

EMERGENCY ADMISSIONS TO A HOSPITAL FOR THE MENTALLY SUBNORMAL

D. A. SPENCER

Medical Director, Stansfield View Hospital, Todmorden, Lancashire

The reception of so-called "emergency" or "acute" admissions into general hospitals and psychiatric hospitals for the mentally ill is an important and essential service which these hospitals provide. Hospitals for the mentally subnormal also have their emergency admissions but this part of their work appears to have received relatively little attention.

This paper reports a survey of the emergency admissions during 1968 to hospitals for the mentally subnormal from a service area with a population of 444,841. This area comprised one County Borough, Halifax, Yorkshire, with a population of 96,073, thirteen urban districts with a total population of 159,212, four municipal boroughs, Brighouse, Keighley, Spensborough and Todmorden with a total population of 140,463 and five rural districts with a total population of 49,093. For the purpose of the study an emergency admission was defined as a case in which a family doctor or mental welfare officer requested the immediate admission of a person to a hospital for the mentally subnormal and the consultant agreed to accept the patient who was admitted forthwith.

The principal features of ten patients who fell into this category are given in the table. The patients are listed in the order in which they presented during the period from 1st January to 31st December, 1968.

Some of these cases raise points which prompt further comments. In cases 2 and 7 the patients were found to have physical disorders on clinical examination after admission to the hospital. In case 5 the patient complained of abdominal discomfort after her admission and she had an appendicectomy for acute appendicitis carried out at a general hospital. These cases emphasise the danger that relatives, health officers and family doctors may be misled into supposing that the behaviour disorder or distressed state of a person known to be mentally subnormal is automatically a result of the mental condition. The seemingly vague complaint of a subnormal person can be too readily dismissed as due to a mental disturbance and the subnormal person's suffering makes him more anxious, frustrated and desperate.

Case 8 demonstrated the problem of the mentally subnormal person who has to be admitted to hospital because a local authority can find no alternative residential accommodation in local health authority hostels or welfare homes. In cases 3 and 10 the patients could have been admitted with advantage directly into a hospital for mental illness where both these patients had had previous treatment. They presented mental illness, in addition to mental subnormality, but as they had acquired the label "subnormal" a consultant in mental illness had recommended that their subsequent admissions should be to a hospital for the mentally subnormal. They came into the category referred to in Paragraph 7 of the Memorandum on Parts I, IV to VII and IX of the Mental Health Act 1959, because they were subnormal and in need of psychiatric treatment as well as training, and therefore more suitably accommodated in units associated with hospitals for medium-stay mentally ill

patients, or in entirely separate units, rather than in the same hospitals as severely subnormal patients. Half of the patients referred, Cases 1, 2, 3, 7 and 9 were already known to the hospital service for the mentally subnormal as they had had in-patient or outpatient treatment, or short term hospital care.

The reception of emergency admissions in a hospital for the mentally subnormal poses problems which are not encountered in other hospitals. On account of the generally slow turnover of patients and the pressure on places in hospitals for the mentally subnormal a bed for an emergency admission may not be vacant. It is not always possible or desirable to erect extra beds for such admissions. During evenings, nights and at weekends, a smaller hospital for the mentally subnormal may not have nursing and medical staff readily available to observe and manage adequately a seriously disturbed and violent patient about whom little information may be obtainable at the time of the admission.

It is likely that some emergency admissions could be prevented by more frequent and closer supervision of mentally subnormal people in the community and a greater readiness on the part of parents and relatives, mental welfare officers and family doctors, to seek expert help and to anticipate problems and difficulties before the circumstances which require immediate hospital admission arise. A worthwhile experiment would be to send a "flying squad" consisting of a psychiatrist, an experienced nurse and perhaps a nurse in training from the hospital to examine and assess the patient and to influence the critical situation in these emergencies. Unfortunately the large service area covered by the hospitals in this study would make this impracticable in many cases.

Summary

This paper presents details of emergency admissions to a hospital for the mentally subnormal during 1968. Because the number of emergency admissions to hospitals for the mentally subnormal tends to be small compared to general hospitals and units for mental illness, hospitals for the mentally subnormal may be less well prepared to receive emergency admissions and some of the problems which these cases raise are discussed.

References:

- Heber, Rick (1959). *A Manual on Terminology and Classification in Mental Retardation*. Monograph Supplement to the American Journal of Mental Deficiency. New York State Albany.
- H.M.S.O. (1960). *Mental Health Act 1959*. Memorandum on Parts I, IV to VII, IX.

Case No.	Source	Day of week	Age	Sex	Status on admission	Subnormal IQ 55-70	Severely Subnormal IQ under 55
1.	County Borough	Tuesday	20	Male	Informal	+	—
2.	Urban District	Monday	19	Male	Informal	+	—
3.	Urban District	Wednesday	16	Male	Informal	+	—
4.	County Borough	Monday	20	Female	Section 25 then Informal	+	—
5.	County Borough	Thursday	17	Female	Section 29 then Informal	+ (IQ 70+)	—
6.	County Borough	Wednesday	21	Male	Informal	—	+
7.	Rural District	Monday	63	Male	Informal	—	+
8.	Municipal Borough	Wednesday	39	Female	Informal	+	—
9.	County Borough	Wednesday	39	Female	Section 29 then Informal	+	—
10.	County Borough	Thursday	20	Female	Section 25 then Informal	+ (IQ 70+)	—

Diagnosis	Heber's A.A.M.D. Classification Code	Reason for Admission	Subsequent progress
Subcultural epilepsy	69	Acutely disturbed behaviour at home	Short Term Care Returned home
Mental Retardation of uncertain cause Acromegaly	69	Disturbed and distressed behaviour at home	Found to have subacute intestinal obstruction— transferred to General Hospital
Mild cerebral palsy with epilepsy	69	Acute depressive illness	Transferred to hospital for mental illness
Subcultural	89	Turned out into street after alterations at home	Short Term Care Discharged home
Subcultural	89	Disturbed conduct at home	Short Term Care Discharged home and re-settled in work after an appendicectomy at a general hospital
Mental retardation of uncertain cause	89	Disturbed conduct at home	Short Term Care Discharged home
Mental retardation of uncertain cause	89	Deteriorating mental and physical condition	Found to have heart failure. Died after a few days of coronary thrombosis
Subcultural epilepsy	89	One parent died, other ill, no alternative accommodation	Awaiting alternative residential placement
Subcultural	89	Disturbed conduct in local health authority hostel	Short Term Care returned to hostel
Subcultural Psychopathic disorder	89	Severely aggressive and destructive outbursts of behaviour in a local health authority hostel	Transferred to hospital for mental illness