THE CHANGING FACE OF PSYCHIATRIC CARE: TRENDS IN ADMISSION TO PSYCHIATRIC HOSPITAL

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It is commonly observed that community care has formed a major part of the rhetoric about care for dependent groups in society for nearly fifty years (Kings Fund, 1987; Griffiths, 1988; DHSS, 1981). Over the past few years, this solution to the needs of vulnerable sections of society has been increasingly favoured by politicians and policy makers alike, whilst at the same time concern over the planning, delivery and costs - to the individuals and their families and friends - has also intensified (Audit Commission, 1986; Griffiths, 1988; Finch & Groves, 1983; Hicks, 1983).

One of the major dependent groups in the debate over community care consists of those diagnosed as mentally ill and, in particular, those who would have once received treatment inside a psychiatric hospital. The concern over what happens to those no longer admitted to a psychiatric hospital, or whose length of stay has shortened dramatically, has led one major pressure group in the field, the National Schizophrenia Fellowship, to reverse previous demands for community care and to express grave doubts over the suitability of what currently passes for community care for a large number of those they represent. Additionally, there is increasing public concern over the emptying of psychiatric hospitals and the growth of homeless men and women with neither accommodation nor social support (Mind, 1988; Busfield, 1989).

Are these fears justified in terms of admission statistics? Between 1976 and 1986, figures for those who have never before been admitted to psychiatric in-patient treatment have fallen from 123 per 100,000 of the population in 1976 to 109 per 100,000 of the population in 1986, an 11% drop (Department of Health, 1990).

However, the figures for total admissions, including both new patients and those who have received in-patient treatment in a psychiatric hospital before, have increased over this same ten year period. In

1976, the total admission rate was 385 per 100,000 of the population but, by 1986, it had climbed to 417 per 100,000 of the population (DOH, 1990). This may be indicative of a policy of earlier discharge (with a much higher proportion of in-patients discharged in their first month of treatment than ten years previously) resulting in a 'revolving door' phenomenon. Patients who are discharged into a community without adequate support and care are re-admitted at a later date. It may indicate a greater willingness on the part of the medical profession to re-admit a former patient than to bring a new patient into that cycle or it may indicate a move forward, with patients being able to survive for longer in the community with only short temporary re-admissions to re-balance medication. Further research needs to be carried out in this area.

It is particularly interesting to note how these figures for total and first admissions break down by age and sex. One of the most well known features of psychiatric statistics is the over-representation of women in both hospital and primary health care figures (Chesler, 1974; Penfold & Walker, 1984; Mind, 1988). Women are more likely to receive a diagnosis of mental illness and are more likely to receive treatment from psychiatric hospital, general practitioner, community psychiatric teams and practitioners outside the NHS, including counsellors, psychotherapists and self-help groups. In addition, surveys which have assessed random populations for levels of psychiatric symptoms have also found more women demonstrating signs of mental illness (Bebbington et al, 1991). Women, in particular, outnumber men for diagnoses of depression and anxiety related disorders (DOH, 1990).

However, women and men have not shared equally in this reduction in their chances of being admitted to psychiatric hospital. In 1976, the sex-specific first admission rate for women was 135.6% of the male rate but, by 1986, this had dropped to 119.0%. This results from the greater fall in the age-sex specific rate for women over the ten year period in comparison with the decline in the rate for men. The female rate fell by 15.6% between 1976 and 1986, the male rate fell by only 3.8% (DOH, 1990).

At the same time, the gap between the sexes for total admissions has also reduced. However, as total admissions have increased over the decade, the reason for the narrowing gap between the sexes is slightly different: a slower increase in the rate for women's total admissions compared with a faster increase in the rate for men's total admissions.

Given the decrease in first admissions, this means that, whilst both men and women have increased their chances of returning to psychiatric hospital after a period as an in-patient, for men the chances of re-admission have increased much more than they have for women.

Why today, might women be less likely than men to be initially admitted or re-admitted to psychiatric hospital? This is likely to be associated with the kinds of illness women suffer, the levels of support available to women from families and friends, available methods of treatment or containment and the expectations held by the medical profession in relation to women's mental health. It is possible that there have been changes in the stereotypical depiction of women as intrinsically more vulnerable to mental illness (Payne, 1991).

However, it is also possible that the narrowing sex ratio simply reflects women's greater likelihood of being treated with psychotropic drugs prescribed by general practitioners (Riska & Hagglund, 1991). Reflecting Land's description of women as the "*emotional buffers*" of the household, it may also be that women are more likely to take and the medical profession now more likely to prescribe medication to enable this buffering to continue without their removal from homes and families (Land, 1977). However, it is difficult to speculate on causes for such a change in the medical profession's perspective in the last decade.

Whilst further research would help illuminate some of these issues, the statistics when broken down by age reveal further clues to the puzzle. Whereas the sex ratio of women to men for all admissions between 1976 and 1986 has changed from 1.40:1 to 1.29:1, the ratio has changed more dramatically amongst some age groups in comparison with others, as the table below shows:

TABLE ONE: ALL ADMISSIONS TO MENTAL ILLNESS HOSPITALS AND UNITS, AGES 15-75+.

Age Group. Year

Sex and age specific rates per 100,000 home population.
Female rate as proportion of male rate.

	1976	1981	1982	1983	1984	1985	1986
All ages	139.7	139.8	136.7	135.2	132.5	132.4	128.6
15-19	158.5	134.3	116.3	119.5	110.9	98.6	101.4
20-24	118.7	103.2	97.2	96.4	89.4	89.6	86.6
25-34	122.7	107.8	103.8	99.8	98.7	94.3	94.0
35-44	132.0	124.9	120.5	117.2	114.5	112.7	111.0
45-54	139.5	148.0	144.5	143.4	139.2	139.7	138.2
55-64	147.7	152.8	155.3	152.3	152.5	157.8	145.6
65-74	148.2	149.0	142.1	141.6	140.5	145.9	142.9
75+	114.9	121.4	116.8	116.6	113.7	111.1	105.0

Source: Calculated from Health and Personal Social Services Statistics, 1990, Table 9.2 (Department of Health, 1990, HMSO, London)

(The figures are based on admission rates, which are age and sex-specific - in other words, rates which already have accounted for the different ratio of women to men in each age group shown.)

As this table demonstrates, the rate at which the gap has narrowed is not equal for all age groups. Amongst some ages - between 45 and 74 - there has been little change in the rate at which women and men are admitted to psychiatric hospital, whilst for younger age groups, there has been a turnabout, with men overtaking women in the rate at which they are admitted.

Bearing in mind that the figures for total admissions reflect largely the extent to which different groups of the population are admitted, discharged and readmitted, this suggests that young men are more

likely than in the past to suffer this 'revolving door' and its consequences.

Turning to first admissions, the table below (again based on age and sex-specific rates per 100,000 of the home population) shows the extent to which women's over-representation in statistics for those entering psychiatric in-patient care for the first time is also related to age. Again, each cell gives women's rate as a proportion of the rate for men.

TABLE TWO: FIRST ADMISSIONS TO MENTAL ILLNESS HOSPITALS AND UNITS, AGES 15-75+.

Age Group. Year

Sex and age specific rates per 100,000 home population.
Female rate as a proportion of male rate.

	1976	1981	1982	1983	1984	1985	1986
All Ages	135.6	130.9	125.3	125.3	123.5	122.8	119.0
15-19	157.5	130.3	110.9	125.4	111.8	98.6	106.2
20-24	128.9	106.8	98.2	97.3	93.4	90.0	94.7
25-34	132.4	119.2	108.6	103.4	101.6	98.3	99.2
35-44	124.1	113.9	110.1	112.5	108.0	102.8	102.9
45-54	119.8	125.3	126.7	120.7	120.0	114.9	117.2
55-64	123.1	131.2	126.4	122.6	124.7	131.9	118.0
65-74	121.1	123.0	116.7	122.0	120.5	128.8	116.0
75+	105.7	109.1	104.4	104.5	104.7	103.5	98.3

Source: Calculated from Health and Personal Social Services Statistics, 1990, Table 9.2 (Department of Health, 1990, HMSO, London)

Whilst the gap between the sexes has narrowed from 1.35:1 in 1976 to 1.19:1 in 1986, the greatest change is seen in the younger age groups and, again in the ages 20-34, there has been a switch in the direction of over-representation with more men than women admitted in these age bands. However, there has also been a switch amongst the oldest age group, the over 75s, with more men than women over this age

admitted to psychiatric hospital for the first time. In fact, despite an overall downward trend in first admissions, the first admission rate for this age group showed an increase of 11% in this decade: with a 17% increase for male admissions compared with a 9% increase for female admissions.

Again, the apparent narrowing of the gap between the sexes overall reveals a more complex picture when broken down by age. It is unlikely that a simple answer, such as the lack of community care, will explain all of these trends. What is more likely is that the answer will be made up of a number of different trends. It may be that those women previously admitted to psychiatric treatment as an in-patients are now more likely to be supported in the community by the increase in the number of community mental health teams, although the recent decline in prescriptions for psychotropic drugs needs to considered alongside this. At the same time, young men may be more likely to be admitted to psychiatric hospital than in the past in relation to changes in other forms of institutional control, policing methods and so on. Amongst the over 75s, the substantial increase in admissions of men may be the result of the failure of other services and psychiatric hospital is being used as a temporary place of care when nothing else is available.

Whilst the underlying causes for these trends are likely to be complex, the extent to which care in the community is matched to the needs of different groups defined as requiring psychiatric care, may well provide a major clue. The real need now is for further research to evaluate these trends.

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