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History of a specialty

Old age psychiatry is a relatively young discipline which grew out of the appreciation (before it became a popular mantra) of the numbers of older people, the distinctive and rich psychopathology of their illnesses and the need to provide bespoke services. Clinical pioneers in the UK such as Felix Post, Tom Arie, Gary Blessed, Klaus Bergmann and David Jolley complemented academics such as Martin Roth, David Kay, Raymond Levy, John Copeland, Elaine Murphy and Robin Jacoby in forming a drive towards the creation of a unique set of circumstances which, coupled with political will in the late 1980s, formed the specialty of old age psychiatry. Advances in the understanding of the dementias and the basic biology of AD (by Bernard Tomlinson and Elaine Perry), gave a scientific boost to the major organic disorders which, until then, had been the focus of service descriptions and clinical characterizations

It is easy to forget that the basic clinical categorization of the major mental disorders in older people only began to be appreciated in the 1950s with straightforward longitudinal studies by Roth and colleagues which tracked the natural history of older people admitted to hospital and eloquently demonstrated by a simple categorization their differing outcomes.

Thus the modern classification of disease was born emphasizing the chronicity of the dementias, the good recovery of the people with depression, and the high mortality rate for delirium.

Old age psychiatry is in robust health in the UK, with over 400 specialist posts in the field and an active training programme, and with an identity and cohesion linked to this critical mass the specialty is booming. However, the threat to all age-related services in the modern NHS leads to a reconsideration of the nature of the specialty—is it all things to all men (and women) over a certain pre-defined age or should it concentrate on organic disorders, the roots from which it grew?

The real excitement in old age psychiatry revolves around the therapeutic advances and basic understanding of the dementias. At no time since the creation of the specialty has there been such a wide array of drug and non-drug approaches to treatment and interest from basic scientists about uncovering not only the basic mechanisms of the major disorders but also seeing how that can be followed through to successful treatments.

This handbook reflects the current state of knowledge in old age psychiatry and will serve as a basis for the challenges which our specialty, in common with many others, faces in the future.

Overview of mental disorder among older people in different settings

Perspectives on which older people have a mental disorder have changed greatly with time. In the 1950s, mental illness among older people would have conjured up images of long-stay wards with dormitory arrangements in the old asylums. Increased interest in epidemiological research, in part driven by an ageing population, has delineated the prevalence of psychiatric disorders in different settings. Old age psychiatrists and community mental health teams tend to see equal numbers of new cases of dementia and functional psychiatric illness. In-patient bed provision is typically about equally occupied by dementia and functional cases. Dementia, by its progressive nature, tends to accrete and the caseloads of community teams will typically have far more long-term patients with dementia. Provision of long-stay care for people with dementia in the UK initially moved from hospital care to local authority care homes but now is almost exclusively provided in privately run residential and nursing homes. Dementia is usual in residents of residential and nursing home, even those in non-specialist elderly frail care homes. About 200 000–250 000 people with dementia now live in care homes in the UK. Depression is common in this setting, with prevalence estimates between 20% and 40%, but this may resolve, especially with appropriate treatment.

In primary care, where most care is delivered, the situation is different. Over 90% of older people consult with their GP each year, allowing unique case-finding opportunities. An average GP will have about 35 cases of dementia on his or her caseload at any time (not all identified), roughly similar to the numbers with declared rheumatoid arthritis or epilepsy. Five to ten new cases of possible or probable dementia may be identified and referred by a GP in a year.

Many cases of psychiatric illness never declare to services. Table 1.1 gives the approximate known prevalence of psychiatric disorders in various settings. It can be assumed that these figures are similar across developed countries. European studies of the prevalence of depression and dementia in the community confirm this. In the developing world, the population is ageing much more rapidly than has ever been seen in the West. Early epidemiological work shows that the prevalence of dementia, and the social consequences of it, are similar among older people in developing countries. Services are rudimentary or non-existent in such countries, leaving people with dementia even more dependent on their families than in developed countries.

Table 1.1 Prevalence of common psychiatric disorders among older people by setting

	Dementia	Depression	Delirium
General hospital admissions	20%	20%	15%
Residential/nursing homes	50–60%	20–40%	5%
Primary care older attendees	5–10%	10–20%	unknown
Community	5–10%	10–15%	unknown

Tips on assessing an older person with psychiatric disorder: 1

General

Take time

Assessment of older people with psychiatric disorder may take some time. Collateral history may be required, while deafness or frailty will prolong assessments. Patients may well have multiple medical, social, and psychiatric problems, increasing assessment time. Patience and planning of assessment times will be needed.

Collateral history

In any psychiatric assessment, a collateral history is desirable. Among older people with cognitive impairment it is essential. In practice, most older people are happy to allow this. A breach of confidentiality is justified if information is required to help maintain the person's safety. Family members, social and health-care staff, or care home staff are invaluable sources of information. Key questions may include: 'How long has she been forgetful?', 'Has she been repeating herself more?', 'Has she locked herself out?', 'Has she left the gas on?', 'Has she been more irritable or resistant?'. Attention may need to be paid to inclusion of the older person in the assessment, rather than just interviewing the informant.

Reduce distractions

Noisy hospital wards are among the worst places to take a history and assess a patient with dementia. Reducing outside noise, minimizing sensory impairments (putting in teeth/hearing aids/spectacles), going to a quiet room, switching off televisions will all be helpful.

Repetition

For those who are frail, deaf, or cognitively impaired, repetition may be needed. This may help to maintain dignity or establish facts. Sometimes it is strategic; for example, in deciding on capacity issues: an older person may forget the detail of what was discussed but may on two separate occasions show clear evidence of capacity so the decision is valid even if forgotten in between

Mental state examination

The structure of mental state examination among older people is the same as with younger people. The emphases within each component are different and are outlined below.

Appearance and behaviour

- Are there signs of recent weight loss? Is there resting tremor? Is there agitation (more common in depression in old age). Does the person show distractibility/poor attention span (common in dementia)? Do they defer to a carer (common in cognitive impairment)?

Speech

- Are they dysarthric (common in Parkinson's disease, motor neuron disease, after stroke, but also in the edentulous)? Are they dysphasic (very common after stroke or as part of a wider picture of impairment in dementia)?

Affect

- Are they markedly low (severe, psychotic depression is more common in old age and often accompanied by agitation and/or retardation)?

Thoughts

- Is there insight into the extent of cognitive impairment and social care needed (frequently deficient in dementia)? Does the person have particular mood congruent delusions (very common in old age depression—especially nihilistic and hypochondriacal delusions)?

Perceptions

- Are there visual hallucinations (characteristic of DLB)? Do they appear distracted by illusions/hallucinations (common in delirium)?

Cognition

- The ability to make a meaningful assessment of cognitive state is essential when assessing older people. Sometimes this is translated as ability to use the MMSE, but other instruments may be more appropriate. For example, the Abbreviated Mental Test score has good sensitivity to change and is often used to demonstrate fluctuating impairment in delirious patients on general hospital wards. The CAMCOG gives a more detailed assessment of cognitive impairment than the MMSE, allowing domains of memory, orientation, speech, abstract thinking, attention/calculation, and visuospatial skills to be mapped. It is sometimes mistakenly thought that a poor score on a cognitive test means a diagnosis of dementia—it does not. At best these instruments are used as screening instruments for significant impairment and as a baseline which may be useful in plotting progress, for example in borderline cases or people on anti-dementia drugs.

Tips on assessing an older person with psychiatric disorder: 2, Physical examination

Some consideration of the patient's physical state should always be made. The prevalence of comorbid physical illness is very high among older psychiatric patients, and physical disorder may be directly relevant to the assessment. For example, if older people with cognitive impairment are hypertensive, have atrial fibrillation, and show localized neurological signs like dysphasia or hemiplegia, the likelihood of VaD is higher. If a patient with dementia reports hallucinations and shows cogwheel rigidity, then DLB is more likely. If an older person with severe depression shows evidence of malnutrition and dehydration then urgent admission for ECT may be required.

The list below should be tailored to the individual case being assessed; not every psychiatric assessment needs all these examinations. The ability to do a comprehensive psychiatric assessment should be accompanied by the skill to do each of these examinations when needed.

System¹

General examination

- Hygiene: Any signs of recent weight loss? Alert? Do they look generally ill?

Systemic disease

- Any jaundice (examine sclerae). Any anaemia? Lymph glands enlarged? Any thyroid signs?

Skin/nails

- Are there any bruises (sign of falls/abuse)? Is skin turgor normal (may be dehydrated)? Any pressure sores (especially bed-bound people)?

Cardiovascular

- Check blood pressure. Is there any postural drop (consider checking this if the patient has been falling/dizzy)? Check pulse. Is there atrial fibrillation? Is the pulse weak and thready (if dehydrated)?

Respiratory

- Is the patient cyanosed? Is the respiratory rate increased (below 16/min is normal)? Are there any clear signs of infection, e.g. localized dullness/crepitations?

Abdomen

- Is there any organomegaly? Is there evidence of faecal loading? A rectal examination is essential if the person is constipated.

Central nervous system

- Is there any obvious sign of visual loss, especially visual field loss? Is downward gaze grossly impaired (found in some disorders causing parkinsonism)? Alcoholics with Wernicke's encephalopathy may show grossly impaired eye movements.

- In the limbs, is there any clear hemiplegia? Check for reduced power, abnormal reflexes, and change in tone in limbs on either side. Is there cogwheel rigidity? Are gait and balance normal (gait ataxia is characteristic of normal pressure hydrocephalus)?

Musculo-skeletal

- Are any joints red/hot/swollen/painful? Is there clear deformity, e.g. ulnar deviation in fingers in rheumatoid arthritis. What restrictions in function do joint problems cause?

Demographics of ageing

The last century witnessed an unprecedented increase in the average human lifespan. The estimated total world population of older people was about 200 million in 1950 and is expected to rise to 1.9 billion by 2050—a nine-fold increase in 100 years. Currently, about 6% of the world's population comprises those aged 65 years or above. There is wide variation across the world in the proportions of older people.

The developing world

The developing world has a bigger proportion of children in the population (nearly 50% in some countries). The estimated current figures suggest that people above the age of 65 comprise about 5% of the population in Latin America and Southeast Asia and 3% in most of Africa. In the developing world, only 20.5% of the population will comprise older people in 2050 (compared with 32.5% for the developed world). Due to its huge total population, this means there will be 1.6 billion older people in the developed world by 2050, or over 80% of the world's elderly population.

North America

In North America, the population of older people was 35.0 million in 2000 (12.4% of the total population). By 2030, these figures are expected to rise to about 70 million (or twice the number in 2000).

Europe

Projected figures in Europe suggest that the number of prevalent dementia cases will rise from 7.1 million to about 16.2 million over the next five decades.

United Kingdom

In the UK over the last 35 years, the population aged over 65 grew by 31%, from 7.4 to 9.7 million, whilst the population aged under 16 declined by 19%, from 14.2 to 11.5 million. The largest percentage growth in population in the year to mid-2006 was at ages 85 and over (5.9%). The number of people aged 85 and over grew by 69 000 in the year to 2006, reaching a record 1.2 million. The proportion of people aged over 65 is projected to increase from 16% in 2004 to 23% by 2031.

The ageing world

The reasons for this explosion in the older population in the world in general, and in the developed world in particular are many, and are not just a result of increasing life expectancy. Other factors including the declining fertility rate, declining child mortality, education, and economic development play a big part. The ageing population of the world presents major challenges for society and for health services. Health services will have to adapt to new demands of an ageing population as well as to associated costs.

Mental health in an ageing world

Mental health issues are extremely important, as mental disorders, notably dementia and depression, are common in old age. Mental ill-health can profoundly affect the quality of a person's old age and has a significant impact upon the use of health and social services.

Challenges in the developed world

Even in a developed country like the UK, with established mental health services for older people, repeated reports have shown that the mental health issues of older people remain poorly understood, highly stigmatized, and are not given the priority necessary in policy, practice, and research—despite official reports since at least 2000 highlighting discrimination and calling for action.

Two-thirds of older people with depression never even discuss it with their GPs, and of the third that do discuss it, only half are diagnosed and treated. This means that of those with depression only 15%, or one in seven, are diagnosed and receive any kind of treatment. Even when they are diagnosed, older people are less likely to be offered treatment, and depression is sometimes still regarded as an inherent symptom of growing older. With the rising numbers of older people there will be an estimated 3.5 million older people with symptoms of depression by 2050.

In the UK there are currently 700 000 people with dementia. Dementia affects one in five people aged over 80 and one in 20 aged over 65. In less than 20 years there will be nearly a million people in the UK with dementia, and this will rise to 1.7 million by 2050. The overall cost of dementia is £7 billion a year, and this will treble in 30 years.

Challenges in the developing world

In the developing world an ageing of the population which is unprecedented in human history is now occurring. This is certain to place huge demands on social structures which will have to cope with increasing numbers of frail and unwell older people. In particular, assumptions that families will look after older relatives may be untenable. There is already evidence that mental health issues are of low priority in poorer countries with small health and social care budgets which are allocated across competing demands. Unrecognized and untreated mental illness may become a fate for many of those growing older in the developing world.

Epidemiology of mental disorders in old age

The epidemiology of mental disorders in old age is a rapidly evolving area. Most epidemiological research in this area has been conducted in Europe and North America. An overview of the prevalence of common mental disorders in old age will be given in this chapter.

Dementia

The prevalence of dementia increases with age. Most studies have shown a prevalence of 0.8% in the 65–70 year age group which increases exponentially to 28.5% in the 90+ age group. The prevalence of dementia is about equal for older men and women and is probably about equal across national boundaries.

Depression

Depression is common in old age and is considered the most treatable/reversible mental health disorder in old age. Studies conducted worldwide suggest an average rate of all depressive syndromes of 13%. Major depression is a powerful and independent risk factor for suicide in older people, with the suicide rate almost twice as high as in younger people. In the European Union, the death rate from suicide per 100 000 populations in people above the age of 65 is 18.8 compared with 9.2 for people below 65 years age.

There is, however, a general consensus that a number of methodological difficulties might have resulted in an underestimation of depression problems in epidemiological studies. The main confounders include exclusion of institutionalized individuals from sampling, diagnosis of dementia, and poor recognition of atypical depression when using DSM or ICD criteria.

Anxiety disorders

There is a paucity of epidemiological research on other psychiatric disorders including anxiety, substance misuse, psychosis, and somatoform disorders in old age. Although these conditions are common in adult age groups, decreasing rates of anxiety disorders and substance misuse have been reported in older age. As the elderly population grows, even currently less common conditions are likely to become more prominent at a population level.

A number of methodological difficulties might account for decreasing rates of anxiety in older people. Firstly the current diagnostic assessment methods focusing on somatic symptoms of anxiety may not adequately differentiate between anxiety and symptoms of medical illness that are more common in the elderly. Secondly the assessment instruments are likely to miss comorbidity with other psychiatric disorders.

Drug abuse

Alcohol and drug abuse are consistently found to be less common among older people. This may be partly explained by premature deaths among substance abusers, by cohort effects (people in their 20s in the 1950s in the UK drank under half the amount of alcohol of their modern equivalents), and personal/societal distaste for substance use in older age.

Psychosis

Psychotic syndromes in later life appear to increase with age if a broader definition is used, but there is a paucity of epidemiological research on specific syndromes such as late-onset schizophrenia and delusional disorders. Psychotic symptoms in other disorders like depression and dementia are much more frequent than true paranoid illness in late life. It is also clear that the devastating effects of schizophrenia among younger people are rarely found among older people newly developing the condition.

Normal ageing

There is no satisfactory definition of the normal ageing process. It can be defined as a cumulative process of adverse changes in physiological, psychological, and social functions that characterize average older people.

Normal ageing as a social concept refers to an accepted range of variation in health, appearance, and performance of adults at different stages of their lives. It is also a scientific concept referring to research findings in gerontology that can be useful in identifying variations from the normal ageing pattern. It is, however, always difficult to make a distinction between normal and pathological ageing.

Biological theories of ageing

According to biological theories the ageing process can be divided into primary and secondary ageing. *Primary ageing* refers to those declines in function that are genetically controlled and *secondary ageing* consists of random changes resulting from acquired disease and trauma. These theories suggest that if the hostile events related to secondary ageing could be prevented, life would be extended, but because of primary ageing decline and death are inevitable.

Deliberate biological programming

Studies on the ageing processes of human cells have shown that mitotic cells can divide a finite number of times and then die. Individual cells have a memory for the number of duplications, which is probably encoded in the genetic material. In other words, there exists a system of programmed cell death, thus making survival beyond a certain time limit impossible.

The ageing clock

This theory is based on the observation of biological clocks in both humans and animals. It suggests that ageing is a process that converts fit adults into frail adults with a progressively increased risk of illness, injury, and death. It refutes the concept of an absolute genetic control on the lifespan of an individual and suggests that living in favourable environments with positive living habits is the biggest influence on lifespan.

Accumulation theories

Other theories suggest that an accumulation of harmful substances such as free radicals and lipofuscin (an insoluble pigmented compound derived from incomplete degradation of normal cellular materials) with time result in an ageing process, eventually leading to death.

Psychological theories of ageing

These can be broadly divided into cognitive and personality theories.

Cognitive theories

The cognitive theory is based on studies of cognitive changes associated with age. In general, adults with higher intelligence and education tend to show minimum decline in their performances with increasing age, while a significant decline is observed in adults with lower intelligence and education. Older adults in general tend to perform less well in new and novel situations. The decline in cognitive skills is neither inevitable nor universal and some skills may improve or may be acquired with age.

Personality theories

Erikson's famous eight-stage theory of ego development suggested that the elderly person might either find ego integrity through satisfaction with his or her past life or despair and disgust over past failures. More recent workers have proposed an anti-stage theory of ageing, where personality, development, and adjustment are affected by historical events throughout the life.

Most studies have reported relative stability of personality traits from adulthood into late life. When personality changes occur, they appear to be related to losses, particularly those involving health and social support systems. Some studies have reported sex differences in personality in older age, men tending to become more affiliative and nurturing and women tending to become more individualistic and more aggressive as they become older.

Further reading

Busse EW (2002). General theories of aging. In: *Principles and practice of geriatric psychiatry*, 2nd edn (ed. JRM Copeland, MT Abou-Saleh and DG Blazer), pp. 19–22. Chichester, John Wiley.

