Letters to the Editor

Longer staying patients on an acute old age psychiatric unit – characteristics and outcome

SIR–In their recent point prevalence survey across North and South Thames regions, Koffman and colleagues [1] provide a helpful quantification of the difficulties faced by acute mental health units serving older people between the increasing demands imposed by ‘demographic ageing’ and dwindling resources in accommodation for a significant number of older people with mental illness. They find that patients felt to be inappropriately located in acute units were more likely to be male, to be suffering from dementia, to have stayed for longer than 3 months and to have had assessment for local authority care management.

In a slightly different approach, we conducted a retrospective case-note analysis of admissions to a single acute old age psychiatric unit serving an urban population of 18000 in the North Thames region. Between 1992 and 1994 (274 inpatient episodes), we identified 23 patients who stayed for longer than 3 months. We compared these case notes with those of 26 patients randomly selected from all inpatient episodes shorter than 3 months. We found that those patients staying longest tended to be older ($P = 0.06$) and more often widowed. There was no significant gender difference. They had fewer relatives living locally ($P = 0.08$) and had received increased input from social services (in particular meals on wheels; $P = 0.013$) before admission. This group had an increased proportion with dementia as a primary diagnosis or in conjunction with depression. Those with depression alone were more likely to have had previous episodes, although overall there were no significant differences in measures of past psychiatric morbidity (neither in legal status on admission nor in measures of physical morbidity). During the index admission, the longer-staying group were more likely to have received ECT ($P = 0.005$) and required increased physical ($P = 0.01$), psychological ($P = 0.01$) and functional ($P = 0.02$) investigation.

Of the discharged controls, 54% went to a flat/house, 29% to sheltered housing and 8% to part III accommodation. Of the discharged longer-stayers, 38% went to a flat/house, only 6% to sheltered housing, 38% to part III accommodation and 13% to nursing homes. Examining the reasons for the extended length of stay, in 52% treatment-related factors were implicated as the main cause. In 30% it appeared to be purely because of placement issues - 39% of these due to an identified lack of places available and in 9% because the home concerned was unwilling to accept the patient.

We hope that our findings complement those of Koffman and colleagues, providing a longitudinal aspect and focusing more broadly on longer-staying patients as a whole, with obviously more varying degrees of ‘appropriateness’ of location (although clearly they are limited in being confined to a single service). Some solutions to the difficulty of delayed discharges lie beyond the control of a single mental health team. However, certain measures may ease strain on resources. Increased community support may be possible for those awaiting longer term placement, identification of ‘high-risk’ factors for longer stay may facilitate earlier discharge planning [2, 3] and resources may be directed towards ‘intermediate care’ settings, specializing in rehabilitation and placement without the substantial costs of acute beds.

R. Stewart

Section of Old Age Psychiatry,
Institute of Psychiatry,
London SE5 8AF, UK

C. Aquilina

Department of Old Age Psychiatry,
Nether Edge Hospital,
Sheffield S11 9EL, UK

M. Blanchard, N. Graham

Department of Old Age Psychiatry,
Royal Free Hospital,
London NW3 4BN, UK


Macrocystosis in elderly patients

SIR–We read with interest the paper by Mahmoud et al. on explained and unexplained macrocytosis in elderly patients [1]. In their comprehensive review they report that 15 of their patients had unexplained folate deficiency and three iron deficiency alone. A triad of macrocytosis, folate and iron deficiency should alert the physician to an underlying cause of malabsorption syndrome [2]. Russell et al. [3] demonstrated that asymptomatic atrophic gastritis and partial or total gastrectomy performed for peptic ulcer can lead to folic acid deficiency. Iron deficiency and macrocytosis may be the only sole manifestation of adult coeliac disease presenting for first time in later life [4]; there