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What is the psychiatry of old age and why do we need it?

The psychiatry of old age (POA) is concerned with the identification, assessment, treatment and care of older adults with mental disorders, and of those who look after them. Mental illness in late life is as old as humanity, and there is a long history of social and medical interventions with affected individuals – some more enlightened than others. In all societies and at all times the care of elderly people has been grounded in the family, and it is only when this source of support is absent or insufficient that the local community or the State has intervened. In mediaeval Europe, the legislation developed for this purpose had as much to do with the management of property as the welfare of the individual, but the records show that in the context of small and relatively cohesive communities it could deliver sophisticated and effective care for insane and incompetent individuals, both rich and poor. The modern history of old age psychiatry in developed societies has its origins in the changing social demography of the nineteenth century, with the rapid urbanization of populations and growth in the numbers of elderly people. With local community support no longer sustainable, the poor and the disabled (elderly people were often both) were particularly vulnerable. The responses to this welfare challenge were many and various, and included Poor Laws, pensions, and institutional solutions such as workhouses, infirmaries, and the lunatic asylums. It was within these institutions, often later re-labelled as 'hospitals', that the frailties of old age were medicalized, and became the professional responsibility of physicians and psychiatrists. So far as mental illness was concerned, however, this was not a responsibility that was especially welcomed by anyone. In particular, elderly people with dementia were felt to be a nuisance; they could not be discharged from acute medical beds, psychiatrists were not interested in them, and no-one had anything to offer beyond institutional warehousing in nursing homes or the back-wards of the old asylums.

This professional pessimism and lack of interest began to be challenged in the second half of the twentieth century by small groups of innovators, particularly in the UK. The creation of 'geriatric medicine' within the new National Health Service (NHS), with its avowed interest in all of the physical and mental problems of older people, and its multi-professional approach to solving them, was an important model for the later development of old age psychiatry by its pioneers, figures such as Tom Arie and Tony Whitehead. An important factor influencing this change of attitude in service providers was research, for example that by Martin (later Sir Martin) Roth in the UK, demonstrating that not all mental illness in old age has the same bad prognosis, and that mortality in individuals

with affective and psychotic disorders was much less than in those with dementia. This optimism was encouraged by the successful application of both physical and social treatments to elderly patients. A number of large-scale epidemiological studies of mental disorders in elderly community populations were carried out at this time in the USA, Scandinavia, and the UK, which characterized the full range of these conditions, and the extent to which those affected by them were out of touch with any services. These surveys also made it clear that only a minority of the elderly population were mentally ill; an important message from the emerging science of gerontology was that physical and mental frailty was by no means the inevitable consequence of ageing, and that the compression of morbidity was a realistic and achievable goal.

Another important factor that has driven change in service provision for elderly people in developed societies has been government health policy, developed in response to demographic ageing, the cost-effectiveness of treatment and care, and rising expectations of the population regarding the quality of that care. By the 1960s, it was widely accepted that the traditional custodial approach to the care of the mentally ill was no longer acceptable, and that the focus of services should move to the home and the community. However, the rate and extent of the development of community-based old-age psychiatry services have differed substantially in different countries; those with universal health and social care funding and centralized health policy and planning, such as the UK and Canada, have created much more comprehensive services than those without, such as the USA. Active and vocal voluntary and other non-government organizations, such as the Alzheimer's Association (USA), Alzheimer's Society (UK) and Alzheimer's Disease International (ADI), have also been a valuable stimulus to service development, particularly for the support of carers. The development of services for the elderly mentally ill, and the international consensus model of their organization published by the World Psychiatric Association in 1997, are discussed in detail in Chapter 11.

The future

Developed societies may have been the first to experience demographic ageing and the growth in the number of elderly people with mental illness, but the rest of the world is catching up fast. According to a recent review, there are currently 24.3 million people with dementia in the world, with 4.6 million new cases annually. The number of those affected by dementia is projected to double every 20 years, with 42.3 million people worldwide living with dementia in 2020, and 81.1 million in 2040. Most of these people with dementia live in the developing world: 60% in 2001, rising to 71% in 2040. This review identified three groups of countries: the developed regions, which start from a high base rate of dementia and which will experience moderate proportional increases in numbers of affected individuals of about 100% between 2001 and 2040; Latin America and Africa, which start from a low base rate, and which will experience more rapid

two- to threefold increases in prevalence by 2040; and India, China, South Asia and the Western Pacific regions, which both start from a high base rate and will experience at least threefold increases in prevalence. By 2040, there will be three times as many people with dementia in this third group of countries than there will be in Western Europe.

Of course, dementia is not the only disorder that will increase in prevalence with demographic ageing. Other conditions such as vascular disease, arthritis, and sensory impairments will all contribute to an increasing burden of chronic physical and mental disability in old age, as will emerging problems such as the global epidemic of obesity. Other factors are also likely to have an impact upon the future welfare and care of elderly people. For example, in developed societies, the shifting dependency ratio of the population will require individuals to continue working beyond traditional retirement age, just as they always have done in poorer countries. Increased geographic mobility, with children moving away from home and parents relocating on retirement, will reduce the availability of informal care, as will the continued growth in the number of single-person households. In the developing world, there will be the problem of the competing demands of young and old for health care, particularly for conditions such as AIDS that disproportionately affect younger, economically active age groups. For some countries, rapid economic growth may help to some extent with the challenges of demographic ageing, but this will bring problems of its own, such as the economic migration of younger people into cities and to more affluent countries. In many parts of the world, the stigma associated with mental disorder at all ages is still a major obstacle to the provision of care. There are other, less predictable, eventualities that could have a major impact upon the capacity of all societies to respond to demographic ageing in the years to come, for example pandemic influenza, which may disproportionately affect the young, or climate change bringing about large-scale population movements and resource wars. On a more positive note, there would be considerable economic and social benefits globally, were we to achieve effective control of widespread endemic diseases such as malaria.

These projections and predictions have profound social and economic implications for both developed and developing societies around the world. Even the richest nations will struggle to maintain levels of health and social care at their current levels, and for much of the developing world the models of service infrastructure pioneered in the UK and other developed countries simply will not be an option. In the absence of cheap and simple cures for disorders such as dementia, other approaches will have to be found. There will need to be a much greater public health focus on primary prevention, particularly the prevention of cerebrovascular disease through effective control of vascular risk factors such as hypertension, diabetes and smoking. The quest to develop a vaccine against Alzheimer's disease (AD) has been stalled in the early stages because of adverse effects in the initial trials, but this approach may still hold some promise, and other evidence-based novel approaches to treating AD are being developed and tried out. In the longer term, there is a growing body of evidence to indicate that the onset of clinical dementia may be delayed in individuals with a greater

amount of 'cerebral reserve', suggesting that better nutrition and education in childhood and young adulthood may have a positive effect on the incidence of dementia in old age. It is not yet clear what, if anything, can be done to boost cerebral reserve in later life; the 'use it or lose it' hypothesis is attractive, but the evidence to support it is still limited. So far as secondary prevention is concerned, there will be a need to develop new service models for societies that can only afford basic levels of health care. Inevitably, these will need to build upon what already exists, for example by developing and extending the role of those professionals such as child nurses who currently visit families in their homes. The focus of their new role would be upon improved detection and family/carer support, through information, training, and developing local community solutions where possible. Public education at all levels will also be important in raising everyone's awareness and understanding of mental illness in old age, and in combating the associated stigma.

FURTHER READING

Article

Ferri, C. P. et al. (2005). Global prevalence of dementia: a Delphi consensus study. *Lancet*, 366, 2112–2117.

This paper uses published evidence to estimate the current and future global prevalence of dementia.

Book

Jacoby, R., Oppenheimer, C., Dening, T., and Thomas, A. (Eds.) (2008). *Oxford Textbook of Old Age Psychiatry*. Oxford: Oxford University Press.

Easily the best of the comprehensive guides to the subspecialty.

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Assessing the elderly psychiatric patient

Introduction

The assessment of older adults with affective, behavioural or cognitive symptoms requires versatility and a wide range of knowledge and skills. Hence, Brice Pitt, one of the pioneers in the subspecialty, referred to the psychiatry of old age (POA) as 'general psychiatry only more so!' This chapter will outline the special features that characterize the assessment of older adults with psychiatric problems, i.e. we will focus on the 'added value' necessary to understand the elderly patient compared to a younger adult. These special features include: (1) flexibility in adapting to the most appropriate place and mode of assessment; (2) inclusion of the informant/caregiver as a fundamental and essential component of the assessment; (3) skill in taking a history that spans a lifetime; (4) special understanding of medical co-morbidity (especially neurologic disorders and the impact of drugs on the central nervous system); and (5) particular skill in cognitive screening, including frontal/executive brain functions.

Where to assess the patient

The doctor's office is not a practical setting for the assessment of any patients except for those who are high functioning, cooperative and competent. For those with significant cognitive impairment, the very frail, the resistant, and the incapable, the patient's own setting is preferred. This is not just optimal, but often necessary. This is the only way that one can properly assess the impact of environmental factors, safety issues and obtain a better sense of how the patient functions in terms of their independent activities of daily living.

Health care systems should provide incentives for physicians to leave their offices or hospitals and go to the patient's own setting. In older adults, the complex and multi-faceted nature of their clinical condition invites the involvement of other health care professionals who can address psychosocial issues and practical concerns. Ideally, the psychiatrist is part of a multi disciplinary team that has the range of expertise that can address medical, cognitive, behavioural and psychological issues while attending to practical concerns such as safety, nutrition, mobility and the well-being of caregivers (see below). A multi disciplinary team based in or closely affiliated with a general hospital setting also can have access to medical consultations and investigations. Because of the high prevalence of

medical co-morbidity, access to these resources is essential. One may need to rule out common systemic medical conditions such as coronary artery disease, heart failure, hypothyroidism, vitamin deficiencies, hepatic and renal dysfunction, or electrolyte imbalances. Hence, ready access to laboratory services is necessary. Moreover, in assessing dementia and other cognitive disorders, neuroimaging is a frequent component of the assessment and differential diagnosis. Selective access to brain scanning technology (usually this will be computerized X-ray tomography (CT), magnetic resonance imaging (MRI); sometimes single photon emission tomography (SPET) will be required) is necessary to assess cerebrovascular pathology, degenerative disorders, or rule out the possibility of space-occupying lesions. For psychiatric services, this is often done in the context of attempting to differentiate mood disorders from dementias and other neurological disorders.

Because of the high frequency of medical co-morbidity and associated drug treatments, we advise that all psychiatric assessments of older adults should be preceded by an assessment by a general practitioner (GP – also known in some parts of the world as a primary care physician). All new changes in affect, behaviour or cognition should be assessed first by GPs and referred to a psychiatric service when the condition is severe, complex or poorly understood. From a primary care perspective, the issue of cognitive screening is an important public health concern which has not yet been adequately resolved. Clearly, the nature of a busy primary care practice necessitates the capacity to perform screening quickly, efficiently and effectively. This will be addressed later in this chapter.

Role of the carer/informant

The historical psychiatric culture has often excluded families from being active participants in the assessment and ongoing management of major psychiatric disorders. This has evolved partly because of legitimate concerns about confidentiality, and the primacy of the doctor/patient relationship. However, one needs to balance this need with the reality that many major mental disorders have a profound impact on families and caregivers and they justifiably have a right to be included in the treatment process. This is also because of the fundamental fact that they can provide vital information that would often be missing if they were not part of the assessment. Referring back to the Brice Pitt dictum that geriatric psychiatry is general psychiatry but 'more so', one can see that in the assessment of an older adult, the absence of a caregiver/informant severely limits the quality of the assessment and hence the ability to make the best judgements in terms of diagnosis and ongoing management. Therefore, we suggest that all psychiatric assessments of older adults should include an informant or carer who lives with the patient or has a very good understanding of the patient's functioning and behaviour. Carers and families should be considered equal partners in the therapeutic alliance that develops with the psychiatrist and the multi disciplinary health care team. The traditional dyad of 'doctor/patient relationship' needs to be transformed into the 'doctor/family relationship' in the psychiatry of old age.

A fortiori, this is the case when the patient is incapable, cognitively impaired or extremely frail and vulnerable. In this case, the caregiver is often acting in the capacity of power of attorney for personal care.

Whom to see first and whether to see patients and families individually or together is an important consideration that has not been given adequate consideration in many psychiatric textbooks. One could hold to the general principle that the patient should be seen first in order to give a sense that his/her concerns are being taken seriously. This is especially true if there is any element of suspiciousness or paranoia that is evident in the initial referral. However, one needs to be very flexible in all aspects of assessment and management. If cognitive impairment is the primary concern, there seems to be little point in spending much time and effort taking a history from a compromised individual. If it is obvious that one is dealing with a significant cognitive concern, then it is probably more efficient to interview the family member or carer first in order to obtain a better sense of the clinical picture before bringing in the patient where the primary focus will be on the mental status examination and cognitive assessment.

If the patient and family members are seen together, this may significantly inhibit the informants from providing an honest and full clinical picture. When seen together, family members or carers often attempt to help the patient who is struggling with cognitive challenges. Moreover, inter-personal dynamics often manifest during the course of the interview. Certainly, that is a reason to see the patient and family together in order to assess such interactions. However, to obtain an optimal history and cognitive examination, this is best done by separating the patient and informants for assessment purposes.

Having completed the assessment and having established a formulation and management plan, then it is best to see the patient and family together in order to minimize divergent interpretations of the assessment and management plan. Even so, this is often a challenge, but there is considerable merit in bringing everyone together at the end to summarize and give feedback.

'Clinical pearl'

As a general rule, carers are always accurate when they indicate that there has been a change in the patient's level of functioning or psychiatric status. Like mothers who report on their children's clinical status, one needs to take this report at face value. However, it has been our experience that the caregiver's interpretation of the changes in mental state or behaviour need to be viewed in a different vein. Very often, the carer's interpretation is mistaken. In particular with early dementias, carers frequently misinterpret motivational deficit and cognitive changes as a sign of depression, or attribute the changes to longstanding personality traits. Carers may feel that their loved one is being deliberately obstinate or retaliating because of inter-personal tensions or conflicts. These attributions do need to be corrected and the best time to do that is at the initial assessment.

History taking

As in general psychiatry, history taking is perhaps the most important element in establishing a provisional diagnosis. The challenge, of course, in taking a history from an 80- or 90-year-old is that one can be overwhelmed by the many details of a long life. The clinician should have the capacity to filter relevant from irrelevant material and focus on major events and patterns of behaviour in order to assess an older adult in a timely fashion. History taking does not involve a detailed description of the early development of an 85-year-old with respect to infant developmental milestones. Rather, one needs to have a general sense of whether development was normal and whether there is any history of major disruptions to normal development because of early losses of a parent from death or divorce or any significant trauma in childhood. One is interested in obtaining a general overview of the patterns of adjustment to school, social relationships, intimacy, work history, retirement, bereavement, and to the disabilities of later life. These facts need to be synthesized into a concise and coherent history rather than a detailed and over-inclusive one. Significantly, sexual history is often omitted because of embarrassment on the part of the examiner. However, changes in sexual function and activity can provide helpful clues regarding the development of mood or degenerative brain disorders, and this aspect of history taking should not be overlooked.

Age of onset is an important variable in all of psychiatry and this is just as true in later life. This will often be a clue as to the role of familial or genetic factors. Even in older adults, a detailed family history of psychiatric disorder is essential. Certainly, conditions that begin earlier in life tend to be more genetically determined and suggest a constitutional vulnerability that is greater than a late-onset mental disorder where medical/neurological disorders and the central nervous system (CNS) impact of drugs play a more central role. This has implications in terms of investigation, further assessment, diagnosis and management.

A special understanding of medical co-morbidity is an important aspect of the assessment of the older adult. This requires particular attention in the history taking, including a review of major illnesses and operations as well as a specific inquiry about any prior head injury. Furthermore, a detailed review of the current drug regimen and recent drug changes is especially important in the assessment of an older adult. Thus, the physician-assessor plays a particularly central role in the assessment of older adults for this reason. This also highlights the importance of having ready access to medical consultation and investigations.

Mental status examination

The mental status examination takes the form of a semi-structured interview and should happen throughout the history-taking process. As in mixed-age adults, the mental status examination begins from the moment one observes the patient for the first time and continues throughout the course of the assessment. What

distinguishes the assessment of an older adult really focuses on the need to do a careful cognitive examination in all cases. One needs to resist the inclination to avoid a formal cognitive screen when the older adult appears to be superficially intact. Clinicians will regret this when it becomes clear later in the clinical course that a cognitive disorder was indeed emerging at the time of the initial assessment. This is especially important in individuals who maintain their social competence through the early stages of a dementing illness. This is also relevant in individuals who have been functioning at a very high premorbid level and the examiner may be hesitant to embarrass the patient. However, this is almost always a mistake and experience suggests that some form of cognitive assessment is essential in every psychiatric assessment of an older adult. How to go about doing a cognitive assessment is a technique that must be learned and then practicsed (see below).

'Clinical pearl' – 'The age and date of birth' cognitive screen

We recommend a 'clinical tip' whereby a cognitive screen occurs imperceptibly at the very outset of the interview. When taking basic demographic information such as name, address, marital, occupational or retirement status, one can determine whether there is a significant cognitive concern. This is done by asking two questions: (1) How old are you? and (2) What is your date of birth? In the context of a demographic inquiry, these are non-threatening questions but will often reveal cognitive impairment if the patient has significant difficulty recalling their age or when the age and date of birth are not congruent. This will allow the examiner to move into a more formal cognitive screen earlier in the process than would otherwise be the case.

As with younger adults, it is best to initiate the interview with open-ended questions after the basic demographic information has been determined. These open-ended questions provide two important outcomes. The first is to allow the patient to review significant ideational, psychological and emotional material without being deflected by structured and focused questions. Secondly, the open-ended questions will help to reveal evidence of thought disorder or over-inclusiveness.

Sometimes, the interviewer's reaction to a patient's history is a sense of 'vagueness'. This is often a clue that there is an underlying cognitive problem and should invite a formal, structured cognitive assessment during the interview. We certainly suggest that if the patient is inclined to be talkative, it is a worthwhile investment of one or two minutes at the outset of the interview to allow the patient free rein while carefully observing for thought content and thought process.

Assessment of appearance and behaviour, speech, thought form and content, mood, the presence of abnormal ideas or experiences and insight and judgement should proceed as would be done for any psychiatric patient. However, the

cognitive assessment needs to be much more detailed than would be the case for most younger patients because of the high prevalence of cognitive disorders in this age group (see below). Patience may be required, because old people become tired more easily than young ones and are much more likely to have sensory impairments that render the assessment more complex and difficult. Sometimes, if the patient becomes fatigued easily, it will be necessary to conduct a full assessment over more than one session. Particular attention should be paid to the presence or absence of any mood symptoms (old people are sometimes reticent to admit to low mood) and it should be noted that any delusional symptoms are likely to be relatively banal and to relate to the patient's immediate surrounds and social circle, in contrast to young patients with schizophrenia in whom bizarre delusions and hallucinations are quite common.

'Clinical pearl' – 'The white roots sign'

Observation as part of mental status can be a clue to underlying diagnosis. Felix Post, one of the original pioneers in the psychiatry of old age, often referred to the 'white roots sign'. This reflects the fact that personal grooming is often a reflection of the underlying clinical status of the patient. Decline in personal grooming is often a clue to the presence of an underlying disorder. For women who are in the habit of dyeing their hair, this is a special clinical opportunity. One can posit a diagnosis of major depression by simply observing the white roots of a woman who has been in the habit of attending regularly at the hairdresser. Since major depression affects initiative and motivation, in severe cases this will impact on an older woman's long established pattern of hair care. With the knowledge that hair grows at the rate of approximately half an inch a month, a two-inch band of white roots suggests a four-month major depression. This clinical observation of course needs to be corroborated by history and the remainder of the mental status examination. However, an observation such as this can certainly establish a hypothesis earlier in the assessment. This needs to be pursued by the examiner by posing more critical questions in order to differentiate major depression from dementia, as will be described in the next chapter.

Cognitive assessment and benefits of early diagnosis

Cognitive assessment is a vital part of the overall assessment of all older adults. No matter how intact an older adult appears or how preserved the social graces, a formal cognitive screening is vital. Otherwise, the risk of missing the early stages of a cognitive disorder is very high. However, one must bear in mind the fact that no cognitive screening measure is an 'Alzheimer test'. The cognitive assessment must always be interpreted in the context of the history and other investigations in order to establish a provisional diagnosis. However, cognitive assessment can help to determine whether the impairment is diffuse or focal in nature and