The secretary, or secretaries, must play a vital role in both running the unit and presenting it to the public. People who telephone for help, or come for help, often make their first contact through the

secretary and this contact can set the whole tone of their future relationship with the unit. The secretary must fully understand both the organisation and philosophy of the unit, so that she can make sensible decisions, when these have to be made. She should also be a friendly warm individual, who immediately makes the person contacting the unit feel welcomed and at home.

There is much talk of therapeutic teams in psychiatry. A therapeutic team can only really be developed if members of that team are accommodated close together, so that communication is a word that is not even thought about, since it is happening all the time. A good therapeutic team must include the unit's secretarial staff, since they not only play an important role in organisation and administration, but also have a clear and obvious therapeutic function.

Experience in a number of hospitals has demonstrated the importance of firstly developing a circumscribed geographically compact unit, with a headquarters that is the meeting place of all involved in treatment. It is often not possible to achieve this situation immediately, but this must always be the final objective. The Brighton unit for the elderly mentally ill both illustrates the importance of the unit concept and the difficulties of fully establishing such a unit. In the past this unit was sited at St. Francis Hospital, Haywards Heath. It had a headquarters, but this did not include accommodation for senior staff other than medical staff. The wards were rather scattered, with some facilities in Brighton General Hospital, fifteen miles away, and a Day Hospital in Bevendean Hospital, also in Brighton. Further developments resulted in some in-patient facilities being provided at Bevendean Hospital and the movement of the headquarters of the unit from St. Francis to Bevendean. Now the Day Hospital at Bevendean also

accommodates the headquarters, with an adjoining in-patient ward of twenty places. The rest of the unit is sited in nearby Brighton General Hospital. This means that while the unit is not completely compact, it is as compact as possible at the present time.

The headquarters of the unit, being sited in the Day Hospital, means that most people involved can meet fairly easily. The Day Hospital also provides out-patient facilities, so that the vast majority of patients coming to the unit, or into the unit, are first introduced to the service via its headquarters. Thus they have a focal point to relate to and call upon when in difficulties.

There is always a danger that hospital staff treat the public in the outside world as almost enemies. People telephone for help and advice and are brushed off with either platitudes or suggestions that they go elsewhere. No hospital unit, whatever it deals with, but particularly mental disorder, is of any use unless people can approach it for help and advice and get that help and advice, with friendship and warmth. Defensive barriers, buck passing and brush-offs may work where organisations deal with inanimate objects, but a caring service must be for caring.

The practical organisation of the unit and its programme is described on the two following pages, but what is said would be meaningless in the absence of the philosophy just described.

The Brighton Unit

The unit consists of the day hospital, with forty places per day and a mixed in-patient ward adjacent to the day hospital, that provides twenty places and also takes a few day patients at Bevendean Hospital.

As already mentioned, the headquarters of the unit is sited in the day hospital and the day hospital also provides out-patient care. There are three out-patient clinics held in the day hospital each week for ordinary out-patients, as distinct from day patients. There are 35 places in Fletching Block, Brighton General Hospital. Both in-patient facilities are mixed acute, medium and long-stay in function.

The staff of the unit consists of one Consultant Psychiatrist, one Registrar or S.H.O. in psychiatry, two part-time Clinical Assistants, one full-time Social Worker and one part-timer, three part-time secretaries who provide a constant service, arranging the days they work between themselves. There is the normal type of nursing staffing for the day hospital and the in-patient unit, with one charge nurse in the day hospital and a charge nurse or sister in the two in-patient units. There is one Nursing Officer in overall charge. There is an active occupational therapy department, with four and sometimes more trained occupational therapists and a number of occupational therapy helpers. There is one physiotherapist, and sessions by a psychologist, speech therapist and chiropodist.

The unit provides a service for people over sixty-five with psychiatric symptoms, and most patients are referred to the unit by their family doctor, or they may be referred by health visitors, social workers or even friends. (In these cases the family doctor must approve). The vast majority of patients are either initially seen as out-patients or on domiciliary visits, with very few patients being admitted without being previously seen in this way. New out-patients come to the unit for two separate days, either a Monday and a Wednesday or a Tuesday and a Wednesday. They are seen and assessed by the Registrar in psychiatry on the Monday or Tuesday and also assessed by the nursing and O.T. staff.

On the Wednesday they are seen by the Consultant and their problems, treatment and care discussed with the whole team. It may be found that ordinary out-patient treatment is all that is required, or it may be that day hospital attendance is considered necessary. Obviously some have to be admitted to hospital.

It is the philosophy of the unit that old people are best supported in their own homes if this is possible, but it is also acknowledged that in-patient care is sometimes essential and often helpful. The patient may be admitted for specific treatment, or to give their relatives or other supporters a rest. Some patients are supported on what is described as a month-in/month-out basis, which consists of admitting the patient for a month, sending him home for a month and then re-admitting him. This system may appear to be a rather unsatisfactory one because of the constant change, but in fact experience has shown that not only do relatives have regular relief, but the patient also benefits from this regular and soon familiar change around.

The unit programme gives an outline of some of the unit's activities.

Activities

There is a great variety of activities in both the day hospital and the in-patient unit. These will be described in later papers.

DEPARTMENT OF GERIATRIC PSYCHIATRY - BEVENDEAN HOSPITAL & B.G.H.

WEEKLY PROGRAMME

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
A.M.	Consultant Ward Round. Fletching Block.	Consultant. Ward Round. Cedar Ward.	Combined Psychiatric/ geriatric round. Starting in Willow Day Hospital & continuing via Cedar Ward, Fletching Block & the Geriatric Unit at Brighton Gen. Hospital, with occasional visits to other wards at B.G.H. & R.S.C.H. Patient/Staff group meeting, Willow D.H.	Consultant. Ward Round. St. Francis Hosp. Patient/Staff Group meeting. Willow D.H.	Out-patient Clinic. Willow D.H. Consultant; Registrar.	Staff round by Consultant.
P.M.	Out-patient Clinic. Willow D.H. Registrar; G.P. Clinical Assistant. New assessments Willow D.H. Registrar	New assessments. Willow D.H. Registrar. Patient/Staff Meeting. Fletching Block. Monthly visits to Beech Cottage by Consultant.	Out-patient Clinics. Willow D.H. New & old patients. Consultant. Registrar. Hospital Clinical Assistant.	Review of day patients. Willow D.H. G.P. Clinical Assistant. Monthly Relatives' Meeting 4 p.m. Willow D.H. (for all relatives).		

9 - 10 a.m. Mon. to Fri. 'Open House', when members of staff can discuss problems or air their views with the Consultant Psychiatrist.

HELPING OLD PEOPLE WITH MENTAL ILLNESS

Tony Whitehead

The proportion of old people in hospital is increasing, yet a significant number of nurses do not particularly care to nurse old people, preferring younger patients, in spite of the old, on the whole, being more appreciative. There is a mistaken belief that the care of younger patients is more important and more rewarding than that of the old. This is incorrect and leads to considerable misunderstanding. Much skill is required to help old people, and if this skill is acquired, the results can be impressive and the work extremely rewarding. Failure to acquire these skills leads to the old person being damaged instead of helped, and staff demoralised and disillusioned.

In this Paper some of the basic principles involved in providing effective help for old people are described. They are based on conversations with hospital staff and the consumer. It may be considered that many of the things that are said are obvious and should be known by any nurse. Unfortunately it is too easy to forget the principles that would be applied when dealing with younger patients when the patient is old and perhaps appears demented.

The first thing to remember is that old people are people and not things. Some may be disorientated and muddled, many will be deaf, or partially deaf, and have a number of disabilities that make it easy for the nurse to fall into the trap of believing that the patient does not understand what is going on so there is no need to talk to him or her. Because of this it is important to emphasise that, whatever the condition of the patient, the nurse should always attempt to communicate with him and explain what she is doing at all times. It is not

unusual to see an old person being moved, or attended to in some way, without the nurse speaking to him or attempting to in any way explain what is being done. This leads to anxiety and fear in the patient which may result in him striking out and, in the long term, helps to destroy the old person's personality. Another manifestation of this attitude is the custom of some nurses, doctors and other professionals to speak about a patient in front of him as if he were not there and possibly say things that could be hurtful and damaging.

Another method of destroying an individual is to take away that individual's opportunity to choose. Because of this it is important to offer choice whenever possible to an old person, even if he appears to be very demented. The patient should have some say in what goes on in the ward, since it is his home and the staff are there to help and not be bossy and authoritarian.

Old people, like everyone else, have likes and dislikes, possessions, and a need to be an individual. This means that they should have their own clothes, as many personal possessions around them as possible, and free access to any friends or relatives they may have. It is often forgotten that they also have sex needs.

It is very easy to come to believe that it is a waste of time talking to an old person who appears to be out of touch and lost. Attempts to communicate often consist of asking questions. It is much better to start by telling the patient something rather than ask a question. For example, a comment on the weather or what is happening in the outside world is much better than to say "What is your name?" or "Where do you live?". It is often very helpful to talk about your childhood and so encourage the patient to start talking about his, which is usually well-remembered.

Remember that the patient may have a much better idea of what she wants or needs than you. Because you are a professional it does not mean that you always know best.

For example, one old lady claimed she was upset by a certain drug, having received it in the past. The professionals paid no attention to her views, gave her the drug and she became very ill.

Another old lady who was perpetually being told to sit down, said that exercise was important and sitting led to weakness of muscles and fragility of bones. Of course, she was correct.

Remembering that the ward is the old person's home, visits by doctors, senior nurses or other officials should not be allowed to interfere too much with what the patient is doing or wants to do. For example, if the patient is interested in a television programme it is quite wrong to switch off the set simply because a doctor or senior nurse has come on to the ward. Remember that the doctors and nurses are there to help the patient, and their needs are secondary to those of the patient.

Every ward should have a programme of activity which includes occupation, entertainment and exercise. This means that programmes should be planned by all the staff involved, including the patients, and these programmes should be kept to as far as possible. A daily programme of entertainment and activity is as important, if not more important, than any specific treatment, so failure to keep the programme going is a failure to treat the patient. Again, the activities of nurses and doctors should be slotted into the programme and not be allowed to interfere with it.

Cot-sides on beds, geriatric chairs used as restraints, hand-feeding and the dreadful custom of telling patients to stay in their chairs and not move because the staff are afraid of falls, are all devices that destroy the personality. Low beds make cot-sides unnecessary, an active ward programme means that restrictive geriatric chairs can be placed in the museum where they belong, patients can be encouraged to feed themselves, even when they are quite disabled, and sensible exercise does not make falls more likely, but reduces the incidence, since immobility leads to weakness while mobility leads to strength.

Food is obviously important and there should be as much variety as possible with little, if any, need for so-called soft diets. Many old people without teeth have got toughened-up gums which can deal with most well-cooked food, while the provision of dentures is an important part of treatment for the majority of patients who, in fact, can cope with them.

Violent behaviour is occasionally ascribed to elderly patients. The odd individual may become violent for no reason, but this is a great rarity, and most violence in hospitals can be prevented by sensible handling on the part of staff. Remember that a soft answer turns away wrath.

Restlessness during the day and night is sometimes a problem. Occupation, exercise, and the stimulation of interest during the day, with a hot drink with a little alcohol at night, do more than any tranquilliser or sedative.

Relatives and friends can play an important part in the rehabilitation of patients. Treat them as allies and not enemies, and

remember, if they are critical it is either because there are very good reasons for their criticism, or because of problems of their own. In the first case, their criticisms should be listened to and something done to remedy them, and in the second case kindly counselling usually produces good results.

Incontinence, particularly of urine, is often a problem, particularly in a demoralised ward. Regular toileting can do much to prevent incontinence, and it is quite illogical to claim that this would be done if there was sufficient staff. Regular toileting takes up less time than changing wet beds and wet clothes. Many old people are incontinent because they either cannot get to a toilet, are embarrassed about asking for a bedpan or bottle, or, if they do ask for these, may not get them for a long time. Commodes by each bed and other methods of making going to the toilet easy can reduce incontinence considerably. It should be remembered that a lot of incontinence on a ward is not necessarily an indication of the mental or physical state of the patients, but can be a manifestation of something being amiss on that ward.

Sometimes staff refer to patients by their first names, but expect to be called by their title or surname by the patient. This is wrong for a number of obvious reasons. It places the staff in the position of master with the patient as servant, takes away the patient's dignity and does little for the nurse's image. It is very reasonable for everyone to use first names, including senior nurses and doctors, and in this situation patients should be addressed by their first names. If, however, the nursing and medical staff don't want to use first names they should not use first names for patients, except perhaps in special situations where a close relationship has developed between an individual doctor or nurse and patient.

The majority of old people who enter hospital because of psychiatric illness can return to the community if they are helped and not damaged by what happens to them in hospital. For those that cannot return, it is still important that every effort should be made to ensure that they make the most of what abilities and aptitudes they may have. It still frequently happens that the admission of an old person to hospital results in a considerable deterioration in that old person, as distinct from an improvement, which should occur in a good therapeutic milieu.

In summary, remember that age does not convert a person into a thing, and being a person means that you are entitled to understanding, respect and individuality. Personal possessions, including personal clothing, knick-knacks and ornaments, occupation, entertainment, exercise and freedom of choice are the rights of every patient, regardless of how demented they may appear to be. The term "completely demented" is often used. This is a meaningless and mischievous term, since every individual who is alive has some feelings, some understanding, and some concept of what is going on. It is easy to lull our consciences by thinking of individual old people as being completely demented, and hence no longer in need of normal human treatment. This is a false salve which leads to misery for patients and degradation for staff. Doctors, nurses and other staff are not the masters of the patients but their helpers.

This is only a brief guide to the care of the elderly mentally ill. Books are available covering more detailed concepts and ideas (see Bibliography), while individual nurses can develop their own personal expertise once they start to follow the basic principles briefly outlined here.

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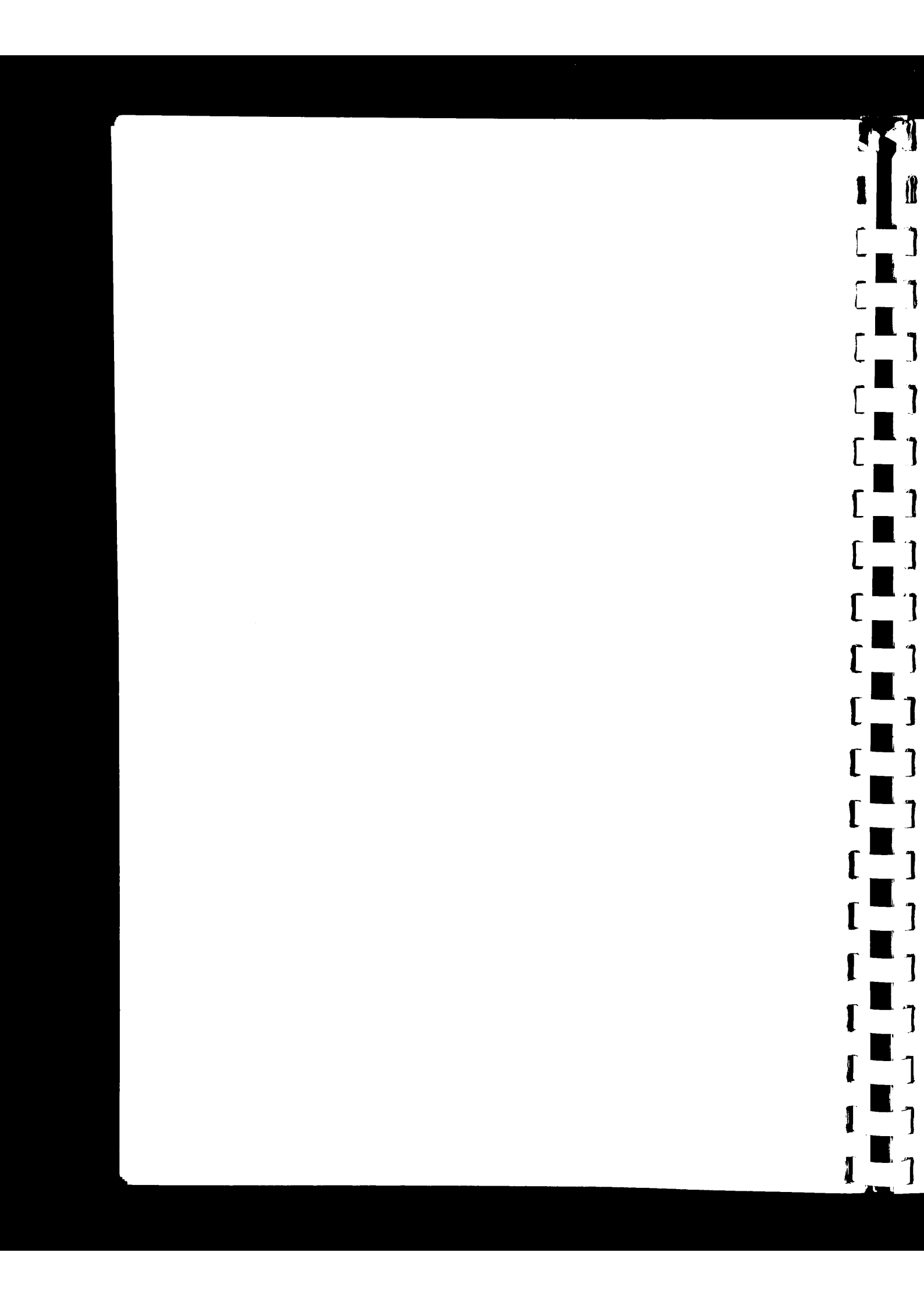


NOTES FOR REGISTRARS, S.H.O'S. & CLINICAL ASSISTANTS.

The unit is run on the principle that old people, like most other people, are best helped and treated out of hospital if this is at all possible. The Bevendean unit consists of Willow Day Hospital, providing forty places per day, Cedar Ward, which provides twenty in-patient places, Fletching Block, Brighton General Hospital, with 35 places. The Day Hospital and wards are mixed sex establishments. The unit provides a service for Brighton and a coastal strip extending to and including Peacehaven and caters for everyone over the age of sixty-five with psychiatric problems.

Cedar Ward and Fletching Block are both admission wards and provide accommodation for long-term patients. The day hospital is also used as an out-patient clinic, with four out-patient clinics being held every week. The vast majority of patients admitted to either day care or in-patient care are first seen either in the community or as out-patients.

Admissions.

Patients are usually referred by their family doctor, but they may be referred by health visitors, social workers, district nurses, or other community workers. In these cases, it is important to ensure that the patient's family doctor is fully aware of what is going on and in agreement. Patients referred are either given out-patient appointments, visited in their homes by the Consultant, with the Registrar or S.H.O. if possible, or on rare occasions admitted immediately to one or other ward. Patients with physical problems as well as psychiatric difficulties should be admitted to Fletching Block because of the better medical and surgical services in Brighton General Hospital. It is important to obtain

as many facts as possible about patients who are referred for urgent admission. It is also important not to be obstructive and often when a patient is referred for urgent admission, a sympathetic conversation with the referring family doctor may result in the patient being either seen at home, or brought up to be seen in the day hospital. Often patients are referred for admission because it is believed that is all that is available quickly. In fact the unit offers a semi-emergency service, with either urgent home visits, or an out-patient appointment within a day or two, or if possible, the actual day of referral. If there are any doubts about what to do when a patient is referred as a case of urgency, an attempt should be made to contact the Consultant Psychiatrist, day or night, seven days a week. He may not be available, but if he is he can then take the necessary decision. If he is not available, the Registrar or S.H.O. can either make the neoessary decision themselves, or refer it to the Duty Consultant.

When accepting a patient for admission it is very important to ensure as far as possible, that their place in the community is not lost. Everyone concerned must be told that there is every chance the patient will be returning to their home after appropriate treatment.

Admission procedure.

Patients are often afraid when they come into hospital, so it is important that they are re-assured and befriended before being exposed to a full psychiatric and physical examination. Sometimes the full examination has to be delayed, but whatever the situation it is important to do what is necessary to ascertain if there is any acute physical disease and assess, as well as possible, their mental disorder. Routine ritualistic investigation can be both misleading and expensive, so it is

best to select special investigations that definitely appear necessary in what is discovered in the history and examination. It is not possible to make rules about this and the majority of patients will end up having at least a chest X-Ray and routine blood investigation.

Psychiatric disease, like any other disease, should be treated as quickly as possible. Information about psychiatric disorders in the elderly and their treatment can be found in one or other of the books mentioned in the bibliography at the end of the Paper "Helping Old People With Mental Illness".

Discharge procedure.

Before patients are discharged it is important that the necessary community agents are informed of what is happening. For example, it may be important to organise a home help, meals-on-wheels and visits by a social worker, or community nurse. Many patients become day patients after discharge from the in-patient unit, this of course should also be organised prior to their discharge.

The family doctor obviously needs to be informed as quickly as possible that the patient is going home and also as quickly as possible be provided with a discharge letter.

Patients taking medication should be provided with a supply to tide them over before either their next visit to the out-patient department, day hospital attendance, or visit by their family doctor.

It is a policy of the unit that all patients discharged are seen at least once as an out-patient if on-going care in the day hospital is not considered necessary.

Unit Programme.

The unit programme gives an outline of the unit's activities. On Monday afternoons or Tuesday mornings, depending on the wishes of the appropriate S.H.O., Registrar or Clinical Assistant, new patients are seen and assessed, prior to them being seen by the Consultant on Wednesday afternoon.

The wards should be visited at least once every day and day patients on Willow Ward should be seen as often as possible and necessary.

As far as possible, the Registrar, S.H.O., or Clinical Assistant can include his special interests in his programme. These notes should be looked upon not so much as rules but suggestions, since most people work best in their own way, provided this way is helpful and does no harm.

However, talking to patients is one of the most important things a psychiatrist can do. The Registrar, S.H.O., or Clinical Assistant will be expected to spend a considerable amount of time talking to patients in both the in-patient wards and the day hospital.

NURSING: BEVENDEAN DAY HOSPITAL (WILLOW WARD)

SISTER SUE VAN MEEUWEN, S.R.N., R.M.N.

DAVID JOHNSON, S.R.N., R.M.N. NURSING OFFICER

Bevendean Day Hospital is situated in the grounds of a small general hospital. About 40 patients attend daily, all of them living in the community with their family or alone. The consultant psychiatrist is responsible for all the day patients, as well as a very active out-patient department within the day hospital. The aim of the unit is to provide facilities for rehabilitation and early assessment and care of elderly psychiatric patients living in the community.

Referrals for day care come mainly from family doctors and social workers. Each patient is seen by the Consultant before attending the day hospital. A psychiatric, physical and social history is taken. Before attending, the patients usually visit the unit for two days in order that they can get used to the atmosphere. This also gives the doctors, nurses and occupational therapist a good insight into the patients' behaviour.

The patients arrive at the day hospital by ambulance, although some do travel by bus, taxis or private cars. Those travelling by ambulance are assessed as to the type of ambulance needed. The ambulant patients travel without an escort, whereas the less ambulant need an escort. Some patients travel by ambulance cars.

Whichever form of transport is used, the driver collects the patients from their homes and returns them back again. With a good relationship between the Brighton Ambulance Service and the day

hospital, patients' relatives are able to convey messages for the doctors and nursing staff in regard to patients' conditions and behaviour.

On numerous occasions it has been known for the ambulance staff to have to dress a patient before bringing him to the unit. If the ambulance men find a patient ill they will contact the day hospital. The staff then act according to the patient's needs, perhaps paying a visit or asking the patient's family doctor to visit.

The aim of the unit is to try to keep the patient as independent as possible. This is made possible by the medical, nursing and occupational therapy staff. The nursing staff consists of a charge nurse, two staff nurses, a state enrolled nurse and two nursing ancillaries. The occupational therapy staff includes two occupational therapists and three occupational therapy helpers. A social worker is also attached to the unit.

The Consultant is based at the day hospital and is available at all times to discuss the progress of patients, and any improvement that could be made to the running of the unit. Daily meetings take place between the Consultant and the charge nurse, but he is available to any grade of staff who has a problem, either with patient or the unit.

Weekly meetings take place for all grades of staff, when they can discuss patients and problems arising within the day hospital. Every month a patients' relatives' meeting is held, and all relatives are invited. We have special speakers to talk about their role within the day hospital. Once again, the Consultant is available to answer any questions that may arise.

The hospital League of Friends is very much involved in the

day hospital. They hold tea parties, dances and entertainment. Visiting the lonely is also part of their role. They also provide a coach once a month to take about 30 patients on an afternoon ride. These outings are usually to visit parks, gardens, zoos and the theatre. Although these outings are very hard work for the staff, they get their reward by seeing the patients enjoying themselves. At Christmas time, the League of Hospital Friends hold a Christmas party when every patient receives a gift.

During their day in the unit, patients receive morning coffee, lunch and afternoon tea. The setting of the tables for the meals is done by the patients as part of their rehabilitation programme.

Bathing is an important part of the nursing staff's duties. At the day hospital there are two bathrooms: one conventional, with a special sink for shampooing, hairdressing being one of the many services provided; the other has a "medic" type bath, which has a seat and removable door for ease of access. It has been found to be of value when bathing physically incapacitated and apprehensive old people.

The launderette, equipped with an automatic washing machine and hot air clothes dryer, is used for washing patients' soiled clothing and also by patients unable to do laundry at home because of physical or mental incapacity.

Within the day hospital we have a small non-profit making shop. This is run by one of the more active patients. The idea of the shop is to help patients with money or shopping problems they may have. Staff and relatives send in unwanted gifts and these are sold for a small sum, the money going towards the patients' outings.

Twice a year we have students from the Hastings School of Nursing who are doing the Joint Board of Clinical Nursing Studies national course in

geriatrics. They spend a week at the day hospital on practical placement, including working with patients, lectures and discussions.

The Patients' Day.

8.30 a.m. The patients begin to arrive and are received by the nursing staff.

9.00 a.m. - 10 a.m. Occupational therapy which includes packing material for the Group central sterile supply dept., toy making, woodwork and embroidery, stool and rug making.

10.00 - 10.30 a.m. Coffee break, followed by medicine administration for those incapable of taking their own (many of the patients are eventually given a supply of drugs and require little supervision).

10.30 - 12.00 noon Occupational therapy continues.

12.00 noon - 2.00 p.m. Lunch followed by medicine round and relaxation period. During this period patients are free to do what they wish. Some like to rest, others may go for a walk around the hospital grounds, some read or like talking to other patients or staff.

2.00 p.m. - 3.00 p.m. Occupational therapy - recreational activities, quiz games, bingo, beauty demonstrations, poetry reading, ball games, etc.

3.00 p.m. Afternoon tea, followed by group meetings, games and discussions, till transport arrives to take them home at about 5.00 p.m.

The Nurses' Day

8.20 a.m. On duty; receive report and discuss day's events. Receive patients, weigh and shave them as necessary. Supervision of patients not in occupational therapy. Supervise patients' coffee break and give out medication.

10.30 a.m. Staff coffee.

Bath patients and wash clothing as necessary.

Toilet supervision.

Collect specimens, give injections, dressings, X-ray escort, assist doctor with physical examinations and blood-taking.

12.00 noon Serve lunch, assist with feeding where necessary. Give out medication, toileting.

12.30 - 1.30 p.m. Staff lunch. Observation and supervision of patients until -

2.00 p.m. Join in activities and observe patients not in occupational therapy.

Serve afternoon tea, give out medication. Toileting.

3.30 p.m. Group meetings, occupy and observe patients until transport arrives to take them home.

Complete observation charts and report sheets.

5.30 p.m. Off duty.

NURSING: CEDAR WARD AND FLETCHING BLOCK

SISTER ANGELA RAMPAUL, S.R.N., S.C.M., R.M.N.

RASHID KAUSMALLY, S.R.N., R.M.N., CHARGE NURSE

Cedar is a 20 bedded, mixed sex, assessment and long-stay ward, situated at ground level in the spacious grounds of Bevendean Hospital, a small general hospital.

Together with the day hospital, housed in Willow Ward, and Fletching Block, it forms Brighton Health District's Department of Geriatric Psychiatry, run by a Consultant Psychiatrist with a special interest in the elderly.

There are two dormitories containing 6 and 12 beds respectively; the former used mainly for male patients, the latter for females. A side ward containing two divan type beds serves a dual purpose. It is mainly used by patients prior to discharge, when they are expected to keep it clean, tidy, make their own beds, etc., in fact all the things they would be expected to do at home. At other times this ward is used to keep very ill patients peaceful and quiet, away from the hubbub and day to day running of the ward. There is a Dining/O.T. area in the remaining half of the male dormitory. A sun lounge has recently been built on to the ward, which serves a dual purpose. It is a quiet area where patients can sit and look over the hospital grounds or entertain relatives and friends in some degree of privacy. During the day it is used as part of the occupational therapy faoility.

All beds are of the King's Fund variety, the advantages being that they can be raised to a comfortable height for bed making and at night they are lowered to a convenient height for the patient so that

their feet are quite firmly on the ground when getting out. The other reasons for lowering the beds is if the patient should unfortunately fall out of bed, the distance of the fall is shorter than from the conventional hospital height bed, and the necessity for "cot sides" is completely obviated:

1. Because the patient would not normally have these at home.
2. Because if the patient is determined to get out of bed, they won't prevent him doing so.
3. Because patients sometimes wake up in the middle of the night desperately in need to micturate; by the time the summoning bell has brought the nurse to "let them out", the probability of the bed being wet is highly likely and can upset the patient.
4. Because the practice is archaic anyway and the effect on the elderly patient can be demoralising.

Each patient has a bedside wardrobe for the personal clothing and belongings, etc.

Occasionally male patients have to sleep in the female dormitory. One has to be selective and tactful when this occurs, but as all beds can be curtained off, this arrangement works well.

The entire ward, with the exception of the two sluices, two toilets and bathroom, is carpeted, this helps to retain the homely atmosphere we contrive to keep at all times and it minimises the effect of falls.

The ward is equipped with a washing machine and tumble drier, so that patients' personal clothing can be laundered.

The purpose of the unit is to assess and rehabilitate patients so that they can return to their own homes, or be rehoused in some form of protected accommodation or nursing home, but some have to remain. Thus the nurse's job is to help and encourage patients to help themselves and make the ward a home.

Referrals for admission are made by G.P's who may have been approached by social workers, health visitors, relatives of the identified patient and, less frequently, by the police. Referrals are also made by consultants in departments of other hospitals - these patients are seen by the Consultant and/or his junior in hospital.

All patients are seen and interviewed by the Consultant either in the out-patient department, or in their own homes, prior to admission.

Admission to hospital can be a traumatic experience for any age group; it is even more so for the elderly. Reasons for admission may be social, psychiatric or physical, any combination of these three, or indeed all of them! Admission to the unit is always made with the Consultant's knowledge and consent.

Shortly after admission the patient is seen and examined by a unit doctor who takes a psychiatric, social and physical history and prescribes medication as necessary. He or she is introduced to other patients, (especially to bedside neighbours!), the geography of the ward is explained and the routine daily occurrances made clear by a member of the nursing staff.

Day staff consist of a ward sister, a charge nurse and staff nurses, one S.E.N., one full time and five part-time auxiliaries, two occupational therapists, two domestics and one part-time social worker. Night staff is one trained psychiatric nurse, one auxiliary nurse, backed up by the night sister in charge of whole hospital and the duty psychiatrist, normally based at Brighton General Hospital.

There is "open" visiting from 2.00 p.m. - 8.00 p.m. and there is no restriction on the number of visitors or the age group of visitors, but obviously the dangers of the very young picking up infections is always mentioned.

Visiting 24 hours daily is permissible for patients dangerously ill and morning visiting is allowed if the afternoon and evening presents a problem to relations and friends.

During term, three young pupils from one of the local secondary schools visit the ward for one morning per week as part of their curriculum. This is in agreement with their headmaster and the voluntary work organiser based at Brighton General Hospital.

Once a week, on Tuesday morning, the Consultant and his juniors, the social worker, the ward sister and one occupational therapist have a detailed discussion about all patients, including their progress, response to their situation, alterations of treatment, etc. Approximately five to six are seen by the mentioned combination of staff, the remaining patients are seen in the ward. Although this is the only time one can be absolutely sure of finding the Consultant on Cedar Ward, he is usually available for discussions regarding patients and can be seen by any member of staff with any problem relating to patient or staff of the unit.

One service offered by the unit is periodic regular admission to give relatives a break. The length of stay depends on individual needs. Some relatives can usually manage with a short break in the summer, when they go on holidays. Others may cope if given a break of one week in four and still others manage very well with the one month in one month out arrangement.

There are fortnightly staff meetings where staff problems, etc. are discussed.

Relatives of patients are seen more or less on a day to day basis, when any problems are ironed out by nursing staff and appointments, via the unit secretary are made for those people specifically wanting to see the Consultant to discuss their relative. There is a monthly relatives' meeting on the last Thursday in the month.

The Hospital League of Friends are very helpful. They visit patients during the summer months. They arrange coach outings for the patients to places of interest and, of course, at Christmas they hold parties for day patients as well as in-patients.

The patients' day starts at 7.00 a.m. when they are woken up with a cup of tea. The capable ones get dressed for breakfast. Those needing help are assisted by nursing staff and they all migrate to the day area in the 'male' dormitory by 7.45 a.m. when they have breakfast. This lasts until about 8.30 a.m.

Medication is given at breakfast time.

Those patients who are capable, make their beds and get themselves ready for the occupational therapists who arrive at 9.30 a.m.

Occasionally there are a few baths to be done at this time, especially if patients have been incontinent during the night.

Coffee is served at 10.00 a.m.

This is followed by O.T. until 11.30 a.m. when patients are asked to get ready for dinner at noon.

Medication follows immediately after lunch and patients are allowed to rest on their beds or easy chairs until 2.00 p.m.

2.00 - 3.00 p.m. O.T.

3.00 p.m. Patients' teas.

3.15 - 4.00 p.m. O.T. continued.

4.00 - 6.00 p.m. In-patients please themselves as to their activity, which may be reading a book or continuing some O.T. or in a group watching T.V.

6.00 p.m. Supper.

6.30 p.m. Medication is again given at this time.

6.30 - 7.30 p.m. Most patients seem to have visitors (returning home from work).

8.00 p.m. Hot drinks if desired.

After 8.00 p.m. Patients may go to bed if they so wish.

Night staff takes over at 8.30 p.m.

The Nurses' day starts at 7.45 a.m. Sister or person in charge takes report from night staff.

A very short, very quick report is then given to other members of nursing staff, i.e. pointing out people not to have breakfast or those who are diabetic, etc.

Breakfast is served.

Medication given out.

A detailed report is given to all staff at 8.30 a.m.

Beds in male section of ward are made. Baths given. Dressings done.

10.30 a.m. Nurses' coffee.

Help O.T. staff.

Continue baths, make remaining beds.

Any other treatments which are necessary. Make sure patients are toileted ready for lunch.

12.00 Noon. Serve lunches.

Medication.

12.30 - 1.30 p.m. Lunch. Late shift day staff given detailed report. Help Occupational Therapists.

3.00 p.m. Give patients tea.

3.30 p.m. Toileting of patients who need it.

3.30 - 4.30 p.m. Launder patients' personal clothing not done in the morning.

4.30 - 5.45 p.m. Help and encourage patients in whatever activity they want to do. See visitors, etc.

5.45 - 6.00 p.m. Get patients ready for supper.

6.00 - 6.30 p.m. Serve suppers (noting especially who eats what and who doesn't!).

6.30 - 6.45 p.m. Give out medication.

7.00 - 8.00 p.m. Write Kardex and office report. Get hot drinks ready for night staff to hand out with night medication.

8.30 p.m. Hand over report to night staff.

9.00 p.m. Night drinks. Medication and sedation are given out.

9.30 p.m. Help such patients as need help to go to toilet before retiring to bed. Place commodes near the bedsides of those patients who need them.

10.00 p.m. All lights out unless patients specially want to carry on watching T.V. (football, etc.)

10.00 p.m. - 7.00 a.m. All patients should be asleep. Night staff (usually two, one of whom is a trained mental nurse and the other a nursing auxiliary - usually one of each sex) are present to supervise and give such help as may be necessary to patients, and at times relatives, needing help.

6.45 a.m. Make early morning cup of tea and wake patients up at 7.00 a.m.

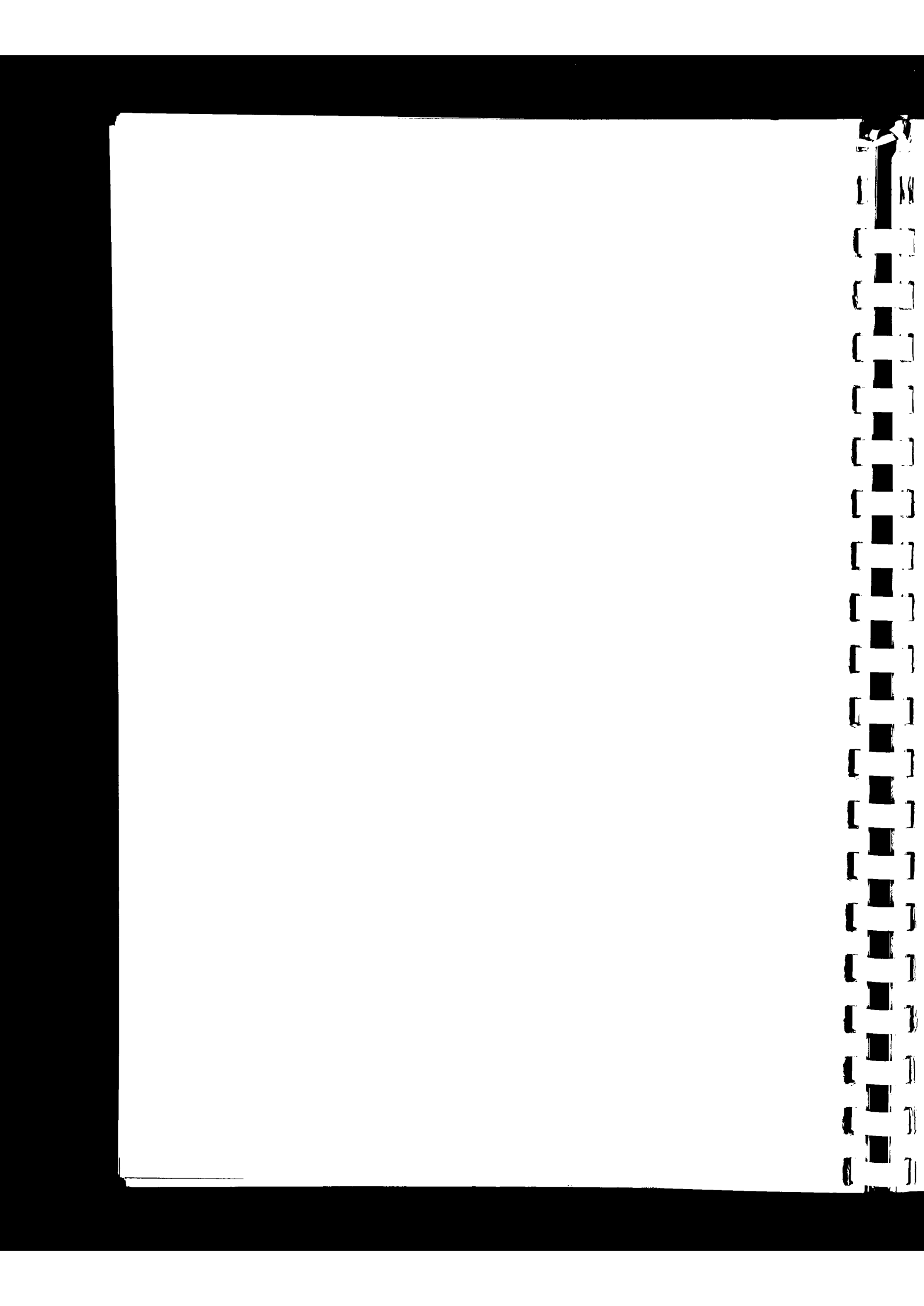
Fletching Block.

Fletching Block in Brighton General Hospital has 35 mixed-sex places on one floor, divided into four small wards, with a floor below for occupation, entertainment and dining.

It provides the same kind of service as Cedar Ward and is an admission, treatment and long-stay facility. The equipment and furnishing is the same, and there is a similar programme and routine. There is a ward round on Monday mornings.

Patients with physical as well as psychological problems are specifically admitted to this ward because of the availability of medical and surgical help, and the close proximity of the Department of Geriatric Medicine. The Unit operates on the principle of mixing short-term and long-term patients, so both wards are admission and long-stay ones.

Staff consists of one ward sister or charge nurse, six staff nurses, eight enrolled nurses, thirteen nursing assistants and one community nurse. There are four trained occupational therapists.



OCCUPATIONAL THERAPY.

The Occupational Therapy Department aims at providing a full and active programme to help improve the quality of life for the patient. It is aimed to stimulate, motivate and interest the patient encouraging them to use all their faculties to the fullest extent. Thus the patient is given a more independent way of life both in and out of hospital. To achieve these aims a programme is planned that occupies the day with activities that are therapeutic, interesting and worthwhile.

The programme planned is designed to be very full with a daily routine which is familiar and reassuring. However, within this routine there is a variety in which the patient has a great amount of choice. Their participation and initiative is encouraged, so making them contribute and think for themselves. Through activities old skills and interests are recalled and new skills learnt.

The daily programme follows the pattern of individual work activities in the morning with a break for coffee. Also at this time music and movement, group meetings, and reality orientation groups take place. After a break for lunch and a rest the afternoon activities are socially orientated. This plan follows a normal pattern of work followed by recreation.

When planning a programme, the following points are considered:-

Activities should:

1. encourage enjoyment and interest. (It is most important that staff should be enthusiastic as this is then transmitted to the patient for greatest benefit.)

2. have a purpose, not just done to pass the time.

3. aim at independence.
4. be something to look forward to, to remember and t. talk about.
5. be stimulating so preventing boredom.
6. encourage self-awareness, self-worth and self-care.
7. not be child orientated which could be damaging.

All these points apply to both work and social activities and aim at a friendly atmosphere.

The department can, through its activities, create a therapeutic environment, one that is stimulating, interesting and enjoyable. This is mainly created by the enthusiasm and interest on the part of the staff. The physical environment is also important in creating an atmosphere, e.g. pictures and articles add interest, notices inform. An atmosphere that is informal, friendly and non-institutionalised is more beneficial to the patient than one which is formalised.

Through the patients' participation in the activities, the O.T. staff can assess their ability to cope with everyday living and level of function. Some patients have a home assessment in their own homes before discharge from in-patient care. This includes cooking, mobility, safety, ability to run a home and look after themselves.

Work Activities

Industrial Types - these are useful for assessment, particularly for men. Activities include compiling files for other hospital wards, C.S.S.D., packing, folding and envelope stuffing and cracker making. All these activities can be broken down into simple stages, are repetitive and, most importantly, they are purposeful and useful.

Craft Activities - included is anything that the staff or patient can do. A list of suggestions follows this article. Some activities are group

orientated such as quilting which has the benefits of everyone contributing to a common aim. Use of scrap material helps to raise funds for a common cause.

Home Activities - such as cooking and gardening are useful as they help to regain interest and confidence. Patients are encouraged to have their hair and nails done and to attend the Red Cross Beauty Therapist once a week. There is a great boost to morale when compliments are made.

Social Activities.

Recreational activities need to be varied and must be enjoyed by all, i.e. staff, patient and visitor. A programme is planned in advance although this can be adapted to meet the immediate needs and moods of the day. A full list of social activities follows this article.

Outings play an important part of the programme. These encourage an interest outside the immediate surroundings of home and hospital. Visits to places of interest, theatre, exhibitions, coffee shops and public houses are just a few of the kinds of outings undertaken. There is also a monthly drive around the surrounding countryside. Highlights of the year are the special parties e.g. birthday and Christmas, fetes and sales and the picnic. All these events give some aim and direction to the work in the department i.e. raising funds.

Finally, it should be remembered that in everything the patient does, it is the effort the patient puts into the activity that is more important than the finished product. Providing the patient is stretched to his fullest potential then greatest benefit is gained from the activities. Each patient has a different level of capability and standard and this must be appreciated. Everyone can participate in some way to their fullest potential and no-one should ever be left on the outside of the group.

Every patient is an individual in their own right and needs individual standards and attention within the group.

SOCIAL AND RECREATIONAL ACTIVITIES

GENERAL ACTIVITIES

Outings: Local sights, exhibitions, shows, picnics, church, cinema, coach/car rides, museums, spectator sports, sales, restaurants, shopping, senior citizen clubs.

Parties: Birthday, international, festival, tea, lunches.

Special Occasions:

Watching T.V., state occasions - Jubilee, big sports events, Easter bonnet parade, Halloween Masks, Christmas decorations, pancake making, sun bonnets for hot days, Country and Western Jamboree, Carnival-wheelchair floats. Lotteries e.g. sweepstakes, raffles.

Outdoor Activities:

Walks, games, fishing, barbeques, picnics.

Bazaars: Christmas, Summer, League of Friends.

Exhibitions:

Demonstrations:

Fashion shows, hair care, make-up.

Collecting:

Stamps, coins, scrap books of events, recipes.

Photography:

Videotaping, photo album of events, slide shows, movie shows.

GROUP ACTIVITIES

Reality orientation

Film discussion

Grooming: beauty, hairdo's, nails and make-up.

Reading

Flower Power: Gardening indoor/outdoor, flower arranging.

Bingo: Regular, music, picture. Written numbers on blackboard for the deaf.
sticks for certain numbers, e.g. 5 and 10 for the blind.
Woodchips are easy to pick up.

Beetle Drives

Jigsaw

Jigsaw Game

Discussion - old time

Sale of work planning

Cookery - Marmalade
bread
cakes
sweets

QUIZZES

Quiz Cards (series of cards with one question and answer on each in topic sections).

Games: Criss Cross Quiz
Ask me Another
Team Quizzes
London to Brighton
Take your Pick
Double or Drop
Time Gentlemen

Picture Quiz: Slides

Famous People

Famous Places

Advertisements

Newspaper quiz: current affairs

Musical Quiz

Sounds Quiz

Taste and smell quiz

Touch Quiz

Panel Games as per Radio and T.V.

Memory: Photographs and advertisements

Words

Tray

Nature Quiz

WORD GAMES

Paper and pencil: Girl's name/Boy's name, etc.

Consequences - Romantic, recipes

Memory tray

In Air under Sea

The Biscuit Story

Words sound alike

Suitcase Game

Little words from a big word

Legs and Wheels

3 of a kind

Lexicon card words in team

Crosswords

Word Pyramid

Puzzles (from books or newspaper)

Spoken and using blackboard: Tell Me

Hangman

Call my Bluff

I spy

Jumbled Words

Drawing words, e.g. Towns

Target

Words ending/beginning

Words contain 2 of same letter

The Ant Game

Suitcase Game

Jigsaw Game

Scrambled Words

Matching the pairs

CARD GAMES

Ordinary Playing Cards: Whist

Pelminism

Sevens

Old Maid

Newmarket

Snap

Rummy

Bridge

Cribbage

Special Cards: Happy families

Animals and flowers

Lexicon

Green cards and dice

ACTIVE GAMES

Outdoor sport: Mini Golf

Croquet

Lawn Bowling

Skittles

Indoor sport: Table tennis

Darts

Skittles/Bowling

Team football

Outdoor sport: (contd.)
- Ball team games
- Lawn darts
- Horseshoes
- Shuffleboard
- Walks

Indoor sport: (contd.)
- Quoits
- Ring toss
- Fishing
- Horse racing
- Bean bag throwing
- Floor beetle
- Flounders

Ball Games:
- Throwing to each other
- Throwing to one in middle
- Bouncing
- Kicking
- Passing around circle
- Throwing into buckets at various heights
- Mountains
- Throwing into numbered boxes
- Passing over head or under legs
- Cane/Walking stick Hockey

BOARD GAMES or Home and Pub Games
- Table Soccer
- Bagatelle
- Shove Ha'penny
- Bar skittles
- Dominoes
- Draughts/chequers
- Chess
- Roulette
- Scrabble
- Noughts and Crosses
- Monopoly
- Snakes and Ladders
- Tiddly Winks
- Chinese Chequers
- Backgammon
- Darts
- Crokinole
- Billiards/snooker/pool
- Jack Straws
- Shapes
- Nature Trail
- Car Capers
- Ox Blocks

MUSIC AND DRAMA

Music:
- Percussion/Band
- Community singing
- Choir

Drama:
- Play reading and acting
- Poetry reading
- Prose reading

- Music: (contd.) Musical appreciation
  Hymn singing
  Old Tyme Music Hall

  Dancing: Folk
  Country
  Ballroom
  Old Tyme

  Music and Movement: Exercise
  Relaxation

  Outside Entertainments

  Tape recording sessions

  Events with music: Quiz
  Juke Box Jury
  Listening and discussing
  Painting to Music
  Musical forfeits

Drama: (contd.) Charades: titles, songs
proverbs, words
Sketches
Talent contests

INDIVIDUAL ACTIVITIES

CRAFTS

Art - Mobiles
Collage
Block printing
Posters
Leaf prints
Origami

Basketry

Braiding - rugs
garlands

Ceramics/Pottery

Chenille Work - flowers
toys
decorations

Copper Enamelling - copper pipes
serviette rings
jewellery

Dough art decorations

Embroidery - Threaded
stitched
liquid

Flower Making - fun fur
paper

Lampshades - raffia

Leatherwork - Chamois washers
Kits
Link Belts

Macrame - Hangings
Belts

Magnetics

Mexican Gods' Eyes - Hangings
Sun Shades

Mosaics - Tea Pot Stands
Plant Pots
Tables

Needlework - Aprons
Cushions
Bags
Dolls' Clothes
Children's Aprons
Pouffee's
Shoe Polishers
Oven Gloves
Toys

Popsicle Crafts - Dishes
Models

Printing - Screen
Type

Quilting - Bags
Cushions
Tea Cosies
Bed Quilts

Rug Making - Stitched
Hooked
Woven

Soft Toys and Dolls

Stool Seating

Tin Cannery

Weaving - Off Loom
Loom

Woodwork - Polished shaped wood - trays
tea pot stands
plant stands
repairing - refurbishing

Carving - wood

soap

Sanding - toys

tables

Jig saws

Stool frames

Bricks

Wool crafts - Knitting - Bedsocks and Bed jackets

Afghans

Long strips - pin cushions

coat hangers

Tea cosies

Tabards

Hand bags

Beach bags

Dish cloths

Dolls' clothes

Toys

Turbans

Crochet -

Yarn Dolls

Pom Pom animals

SCRAP CRAFTS

Decorations

Bottle top boot scraper

Calendars

Detergent bottles - scrubbers

wig stand

dolls

skittles

Note book

Scrap book

carnival wavers

waste paper bins

bird boxes

wool holders

Greeting Cards - labels

wheelchair table cover

place mats in fablon

collage

Garlands - tinsel

polythene

Logs - rolled newspaper

Masking Tape Boxes - polished

Magazines - figures

rolled waste paper bins

collage and decouperage

Menu and recipe cards

coat hangers:-

radiator brushes

animals

stamps:

Bingo boards

book marks

pictures

packets

PRACTICAL AND INDUSTRIAL ACTIVITIES

Bandage rolling

Bedmaking

Compiling - notes

letters

handouts

Cracker making

Dusting

Envelope stuffing

Folding - napkins

laundry

Mending

Packing

Preparing tables for meals

Washing-up

C.S.S.D. - packing)
sealing)
stamping)

Running a shop

Cookery

Ironing

SOCIAL WORK

Venetia Carse
Ray Ashbridge

Since the reorganisation of the Health Service in 1974, hospital based social workers have been employed by the local authority social service department. (In this case East Sussex County Council Social Services Department). Social workers in this situation are managed in small groups by a principal social worker, whilst overall responsibility is undertaken by a social services manager (Health). Hospital based social workers are attached to a divisional social services office for administrative purposes.

This structure is separate from the Health Service structure and can cause confusion and misunderstanding for patients and other members of staff. However, it does place the social worker in a good position to know about resources available, and how to mobilise these resources fairly quickly.

The hospital is an essential and integral part of the community, and much of the social work carried out is field work - visiting patients and relatives in their homes for social histories, home circumstances, reports and supportive visiting. Follow-up visits are made to patients who have been admitted to local authority Part III homes for at least three months as a matter of policy: In many cases contact continues well beyond this limit.

The social work establishment consists of one full-time social worker and one part-time social worker.

The Patient.

Every over-65 admitted or attending the Day Hospital is recognised in his own right with a lifetime of experiences, a home set-up and a place in the family and community unique to himself. Each comes to us as a result of some breakdown in his environment, health or personality. This can be the loss of a lifetime partner, causing acute depression, or a long-term sense of loneliness resulting in lack of self-care. It can be some mental relapse or impairment, a gradual increase in personal eccentricity resulting in anti-social and unacceptable behaviour, perhaps the reluctant withdrawal of support by already pressurized family and neighbours. But whatever the reasons, by the time the over-65 is referred to the unit, he is usually in need of all the skills the Psycho-Geriatric Team can offer.

Each patient brings to hospital his hopes, fears, weaknesses and strengths. Each has a future before him, though each at the time may be without hope and see no reason for living. But each, with professional understanding, treatment and aftercare arrangements, can be helped to accept the mental and physical limitations of growing older - and will find that life still has something to offer.

The Social Worker: Diagnosis, Treatment and Aftercare.

Although not employed by the hospital authority, the social worker is employed in the hospital and should be regarded as an integral member of the multidisciplinary hospital team.

The social worker works closely with hospital staff, patients, relatives, neighbours, with State and voluntary bodies. They attempt to put their finger on the personal and social causes of a breakdown.

They act, when necessary, as confidante, adviser and reassurer. They help to keep a patient's affairs intact whilst he undergoes treatment. Finally, as he moves towards recovery, they try to ensure that adequate provision is made for his discharge and that he does not return to just those conditions that precipitated his illness.

Social assessment is a valuable part of the whole basic assessment process for new patients and can form the basis of a plan or programme of help for the patient and/or relatives. Counselling may be just as necessary for the relatives as for the patient. The work can be broken down into the social history, practical help, therapeutic listening, talking with relatives and after-care.

The Social History.

Either in writing or verbally, giving or filling in the relevant details of the patient's background; reporting a relative's or friend's version of the events leading up to hospital admission; assessing the attitudes of family or neighbours; tracing contacts with outside organisations and suggesting how best to help and support the patient in the event of his being discharged home.

Practical Help.

Whilst in hospital care, the patient may need practical help or advice in the managing of his affairs and in working out such problems as may be part cause of his illness and/or a factor retarding his progress. Older people, with memory or hearing defects and/or anxiety symptoms, can prove very time-consuming. Whilst important to help them, even encourage them, to take an active part in their affairs and decisions, it is often more practical to obtain consent to work through relatives or direct with outside organisations, but always keeping the patient fully informed.

Such practical help may include:-

(a) Contacting relatives in an endeavour to obtain better understanding and co-operation (see "Talking with Relatives")

(b) Contacting Local Authority Social Services Department about security of property, where necessary cleaning and making rooms habitable, obtaining special aids for the physically disabled, and generally liaising with any social worker involved with a client in regard to future care and plans.

(c) Contacting landlords, etc., about retaining accommodation, the payment of rent and outstanding bills.

(d) Contacting Social Security, Bank Manager, Solicitor and Court of Protection about finances and management of affairs.

(e) Contacting employers (some over-65's still work and fear losing their jobs).

(f) Contacting Voluntary Associations re friendly visiting, the joining of clubs and any other activities that will lead to a fuller life.

Therapeutic Listening.

Therapeutic Listening is shared by all staff who have contact with the patient. It is especially valuable to the old person, and revealing to his confidante, in that parties are made acutely aware of one of the root causes - perhaps the root cause - of the patient's condition; his loneliness. The price the old person pays for a long life is inevitably loss of relatives and friends, of interests and activities, perhaps to a point where he turns in upon himself and becomes 'peculiar'. which makes things disproportionately worse, because the younger and more normal regard eccentricity with suspicion and are very ready to be frightened off. Loneliness breeds behavioural problems - behavioural problems breed loneliness: a vicious circle. For the patient

to be able to bring this out from under the carpet, and look at it and dust it off, and get it in perspective and realise that it is neither unique - nor shameful - nor irretrievable, is in itself a therapy of the highest order.

Talking with Relatives.

It is frequently the near family who need most to be listened to by the social worker and reassured. They can arrive for an appointment in aggressive mood, but, given time and a fair hearing, they will often admit to feelings of guilt at being unable, or unwilling, to do more for their older dependants. Some may seem selfish, but most already live under considerable pressures and - probably quite rightly - feel that their first loyalty is to husband and children. It helps them to talk it out, and they will usually come to appreciate the hospital's support and understanding - and find themselves able to co-operate more fully.

Aftercare.

The attempt is made, whenever possible, to discharge the patient to his own home. This normally coincides with his wishes. Old people, however frail or confused, are loth to give up their independence. They tend to put up with discomfort and loneliness rather than forfeit their homes. Often their assessment of their ability to cope is unrealistic: they expect their family and neighbours to support them as before and do not realise family and friends were pushed to extremes before their admission and are now withdrawing help.

Discussion between the Social Worker and relatives often confirms this situation. None the less if, after full discussion with the Medical, Nursing and Occupational Therapy Staff, and possibly a trial day at home, it is felt that the patient might manage, he is brought to Bevendean Day

Hospital several times a week, and Home Helps, Meals-on-Wheels and other facilities are laid on by the social worker to try to sustain him at home. Voluntary workers can also play their part, e.g. friendly visits, outings, etc. (Age Concern and local Round Table organisations, for example).

Exemplar of an Old Lady in Aftercare.

Let us take the case of an elderly out-patient or day patient whose ability to look after herself is again in question. She may have failed to attend; and reports from family or the Community Services suggest she is leaving the gas on, has had several falls and is incontinent.

The social worker will probably visit and report back. Steps will be taken to ensure that the patient attends the Outpatient Clinic on Willow Ward, where her medication and incontinence will be looked into. Increased and regular attendance on Willow Ward and a stepping-up of Community Support may be necessary, and adjustments made to her home as follows:-

(a) Replacement of gas by protected electric fires.

(b) Replacement of slippery mats by a carpet.

(c) Adjustment of height of kitchen shelves.

(d) Provision of commode in bedroom for night use.

(e) Supply of sheeting and warm blankets.

(f) Adjustment of Social Security Allowance to cover extra fuel bills.

(g) Special supervision at weekends with family or neighbour cooking midday meal and calling in the evening to make sure all is well, and that medication is taken.

Should these precautions, some of which will have been worked out with the hospital occupational therapy department, in conjunction with the local authority social services department occupational therapists

and home care adviser fail, it may be necessary to readmit and reassess her situation. (These adaptations can be carried out by the social services department under the provisions of the Chronically Sick and Disabled Persons' Act 1970).

The social worker now has to consider several major alternatives.

The Family.

Will a relative take the old lady in? Her pension, plus possible Supplementary Benefit and Attendance Allowance, might enable a daughter (if able and willing) to put a room aside or give up work to look after her. Attendance at the Day Hospital would still be offered.

Rehousing and Residential Care.

Rehousing can mean a number of things from rehousing by the local authority housing department in more suitable accommodation (e.g. purpose built flats for the disabled, sheltered housing schemes with warden supervision or similar facilities provided by voluntary associations, including group homes.)

Also to be considered here are the varying types of local authority homes for the elderly provided under Part III of the National Assistance Act 1948. This accommodation ranges from up-to-date purpose built establishments to older converted properties. Types of care range from full supervision to the group living concept where independence and self help is encouraged. (This is currently practised in three old people's homes in the Brighton area).

Part III accommodation is also used to provide short-term care, basically to provide relatives with a respite from the continued care of an elderly, perhaps frail, relative who is not able to fully look after

herself. The concept of rotating care is also practised in the area (four or six weeks in Part III followed by four to six weeks at home and so on.)

The Private Home.

To put whatever resources she has towards fees in a private rest home or nursing home. Such homes, especially when the requirement is a single room, tend to be expensive; but in homes registered with the local authority, Social Security may help. Attendance Allowance can be applied for and the relevant voluntary associations approached to make up the balance. Sometimes the private home welcomes small pieces of furniture.

The social worker attempts to keep an up-to-date and 'visited' list of homes that can be recommended in Brighton. The social worker discusses fully the mental and physical condition of the patient before suggesting a particular home. The social worker and the ward sister often telephone the Matron to brief her on behavioural difficulties and pass on nursing information. Finally the social worker tries to ensure that relatives and the patient see the home prior to admission. The unit is willing to continue treatment of those patients and to readmit, if necessary.

The Social Worker on the In-Patient Wards.

From 10.30 a.m. to 12.30 a.m. on Monday and Tuesday the social worker attends ward rounds on Fletching Block and Cedar Ward. Present are the Consultant, the Registrar, the Ward Sister and the Occupational Therapist.

Here, each in-patient's medical and social history may be discussed, his progress assessed and his future treatment planned. Here full opportunity is given for 'report-back' by the social worker on information requested and action agreed upon the previous week. Here, also, depending on the

patient's mental and physical progress, the social worker works out with the team what possibilities should be looked into for the immediate future.

It is mainly at these ward rounds that the social worker picks up the guidelines for "follow-on" work, talking to the patients themselves and communicating with a variety of people and organisations outside the hospital. For instance:-

(a) Interviewing of relatives and neighbours to obtain information - assess attitudes - increase understanding - improve relationships, to seek co-operation and offer in return her guidance and support. Sometimes such an interview takes place in conjunction with the ward sister, a helpful and constructive extension.

(b) Telephoning relatives to make appointments and/or to exchange views on plans already discussed and put into practice. Telephoning those State, Local Authority and Voluntary Organisations already in contact with the patient and others who may yet be called on to provide support.

(c) Home Visits to obtain a clearer picture of home circumstances: these provide a more relaxed atmosphere in which to discuss personal problems.

(d) Further discussion with hospital staff as matters take shape.

(e) Writing of letters - of Reports, and the filling-in of forms.

The Social Worker on Willow Ward.

Out-patients and their relatives have similar and equal access to the social work service as have in-patients and day patients. Broadly speaking, the work is similar to that on the in-patient unit, but the social workers are more likely to find themselves dealing with the out-patient 'in crisis', and this can involve more urgent visiting and immediate action. Social workers also attend each Thursday morning an Allocation Meeting to discuss which old people in hospital or the community should take up current old people's home vacancies. It is a case of fitting the right individual into the right home: physical and mental limitations are borne in mind and priority is given to those most in need. The meeting takes place at the East Sussex Social Services Department in Brighton, where the social worker meets up with colleagues working in other places.

This seems the fairest way of allocating the few vacancies that crop up amongst the many old people on the waiting list.

Inevitably there is over-lapping of departmental functions and skills. The social worker's work is greatly helped by the socially orientated nursing staff, and by the sort of co-operation that exists between the disciplines.

THE MEDICAL SECRETARY.

There is little doubt that most people find large establishments, particularly hospitals, rather frightening places. It is equally true that most people find small establishments much less disturbing. It has become an established principle that large institutions can be split up into smaller units and accrue to themselves all the advantages of a small establishment, yet have available the services and facilities of the large institution. To make the idea of mini-hospitals within a large hospital really work, the mini-hospital must have its own staff and its own ethos. An important member of that staff is the medical secretary, since he or she usually has the first contact with the patient, the patient's relatives or the referring agent, be that the family doctor, social worker or other community worker. Obviously this is not true of all units and all hospitals, since the first contact may be via a porter, an appointment clerk, out-patient sister or what-have-you. However, there are many advantages in having a medical secretary who plays the role of first contact and also carries out the duties that may otherwise be considered the responsibility of appointment clerks, etc.

Since the medical secretary should play an important role in the service provided by any unit, he or she must be looked upon as an essential member of the "therapeutic team".

The establishment of units within a hospital should mean that each unit is responsible for its own out-patient appointments, organisation of domiciliary visits and other excursions into the community and everything else to do with that unit. The present system of large out-patient departments run rather separately from the rest of the hospital is no longer an acceptable concept. Each unit should run its own out-patient

clinics. If this is accepted, the unit's medical secretary then becomes responsible for making out-patient appointments and all that goes with the administration of an out-patient facility. It may be necessary for others to assist in this service, but they must also be members of the unit. For example, ward clerks, sisters, charge nurses, etc., may, and should, be involved in the administration of the out-patient facility.

The Department of Geriatric Psychiatry, Brighton.

This unit, which consists of a day hospital which also doubles as an out-patient department and two in-patient units, provides a service for people over the age of 65 with psychiatric disorders in Brighton. The vast majority of patients helped by the unit are initially referred to the medical secretary, who is fully aware of the philosophy, administration and capabilities of the unit. The headquarters of the unit is situated in the day hospital so that the medical secretary has the closest contact with both the day hospital and its out-patient facet. One in-patient unit is adjacent to the day hospital, and again there is close contact between the other unit and the medical secretary.

There are three part-time medical secretaries providing one and a half full-time cover. They organise the day-to-day work between themselves and are so able to provide a constant cover, deputising for each other if one is away on leave or for other reasons. This means that there is no need for a locum so that a constant, consistent service can be provided.

The Practical and the Intangible.

The medical secretaries carry out the normal duties of medical secretaries, that is deal with queries, organise appointments, type letters, complete the front sheets of case papers, keep records and do all the other usual clerical tasks. This is clearly an important function but could be

done by a well-programmed machine. The more important human functions of the medical secretaries are to deal with people in a friendly, warm, helpful and informed manner. Anxious doctors, social workers and other community workers ask for help. Patients in distress, relatives often in more distress also telephone in for help and advice. Dealing with those people who may be angry, distressed and usually rather anxious, is one of the more important functions of the medical secretary. Dealing with these situations is possibly more important than the more humdrum clerical work that is normally viewed as the responsibility of secretaries.

If you telephone or visit many hospitals you may be met with indifference, buck-passing or even aggressive rejection. This is often due to a system that does not allow individuals in the hospital to have and feel a commitment to the establishment. A well organised small unit should counter these tendencies and, in fact, experience suggests that this is almost inevitably the case. When secretaries are grouped together in a kind of typing administrative pool, commitment is difficult and sadly sometimes non-existent. When the medical secretary is definitely a part of a unit, both in the physical location of his or her office and in close contact with other workers in the unit, commitment is usually a reality.

When the medical secretary is part of a unit he or she quickly becomes aware of the philosophy of that unit and what it can or cannot provide. This means that when people telephone or visit for advice and help this can be given without the anxiety-provoking reactions of the uninformed. Obviously the personality of the secretary is important and here cheerful friendliness must be a vital characteristic. People who are worried and anxious are often "difficult". A realisation that anxiety provokes aggressive and difficult responses should mean that those dealing with these people do not respond angrily and in a "difficult" manner themselves. Again being part of a psychiatric unit should, and usually does, give the medical secretary this sympathetic understanding of others.

When medical secretaries are also responsible for out-patient appointments an even closer contact develops between them and the clients. This again not only increases the medical secretary's knowledge of what the unit is about but means that while other staff may change there is a constant person that the patient can relate to and so feel at home when visiting the unit.

Conclusions.

If a hospital is divided up into a number of semi-autonomous units, each unit should have its own medical secretarial staff. The medical secretary or secretaries should be accommodated within that unit and provide all the secretarial services for the unit without outside help. One result of such a system is that the secretary gains a deep understanding of the unit's working and is well equipped to deal with whatever queries may come up. It can be claimed that any unit which does not have such a system cannot provide the service to the community that it has within its potential.

FUTURE DEVELOPMENTS AND PLANS.

It has been recognised for a long time that large mental hospitals were not the best place to treat and support the mentally ill. This applies particularly to the elderly, for many reasons, not the least being the danger of mental hospitals becoming geriatric ghettos. Because of this, plans were made in 1970 to develop a comprehensive service for the elderly mentally ill in the Brighton hospitals.

The first step in this plan was the opening of Cedar ward at Bevendean Hospital, followed by the upgrading of Fletching block at Brighton General Hospital. This block opened in 1978 and provides 35 places in the first place. This means that all the present Brighton and Peacehaven unit is accommodated on the coast without any need for facilities at St. Francis Hospital.

However, Hove, Portslade, Newhaven and Lewes and associated districts will still require facilities. It has been variously estimated that between 40 and 50 beds and day patient places, or even more, will be required.

The next stage will be the establishment of a 50 place day hospital at the Lady Chichester Hospital, Hove, and a 20 place day hospital at the Hillcrest Clinic, Hillcrest Road, Newhaven. It is also hoped to establish a small in-patient unit of between 10 and 20 beds at the Lady Chichester Hospital, Hove, plus 35 more places in Fletching Block. When these things happen the Brighton unit will not only be self-contained but able to provide a service for Lewes and Newhaven and their associated rural areas. This will be possible because of the increase in beds

resulting from moving the unit from St. Francis to Fletching Block and the opening of the Hillcrest Day Hospital. Lewes and Newhaven, though in the Brighton Health District, are at present served by Hellingly Hospital. The Hove and Portslade unit will have a day hospital and in-patient units at the Lady Chichester Hospital but still may be dependent on St. Francis Hospital and Brighton General Hospital for some beds.

It is suggested that any short fall of beds will be for the long stay and investigations should be carried out to discover how best to accommodate these patients. It may be that small hostels, more homes than hospitals, or converted terraced houses would be the best type of accommodation. There is a place here for co-operation between hospitals, local authorities and voluntary organisations.

It is suggested that the idea of two units that are independent be continued.

A DAY IN THE LIFE OF ...

a psychogeriatric day hospital at Bevendean Hospital, Brighton.
Described by Ronald McArthur, R.G.N., R.M.N., Charge Nurse.

Bevendean Day Hospital opened on December 2nd, 1968. Dr. K. Bergmann, the consultant psychiatrist responsible for its formation, defined it as "a unit providing facilities for early assessment and care of elderly psychiatric patients, close to the centre of the community." Previously the available facilities consisted of a small number of beds and limited day care in the wards and occupational therapy departments of other hospitals in the group.

The building is a converted ward in the spacious grounds of Bevendean Hospital, formerly an isolation hospital, now catering for general medical and chest patients. There are two consulting rooms: the one used by the consultant for his weekly session has a fitted carpet and pleasant furniture which helps to induce a relaxed atmosphere; the main feature of the other room is a bed and resuscitation equipment which has been found to be of value.

In the nurses' room the main feature is the "Graphdex" board, on which are clearly indicated the names of patients and their attendance days, also such information as nursing procedures and investigations to be carried out.

On arrival patients are received in the cloakroom by a member of the nursing staff. Next they enter the lounge, where there is a TV set, popular for afternoon sporting events and early evening programmes.

A large activities room is provided for occupational therapy; also a separate office and preparation room. The kitchen is used both for

serving meals and occupational therapy; a gas stove of the type supplied to the disabled persons is fitted. Adjacent to the kitchen is the dining room where patients have morning coffee, lunch and afternoon tea.

There are two bathrooms; one is conventional, with a special sink for shampooing, hairdressing being one of the services provided by the occupational therapy staff. The other has a "medic" type bath which has a seat and removable door for ease of access; it has been found to be of value when bathing physically incapacitated and apprehensive old people.

The launderette, equipped with an automatic washing machine and hot air clothes drier, is used for washing patients' soiled clothing and also by patients unable to do laundry at home because of physical or mental incapacity.

The hospital is staffed by a consultant psychiatrist and a full-time medical officer of senior house officer grade; a charge nurse and a staff nurse, S.R.N., R.M.N.: staff nurse S.R.N.; a S.E.N. with psychiatric experience; a nursing assistant and a part-time receptionist. There is an occupational therapist with two helpers, and a part-time domestic. The social worker who attends for two sessions weekly acts as liaison officer with the local authority services, mental health social workers and home helps, etc. He attends the assessment clinic to advise on social problems and is in contact with patients to assist and advise when required. A chiropodist attends once a month.

Patients are referred to the unit in a variety of ways - the majority through their general practitioner, others by mental health social workers, either alone or in co-operation with the G.P. Other consultants, psychiatric and general, send patients from their wards and clinics. A number of patients attend, pending or after discharge from hospital.

Most patients attend the assessment clinic in the first place. They are generally required to attend on two days as this allows sufficient time for full medical and psychiatric examinations to be conducted before they are seen by the consultant; investigations such as urine and blood tests, X-ray, electrocardiography, electro-encephalography and psychological examinations are ordered as necessary.

Following assessment, the consultant recommends the line of action, which is normally one of the following:

1. Suggested treatment by the G.P., with an appointment at the hospital to check progress.

2. Referral to another consultant if the problem is not wholly psychiatric.

3. Admission to a psychiatric unit or hospital.

4. The majority are admitted to the day hospital for observation and treatment. This entails attending for from one to five days a week and patients are normally seen once a month, or more frequently, by the consultant to check progress.

Treatments: Drug therapy, oral and by injection, in association with occupational therapy is the main line of treatment. If electroconvulsive therapy is indicated this is arranged with the nearby psychiatric unit, the patient being taken there from home in the morning, and after recovery being brought to spend the rest of the day in the day hospital. Nursing procedures such as dressings to wounds and ulcers are carried out.

A number of the patients need to be bathed and have their clothes washed; urinary and faecal incontinence is treated by regular toileting.

Apart from general observation of the patients, charts are completed at regular intervals to give a definite record of their physical and mental state and mood; weekly weighing is also a useful check on progress.

Qualifications for admission.

To qualify for admission patients must be of retirement age and suffer from a psychiatric condition. Approximately 80 per cent of admissions are women suffering from depression in its various forms. Most are widows living alone and isolated from the community; generally they respond to treatment by anti-depressants and from the stimulation of being occupied and making social contact with other patients. A small number of them suffer from paraphrenia; they usually appear well preserved but are plagued by bizarre and distressing delusions. With drug therapy and regular attendance they are relieved of their symptoms to a great extent and can lead a happy and useful life at home.

The other main group of patients suffer from organic conditions, such as senile dementia and Parkinsonism. There have been good results with this time-consuming and tragic group, in the main by relieving their relatives of the strain of caring for them part of the time at home, often in trying circumstances, and also by delaying deterioration and the inevitable admission to hospital.

When first introduced to the unit patients tend to be apprehensive but the majority, in time, become familiar with the ward and staff, make friends with other patients and come to depend on the unit for a great deal of support. Some find that as their condition improved they need

more time to attend to their homes and request reduction of attendances; others are persuaded to reduce their days at the hospital and join social clubs in an attempt to return to normal. Attendance is also increased as necessary. Some have refused to attend after assessment and are referred back to their G.P. and social worker. A number have recovered sufficiently to be discharged home; others are admitted to hospital either for treatment of relapse or terminal care.

Most patients are brought to the hospital by ambulance, but some come by the Red Cross hospital car service. These drivers are extremely helpful, getting to know their patients well and bringing to the notice of the staff any aspect of their condition or home circumstances they are concerned about. A few patients are brought in by relatives or they make their own way to the hospital.

Associated units

The nearby psychiatric emergency unit at Brighton General Hospital is used for investigations and the short-term treatment of all types of mental illness; this unit has eight psychogeriatric beds. Fifteen miles from Brighton is St. Francis Hospital, Haywards Heath, a large mental hospital. Here there are 212 psychogeriatric beds, mainly used for rehabilitation and long-term treatment. Lastly there is the day centre at Woodingdean provided by Brighton Council. This takes psychogeriatric patients who are termed "members" of the centre; these are patients not in need of the full range of day hospital care, or who have recovered sufficiently to be discharged but are still in need of supervision and "socialisation". Members pay $12\frac{1}{2}$p. per day for meals and transport.

There is close liaison between the four units and patients may be transferred to meet their immediate needs.

The average number of patients attending Bevendean is 60, with a daily average of 35. In 1969 there were 161 admissions, 12 of these

being readmissions; 41 attended for assessment only. Seventy-two patients were discharged; 25 went home, nine going on to attend the day centre which opened at the end of November 1969; 31 were admitted to hospital and six died while they were attending.

The main functions of the day hospital are:

1. To decrease the demand for hospital beds by delaying the need for admission of those with deteriorating organic conditions, and also by caring for patients living alone and in need of supervision, or who are prone to relapse and require repeated hospitalisation.

2. To care for patients after discharge from hospital, giving them support in their readjustment to living in the community.

The patients' day -

8.30 a.m.	The patients begin to arrive and are received by the nursing staff.
9.00 a.m. - 10.00 a.m.	Occupational therapy; packing materials for the group central sterile supply department.
10.00 a.m. - 10.30 a.m.	Coffee break, followed by medicine administration for those incapable of taking their own. (Many of the patients are eventually given a supply of drugs and require little supervision. The drugs are dispensed mainly by the hospital pharmacy)
10.30 a.m. - 12.00 noon	Occupational therapy - craft work.
12.00 noon - 2.00 p.m.	Lunch, followed by a medicine round and relaxation.

2.00 p.m. - 3.00 p.m.	Occupational therapy - recreational activities, quiz games, bingo, beauty demonstrations, etc.
3.00 p.m.	Tea; medicines; followed by group meetings, games and discussions, till transport home arrives at about 5.00 p.m. Some patients may stay later if relatives are to be late home.

The nurses' day

8.30 a.m.	On duty; receive report and discuss day's events.
	Receive patients, weigh and shave them as necessary.
	Supervision of patients not in occupational therapy.
	Prepare coffee, supervise patients' coffee break and give medicines.
10.30 a.m.	Staff coffee.
	Bath patients and wash clothing as necessary.
	Toilet supervision.
	Collect specimens; give injections; dressings; X-ray escort; chaperone patients; assist doctor with physical examinations and blood-taking.
	Prepare dining room and patients for lunch.
12.00 noon	Serve lunch; assist feeding as necessary.
	Give medicines.

12.30 a.m. & 1.30 a.m.	Staff lunch. Observation and supervision of patients until -
2.00 p.m.	Join in activities and observe patients not in occupational therapy. Prepare patients' tea, serve it at 3.00 p.m. Give medicines and clear dining room.
3.30 p.m.	Group meetings; occupy and observe patients till transport arrives. Complete observation charts and report cards.
5.30 p.m.	Off duty. A late nurse looks after any patients going home late and does any work required until off duty at 7.30 p.m.

I should like to thank Dr. K. Bergmann, now consultant psychiatrist at Newcastle General Hospital, for his help and encouragement, the staff of the day hospital for their constant support and Mr. R. A. Strank, head of nursing services, Bevendean Hospital, for permission to submit this article.

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Things have changed a little since then and will continue to change.

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A CLINICAL ROLE FOR SENIOR NURSES

Tony Whitehead, M.B., B.S., D.P.M., M.R.C.Psych., and
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Shortages are commonplace in the Health Service. The most important shortage is of trained, well motivated personnel, yet what is available is often misused or neglected. Trained nurses who are good at their job and are effective therapists cannot reap the benefit of promotion without moving farther and farther away from the patient and the utilisation of their training and expertise. One method of preventing this loss of skilled help has been put forward in a paper advocating two ladders of promotion in nursing. (1) One ladder would be the present nursing administrative one, while the other would consist of a series of clinical appointments with increasing responsibility. Equivalent positions on each ladder would carry the same pay and status with equal opportunities for promotion. This scheme would ensure that nurses who were suitably skilled and preferred to work closely with patients could do so, while still gaining promotion and status.

There are a number of possible clinical roles for senior nurses and it was decided to explore some of these possibilities at St. Francis Hospital.

St. Francis Hospital.

St. Francis Hospital is a psychiatric hospital serving an area made up of Brighton, Hove and part of East Sussex with a population of approximately 400,000. It has 780 beds and is divided into 4 units, one of which - the West Unit - provides a psychogeriatric service for the area. There is also a separate Adolescent Unit of 30 beds and a General Hospital Psychiatric Unit at Brighton General Hospital which has 36 beds.

A Principal Nursing Officer was appointed prior to the publication of the Salmon Report. The four units in the main hospital have two unit nursing officers each and not one, as recommended in the Salmon Report. This is believed to have certain advantages. When a unit nursing officer is off duty, on holiday or sick, there is no need for a Sister or Charge Nurse to act for them. Most hospitals, be they psychiatric or general, tend to be short of staff, particularly at ward level. If a Sister or Charge Nurse has to take on other duties this can seriously interfere with patient care. Two unit officers per unit provided an administrative structure in which an investigation of possible clinical roles for senior nurses was feasible.

The Firle Experiment.

It was decided to allow one of the unit officers on the West Unit (D.F.) to have complete clinical responsibility for one of the West Unit wards. Firle Ward was chosen. This ward accommodated 45 elderly ladies, some of whom had been in the hospital a long time, while others were medium or short stay. The unit officer was to be responsible for organising the therapeutic milieu, taking histories, assessing patients, suggesting treatment and deciding on discharge and after-care. Everything that would normally be looked upon as the responsibility of a doctor was to be carefully supervised and approved, or otherwise, by the Consultant Psychiatrist involved (J. A. Whitehead). The experiment was to run for six months, since this appeared to be a reasonable period, and is the normal span of a pre-registration house physician's appointment.

The ward had a normal staff for the hospital which operates a two shift system with a charge nurse and two student nurses on one shift and a sister and two student nurses on the other shift. The unit officer, as well as being clinically responsible for Firle Ward, would carry out

his normal duties on the unit which included, with the other unit officer, the operation of a boarding-out scheme that placed patients with families in the community.

The unit officer had had no special training or experience prior to the experiment and was not to receive any help unless he either asked for it or it was considered that patient care was suffering.

Before the experiment started, the ward had received rather infrequent visits from medical staff because of staff shortages and the only activities were two one hour periods of music therapy per week, part-time occupational therapy for eight patients and a yearly coach outing.

Assessment.

The experiment ran for the proposed six months and appears to have been a success. At first the unit officer had some difficulties with both junior medical staff and nursing staff. Some doctors and nurses were rather unwilling to accept his new role. It was found that these difficulties were mainly due to lack of adequate discussion at all levels before the experiment started.

During the experimental period, the Unit Officer only had to call in a doctor on 6 occasions and each time it was because a patient had developed some physical ailment. On these occasions the Nursing Officer had made the correct diagnosis and suggested treatment similar to that prescribed by the doctor. On only one occasion did the Consultant Psychiatrist disagree with the treatment suggested by the Unit Officer.

During the experiment the number of in-patient beds was reduced from 45 to 38. There were 11 admissions direct to the ward and 18 admissions from other wards. 17 patients were discharged to the community and 8 patients transferred to other wards. A small number of day patients also

attended on the ward, but during the experimental period a new Day Hospital was opened in the hospital and they were transferred there. During the period 7 new day patients started their treatment on Firle Ward.

The patients and nursing staff fairly rapidly accepted the Nursing Officer's new role and at the end of the experimental period expressed a desire that his involvement should continue.

The most significant contribution of the Unit Officer has been towards improving the therapeutic milieu of the ward. He started staff/patient meetings which are now well established. Occupational therapy has been considerably expanded and is now available five days a week for all suitable patients. A reasonable programme of social activities has been evolved, including coffee mornings, bingo sessions, dances and coach outings. Patients are encouraged to go into the town, do their own shopping and visit the hairdresser and beautician regularly. Volunteer workers have been introduced to the ward, which now has 16 volunteers visiting it regularly.

With the help of the unit social worker he has been able more fully to investigate the background of each patient and has been able to involve the relatives much more than was the case in the past. Now many more patients go out of the hospital, when before they rarely left the ward.

Discussion.

There are many ways of exploring the possibilities of clinical roles for senior nurses. We have approached the problem by giving the nurse a medical role and observing what part of a doctor's duties he does best.

Psychiatric, sub normality and geriatric hospitals still have large numbers of long-stay patients and new admissions often become

institutionalised, in spite of progress in treatment and care. Doctors, both senior and junior, are often heavily committed to a variety of clinical and other duties, which means that they can spare little time for developing and maintaining the sort of regime in the hospital which rehabilitates long-stay patients and prevents the insidious disease of institutional neurosis striking both those who have been in hospital too long and more recent admissions. The Unit Officer in this experiment has successfully developed an effective therapeutic milieu on the ward for which he was responsible. An important function of the nurse is the personal care of the patient, and it would appear that involving themselves in the development of therapeutic rehabilitative programmes would be a natural evolution of this traditional role.

During the past few years there have been a number of alarming reports about psychiatric, sub-normality and geriatric hospitals. Most of the malpractice revealed in these reports would not have occurred if there had been a satisfactory therapeutic milieu in those hospitals.

It may be claimed that the development of these effective therapeutic regimes should either be the responsibility of the medical staff or nursing staff at ward level. We consider that neither are really satisfactory answers. There is a need for a group of people in each hospital to involve themselves full time in developing and maintaining the sort of activities that are essential in any so-called long-stay hospital and would equally benefit the ordinary general hospital, where there is still too much preoccupation with the technicalities of medicine and nursing and little regard for the overall emotional and social problems of the patient. The group of people committed to developing these programmes should be various grades of senior nurses who have chosen a clinical, as distinct from an administrative, role in nursing.

We consider there should be two ladders of promotion for nurses, and think we have demonstrated one function of a clinical nurse. There are many other possible clinical roles, ranging from psychotherapy and community work in psychiatry to other special clinical responsibilities in general medicine and surgery. The establishment of the role we suggest in the first place would be one step towards both improving the status of nursing and the care of the patient.

Acknowledgements.

We would like to thank the medical and nursing staff at St. Francis Hospital, the patients on Firle Ward and particularly Mr. J. Barry, the Principal Nursing Officer, for his considerable help and encouragement.

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COMMUNITY AND HOSPITAL SERVICES IN BRIGHTON

Tony Whitehead, M.B., B.S., D.P.M., M.R.C.Psych.

There are strong arguments for and against providing special services for old people with mental illness. Many workers rightly claim that the old should not be segregated from the rest of society, be this in the community or in hospital. Unfortunately, hospital services are such that it is difficult to provide effective therapeutic help for old people, particularly those with mental illness, if special services are not provided.

However, the provision of in-patient and community services for old people with mental illnesses should not mean that the old person is segregated from the rest of society. An emphasis on day hospital and community support, with in-patient units that are open and encourage not only normal visitors but volunteers, school children and other interested and caring groups, can mean that the benefits of specialisation are not destroyed by isolation.

Over the past 10 to 15 years a large number of units for the elderly mentally ill have been developed. The one to be described in this article was originally established in July 1966. At that time the only facilities were a group of in-patient wards at St. Francis Hospital, Haywards Heath, and the use of a few beds in the general hospital psychiatric unit at Brighton General Hospital.

Day Hospital.

Perhaps the most important part of any service for the old, regardless of the type of illness from which they suffer, is a day hospital, and in December 1968 a day hospital was opened in Bevendean Hospital,

Brighton, providing between 30 and 35 places per day. By the Spring of 1971 another day hospital of similar size was opened at St. Francis Hospital.

About this time it was decided that the catchment area, which consisted of Brighton, Hove, Portslade and a triangular area of East Sussex with a base extending from Portslade to Peacehaven and an apex just south of Crawley, warranted two units for the elderly mentally ill.

In January 1972 two units were established, one with a headquarters at Bevendean Hospital, providing services for Brighton, and the other with its headquarters at St. Francis Hospital, providing services for the rest of the catchment area. The populations served by the two units were approximately equal.

After division the in-patient facilities still remained at St. Francis Hospital, but plans were made to develop a completely independent unit for Brighton, with all the facilities, both day hospital and in-patient, in Brighton hospitals near to the population served. The first stage of these plans became effective in April 1973 with the opening of an in-patient ward at Bevendean Hospital.

The Brighton unit's facilities now consist of a mixed day hospital providing approximately 40 places a day at Bevendean Hospital (Willow Day Hospital); a mixed admission and treatment ward providing 20 places at Bevendean Hospital adjacent to the day hospital (Cedar Ward); three mixed wards at St. Francis Hospital (Rottingdean, New Stoneham and Kingston wards) providing 66 places.

Plans are now proceeding to provide sufficient in-patient accommodation at Brighton General Hospital to replace the present facilities at St. Francis Hospital and make an independent Brighton-based unit a total reality.

The unit is run on the principle that old people prefer to remain at home in the community and tend to do better in every way if services are such that this is possible.

Emphasis on community and day hospital care does not mean that those that have to come in to hospital, for whatever reason, are neglected. Attempts are made to invest as much interest and energy in the in-patient facility as the day hospital and community facilities.

Admission to hospital can be very destructive. Because of this, every effort is made carefully to assess patients before they are admitted, so ensuring as far as possible that admission is really necessary.

When patients are admitted, everything possible is done to ensure that they will have a place in the community to return to when they are ready to be discharged. Unfortunately some cannot be discharged, but until this is established without reasonable doubt, efforts to maintain their place in the community are continued.

The Brighton unit, like the St. Francis unit, has a consultant who spends most of his time working with the elderly. Registrars and general practitioner trainees appointed to the general psychiatric service for the district spend part of their time working in the unit, staying for a period ranging from three to six months. A general practitioner clinical assistant works two sessions a week in the unit.

There is a normal nursing and occupational therapy provision and, as well as being closely involved with the local social services department, two part-time social workers are attached to the unit.

The mixed admission and treatment ward has now been open for a year and its operation and function is described in an article 'A programme

for hospital treatment', by Sister Jacqueline Pitts.

L. A. Provisions.

The local authority has a day centre for the elderly mentally ill at Beech Cottage in Woodingdean, Brighton. This provides 26 places a day and is mixed. Close liaison has been developed between the day hospital and the day centre with a fairly free flow of patients between the two facilities. The unit consultant visits Beech Cottage regularly.

The local authority has a flourishing boarding-out scheme which plays a significant role in making the hospital unit operate effectively.

There are the usual services provided by the social services department and, as well as the normal day-to-day liaison between hospital and local authority staff, a monthly meeting is held in the day hospital attended by hospital and local authority personnel who formalise this liaison.

Plans are being made to appoint a hospital-based community nurse who, among other things, will be invaluable in assisting the patients to attend the day hospital. It is hoped that an emergency team will be formed to deal with crisis situations in the patients' homes, so that these do not too often lead to admission to hospital.

Community Relations.

A monthly relatives' conference is held in the day hospital, and relatives and friends of patients are encouraged to visit and involve themselves in the unit as much as possible. There is no restriction on visiting.

At St. Francis Hospital volunteers are encouraged to work in the wards and local schools have become involved in providing help.

Normal domiciliary visits and home visits are carried out by the

medical and social work staff, and no opportunity is missed to keep in touch with the community and provide information, help and advice.

Services for the elderly mentally ill should be closely linked, and preferably integrated, with geriatric medicine. There has been much talk of the misplacement of elderly patients, and in 1970 the D.H.S.S. recommended the provision of psychogeriatric assessment units of 10 to 20 beds which could be used jointly by the psychiatrist and geriatrician. Experience in Brighton suggests that the provision of such special units is unnecessary and other effective methods are available for solving the problem of misplacement.

The establishment of psychogeriatric facilities in the general hospital milieu can result in a close relationship developing between the psychogeriatric and geriatric services. In the Brighton unit such a relationship has developed, formalised in a regular weekly combined round, which usually starts at the day hospital, where day patients can be dually assessed. This is followed by a visit to the in-patient unit and the geriatric unit in Brighton General Hospital, which is close to Bevendean Hospital.

Patients on general medical or surgical wards who have been referred to the psychogeriatric unit are also visited on this combined round. Coupled with this round there is a free interchange of advice and help between the two units at all times. As a result of this arrangement, very little misplacement occurs, and when it does, or when the condition of an in-patient or day patient changes in the course of illness, appropriate expert help and advice is readily available.

There is little transfer of patients between units, since most facilities are to hand for both, and advice and treatment are always available, regardless of the condition of the patient and the unit in which he may find

himself.

It is of some interest that equal numbers of patients tend to be seen jointly in each department, which is in line with the findings of other workers operating other methods of dealing with this problem.

Old people with psychiatric illness appear to cause a lot of anxieties in both hospital and community services. There are fears that psychiatric hospitals will become geriatric ghettoes where old people are dumped and then forgotten about.

There is a danger of this happening, but it can be prevented. In Brighton a service for the elderly mentally ill has been evolved which removes the provisions for their care from the mental hospital into a general hospital service, closely linked to the geriatric department and local authority services.

Geriatric medicine is now well established. Geriatric psychiatry is becoming established, and it would appear important that both these services for the elderly move as quickly as possible towards a closely integrated, comprehensive hospital service for the elderly which is community orientated and linked closely to community services, both local and authority and voluntary. Such developments should ensure that the elderly in need of help, treatment and support receive it to their benefit and not to their disadvantage.

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A PROGRAMME FOR HOSPITAL TREATMENT

Jacqueline Y. Pitts, S.R.N., R.M.N.

Brighton has a population of 163,860, 37,055 of whom are over 65 years old. On April 11th, 1973, Cedar Ward, Bevendean Hospital, was opened to provide mixed in-patient beds for elderly people with mental illness from the Brighton area.

Until this in-patient ward was opened to work in conjunction with the Brighton Psychogeriatric Day Hospital (Willow Day Hospital), all psychogeriatric patients in Brighton had been admitted either to a large local psychiatric unit catering for admissions of all ages, or directly to St. Francis Hospital, Haywards Heath, which is 15 miles outside Brighton.

Bevendean Hospital was originally an isolation hospital and consequently has large spacious wards and pleasant grounds. It now consists of four wards catering for chest and general medical patients, Cedar Ward and Willow Day Hospital, which was opened in 1968.

The day hospital provides day-patient care for approximately 85 patients, who attend sometimes as little as once a week or as much as five days a week, depending on the patient's needs and requirements for treatment and social contact.

Cedar Ward is housed in a converted ward separate from the rest of the hospital. It is divided into two large main rooms. One, where the female patients sleep, is equipped with King's Fund beds with small personal wardrobes incorporating five drawers and a mirror. The beds, although of a divan height, can be raised for bedmaking, and this enables patients to make their own beds without any difficulty in bending.

The other large room is used mainly as a day room, with a dining area and occupational therapy area. Patients eat their meals at tables which seat four people. This room also has five beds and accompanying wardrobes for men.

There are two shower-rooms in the ward and a bathroom with an Ambulift which is a great help when bathing confused and apprehensive patients. The ward office leads off the day room and the door is kept permanently open for all patients and relatives to feel free to discuss any problems. A carpeted room leads off the female dormitory and is used as a quiet room for patients and their visitors. It is also used for assessment clinics and on Tuesday afternoons it is used as an office by the social worker.

A kitchen, equipped with an electric cooker, fridge and the usual culinary equipment, is used occasionally by the occupational therapy department to carry out assessments of patients who are returning to their own homes. It is hoped eventually to provide a larger assessment kitchen with both gas and electric cooking facilities.

At the present time, the patients' personal laundry is done in the adjoining day hospital's automatic washing machine and tumble drier, but this type of equipment is soon to be installed in Cedar Ward. Other equipment bought during the past year for the patients' benefit has included a salon-type hair dryer, a record player with a selection of classical and 'favourite' records, two radios and a budgerigar and cage. Recently a new television set was donated to the ward.

Staff.

The ward is staffed by a consultant psychiatrist, a full-time medical officer of senior house officer grade and a part-time clinical assistant who is also a local general practitioner. The nursing day staff consists

of a sister and a charge nurse, both S.R.N., R.M.N.; two staff nurses, one S.R.N., R.M.N. and one R.M.N.; and three full-time and three part-time nursing assistants.

Night nursing staff includes a staff nurse, R.M.N.; a state enrolled nurse and two nursing assistants. The occupational therapy staff consists of a part-time occupational therapist and a full-time occupational therapy helper. This last grade, like the nursing assistants, receives in-service training.

There is a good basic nursing training scheme for the nursing assistants in the hospital but in Cedar Ward it has been felt necessary to supplement this training with a scheme especially relevant to psychogeriatric nursing. This is found to be extremely useful in aiding the nursing assistants to understand the type of patient being helped and in turn this understanding gives them more job satisfaction and improves their standards of help and care.

Untrained staff are initially apprehensive about working in this field, but it has been found that, by careful placement of staff and with training, they soon settle into the ward routine and enjoy the experience.

The ward caters for all types of mental illness in the elderly, including neuroses, depressive reactions, manic depressive psychoses, paraphrenia and acute and chronic brain syndromes.

On admission all patients are examined fully by the medical officer. A full medical and psychiatric examination is carried out and investigations are ordered as necessary. Urine is ward - and often laboratory - tested. Blood is taken for full blood count and urea and electrolyte levels as well as other tests deemed necessary and usually a routine chest X-ray is carried

out.

Sometimes, patients are found to have underlying urinary tract or chest infections which can lead to toxic confusional states and, if these are promptly treated, a dramatic improvement can result in the patient's mental and physical state. If the patient requires specialised treatment, referral will be made to the appropriate consultant. As Dr. Whitehead has already stated in the previous article*, there is a weekly combined round with the department of geriatric medicine and patients with physical illnesses are seen and examined on this round.

Treatment.

Many patients require drug therapy which is usually oral, but occasionally intramuscular, slow-release, anti-psychotic drugs, for example Depixol (flupenthixol) may be prescribed. If electroconvulsive therapy is recommended this is carried out in a nearby psychiatric unit. The patient is transported there by ambulance and, after recovery, is returned to the ward. Eventually it is hoped that any ECT required will be carried out in the ward.

Occupational therapy is an important part of the patient's treatment and during the week patients take part in two sessions per day. The morning session of two hours is usually devoted to craft work, for example basket work, lampshade making, sewing of soft toys, and so on, and to the packing of simple CSSD packs for use by the hospital group. Two hours in the afternoon are utilised for social activities such as bingo, general knowledge and other quizzes, games, collage making, beauty therapy and sometimes a party.

* 'Community and Hospital Services in Brighton'.

The nursing staff carry out all nursing procedures such as dressings to ulcers, bathing, serving lunches and dispensing of medicines. Patients are supervised and encouraged to dress themselves, carry out their personal toilet and, if possible, make their own beds, lay tables and assist with the washing up.

Urinary and faecal incontinence is kept to a minimum by regular toilet training and sometimes by the use of drugs acting on the genito-urinary system, such as Cetiprin (emepronium bromide). Constipation, often a major problem and cause of worry in the elderly is treated by using regular doses of faecal-softening agents, e.g. Dioctyl (dioctyl sodium sulphosuccinate) or Duphalac (lactulose). Sometimes patients require rectal suppositories or enemas. A high level of fluid intake is maintained to help prevent constipation, urinary tract infections and possible toxic confusional states.

All patients are given diets according to their needs but the majority of patients enjoy a high protein diet with carbohydrates kept to the minimum. Many patients before admission have existed on diets with a high content of starchy foods and consequently may be malnourished and overweight. As far as possible they are educated in the importance of a well balanced diet.

Most patients possess National Health Service dentures and can enjoy ordinary food but even those who may have a few, or possibly no teeth at all, can manage most food and do not require special soft diets. A dentist attends the hospital weekly and immediate dental problems are solved by him.

Visitors are encouraged to visit frequently and official visiting times are between 2.00 p.m. and 8.00 p.m. daily but they are allowed to

visit at any other time if these are inconvenient. Table 1 shows a typical day's programme for the patients.

Meetings.

The success of a ward of this type depends a great deal on good communications between patients, medical, nursing and occupational therapy staff and social workers.

Regular weekly meetings are held between the staff involved in patient care. On Monday afternoons there is a meeting between medical, nursing and occupational therapy staff to discuss patients' progress, possible discharges and policy regarding treatments. On Tuesday mornings there is a consultant's clinic in the ward, on Wednesday mornings a combined psychiatric and geriatric round while on Thursday afternoons there is a nursing staff meeting.

In addition, monthly meetings with relatives have been implemented which allow all relatives to discuss their problems in general terms. It is of great benefit to relatives to realise that they are not isolated in the problems involved in caring for their elderly folk at home and that they can obtain help and support from all staff when necessary.

Discharges.

Of 222 patients admitted in the first year 158 patients were discharged back to the community. These patients were discharged back to their own homes or to protected accommodation or to welfare accommodation with day care and outpatient clinic follow-up.

Of the 37 patients transferred to other hospitals, 30 of these were transferred to long-stay wards at St. Francis Hospital, Haywards Heath, but many of these have now been discharged to nursing or welfare

homes. The full breakdown of those figures is given in Table 2 and a classification of the patients admitted according to age is shown in Table 3.

Old people with mental illnesses are people in difficulties and require and respond to the same kind of care, help and understanding as anyone else. It would appear that the outlook for these patients is much better than is generally realised.

TABLE 1 Programme showing a typical day for the patients.

7.00 a.m.	Rise, wash and dress. Make bed if possible.
8.00 a.m.	Breakfast. Drug round. Washing, toilet. Bedmaking.
9.30 - 11.30 a.m.	Occupational therapy.
10.00 a.m.	Coffee.
11.30 a.m.	Toilet. Laying of tables for lunch.
12.00 Noon	Lunch. Drug round. Toilet.
1.00 - 2.00 p.m.	Patients' time for resting, writing letters, walks, etc.
2.00 - 4.00 p.m.	Occupational therapy followed by toilet training.
3.00 p.m.	Tea.
4.00 - 6.00 p.m.	Patients' own free time, usually occupied with visitors and television viewing.
6.00 p.m.	Supper. Drug round. Toilet. Bathing of patients.
8.00 p.m.	Hot milk drinks.
8.00 p.m.onwards	Patients are helped to bed or put themselves to bed.
10.00 p.m.	Drug round. Lights out.

TABLE 2 Breakdown of figures for admission and discharge of patients in first year (1973)

	Admissions	Back to Community	Died	Transferred to other Hospitals
Male	65	41	11	9
Female	157	117	16	28

TABLE 3 Classification of patients admitted according to age

	60 - 69 yrs.	70 - 79 yrs.	80 - 89 yrs.	90 - 99 yrs.
Male	14	35	14	4
Female	26	61	66	11

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GERIATRIC PSYCHIATRY IN THE GENERAL HOSPITAL

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Summary.

The development and operation of a unit for the elderly mentally ill in a general hospital complex is described, with particular reference to its relationship with the department of geriatric medicine. The dangers of psychiatric hospitals becoming psychogeriatric hospitals with deteriorating standards of care as a result of the development of general hospital psychiatry are discussed, and the developments in the Brighton area offered as one solution to this problem.

Introduction.

In 1965 one of us (T.W.) published a paper on the psychogeriatric service developed at Severalls Hospital, Colchester.[1] Since then many psychiatric hospitals have developed special units for the elderly mentally ill and, at the same time, there has been an acceleration in the movement of acute psychiatry from the psychiatric hospital to the general hospital unit.

Before 1965 it had been pointed out that many old people entered psychiatric hospitals who should not do so, and there was considerable misplacement of the elderly when they became ill or failed to cope in the community. It was suggested that mental hospitals took old people who should have gone to geriatric units and vice versa, with the same kind of thing happening in welfare homes. One solution to this problem was the development of special combined assessment units to which both the

psychiatrist and geriatrician had the right to admit when they had doubts about the diagnosis. Patients in the unit were then assessed by both the psychiatrist and the geriatrician. A unit developed along these lines in Nottingham also gave the local welfare department the right to admit and take part in assessment in the unit.(2) In 1966 Kay et al.(3) suggested that each district service should have one of these units. In 1970 the Department of Health and Social Security recommended the provision of psychogeriatric assessment units of 10 - 20 beds for 250,000 total population, and suggested that they should be sited in the general hospital or the geriatric hospital.(4)

There has been a special unit for the elderly mentally ill in the Brighton area since 1966, and when the possibility of establishing a combined assessment unit was raised it was decided that a different approach may be more effective.

Origins of the Brighton Department of Geriatric Psychiatry.

In 1966 a special unit for the elderly mentally ill was established at St. Francis Hospital, Haywards Heath. Brighton is part of this hospital's catchment area. The unit at first only consisted of a group of inpatient wards, but in 1968 a day hospital was opened in a small general hospital in Brighton (Bevendean Hospital). At this time elderly people requiring admission went into the psychiatric unit at Brighton General Hospital and were transferred to the unit at St. Francis Hospital if they required prolonged treatment or permanent care. In 1971 a second day hospital was opened at St. Francis Hospital, and in January, 1972, the whole unit was divided into two, with a consultant in charge of each unit. One unit served Brighton and consisted of the day hospital at Bevendean and three inpatient wards at St. Francis Hospital, with the use of some of the acute beds in the general psychiatric unit at Brighton General Hospital. The

other unit consisted of the day hospital at St. Francis Hospital and four inpatient wards, one of which was an acute admission and treatment unit.

From 1971 onwards plans were being made in joint consultation with the department of geriatric medicine in Brighton to provide a comprehensive unit for the elderly mentally ill in the general hospital complex in Brighton.

The first stage of this plan was the establishment of a 20-bed mixed admission and treatment unit at Bevendean Hospital adjacent to the existing day hospital. This ward was opened in April, 1973, and, at that time, combined assessment rounds were started. Once a week the psychiatrist in charge of the unit and the senior registrar in geriatric medicine, plus their junior colleagues, visit the day hospital, the inpatient unit, the geriatric unit in the nearby larger general hospital, and any medical or surgical wards with patients referred for geriatric and/or psychiatric help. In the day hospital outpatients or day patients are jointly assessed. Inpatients are seen who are presenting medical difficulties to the psychiatrist or psychiatric difficulties to the geriatrician. Coupled with this formal session there is a free interchange of advice and help between the two units at all times. As a result of this arrangement very little misplacement occurs, and when it does, or when the condition of an inpatient or day patient changes in the course of his illness, expert help and advice are readily available. There is little transfer of patients between units, since most facilities are to hand for both, and advice and treatment are always available regardless of the condition of the patient and the unit in which he may find himself. The only reasons for transfer would be serious behaviour problems in a patient in the geriatric unit, or physical disease requiring special medical attention in a patient in the psychiatric unit. The site of the unit means that other specialised advice is easily available, plus all the usual facilities of a general hospital. Patients

who require investigation and treatment for physical disease, but are disturbed in their behaviour, for whatever reason, can be admitted to the unit and still be investigated and treated by the appropriate specialty.

In December, 1973, Arie and Dunn, a psychiatrist and geriatrician, described a "'Do-it-yourself' psychiatric-geriatric joint patient unit".(5) Here four beds in a geriatric hospital were allocated for combined assessment. They found that they tended to admit equal numbers to these beds, and it is interesting that on our combined assessment rounds we also tend to see equal numbers in each department.

The unit still has three wards at St. Francis Hospital. However, an empty block at Brighton General Hospital is being upgraded and modernised to provide four wards for these patients. When this work has been completed all the hospital facilities for the elderly mentally ill from Brighton will be established in the Brighton hospitals.

Some Statistics.

Brighton has a population of 163,800, (37,000 over 65). At the present time there are 40 day places for the elderly mentally ill and 86 inpatient beds. A day centre for the elderly mentally ill, run by the social services department, provides a further 26 day places. These facilities, backed up by relatively good community care and a flourishing local-authority boarding-out scheme, seem to be adequate at present. When the St. Francis part of the unit is moved to the general hospital the number of beds will remain unchanged.

During the first year of operation of the admission-and-treatment unit at Bevendean Hospital there have been 232 admissions, 65 men and 167 women. Of these, 158 (41 men and 117 women) were discharged back to the

community, 27 (11 men and 16 women) died, and 37 (9 men and 28 women) were transferred to the medium and long stay wards at St. Francis Hospital. The age range has been from 60 to 99, with 4 men and 11 women falling within the 90 - 99 age bracket.

112 (87 women and 25 men) inpatients in the psychiatric unit and 119 (79 women and 30 men) inpatients in the geriatric unit have been seen on the combined assessment round, together with 87 (62 women and 25 men) out-patients and day patients.

There have been only two transfers each way between the units, all 4 patients being women.

Discussion.

Combined assessment units can play a part in preventing old people being misplaced and in creating a situation in which treatment can be more effective. However, the medical and psychiatric condition of old people varies from time to time, and however effective combined assessment may be at the time of admission, later the psychiatrically ill may become seriously physically ill while the victims of organic disease can later develop psychiatric symptoms. We consider that geriatric medicine and geriatric psychiatry are so closely related that it is more reasonable to develop close links between the total geriatric and psychogeriatric departments than to establish a special small unit for combined assessment. This kind of integration is only possible if the psychogeriatric unit is close to the geriatric unit. The establishment of comprehensive departments of geriatric psychiatry in the general hospital not only makes integration with geriatric medicine possible, but prevents psychiatric hospitals becoming demoralised and poorly staffed, hidden-away-in-the-country repositories of the old. We consider that the transfer of psychogeriatric facilities from the mental hospital to the general hospital should occur at the same time, or preferably

before the establishment of acute psychiatric units in the general hospital complex.

Close links between departments of geriatric psychiatry and geriatric medicine not only benefit conditions in both units, but make possible a wider training for junior doctors in psychiatry and geriatrics. This must be to the mutual advantage of psychiatry and geriatrics, since increased knowledge of medicine is useful and important to the psychiatrist, while the geriatrician who knows something of psychiatry and emotional problems will have a better understanding and more expertise in treating his patients.

It is not suggested that the type of service and organisation being established in the Brighton area is the only effective one. There are many ways of dealing with the problem of mentally ill old people, but we believe our system is at least worthy of examination.

We thank Dr. Tony Clark and the staff of the department of geriatric psychiatry, the department of geriatric medicine, and the Brighton social services department for their help, involvement and enthusiasm. Requests for reprints should be addressed to J. A. Whitehead, Bevendean Hospital, Bevendean Road, Brighton. BN2 4DS.

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HELP FOR OLD PEOPLE

Tony Whitehead

Over the years a lot of anxiety has been expressed about psychiatric hospitals becoming geriatric ghettos. As early as 1963, David Enoch, a psychiatrist, was claiming that psychiatric hospitals were becoming dumping grounds for old people. Since then many others have made similar claims, backing up their anxieties with convincing statistics. The present situation confirms all these fears, with many psychiatric hospitals now accommodating large numbers of old people.

The development of general hospital psychiatry has meant that more and more facilities for younger patients have been removed from the psychiatric hospital and sited in the general hospital. This has played a part in making psychiatric hospitals, hospitals for the elderly, but other factors have played an important role in this sad development.

It can be argued that if a psychiatric hospital has developed a progressive and humanitarian regime of patient care, there are no reasons why it should not accommodate elderly people in need of institutional care. This is true, but unfortunately every psychiatric hospital is not run on progressive lines and even when it is there may be a tendency to admit old people on the assumption that they will remain there until they die. Some patients, unfortunately, do need long term institutional care but the majority of elderly people, with psychiatric problems, can and should be helped and supported in the community. Psychiatric hospitals that have not developed special services for the elderly usually fail to provide this sort of help and hence become repositories for the elderly.

Another serious problem with many psychiatric hospitals is that they are sited away from the community they serve. This means that

elderly patients once admitted are cut off from their familiar surroundings and separated from their friends and relatives by distance. Elderly patients have elderly friends and relatives, who themselves may be disabled. For these, long journeys by public transport are always worrying and often impossible.

It would appear that a combination of not developing special services for the elderly mentally ill, coupled with a movement towards general hospital psychiatric units for younger patients, have played a major role in making so many psychiatric hospitals geriatric ghettos. Many districts have developed special services for the elderly mentally ill and when this has happened old people have had a better deal, with fewer being admitted permanently to hospital.

Needs of Old People.

Old people have the same needs as any other age group and these needs do not evaporate when they become the victim of so-called psychiatric disorders. Most people need the security of a home and the elderly are particularly dependent upon this security and its comfort of the familiar. They also need friends, money, food, warmth, a reason for living, respect as a human being and the right to be themselves.

When an elderly person gets into difficulties, they are often multiple difficulties. A physical illness or disability may bring with it depression and a failure to manage the everyday tasks of life. People do not have physical illness or mental illness, or social problems. They usually come together interwoven and inter-related.

When an old person needs help, the need is for help in the home, not incarceration. It is well known that admission to hospital, or some other type of institution can be a catastrophic event in an old person's life. The sudden change of environment can be damaging enough in itself,

but separation from the familiar and the breaking of the threads of support and comfort developed over the years can cause irreparable damage.

From this it would appear that varied types of help may be necessary and this help should be provided in the home if at all possible. Agencies that may need to provide help range from Departments of Geriatric Medicine and Psychiatry to Social Service Departments, Voluntary Organisations and other branches of medicine and surgery.

Outline of a Service.

A psychiatric service for the elderly must be community orientated and utilise the team approach. The service may be based on a mental hospital, but should preferably be contained within the general hospital complex. The reasons why a general hospital base is best are that it is more likely then to be sited in the community served, have close links with geriatric medicine, other branches of medicine and surgery, community agencies and on the whole be more able to be truly community orientated.

The service needs to develop certain facilities, including a day hospital, or day hospitals, a range of in-patient facilities and an involvement in boarding-out and the provision of group homes and hostels.

The service must be run closely with the Department of Geriatric Medicine, the local Social Service Department and the various Voluntary Organisations involved with the elderly. These relationships must be at a worker level, as distinct from co-ordinating committees and other administrative manoeuvres divorced from where the work is actually done.

The staff of the service must actively involve themselves in community work, with home visits an important part of their duties. An Emergency Service needs to be developed, so that help can be provided

quickly and effectively at any time.

It is recommended by the Department of Health and Social Security that combined assessment units be established in each district. The idea is that a number of beds are set aside for the admission of patients in which there is confusion about their needs. Once in one of these beds, the patient is then assessed by a psychiatrist, a geriatrician and a social worker, who finally agree which of them should be helping the patient. This is not a very good idea, since the patient should be assessed at home, or in a day hospital and helped without admission, if this is possible. The various services involved should combine in assessment and providing help without the need for a special institution for co-operation.

Unfortunately some old people do have to come into hospital and for these in-patient accommodation should be provided that is homely and supportive. The number of actual beds required is difficult to assess, since this must depend upon the amount of community support available. The actual number of beds is critical for each district, since too many result in too many old people being admitted, while too few means that some old people have to suffer unnecessarily and inexcusably.

The following is an example of one service for the elderly mentally ill.

The Brighton Service.

Brighton,being on the South Coast, has a disproportionate population of elderly people (162,700 total population, of which 34,800 are over 65.). Traditionally, its psychiatric service was based on St. Francis Hospital, Haywards Heath, which is fifteen miles away on the other side of the Downs. Because there was an 'elderly problem' in Brighton, a special service for the elderly mentally ill was established in 1966. This, of course, was based on St. Francis Hospital. This was clearly unsatisfactory and the

first stage in developing a service within Brighton itself was the establishment of a day hospital in a small general hospital in Brighton (Bevendean Hospital) in 1968. This provided 40 places per day, plus out-patient facilities. In 1973 it was possible to open a converted ward, adjacent to the day hospital, to provide 20 in-patient places. This meant that most patients requiring admission to hospital could be admitted to a place in Brighton, treated and discharged home without having to be transported over the Downs to St. Francis Hospital. However, some still had to go to St. Francis and those requiring long-term care inevitably went there. Plans were made to establish another in-patient unit in another nearby general hospital and in 1978 this unit was opened, so providing all the physical requirements of a self-sufficient general hospital based unit for the elderly mentally ill.

Buildings are clearly not all important and while these physical things were happening a service was developed that was designed to help and support as many old people as possible in the community. Close links were developed with the Department of Geriatric Medicine, the local Social Service Department and other interested agencies. The psychiatric unit is run so closely with the department of geriatric medicine that a combined assessment unit is totally unnecessary and there are never arguments about who should look after whom. Doctors, nurses and social workers actively involve themselves with community support of patients, while the day hospital provides an essential service to make this possible. The majority of patients referred to the unit are supported in the community, with or without day hospital care. Some patients need to come into hospital for short periods, while others need to come in recurrently. Both the in-patient units are mixed sex facilities and cater for all types of patients, ranging from those who come in for a short time to the few that need to remain in hospital indefinitely.

Day care has been mentioned and emphasised. It appears that day care facilities are essential to any service for the elderly mentally ill. The day hospital provides the full range of treatments that are available in an in-patient unit, without the trauma of admission to hospital. It also provides food, occupation, company and entertainment. The work of the day hospital is assisted by a Local Authority Day Centre for the elderly mentally ill, which is run closely with the day hospital. Between them 66 day places per day are provided.

With this emphasis on day care and community support, it is possible to provide an adequate service with only 55 in-patient places. Twenty of these are provided in the in-patient unit adjacent to the day hospital and 35 places in the nearby large general hospital.

Perhaps the most important thing about the Brighton unit is that a genuine team approach is used, with all staff members having and feeling an involvement and responsibility in providing an effective and helpful service. All types of emotional and psychiatric problems are dealt with and this is essential for such a service to be effective. There is no place for separating those with so-called organic brain disease from the rest.

One major problem with a special service for the elderly is that this tends to separate even more the elderly from other age groups. This is a serious problem, but the fact that most patients are supported at home, in normal communities, coupled with the encouragement of school children and other young people who involve themselves in the in-patient units, prevents to some degree the dreadful segregation of the elderly from the rest of society.

This brief outline of the Brighton service illustrates what can be done to help old people who become mentally ill without secreting them

away in mental institutions. Different districts have different problems, which require different solutions but it would appear that whatever the local situation may be, it is essential that a group of people commit themselves to providing a service and ensure that the service is truly community orientated, with a base within the community served. When this happens more old people are helped and fewer incarcerated.

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