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542 Chapter 13 Old age psychiatry Psychiatric illness in older people and old age psychiatry as a specialty Old age psychiatry, sometimes known as psychogeriatrics, is a compara tively new specialty, which has developed over the last 50yrs in response to demographic changes and the growth of geriatric medicine. It was inspired by the ‘social psychiatry’ movement and its growing emphasis on the care and welfare of vulnerable sectors of the population. Psychiatric illnesses in older people include: • Pre-existing psychiatric disorders in the ageing patient. • New disorders due to specific stresses and circumstances of old age (e.g. bereavement, infirmity, dependence, sensory deficits, isolation). • Disorders due to the changing physiology of the ageing brain. • Psychiatric complications of neurological and systemic illnesses [e.g. delirium (E Acute confusional state (delirium), p. 854) is particularly recognized as a common complication of a variety of physical health problems in the elderly and needs to be considered in any patient where there has been an unexplained change in their cognitive functioning or level of awareness]. Psychiatric problems often coexist with physical problems, and treatment strategies need to take account of this (as well as the different pharmaco kinetics of the older patient; E Psychopharmacology in the elderly, p. 558). Furthermore, the elderly are more likely to manifest physical symptoms of psychiatric disorders than younger adults. Cognitive assessment and phys ical examination are always essential parts of psychiatric management of the older person. Dementia is generally the main focus of interest in old age psychiatry, but the discipline also involves the treatment of general psychi atric illnesses in older adults. Since older people are often dependent on others, consideration of the role and needs of carers are important aspects of holistic care. Psychiatric care of the elderly is inherently multidisciplinary and interfaces with mul tiple services, both state and independent (e.g. social services, housing and welfare services, the legal system, charity organizations, and religious institutions). The demographics of old age In developed countries, such as the UK, the elderly population has been increasing steadily over the last century. For example, in the UK, the per centage of the population older than 65yrs was 5% in 1900 and 15% in 2003, and is projected to rise from 18% in 2016 to 23.8% in 2036.1 This trend is largely attributed to the decline in infant mortality, control of infec tious diseases, and improvement in sanitation, living standards, and nutri tion, as well as a declining birth rate. The implications of increasing numbers 1

Office for National Statistics (2016) National population projections: 2016-based statistical bul letin. M https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/bulletins/nationalpopulationprojections/2016basedstatisticalbulletin#changes-since-the-2014-based-projections [accessed 11 July 2018].

543 PSYCHIATRIC ILLNESS IN OLDER PEOPLE & OLD AGE PSYCHIATRY of elderly people in society are many, including a drop in the proportion of the working population, an increase in overall disability and health needs, and a corresponding increase in the need for both health and social services. In terms of psychiatric disorders, it is well known that certain disorders increase in frequency with advancing age. For example, 5% of people older than 65yrs suffer from moderate to severe dementia and the prevalence in creases to over 30% in those over 85yrs. A recent survey in England showed the prevalence of symptoms of common mental disorders to be 10.2% in those aged 65–74yrs and 8.1% in those aged 75yrs and over.2 Other research has shown a particularly high prevalence of mental dis order among elderly people in sheltered accommodation. Of the 80,000 people in the UK who die in care homes annually, up to two-thirds have some form of dementia. Up to two-thirds of patients >65yrs in general hospital wards have a psychiatric disorder; of these, 20% may suffer from delirium, 31% from dementia, and 29% from depression at any one time.3 Finally, it is regrettably also the case that psychiatric disorders are com monly either undiagnosed or misdiagnosed at primary care level. Having said this, research has demonstrated a marked improvement over the last decade in both diagnosis and management at this level. The role of the old age psychiatrist • Advocate The old age psychiatrist can be an active proponent of the interests of the elderly, e.g. sourcing funding, providing education to the public, dispelling the stigma of ageing. • Teacher An old age psychiatrist is well placed to provide education in both medical and non-medical contexts. Medical and nursing students, across-discipline specialists and trainees, school pupils, community forums, and service organizers may all benefit from their expertise. • Health educationalist/promoter Holistic care of the elderly includes both health education and preventative intervention. • Student Old age psychiatry is a major area of research, and the changing demography of ageing allows for academic collaboration with other disciplines, e.g. sociology, history, and human geography. • Innovator Individuals working in this area have had the opportunity to be creative and innovative in developing appropriate services. • Team player Old age psychiatry is a truly multidisciplinary discipline. • ‘Missionary’ The global challenges for the twenty-first century include expanding the discipline within developing countries, as well as finding new strategies for caring for the growing numbers of elderly people within the first world.4 2 McManus S, Bebbington P, Jenkins R, Brugha T (eds) (2016) Mental health and wellbeing in England: adult psychiatric morbidity survey 2014, p. 44. Leeds: NHS Digital. 3 Royal College of Psychiatrists (2005) Who cares wins. M https://www.bgs.org.uk/sites/default/files/content/resources/files/2018-05-18/WhoCaresWins.pdf [accessed 15 January 2019]. 4 Jolley D (1999) The importance of being an old age psychiatrist. In: Howard R (ed). Everything You Need To Know About Old Age Psychiatry, pp. 107–19. Petersfield: Wrightson Biomedical Publishing Ltd.

544 Chapter 13 Old age psychiatry Normal ageing Neurobiology of ageing5 • The weight of the brain decreases by 5% between 30 and 70yrs, by 10% by the age of 80, and by 20% by the age of 90. There is a proportionate increase in ventricular size and the size of the subarachnoid space. • MRI shows changes in grey and white matter and a reduction in volume prominent in the hippocampus, association cortices, and cerebellum. • Cortical blood flow in the frontal and temporal lobes and thalamus decreases with age. • There is some nerve cell loss in the cortex,

hippocampus, substantia nigra, and Purkinje cells of the cerebellum, but less than was thought previously, and reductions in dendrites and synapses are thought to be more important. The cytoplasm of nerve cells accumulates a pigment (lipofuscin), while there are also changes in the components of the cytoskeleton. • Tau protein (links neurofilaments and microtubules) can accumulate to form NFTs in some nerve cells. In normal ageing, NFTs are usually confined to cells of the hippocampus and entorhinal cortex. • Senile plaques (extracellular amyloid and neuritic processes) are found in the normal ageing brain in the neocortex, amygdala, hippocampus, and entorhinal cortex. • Lewy bodies (intracellular inclusions) occur normally and are confined to the substantia nigra and the locus caeruleus. • Hirano bodies occur in new hippocampal pyramidal cells. • Amyloid deposits (β-amyloid and A4 amyloid) may be widespread in superficial cortical and leptomeningeal vessels, as well as patchy within the cortex. Psychology of ageing • Cognitive assessment is often complicated by physical illness or sensory deficits. • IQ peaks at 25yrs, plateaus until 60–70yrs, and then declines. • Performance IQ drops faster than verbal IQ, which may be due to reduced processing speed or the fact that verbal IQ depends largely on familiar, 'crystallized' information, while performance IQ involves novel, fluid information. • Problem-solving deteriorates due to declining abstract ability and increasing difficulty applying information to another situation. • Short-term/working memory (WM) shows a gradual decrease in capacity, and this is worse with complexity of the task and memory load. • Long-term memory (LTM) declines, except for remote events of personal significance which may be recalled with great clarity. • There is a characteristic pattern of psychomotor slowing and impairment in the manipulation of new information. • Tests of well-rehearsed skills, such as verbal comprehension, show little or no decline. 5 Bittles AH (2009) The biology of ageing. In: Gelder M, Andreasen N, Lopez-Igor J, Geddes J (eds). New Oxford Textbook of Psychiatry, pp. 1500–10. New York, NY: Oxford University Press.

Normal ageing Social problems of old age With the breakdown of traditional family structures in many societies, increasing numbers of elderly people live alone or in homes for the aged. Old age can be a period of life marked by loss. Losses may include: loss of status, loss of independence, loss of health, loss of friends, and loss of spouse/partner. Most elderly people have limited income and are un employed. Increases in medical problems compound dependency and care needs. The elderly face variable degrees of isolation, marginalization, and stigmatization. 'No one ever told me that grief felt so like fear. I am not afraid, but the sensation is like being afraid. The same fluttering in the stomach, the same restlessness, the yawning. I keep on swallowing. At other times it feels like being mildly drunk, or concussed. There is a sort of invisible blanket between the world and me. I find it hard to take in what anyone says. Or perhaps, hard to want to take it in. It is so uninteresting. Yet I want the others to be about me. I dread the moments when the house is empty. If only they would talk to one another and not to me.' CS Lewis in A Grief Observed, writing as Clerk NW (1961). Lewis, the academic, theologian, and author of The Chronicles of Narnia, wrote this firsthand account of bereavement following the death of his wife Joy Davidman from metastatic bone cancer.

546 Chapter 13 Old age psychiatry Multidisciplinary assessment Elderly people suffering from mental health problems often have a range of physical, psychological, social, and spiritual needs. This implies that individual assessment, management, and follow-up require collaboration between health, social, and voluntary organizations and family carers. Assessment of the older patient with mental illness includes: • Full history from the patient, family, and carers. • Full physical and

neurological examination. • MSE, including thorough cognitive assessment. • Functional assessment (evaluation of the ability to perform functions of everyday living). • Social assessment [accommodation; need for care; financial and legal issues, especially driving status and power of attorney (PoA) (E Power of attorney, p. 562); social activities]. • Assessment of carers' needs. The best place for performing an assessment is in the patient's home. A home visit has the advantage of being more convenient and relaxing for the patient, and it provides the health carer with an opportunity to assess living conditions, social activities, and medications kept in the house. In addition, family members, neighbours, and carers may be avail able for interviewing. Historically, day hospital would have then been involved in more complex cases, but this now tends to be replaced by Intensive Home Assessment and Treatment teams that can also lead to admission being avoided in some cases. Sometimes a brief admis sion is indicated, especially if the elderly person has pressing physical or psychiatric needs or if support is unavailable (or respite is desper ately needed). A full assessment will require multidisciplinary input and may involve doctors, nurses, occupational therapists, psychologists, so cial workers, voluntary workers, legal professionals, and others involved with the elderly. In obtaining a thorough history, it is important to allow the patient to tell their own story. One needs to enquire about the presenting problem and how it has evolved, whether it is a new or long-standing problem, and whether the individual has a personal or family history of mental problems. In addition, enquire about losses, social history and social circumstances (housing, income, social activities, etc.), medical problems and medications, alcohol history, and the presence or absence of family support and carers. It is particularly im portant to assess ADLs such as the level of independence and the ability to cook, shop, manage money, remember dates/appointments, maintain the home, and cope with bathing, toileting, laundry, etc. MSE needs to include an assessment of sight and hearing, as well as de termine the presence or absence of anxiety or mood symptoms, thoughts of suicide, abnormal beliefs or perceptions, and cognitive impairment. Cognitive assessment must include: orientation; memory; concentration and attention; language, praxis, and simple calculation; intelligence; insight;

Multidisciplinary assessment and judgement. The Addenbrooke's Cognitive Examination, third edition— Revised (ACE-III-R) is freely available online (and training is easily accessed too)6 and covers these domains, giving a sub-score breakdown in the fields of attention, memory, fluency, language, and visuospatial ability. There is a wide range of rating scales for assessing mental state, cognitive perform ance, ADLs, and carer burden—see Burns et al.7 (2002) for an overview. Key questions for carers include: • Relationship to the patient. • Amount of care provided. • Degree of stress under which they are. • What help they would accept. • Understanding and knowledge of the patient's illness. • What expectations they have from services. • Their awareness of support or voluntary organizations.8 It is also important to clarify whether they hold any legal powers that per tain to the patient [e.g. lasting power of attorney (LPA), legal guardianship]. 6 ACE-III training is available at: M http://www.nes.scot.nhs.uk/education-and-training/by-discipline/psychology/multiprofessional-psychology/psychology-and-psychological-interventions- in-dementia/ace-iii-trainer.aspx [accessed: 11 July 2018]. 7 Burns A, Lawlor B, Craig S (2002) Rating scales in old age psychiatry. Br J Psychiatry 180:161–7. 8 Butler R, Pitt B (1998) Assessment. In: Butler R, Pitt B (eds). Seminars in Old Age Psychiatry, pp. 1–16. London: Gaskell.

548 Chapter 13 Old age psychiatry Specific aspects of psychiatric illnesses in the elderly 1: overview, neuroses, and psychoses Overview The range of psychiatric illnesses in the elderly is very similar to that in younger people. However, the individual factors that contribute to aetiology,

clinical presentation, and management strategy differ due to the specific biopsychosocial conditions of old age. In order to grasp a full understanding of elderly psychopathology, it is necessary to appreciate the physiological, psychological, and sociocultural factors unique to this age group. Disorders in the elderly may present with some ‘classic’ symptoms (common to adult psychopathology), but very often their clinical manifestation varies signifi cantly due to the unique conditions of old age. The following pages focus on the ‘unique’ features of psychiatric illnesses in the elderly. Neuroses Prevalence Depression and anxiety are common in old age. There is no de cline in their prevalence with advancing age, but of concern is the fact that there is a reduction in referrals to psychiatry. This may be due to i ac ceptance of symptoms by the elderly or due to deficiencies in detection by health professionals. The estimated prevalence of neurotic disorders is 1–10%, with a ♀ predominance and roughly equal frequency of ‘old’ and ‘new’ cases. Clinical features Non-specific anxiety and depressive symptoms predom inate, and hypochondriacal symptoms are often prominent. Obsessional, phobic, dissociative, and conversion disorders are less common. Factors such as physical ill health, immobility, and lack of social support may give rise to fear and a lack of confidence about going out of the home. Aetiology Multiple factors may contribute to new neurotic symptoms in the elderly. Among these, the most common are: major life events, physical illness, feelings of loneliness, impaired self-care, and ‘insecure’ personality style. Differential diagnosis Physical illness; acute or chronic organic brain dis ease; affective disorders. Management • The mainstay of treatment is to identify and manage aetiological factors. This obviously very often calls for social interventions, and thus a multidisciplinary approach is essential. • Counselling may be difficult, especially where older people have had limited exposure to psychological methods, but there is increasing evidence for the efficacy of CBT in the elderly. • Antidepressants may be indicated for severe and disabling symptoms and are certainly preferable to BDZs.

549 PSYCHIATRIC ILLNESSES ELDERLY 1: NEUROSES & PSYCHOSES Psychotic illness Psychotic illness in the elderly broadly falls into three categories: • ‘Old psychosis’— psychotic illness that has developed earlier in adult life and for the ongoing treatment of which the patient may ‘graduate’ from general adult to old age services (E Old psychosis, p. 550). • ‘New psychosis’—psychotic illness which develops later in life and is thus referred directly to old age services as a new presentation (E New psychosis, p. 550). • Other conditions—which give rise to paranoid and/or hallucinatory symptoms but which are not primarily psychotic illnesses (see Box 13.1). Box 13.1 Other conditions with paranoid or hallucinatory symptoms These include the following conditions: • Secondary paranoid states—due to organic disorders or substances (E Psychiatric presentations of organic illness, p. 126). • Delirium (E Acute confusional state (delirium), p. 854). • Dementia (E Dementia: general overview, p. 152). • Affective disorders (E Specific aspects of psychiatric illnesses in the elderly 2: primary psychoses, p. 550). • Schizoaffective disorder (E Disorders related to schizophrenia, p. 228). • Hallucinations of sensory deprivation—in the elderly, complex visual hallucinations can occur as a non-specific phenomenon, secondary to visual impairment—sometimes referred to as Charles Bonnet syndrome. Hallucinations may be well formed, containing animals, people, or scenes. May be partial or complete insight. Differential diagnosis includes: DLB (E Dementia with Lewy bodies, p. 162) and acute confusional state (E Acute confusional state (delirium), p. 854). Reassurance may be adequate, but in some cases, a small dose of antipsychotic medication may reduce distressing symptoms.

550 Chapter 13 Old age psychiatry Specific aspects of psychiatric illnesses in the elderly 2: primary psychoses Old psychosis With the advent of antipsychotic drugs in the 1950s, there followed a pro gressive decrease in the numbers of long-stay patients with schizophrenia in institutions. Thus, more and more ageing patients with chronic schizo phrenia moved into the community, and in countries such as the UK and the USA, many of these patients are increasingly referred to old age psychiatry services. Caution needs to be observed when considering changing/redu cing/stopping long-term antipsychotics in this group, as this not uncom monly may precipitate a relapse, even in persons who have been stable for years. It is advisable that the patient has a psychiatric review and opinion in this regard. New psychosis The terminology used to describe psychosis in older adults has varied throughout the twentieth and early twenty-first centuries. Historically, the term ‘late paraphrenia’ was often used to describe psychosis in the elderly, after the observation by Roth and Morrissey in 1952 that there were clin ical similarities between paraphrenia (as originally described by Kraepelin in 1909) and the most common forms of psychosis in those aged >60yrs. The usefulness of the term has since come into question, and an international consensus has suggested that the terms late-onset schizophrenia (for onset between 40 and 60yrs) and very-late-onset schizophrenia-like psychosis (for onset >60yrs) are more useful for describing psychosis in older adults and for guiding research in this area.9 These terms recognize that schizo phrenia is heterogenous but emphasize that there are more clinical similar ities between early- and late-onset schizophrenia than there are differences. At present, neither ICD-10 nor DSM-5 (nor ICD-11) have age-specific cut- offs in their diagnostic classifications of psychotic disorders. Epidemiology Good-quality data are sparse. Relatively rare condition; population studies estimate <1% prevalence. 710% of admissions to psychiatric wards for the elderly will have the condition. One study showed that, using ICD-10 cri teria, 60% of cases were paranoid schizophrenia, 30% delusional disorder, and 10% schizoaffective disorder.10 ♀:♂ = 4–9:1. Aetiology • Genetics The risk of schizophrenia in first-degree relatives is 3.4% in late paraphrenics, compared with 5.8% in young schizophrenics, and <1% in the general population.11 9 Howard R, Rabins PV, Seeman MV, et al. (2000) Late-onset schizophrenia and very-late-onset schizophrenia-like psychosis: an international consensus. Am J Psychiatry 157:172–8. 10 Howard R, Castle D, Wessely S, et al. (1993) A comparative study of 470 cases of early-onset and late-onset schizophrenia. Br J Psychiatry 163:352–7. 11 Kay DWK, Roth M (1961) Environmental and hereditary factors in the schizophrenias of old age (late paraphrenia) and their bearing on the general problem of causation in schizophrenia. J Ment Sci 107:649–86.

551 PSYCHIATRIC ILLNESSES ELDERLY 2: PRIMARY PSYCHOSES • Premorbid personality Characterized by poor adjustment, and 745% show lifelong paranoid and/or schizoid traits. • Sensory impairments Such as deafness of onset in middle life, increases the risk of late paraphrenia. • Social isolation and major life events May also contribute. • Organic factors Structural imaging demonstrates mild ventricular enlargement; cerebrovascular pathology is a common comorbidity. Clinical features Although there are many features in common with early-onset schizo phrenia, patients with late-onset illness are more likely to experience hal lucinations, whether auditory (typically third person; occur in 775%), visual (13%), somatic/tactile (12%), or olfactory (4%).12 Persecutory delusions are the most common symptom of late paraphrenia (roughly 90% of patients) and tend to relate to commonplace themes (such as neighbours spying, entering the patient’s home, moving items, etc.). Partition delusions are also a notable feature in this age group and may arise secondary to persecu tory delusions (see Box 13.2). Other common delusions include: referen tial, misidentification, hypochondriacal, and religious. Schneiderian first-

rank symptoms are common (46%), while negative symptoms, blunting of affect, formal thought disorder, and catatonia are extremely uncommon; 10–20% may present with delusions only. Treatment • Relieve isolation and sensory deficits. • Establish rapport and develop a therapeutic alliance (often difficult!). • Exclude cognitive or medical disorders. • Hospital admission is often required. • Low-dose atypical antipsychotics preferred, as the elderly are very sensitive to side effects, but non-compliance secondary to lack of insight is often an issue. 12 Almeida O (1998) Late paraphrenia. In: Butler R, Pitt B (eds). Seminars in Old Age Psychiatry, pp. 148–63. London: Gaskell. Box 13.2 Partition delusions* These have been defined as 'the belief that people, animals, materials or radiation can pass through a structure that would normally constitute a barrier to such passage . . . [They] arise as secondary phenomena to the primary delusional experience of being observed, spoken about or phys ically affected by some agent outside the home.' This type of delusion seems to be particularly common in older adults who develop psychosis, with prevalence in this study of 68% compared to 20% of young schizo phrenic subjects. Reprinted from Howard R, Castle D, O'Brien J, et al. (1992) Permeable Walls, Floors, Ceilings and Doors. Partition Delusions in Late Paraphrenia. Int J Geriatr Psychiatry 7: 719–724 with per mission from Wiley.

552 Chapter 13 Old age psychiatry Specific aspects of psychiatric illnesses in the elderly 3: mood disorders Epidemiology Less than 10% of new cases of mood disorder occur in old age. Episodes occur more frequently, last longer, have a worse prognosis, and are more likely to be chronic. Gender differences in prevalence also diminish with advancing age. Prevalence of clinically significant depression is 10% for those

> 65yrs, with 2–3% being severe. Rates of depression differ, depending on the setting: 0.5–1.5% in the community; 5–10% of clinical outpatients; 10– 15% of clinical inpatients, with up to 30% of inpatients suffering from at least mild depression; and 15–30% in residential or nursing homes. Mania accounts for 5–10% of mood disorders in the elderly. Aetiology A positive family history becomes less relevant in older-onset mood dis order. Physical illnesses are associated in 60–75% of cases. Major life events are common, as is the lack of a confiding and supportive relationship. Older patients are less likely to complain, as losses are 'expected'. Neuroimaging yields conflicting results, and brain changes noted may relate to the normal ageing process. The strongest imaging evidence for brain changes is for mania in men. Clinical features There are no clear distinctions between the clinical presentation of depres sion in the elderly and that in younger people. However, some symptoms are often more striking: • Severe psychomotor retardation or agitation occurs in up to 30% of depressed elderly patients. • A degree of cognitive impairment has been detected in 70% (especially with effortful tasks). • Depressive delusions regarding poverty, physical illness, or nihilistic in nature are common (e.g. Cotard's syndrome; E Dictionary of psychiatric symptoms, p. 105). • Paranoia is also common, while derogatory and obscene auditory hallucinations may occur. • Classic symptoms may not even be evident, and the patient may instead present with somatic, anxiety, or hypochondriacal complaints. A high index of suspicion is required when older patients present with these symptoms, especially abnormal illness

> behaviour. Pseudodementia A minority of retarded, depressed elderly present with ‘pseudodementia’ (i.e. marked difficulties with concentration and memory). Features sug gestive of pseudodementia include: previous history of depression; de pressed mood; biological symptoms; ‘islands of normality’; exaggerated symptoms; poor effort on testing, frequent comments such as ‘I can’t be bothered’, ‘it’s too difficult’ to relatively easy tasks; and response to anti depressant medication. For some, this may herald/uncover the onset of a dementia syndrome, and there is a proven association between depressive pseudodementia and a later diagnosis of dementia.

553 PSYCHIATRIC ILLNESSES ELDERLY 3: MOOD DISORDERS Mania or hypomania Present similarly as in younger patients; however, they are more often followed by a depressive episode in older patients. There is usually a history of bipolar affective disorder. A first episode of mania in an elderly person requires careful screening for cerebral or systemic pathology (e.g. stroke or hyperthyroidism). Differential diagnosis Dementia—difficult to distinguish and can occur together; if in doubt, best to treat; paranoid disorder—depressive paranoia and delusions may be diffi cult to distinguish from psychoses; stroke—especially after left frontal cere brovascular accident (CVA) or secondary to lability, reactive stress, organic apathy, d motivation, or drug side effects associated with stroke; Parkinson’s disease—drug side effects in treating may suggest depressive illness; other physical disorders, e.g. infection, hypothyroidism, tumours, alcohol, drug side effects. Note: full physical investigation is vital. Management • Antidepressants First-line is SSRIs due to d side effects and relative safety in OD. TCAs are not absolutely contraindicated in the elderly, but care must be exercised in prescribing. ECG and BP monitoring is important due to postural drops, as well as other cardiac problems. Others include: SNRIs such as venlafaxine; and occasionally moclobemide (delayed hypotension a problem). General rules include: low starting dose, gradual increases, and longer maintenance periods (up to 2yrs); beware of suicide risk; consider lithium augmentation. Caution needs to be observed when considering changing/reducing/stopping long-term antidepressants in this group, as this may precipitate a relapse, even in persons who have been stable for years. • ECT (E ECT 2: indications, contraindications, and considerations, p. 296) First-line treatment for severe illness and specifically where there is marked agitation, life-threatening stupor, suicidality, or contraindications, failure, or excessive side effects of drugs. ECT is generally safe and effective. Dementia is not a contraindication. Post-ECT confusion may be a problem, in which case treatments should be given at longer intervals. • Psychological treatments Therapies include: CBT for depression; supportive psychotherapy; and bereavement counselling. • Treatment of mania Age-appropriate doses of antipsychotics may be used, in particular haloperidol and risperidone. Lithium is first line in prophylaxis, but lower dosages are indicated (levels: 0.4–0.8mmol/L) and regular thyroid and renal checks (at least 3-monthly) are essential. Also note that levels may easily change in the presence of infection, dehydration, and use of other medications (e.g. diuretics). Levels should be taken at 10–14hrs after the last lithium dose. Following an increase in lithium dose, 5–7 days should be allowed for serum levels to stabilize. Prognosis Generally, prognosis is good, especially if: onset <70yrs; short illness; good previous adjustment; absent physical illness; and good previous recovery. Poor outcome is associated with: severity of initial illness; psychotic symp toms; physical illness; poor medication compliance; and severe life events during follow-up period.

554 Chapter 13 Old age psychiatry Other mental health problems in the elderly Alcohol problems With decreasing tolerance for alcohol in advancing age, there is a cor responding increase in the risk of intoxication and adverse effects. Risk factors for late onset of alcohol problems include: ♀ gender; higher socio- economic class; physical ill-health; precipitating life events; neurotic person ality; and psychiatric illness. Principles of management • Prognosis is good if alcohol problems commence secondary to practical problems. • Encourage and facilitate involvement in non-drinking social activities. • In extreme cases, consider the need for supervision of finances. • Orientate towards reducing physical problems. • Moving to residential care may reduce social isolation. Caution must be displayed when detoxing the elderly from alcohol with BDZs. There may be comorbid cognitive impairment, which makes the pa tient more susceptible to BDZs, precipitated deliriums (secondary to use of too high doses), rather than alcohol withdrawal delirium, and this should always be considered in the differential diagnosis of elderly persons with a non-resolving delirium in this context. Drug abuse Generally, illicit substance abuse is not a significant problem in the eld erly, although with changing demographics, this may increasingly become a problem. However, misuse of prescription drugs (especially BDZs, opi ates, and analgesics) frequently becomes a problem in this age group. Dependence on such medications may result from careless prescription of long-term treatments for common problems of ageing such as insomnia and arthritis. With the best of intentions, doctors may believe that it is ‘cruel’ to withdraw patients from these medications, especially if the pa tient has been using the drug for years and is advanced in age. Underlying this belief is the common clinically evidenced precipitation of difficult-to- treat anxiety. However, it is important to consider whether withdrawal may actually enhance quality of life by diminishing chronic side effects such as depression. Sexual problems Factors influencing the sexual life of younger adults are relevant to older people too (e.g. social stresses, illness, and side effects of medications). In addition, the elderly may experience added problems related to the specific physiological changes that accompany ageing. Dementia sufferers may be come sexually demanding as part of the disinhibition that frequently char acterizes this disorder. Health carers may fail to detect sexual problems experienced by older people, as a sexual history is commonly overlooked. This may result from incorrect assumptions that carers often make re garding sexuality in this age group. The patient themselves may assume that

Other mental health problems in the elderly his or her sexual dysfunction is a ‘normal’ aspect of ageing. Some practical remedies are: HRT; vaginal lubricants and topical oestrogen; and, of course, sildenafil (Viagra®). Personality problems Personality traits often become more prominent and rigid in old age—in particular, traits such as cautiousness, introversion, and obsessionality. Paranoid traits may intensify, especially when there is increasing social iso lation. In some cases, this may be mistaken for a paranoid psychotic state such as delusional disorder. Psychopathy is said to burn out with advancing age, and criminal behaviour is uncommon in the elderly, although it may be on the rise.13 Roughly 5–10% of older people exhibit features of PD and generally come to the attention of health services when they are resi dents in homes for the elderly. Since PD is, by definition, lifelong, any signifi cant change in personality needs explanation. Both organic and functional brain disorders may manifest as ‘a change in personality’. Personality prob lems are often the cause of Diogenes syndrome—also called senile squalor syndrome—in which individuals become increasingly isolated and neglect themselves, living in filthy, poor conditions. They are often oblivious to their condition and resistant to help, necessitating intervention (E Hoarding dis order (DSM-5), p. 389). Suicide Old age is a risk factor for suicide, and it is estimated that 720% of all sui cides are of the elderly. There is a ♂ predominance of 2:1 in this age group, as suicide rates

tend to increase with age in men and decrease with age in women. The rate of elderly suicides declined markedly during the 1960s, due to detoxification of the mains gas supply. Predictive factors for suicide in the elderly include: • Increasing age. • ♂. • Physical illness (35–85% cases). • Social isolation. • Widowed or separated. • Alcohol abuse. • Depressive illness, current or past (80% cases). • Recent contact with psychiatric services. • Availability of means. Self-harm Self-harm is relatively uncommon with older people, accounting for only 5% of cases. Gender distribution is roughly equal. Apparent self-harm in this age group is much more likely to be a failed suicide and thus should be taken very seriously. It is important to exclude depression and also PD, as 90% have a depressive illness. Also 60% are physically ill; 50% have been previously admitted to a psychiatric hospital, and 8% go on to complete a suicide within 3yrs. 13 See, for example: M http://www.telegraph.co.uk/news/uknews/crime/12171352/Silver- haired-Saga-louts-causing-trouble-in-the-Lake-District.html [accessed 11 July 2018].

556 Chapter 13 Old age psychiatry Issues of elder abuse In recent decades, the unfortunate problem of elder abuse has become in creasingly recognized.14,15 It is often overlooked and requires an integrated response from multiple disciplines and agencies, including health and social services, the criminal justice system, and the government. The need for a unified multidisciplinary approach cannot be emphasized enough, as a frag mented response is fraught with problems. Types of elder abuse Elder abuse is an all-inclusive term representing all types of mistreatment or abusive behaviour towards older adults. This mistreatment can be an act of commission (abuse) or omission (neglect), intentional or unintentional, and of one or more types: • Physical, sexual, verbal, or psychological abuse. • Physical or psychological neglect. • Financial exploitation. The abuse or neglect results in unnecessary suffering, injury, pain, or loss and leads to a violation of human rights and a decrease in the quality of life. Epidemiology of elder abuse Occurs in both domestic and institutional settings: • Domestic settings 74–6% of elderly people report incidents of abuse or neglect in domestic settings. The most common forms of abuse are verbal abuse and financial exploitation by family members and physical abuse by spouses. Gender distribution (of victims) is equal, and economic status and age are unrelated to the risk of abuse. Importantly, elder abuse is under-reported—450,000 older adults in domestic settings were abused, neglected, or exploited in the USA during 1996, of whom only 70,000 self-reported. • Institutional settings No data exist for the extent of abuse within institutional settings. However, one survey of nursing home staff in a US state disclosed that 36% of staff had witnessed at least one incident of physical abuse in the preceding year, while 10% admitted to having committed at least one act of physical abuse themselves. Explaining elder abuse The main risk factors for elder abuse are: dependency and social isolation of the victim; the carer has mental or substance misuse problems; and absence of a suitable guardian. Factors vary according to the type of abuse; for ex ample, dependency is a risk factor for financial or emotional abuse, but not necessarily for physical abuse. Also the causes of spouse abuse may differ from the causes of abuse by adult offspring. 14 Payne BK (2002) An integrated understanding of elder abuse and neglect. J Crim Just 30:535–47. 15 Wolf RS (1999) Suspected abuse in an elderly patient. Am Fam Physician 59:1319–20.

Issues of elder abuse An integrative response to elder abuse Prevention is the best approach, and a number of measures have proved effective: training and support of carers, reducing isolation of elders, respite care, CPN visits, etc. Responding to abuse effectively requires a multidiscip linary approach and a proactive system of assessment of suspicious cases (a number of assessment instruments have been developed).16,17 There may now also be legislation available to allow

assessment and intervention, e.g. the Adult Support and Protection (Scotland) Act 2007. Assessment will ne cessitate capacity evaluation (E Capacity and consent, p. 856), which may reframe the legal context of the alleged abuse and serve to preserve and promote the dignity and independence of older adults.18 16 Fulmer T (2003) Elder abuse and neglect assessment. J Gerontolog Nurs 29:8–9. 17 Reis M (1998) Validation of the indicators of abuse (IOA) screen. Gerontologist 38:471–80. 18 Falk E, Hoffman N (2014) The role of capacity assessments in elder abuse investigations and guardianships. Clin Geriatr Med 30:851–68.

558 Chapter 13 Old age psychiatry Psychopharmacology in the elderly General considerations Older people often have a number of physical health problems, for which they may need multiple medications (a phenomenon referred to as ‘polyph armacy’).19,20 As the number of medications rises, so too do the risks of side effects and drug interactions. Many of the drugs used to treat psychiatric illness have significant side effects, particularly cardiac, metabolic, and extra-pyramidal. Older patients are more prone to experience side effects due to changes in how the body handles drugs (E Pharmacokinetics, see below), and therefore, the side effects of any medication need to be weighed carefully against any potential benefits. Because of this, a careful and con sidered approach should be taken when prescribing for older patients, and a patient’s medications should be reviewed frequently. Certain medica tions will require structured ongoing monitoring of blood tests and physical health parameters (particularly lithium, clozapine, and antipsychotics), but all those who prescribe for the elderly need to be cognizant of their pa tients’ wider physical health. Pharmacokinetics The physiological changes associated with ageing mean that the older patient’s system handles drugs quite differently from that of a younger individual. • Absorption There are reductions in gastric pH, mesenteric blood flow, and gut motility, resulting in a reduced rate of absorption. • Distribution of drugs This is also altered. Reduced body mass (but with proportionally i body fat), reduced body water, and lower albumin can cause i levels of free drug and longer half-lives, especially of psychoactive drugs. • Drug metabolism This is reduced due to d blood flow to the liver and loss of efficiency of liver microsomes. • Excretion This is reduced with the natural drop in renal clearance that accompanies old age. Thus drug effects are generally prolonged and cumulative, and the risk of toxicity is high. This is particularly important in patients on lithium, which is solely excreted by the kidneys without any preceding biotransformation. Pharmacodynamics Technology, such as PET, is enlightening our understanding of the direct effects of drugs in the CNS. Specific differences in these effects in the eld erly include: • Dopaminergic system—there are fewer DA cells in the basal ganglia; thus, there is i sensitivity to EPSEs of neuroleptics (not dystonias). • Cholinergic system—there is a normal reduction in cholinergic receptors with advancing age. 19 Gareri P, Falconi U, De Fazio P, et al. (2000) Conventional and new antidepressant drugs in the elderly. Progr Neurobiol 61:353–96. 20 Taylor D, Paton C, Kapur S (2015) The Maudsley Prescribing Guidelines in Psychiatry, 12th edn, pp. 477–86. Chichester: John Wiley & Sons, Ltd.

Psychopharmacology in the elderly • Noradrenergic system—NA levels decrease with age, which may cause this age group to become increasingly vulnerable to mood disorders. • Narcotics and sedative hypnotics—there is i sensitivity to sedatives in the elderly, due to a reduction in the number of available receptors. The implications of these changes are that elderly patients are more sensi tive to almost all drugs used in psychiatry (see Box 13.3). Box 13.3 General principles of prescribing • Start with a very low dose, and increase slowly (‘start low, go slow’). • Maximum efficacy is often achieved at significantly lower doses than in younger adults. • Beware of

dangerous side effects such as postural hypotension, arrhythmias, and sedation. • The elderly are particularly sensitive to EPSEs and anticholinergic side effects. • Beware of drug interactions due to the common problem of polypharmacy in the elderly. • Atypical antipsychotics are generally better tolerated than conventional ones. • SSRIs, SNRIs, and NARIs are generally safer than TCAs, while MAOIs and lithium may be useful in resistant depression. • Monitor lithium therapy closely, as levels can fluctuate easily and long- term effects on thyroid and renal function are not infrequent. • Always consider suicide risk, as old age is a risk factor for suicide.

560 Chapter 13 Old age psychiatry Services for the elderly Services for the elderly are organized differently, according to government policies and the availability of resources. In principle though, the ideal ser vice should plan to: • Maintain the elderly person at home for as long as possible. • Respond quickly to medical and social problems as they arise. • Ensure coordination of the work of those providing continuing care. • Support relatives and others who care for the elderly at home. • Promote liaison between medical, social, and voluntary services. Primary care services At the primary care level, GPs, health visitors, com munity nurses, and health workers will deal with most of the problems of elderly people. Acute and long-term hospital services Elderly patients often require admission for acute assessment and treatment, respite care, or long-term care. Services may be situated within general medical wards for the elderly or within specialized old age psychiatry units. The advantage of acute ser vices being located in general hospitals, rather than psychiatric hospitals, is that a range of associated specialist services (such as old age medicine, neurology, and radiology) are often more readily available. Day and outpatient care Ideally, a service should have outpatient facil ities for the assessment, treatment, and follow-up of mobile elderly patients with mental health problems. Sometimes these clinics offer a specialist ser vice such as the ‘Memory Clinic’. Day-care services may take the form of a general or psychiatric day hospital, and local authorities often provide day centres and social clubs for functional and social support. Community psychiatric nurses CPNs provide a vital link between pri mary care and specialist services. They often perform assessments on pa tients after receiving a referral from a GP. They also monitor treatment in collaboration with GPs and the psychiatric services. In addition, they take part in the organization of home support for elderly patients with dementia. Informal carers These are the unpaid relatives, neighbours, or friends who care for the elderly person at home. Demographic changes and the move to community care have i the burden on carers. Informal carers are twice as likely to be women. Carers often suffer considerable stress, espe cially when the patient is suffering from advanced dementia. Relieving carer burden is a challenge for any service. Active involvement of medical and so cial personnel, as well as provision of education and respite, are important aspects of carer support. Domiciliary services These include: home helps; meals at home; laundry and shopping services; and emergency call systems. In some countries such as the UK, local authorities provide these services; however, in many others, these services are either privately engaged, obtained from voluntary organ izations, or unavailable.

Services for the elderly Voluntary organizations Increasingly, there are a range of voluntary and charitable organizations with the aim of helping the elderly, particularly those with dementia. In the UK, organizations like the Alzheimer’s Society may be involved in providing support in the post-diagnosis period. Local mental health charities may run a variety of reminiscence groups for those with dementia, often around a particular area of interest such as football or music.21 Increasingly, public institutions, such as art galleries, concert halls, and cinemas, may have specific ‘dementia-friendly’ events. For many pa tients, churches and other faith communities are an important source

of support and identity throughout their life. Particularly for elderly patients, these can provide a much needed point of connection and a sense of com munity during a period of life often marked by fragmentation and loss. Residential and nursing care In most countries, the local authorities take responsibility for providing old people's homes and other sheltered accom modation. These range in standard, from large, crowded institutions to small, independent units, and, ideally they need to balance individual privacy with involvement in outside activities. In many communities, private homes are available, but financial constraints put these out of the reach of the majority of older people. In planning residential care for the elderly, au thorities need to provide for a wider range of accommodation—a small supported unit with two or three people may be ideal for the still inde pendent and mobile individual, while larger homes with nursing support are required for those who are more dependent, with a number of physical and/or psychiatric needs. 21 See, for example, M https://www.playlistforlife.org.uk [accessed 11 July 2018].

562 Chapter 13 Old age psychiatry The end of life, power of attorney, and other legal matters The end of life Managing a patient's final weeks or days and ensuring that their death is a 'good death' are a challenge that has only recently been addressed in our health services and training programmes.22 Many health professionals have never received any guidance regarding their involvement in this common and extremely important phase of people's lives. Contemporary palliative services stress the following components in providing a 'good death': • A multidisciplinary approach. • Ability to 'diagnose dying'. • Communication with the patient and family. • Provision of adequate physical support (e.g. analgesia, hydration). • Minimize unnecessary interventions. • Establish a non-resuscitation plan. • Psychological, social, cultural, and spiritual support. Power of attorney An LPA (in England and Wales; E Lasting powers of attorney (LPA), p. 942) or enduring power of attorney (EPA) (in Scotland; E Powers of attorney, p. 945) is a legal procedure in which a person nominates someone to make decisions on their behalf in the event that they become unable to do so themselves. Broadly, each allows a person to nominate one or more trusted individuals (often family, friends, or a solicitor) to make decisions on their behalf and to specify what powers these individuals have. A PoA may give the appointed person power to make decisions about finances and property or about health and personal welfare, or both. Different powers may be appointed to different attorneys (e.g. a person might give their family PoA over their welfare and their solicitor PoA over their finances). An LPA or EPA is signed in advance of an individual losing capacity and only comes into action when capacity is lost. It is important as an old age psych iatrist to know whether an incapacitated patient has a PoA in place, so that you can involve the appropriate individuals in any decision-making relating to their care. Further information about PoA in the UK can be found on the website of the Office of the Public Guardian for the appropriate devolved nation (or the Office of Care and Protection in Northern Ireland). Advance directives An advance directive, also referred to as a living will or an anticipatory care plan, is an instruction made by an individual (usually written and witnessed) stating their preferences for future treatment during a terminal illness. Usually the person specifies the degree of irreversible deterioration after which they want no further life-sustaining treatment. Often the statement will outline the patient's refusal of certain medical interventions in particular circumstances. If a health professional is asked to assist someone in drawing up an advance directive, the following issues should be considered: • The patient should be fully informed about the illness and treatment options. 22 Ellershaw J, Ward C (2003) Care of the dying patient: the last hours or days of life. BMJ 326:30–4.

563 END OF LIFE, POWER OF ATTORNEY, AND OTHER LEGAL MATTERS • The patient should be mentally competent. • The patient should be reflecting his/her own views, free from influence. The Mental Capacity Act 2005 (covering England and Wales) allows for ‘advance decisions’ (E Mental Capacity Act: England and Wales, p. 942) in case of future incapacity. If a patient lacks capacity, and information about a written or verbal ad vance refusal of treatment is recorded in their notes or is otherwise brought to your attention, you must bear in mind that valid and applicable advance refusals must be respected, although basic care (i.e. analgesia, catheter, fluids) should be provided in all cases. A valid advance refusal that is clearly applicable to the patient’s present circumstances will be legally binding in England and Wales (unless it relates to life-prolonging treatment, in which case further legal criteria must be met).23 Valid and applicable advance re fusals are potentially binding in Scotland and Northern Ireland, although this has not yet been tested in court. The code of practice of the Scottish legislation states that all practitioners have an ‘unqualified obligation’ to ‘take account of the present and past wishes and feelings of the adult in so far they can be ascertained’, but caution that an advance statement, while potentially legally binding, ‘should not be viewed in isolation from the sur rounding circumstances’.24 The BMA Ethics Department has its own code of practice on these issues.25 Withdrawal of treatment26,27 The active or passive involvement of a carer in hastening an individual’s death is highly controversial and morally complex. Differing degrees of in volvement should be distinguished: • Withdrawal of active interventions, such as medications and blood transfusion, is an accepted aspect of palliative care and draws little debate. • Withdrawal of life-sustaining treatment such as fluids and food. This is equivalent to ‘allowing a patient to die’. Since the current emphasis is on preserving human dignity, rather than preserving life, this is morally acceptable for many and should not be considered euthanasia. • Active intervention which hastens or precipitates the patient’s death—euthanasia. This is distinguishable from homicide in that the patient has either consented to the assisted death or is unable to (e.g. comatose), and the intervention is regarded as a ‘mercy killing’; it does, however, remain illegal in the majority of countries. 23 Department of Constitutional Affairs (2007) Mental Capacity Act 2005 Code of Practice, pp. 58– 77. London: The Stationery Office. 24 The Scottish Government (2010) For practitioners authorised to carry out medical treatment or research under Part 5 of the Act. In: Adults with Incapacity (Scotland) Act 2000: Code of Practice, 3rd edn, pp. 18–19. 25 BMA Ethics Department (2007) Advance decisions and proxy decision-making in medical treatment and research (updated January 2018). M https://www.bma.org.uk/advice/employment/ethics/ mental-capacity/advance-decisions-and-proxy-decision-making-in-medical-treatment-and-research [accessed 11 July 2018]. 26 Hermsen MA, ten Have HA (2002) Euthanasia in palliative care journals. J Pain Sympt Manag 23:517–25. 27 Sharma BR (2003) To legalize physician-assisted suicide or not?—a dilemma. J Clin Foren Med 10:185–90.