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Foreign reports

Psychiatry in Gibraltar: in-patient statistics

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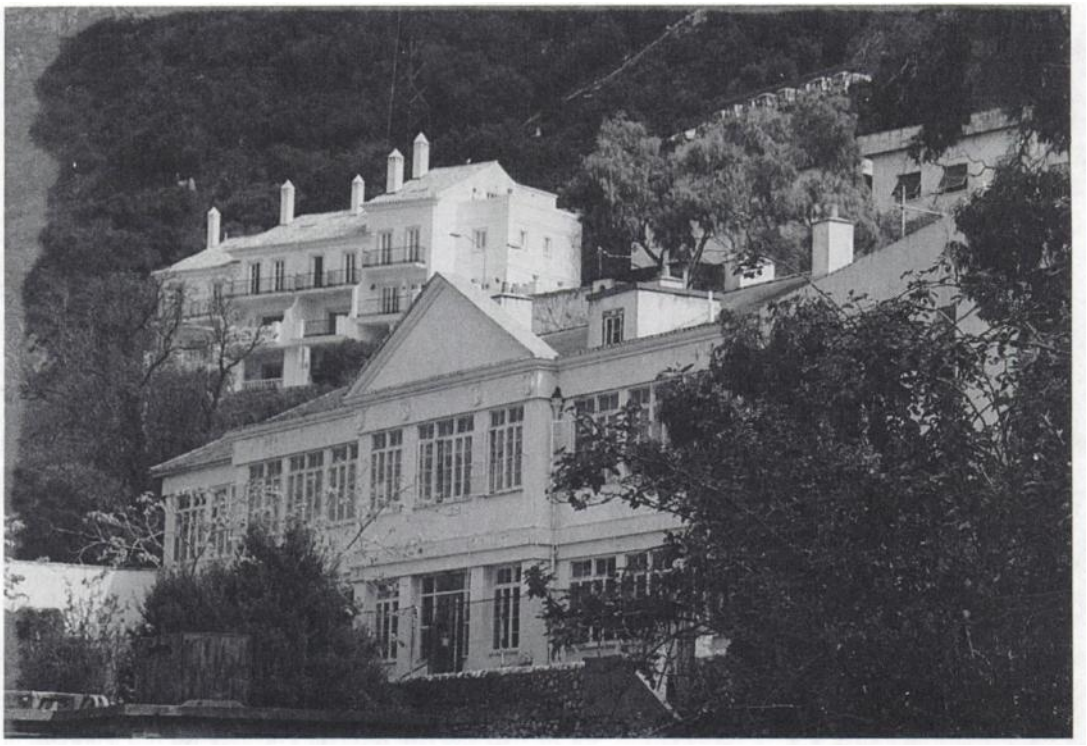
Gibraltar is one of the few remaining British colonies and the historical development of medical services on the Rock, named after its Moorish conqueror Gebel Tariq in AD 700, has been reviewed by Montegriffo (1978). The Rock provides a useful small community for studying the mental health of its population, being 1 × 3 miles in area and with a population of 29,166 (1986 census). The population has remained static for the last decade with the male/female ratio 15/14. There were 507 births, male/female ratio 254/253 and 290 deaths (154 males and 136 females, 1986 census). The age distribution has altered; the percentage over 65 years in 1970, 9.8% and in 1980, 11.2%.

The Gibraltarians have a multiracial background with origins in British, Italian, Maltese, Portuguese, Jewish, Spanish, Moroccan and Asiatic culture, but the national feeling on the Rock is strongly British. Given the shortage of space there are an estimated 7,846 dwellings (1986) with plans for further building after reclamation of land from the sea. This means that often two or three generations of a family live in the same household. Financially, it is estimated that one in every thousand Gibraltarians is a millionaire. Although Westminster has influence through the Governor of Gibraltar and UK foreign policy, the Rock is managed through a small locally elected legislative assembly of politicians. In 1969 the land border with Spain was closed as were ferry services to Algersera in 1970. This resulted in separation of family members living in Spain with acrimonious meetings and only visual sightings of relatives on

A view of Gibraltar



King George V Hospital

Sundays across the border. In 1982 pedestrians were allowed to walk into Spain and in 1985 access to vehicles were reopened. Tensions have been considerably reduced since but the border re-opening may also have opened the door to increased illegal trafficking of goods.

In this paper we review the utilisation of in-patient psychiatric services over the period of one year on the Rock.

Psychiatric services

In-patient psychiatric care is provided at King George V Hospital (KGV), a 57-bedded unit with medical cover by one consultant psychiatrist. Community psychiatric care was, until recently, shared by two mental welfare officers who had a dual role of social worker and community psychiatric nurse (CPNs). This latter role has recently been replaced by three CPNs. A general practice health centre provides primary medical care. Out-patient and liaison psychiatric services are provided at KGV as well as St Bernards Hospital, a DGH facility on the Rock. Most of the nursing staff and health care professionals receive training in the UK and the delivery of health care is modelled on the NHS. One noticeable difference is that the 1959 Mental Health Act was still in operation with considerable difficulties in utilising the 1983 Mental Health Act. KGV has two wards, an assessment ward (upstairs) which has 25 beds (excluding two strong rooms and one padded cell), and a long-stay ward (downstairs) which has 32 beds, occupied mainly by patients suffering from chronic schizophrenia or senile dementia. The main purpose of this survey was to assess the patients' diagnoses and duration of in-patient stay at KGV over one year.

The study

All cases admitted to KGV during 1988 were reviewed for diagnosis, sex, age, race, length of stay, family history of psychiatric illness and recurrence of admissions. Information was obtained from case-notes, the consultant psychiatrist, permanent nursing staff, mental welfare officers and the patients and their relatives. The diagnostic criteria were in accordance with ICD-9 and DSM III-R classificatory systems.

Findings

Summarising the length of stay of the 93 patients (excluding readmissions) indicates an exponential decline ($r = 0.93$) with duration of admission between

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four to eight weeks common. Eight patients were readmitted: two with schizophrenia, one with major depression, one with manic depressive illness and four patients with personality disorder who accounted for nine of the 13 readmissions.

Admissions according to diagnoses showed schizophrenia to be the largest diagnostic category ($n=32$ [34.2%]), nearly three times the admission rate compared with manic depressive illness ($n=11$ [11.8%]), and over twice the rate in the UK (14.9%), (OHE, 1989). Other diagnostic categories included personality disorder 22 (23.6%), substance misuse 14 (15%), major depression 11 (11.8%), obsessive compulsive disorder 4 (4.3%, paraphrenia 3 (3.2%) and dementia 1 (1.0%). The mean and median length of hospitalisation was significantly greater for manic depressive illness (44 and 40.5 days) than schizophrenia (26 and 29 days), $P<0.01$). The mean and median length of stay for personality disorder was 19 and 10.5 days, substance misuse 18 and 14.5 days, major depression 24 and 10 days and OCD 38 and 34 days. Males were almost two times more likely to be admitted with schizophrenia ($n=20$, mean age 35.5) than females ($n=11$, mean age 34.8). This contrasted with an almost equal sex distribution for manic depressive illness (M:F 6:5), with the mean age of men being about ten years older, (M:F mean age 49.6:39.5). Sex and mean age differences in other diagnostic categories were personality disorder M:F 11:11 mean age 36.3:36.0, substance misuse M:F 13:2 mean age 35.5:36.0, major depression M:F 4:2 mean age 54.3:60, OCD M:F 2:2 mean age 53.5:43.5, paraphrenia M:F 0:3 mean age 0:71.6, and dementia M:F 0:1 mean age 0:67. Family history of major psychosis (in parents, sibs or first degree relatives) was present in 35.5% (11) of schizophrenic patients, 27.3% (3) of manic depressive patients, 25% (1) with obsessive compulsive disorder, 18.2% (4) with personality disorder and 16.7% (1) with major depression. No racial preponderance was observed in any of the diagnostic categories. The one patient with senile dementia and the three paraphrenic patients became chronic and were transferred to the long-stay ward.

Comment

The effect of extended families living in the same household due to shortage of accommodation had no major adverse effect in managing the majority of patients. It was, however, apparent that family tensions had increased during the border closure with Spain. Most families were supportive of their mentally ill relatives but the societal stigma of being admitted to KGV was strong. It was heartening to see that useful employment was available in the community for some chronic patients. The greater length of stay for patients with bipolar affective disorder compared with schizophrenia indicates the severity of affective illness which is often underestimated. The greater number of males admitted with schizophrenia supports the neuro-developmental model proposed to account for the sex difference in schizophrenics (Castle & Murray, 1991). The higher prevalence of schizophrenic illness in men as denoted by hospital admission statistics could be due to a net emigration of female schizophrenic subjects from the Rock, but this is unlikely as the sex distribution of the population has remained fairly static. It could be said that females were cared for at home and remain undetected, but help-seeking behaviour between males and females is not significantly different (Hafner *et al*, 1989). As the average age of the male schizophrenic patients is slightly higher than the female, earlier presentation of the illness in males is unlikely to account for this difference (Angermeyer & Kuhn, 1988). It may be that the incidence of schizophrenia is genuinely higher; a male:female ratio 2:1 suggesting a possible sex chromosome linkage for the disease. Admissions for schizophrenia were more than twice, personality disorder three times and substance misuse nearly twice the rate in UK, (OHE, 1989). The latter may be a reflection of increased drug trading between North Africa and Spain since the border reopening (of cannabis, in particular, which has been legalised for personal use in Spain).

The exponential decline in length of stay is not an uncommon finding in NHS hospitals and supports the notion that, as length of hospital stay becomes shorter, the greater the chance of further hospital admittance. The differential length of stay for the various psychiatric disorders reported has implications for the planning of in-patient services on the Rock and in the UK.

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