ABC of mental health
Mental health in old age

A J D Macdonald

Psychiatric care of elderly people can be more interesting than that of younger patients. Successful treatment of elderly patients requires a demanding mélange of psychological, medical, social, political, and managerial skills—an epitome of modern medicine.

Depression

The prevalence of depression among people aged over 65 is 15% in the general community, 25% in general practice patients, and ⩾30% in residential homes

Important biological symptoms of depression in old age are change in sleep patterns (especially reduced sleep and early morning wakening); decline in appetite and weight loss; regular variation of mood over day (especially worse in early morning); constipation; physical and mental slowing not accountable by other disorders; and suicidal thoughts.

The central question for doctors is whether a depressive state will respond to treatment (including electroconvulsive therapy); all other questions are either peripheral or secondary to medical practice. Social engineering is not the doctor's role. Even deciding to admit a patient to hospital is secondary to treatability: there is little point in admission if the patient, however suicidal, is unlikely to improve; better to reserve your place in the coroner's court and concentrate on more treatable patients.

The categories of depression in elderly people that respond well to treatment are

- Depression lasting more than a year—biological symptoms attenuate over time, so ask about symptoms at onset
- Depression with fixed, unreasonable beliefs of poverty, sin, guilt, persecution, filth, or dreadful internal disease or abnormality (patients particularly benefit from electroconvulsive therapy)
- Depression with hallucinations of voices haranguing, foul smells, or disgusting tastes (patients particularly benefit from electroconvulsive therapy).

Management

The mainstay of treatment is an effective antidepressant drug. Side effects are common and sometimes troublesome, but the rewards of persistence are worth while (70% of treated patients improve).

Chances of depressed patient responding to treatment

Increased if	*Unaffected by*
• Biological symptoms of depression prominent	• Age alone
• Record of clear change in patient's mood, however long ago	• Obvious precipitating event (such as bereavement)
• History of previous successful treatment	• Social and interpersonal difficulties (these often a consequence of depression)
• Family history of biological depression or mania	• Poverty and poor living circumstances
• No clinical evidence of dementia or from informant's history	• Intercurrent physical illness, unless terminal stages
	• Mild or moderate dementia

Criteria for hospital admission of elderly patients with depression

Those who are likely to benefit from treatment and who

- Express suicidal ideas of a definite sort, or who attempt suicide
- Have problems with compliance or delivery, leading to unduly protracted treatment
- Require electroconvulsive therapy for delusions and hallucinations
- Neglect themselves substantially, particularly their fluid intake
- Require removal from a hostile social environment
- Are in such distress as to need tranquillisation or skilled nursing care
- Have physical illness that would complicate treatment
- Harm themselves, or threaten to, for the first time (especially men)

Treatment regimen for dothiepin in elderly patients

	Bedtime dose	
	At home	**In hospital or nursing home**
Starting dose	25 mg	50 mg
Increment interval	7 days	5 days
Increment	25 mg	25 mg
Time to reach dose of 150 mg	42 days	20 days
Final dose	150 mg or maximum lower dose tolerated	
Check blood pressure (lying and standing)	Weekly (Until final dose achieved for a week; thereafter only if symptoms of postural hypotension occur)	Every 2 days

Common side effects of dothiepin in elderly people

Symptoms	Remedy	Other problems	Remedy
Dry mouth	Fluids, lozenges	Electrocardiographic changes	Little practical importance
Constipation	Fluids, dietary fibre	Urinary hesitancy or retention	Stop: use selective serotonin reuptake inhibitor
Sweating, especially at night		Increased risk of epileptic fits	Rarely important
Drowsiness	Take drug at bedtime	Postural hypotension	Reduce dose, then cautious increase
Dizziness on standing up	Monitor blood pressure for postural hypotension	Risk of overdose	Drug very dangerous in overdose; monitor risk of suicide, prescribe frequent small script
Vivid dreams	Warning, reassurance	Worsen delirium	Do not use if risk of delirium high
Fine tremor	Reassurance		

Selective serotonin reuptake inhibitors have remarkably few side effects, are safe in overdose, and can be used as first line treatments, although they may be slow to act. The criteria for use of these drugs in elderly patients are if patients find the side effects of tricyclic antidepressants intolerable, if clinically relevant cardiac arrhythmias occur with tricyclics or are confidently predicted by an expert, in cases of poorly controlled epilepsy, in cases of depression with substantial dementia, and if the risk of delirium is high.

How long should antidepressants be continued? Although patients hate this, it seems that at least two years is the answer. Some elderly patients, especially with late onset or recurrent depression, should take antidepressants or lithium indefinitely.

How long to continue treatment with antidepressant

Category of depression	Treatment
Early onset (as in 30s), recurrent	Indefinite, with or without lithium
Late onset (as in 60s), recurrent	Indefinite, with or without lithium
Late onset, single episode	Two years

Maintenance dose of dothiepin 75 mg daily
Maintenance dose of lithium in elderly people usually in low therapeutic range (0.4-0.6 mmol/l) but may have to be higher (about 0.9 mmol/l) to work

Supporting the carers of depressed people

Carers need to discuss treatment and report on progress, but also need to air feelings and fears and to seek advice. Many patients leap to conclusions about the causes of their illness and plan major changes in their life (such as moving to a new home): making or allowing major life changes while a patient is depressed is folly.

Advice to carers of people with depression

General problems—Don't take personally; understand biological control; arrange respite from close contact; keep in touch with professional support
Anxiety—Encourage anxiety management; avoid use of stimulants and benzodiazepines
Irritability—Keep an emotional distance for duration of episode (seek support elsewhere); check when appropriate to re-engage fully
Suicidal ideas—Don't dismiss or exaggerate; call doctor if unsure of change in risk; don't take personally; reduce availability of means
Hypochondriacal ideas—Encourage only initial investigation or consultation, then discourage further consultations
Withdrawal, decline in self care—Set gentle limits and insist these are met; minimise use of substitution services (such as meals on wheels)
Excessive side effects—Know what to expect; don't collude with autonomous decisions
Desire to change life radically—Don't collude; wait until better

Anxiety

The prevalence of general anxiety among people aged over 65 in the community is 4%, and the prevalence of phobias is 10%

Anxiety in elderly people is managed exactly as in younger patients—and with equivalent success—although the circumstances may differ.

Supporting the carers of people with anxiety

Carers can be sucked into overprotection, which can wreck behavioural programmes, or adopt a self protective, indifferent attitude that hinders the patient's recovery. They need to know the consequences of their actions and attitude to the patient, and of the measures that they can take to assist the treatment programme. Again, they need the chance to express their frustrations and to feel that they are understood and appreciated—they may get little reward from the patient.

Special features of anxiety in elderly people

- Very often secondary to depression so inquire about depressive symptoms and, if these are present, treat depression first
- Very often caused by neglect of consequences of frightening physical illness, falls, etc, so follow up elderly people after hip fractures, falls, crime, or unexpected illnesses to make sure that agoraphobia does not become chronic
- Late onset anxiety may be a sign of early dementia so check cognitive state and accept that normal anxiety management techniques may not work as well, and that some tranquillisation (such as thioridazine) may also be necessary
- Daytime benzodiazepines almost universally cause dependence in elderly people so avoid them
- Panic disorder is sometimes difficult to distinguish from medical conditions such as paroxysmal nocturnal dyspnoea and cardiac dysrhythmias, so always examine and investigate accordingly

Psychotic disorders

These are conditions in which delusions (fixed, unreasonable ideas such as that neighbours are pumping noxious gas through the heating pipes) or hallucinations (such as voices plotting, commenting, or calling or strange smells or sensations) occur in the absence of substantial depression or dementia. Positive symptoms are those things (delusions and hallucinations) that "normal" people do not have. Negative symptoms are the lack of things that "normal" people do have (energy, interests, self care, reactive mood, social graces).

Acute, transient psychotic episodes are unusual in late life. More common are two categories of chronic problem with different features: persistent delusional disorder (once called "late paraphrenia") and the persistence into old age of chronic schizophrenia.

Persistent delusional disorder—In this disorder gratifying results can be seen after only a few weeks of treatment with an antipsychotic drug such as trifluoperazine, 2-5 mg thrice daily, or haloperidol, 2-10 mg daily. Use of the promising atypical antipsychotics such as olanzapine is not yet established. However, it is often the case that, although the symptoms and disturbance abate, the price is, at best, the loss of "sparkle" and,

The prevalence of psychotic disorders among people aged over 65 in the community is 1%

Psychosis in elderly people

	Onset	Positive symptoms	Treatment
Persistent delusional disorder	Old age	Common	Gratifying response
Chronic schizophrenia	Youth or middle age	Unusual	Needed initially to prevent further decline

at worst, the disappearance of any interest in life whatsoever. Forced intervention under the Mental Health Act should be considered only if there is substantial and prolonged distress to the patient or, which is rarely the case, definite danger to others.

Chronic schizophrenia—In contrast, chronic schizophrenia in old age is dominated by negative symptoms. Long term antipsychotic medication, sometimes by depot injection, can keep these symptoms under control and prevent the recurrence of positive ones. Old age is no bar to the use of new antipsychotic drugs such as clozapine or olanzapine.

Dementia

The prevalence of dementia among people aged over 65 is 5% in the community and ≥80% in residential or nursing homes

Dementia is a syndrome (characteristic collection of symptoms and signs) caused by several diseases. While the syndrome is well known, hypotheses about cause have changed over time, even in the past 10 years. Received wisdom suggests that Alzheimer's disease is the most common cause, with vascular disease (mostly cerebral infarcts) second, followed by a combination of these two. New ideas include Lewy body dementia (a sort of cortical Parkinson's disease). The idea that the dementias represent an extreme of normal aging has been disproved but is still prevalent.

Donepezil, which apparently slows progression in Alzheimer's disease without severe side effects, is the first treatment based on the cholinergic hypothesis to become available, though protocols for its use are rudimentary. Although it was designed for mild or moderate cases of Alzheimer's disease and not other circumstances or diseases, theoretical contraindications (such as vascular or Lewy body disease) are disputed.

Assessment of dementia

The aims of medical assessment of dementia are

- To distinguish between Alzheimer's disease, vascular dementia, Lewy body disease, and the other dementing diseases (anticholinesterases may help Alzheimer's disease, anti-clotting drugs such as aspirin may prevent further damage in vascular dementia, while antipsychotics may be contraindicated in Lewy body disease)
- To identify the very rare treatable causes of dementia (as treatment may arrest the condition and hence the dementia)
- To identify any condition that can exacerbate cognitive, social, or functional impairment (such as constipation, urinary tract infection, cardiac failure, etc).

In its early stages the most reliable method of identifying any dementia, and whether Alzheimer's disease is likely, is by interviewing the patient's closest relative. Detailed psychological tests are overrated and very difficult to obtain. The search for treatable physical illnesses that can cause dementia is an esoteric and rarely rewarding activity, but other more important functions are also served by a physical examination and routine investigations.

Management of dementia

Although old age psychiatry is often seen as synonymous with managing dementia, less than half of newly referred patients have dementia. Dementia is far too big a problem to be dealt with by one specialty—most of the old health districts contained 2000-3000 cases—and the role of psychiatrists is properly confined to certain aspects of this condition. Until potentially

Syndrome of dementia

- Decrement in memory, thinking, orientation,* comprehension, calculation, language,* judgment, social and personal relationships, self care, praxis,* and continence
- Behavioural changes such as withdrawal, decline in interests, coarsening of personality and humour, irritability, and even aggressive outbursts
- Can be preceded by depression, anxiety state, or psychosis; revealed when prodromos clears or is treated
- Progressive: "stepwise" in vascular dementia, inexorable in Alzheimer's disease
- Consciousness and awareness of surroundings remain mostly clear

*Early changes in these features more common in vascular dementia

Protocol for the routine physical investigation of cognitive impairment (delirium or dementia)

Patients of any age with rapid onset or fluctuating cognitive impairment, especially if drowsy

Full examination, investigation, and possible referral for delirium or acute confusional state

Patients aged over 75 with dementia syndromes of insidious onset

1 Collateral history (systematic inquiry)
2 Physical examination
3 No blood, urine, radiological investigations unless indicated by 1 or 2 or for possible anticholinesterase treatment of Alzheimer's disease

Patients of any age with unusual patterns of cognitive impairment in clear consciousness, or patients with onset at age under 75 years

1 Collateral history (systematic inquiry)
2 Physical examination
3 Full blood count, erythrocyte sedimentation rate, urea and electrolytes, Venereal Disease Research Laboratory test, thyroid function tests, chest *x* ray, urine microbiology, computed tomography of brain
4 Any further investigations suggested by 1-3

Some of the rare reversible causes of dementia syndrome*

- Hypothyroidism
- Hyperparathyroidism
- Communicating hydrocephalus
- Syphilis
- Slow growing operable cerebral tumour (not just neoplasm)
- Renal failure
- Severe depression
- Untreated schizophrenia
- Vitamin B_{12} or folic acid deficiency
- Severe anaemia in very old people
- Heavy metal or chronic anticonvulsant toxicity

*Most exacerbate non-treatable causes of dementia

Questions for relatives to detect possible early dementia

- Have you noticed any change in personality?
- Have you noticed increased forgetfulness or anxiety about forgetting things (such as using lists more, etc)?
- Have any activities been given up (hobbies and interests, shopping, dealing with finances) and why?
- Have you noticed nocturnal confusion or muddling when out of usual routine or environment, or unusual avoidance of new circumstances?
- Have you noticed surprising failure to recognise people (such as more distant relatives)?
- Have you noticed undue difficulty in speech?
- Have changes been gradual or has there been sudden worsening?

effective treatments have been developed, the bulk of the work required is social in nature. However, for quixotic reasons, areas vary hugely in both the total resources available to care for those with dementia and in the balance of agencies providing them.

Voluntary organisations

- Age Concern England, Astral House, 1268 London Road, London SW16 4ER (tel 0181 679 8000)
- Alzheimer's Disease Society, Gordon House, 10 Greencoat Place, London SW1P 1PH (tel 0171 306 0606)
- Carers National Association, 20-25 Glasshouse Yard, London EC1A 4JS (tel 0171 490 8818)
- Cruse Bereavement Care, 126 Sheen Road, Richmond, Surrey TW9 1UR (tel 0181 940 4818)
- Help the Aged, St James's Walk, London EC1R 0BE (tel 0171 253 0253)

Supporting carers of people with dementia

The medical role is fairly circumscribed, but nearly every survey of carers reveals their desire for more support from their general practitioner. Most carers need a clear and sympathetic explanation of what is happening and what is likely to happen, and general practitioners, geriatricians, and psychiatrists are in the best position to provide this.

Carers need to feel that they are taken seriously and that intercurrent physical illnesses will be treated swiftly yet thoughtfully. It is a medical disgrace if this does not occur.

Delirium ("acute confusional state")

The syndrome of delirium is characterised by

- Decrement of attention, thinking, and awareness of surroundings ("clouded consciousness")
- Decrement in memory, orientation in time, and person
- Abrupt onset and markedly fluctuating course
- Visual phenomena (illusions, hallucinations) are common
- Changes in behaviour—mostly hypoactive, occasionally very disturbed and distressed.

This acute syndrome can occur during chronic dementia. It is important to recognise that abrupt worsening of a dementia may be due to a delirium, which may be caused by a treatable condition. The most common causes of delirium in elderly people are infections of the urinary tract, chest, skin, or ear; onset or exacerbation of cardiac failure; iatrogenic (nearly any drug can cause delirium, but especially psychotropic and antiparkinsonian drugs); and cerebrovascular ischaemia.

Management

Management consists of treating the underlying cause, and sometimes tranquillisation is needed to settle agitation (use thioridazine or haloperidol). Classical delirium ends either in death or in resolution (even if this is a return to pre-existing dementia). Removal of an acutely delirious patient from home to hospital may worsen the delirium, so home management is preferred.

Elder abuse

The prevalence of abuse of elderly people is unknown

British society is ageist—mental incapacity is assumed to be an inevitable consequence of aging. It follows that cruelty towards elderly people is regarded much as if they were pet animals. This intensely demeaning concept is enshrined in the horrific

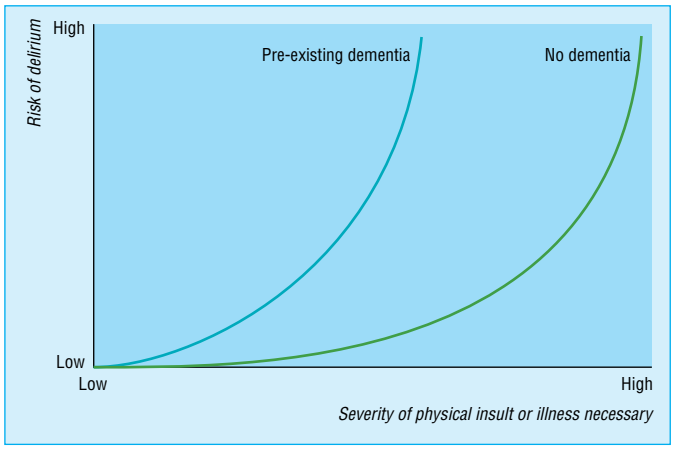
Role of old age psychiatry service in dementia

- Assessment of eligibility for treatment of Alzheimer's disease
- Assessment of need for further medical investigation (for treatable contributors or causes)
- Assessment and management of substantially disturbed behaviour (aggression, various sorts of escapology, sexual disinhibition, etc)
- Help with support and sometimes psychiatric treatment of carers
- Certain administrative functions, such as Court of Protection
- Long term day care or residential care for very disturbed patients
- Use of Mental Health Act to help assessment in difficult cases

Who does what in care of dementia

Assessment of needs—Provided by local authority
Community support (such as home help)—Provided by local authority, voluntary and private agencies
Sitting services (respite)—Provided by local authority, voluntary and private agencies
Day care (respite)—Provided by local authority, voluntary agency
Residential care (respite, permanent)—Provided by local authority, voluntary agency, private home
Medical assessment—Provided by general practitioner, geriatric services, old age psychiatry services
Management of intercurrent physical illness—Provided by general practitioner, geriatric services
Diagnosis and explanation—Provided by general practitioner, geriatric services, old age psychiatry services
Emotional support of carers—Provided by general practitioner, geriatric services, old age psychiatry services, local authority, voluntary organisations

The prevalence of delirium is 30% among elderly people admitted to hospital



Relation of severity of insult to ease of induction of delirium

Circumstances in which abuse of people with dementia may occur

- Severe stress or frank psychiatric disorder in carer
- Intense provocation by victim's unremitting disturbed behaviour
- Ignorance of dementia (such as, "He's deliberately soiling") or neglect of emotional aspects of caring
- Ignorance of strategies to deal with provocation
- Continuation of pre-existing abusive relationship
- Retribution for past unpleasantness of present victim
- Retaliation for present aggressive behaviour by victim
- Deliberate cruelty
- Exploitation for financial ends

phrase "elder abuse." The real issue is abuse of anyone of whatever age who is incapable of self defence or reparation. Among elderly people, those with dementia deserve most of our attention. The risk of abuse is increased in certain circumstances, and each suggests a different response. A coordinated approach between health services, social services, and the police is now often achieved by local agencies set up specifically to this end.

Psychiatric emergencies

Elderly people may sometimes give cause for concern, and their carers may require reassurance, but genuine emergencies are relatively rare. In the following three situations, however, prompt action is necessary.

Confused person found wandering—Obtain a history from a relative or neighbour. Conduct a medical examination and perform any investigations that might be indicated. If the person is medically ill, he or she should be admitted to a medical bed, under common law if necessary. If the person is not medically ill but is still unsafe to go home (such as during winter), seek admission to emergency residential care.

Aggressive behaviour in patient with dementia—Assess "ABC" (Antecedents, Behaviour, Consequences) of circumstances in which aggression took place. If the aggressive behaviour was uncharacteristic, unprovoked, or not context specific, assess the patient for delirium. If tranquillisation is required use haloperidol or thioridazine (but not benzodiazepines). If the patient is extremely disturbed admit to an old age psychiatry ward for assessment (using the Mental Health Act if necessary).

Any serious suicide attempt or trivial suicide attempt or self harm for first time in old age—Admit the patient, especially if a man, to an old age psychiatry ward (using the Mental Health Act if necessary).

What to do about elderly people refusing treatment

As compulsory treatment can be given only in hospital, admission is the only option

Dementia and acute physical illness—Use common law to admit to care of the elderly ward

Dementia and danger to self (such as nocturnal wandering in winter)—Admit under Mental Health Act only if all reasonable alternatives (such as night sitter service) have failed; not permitted if alternatives have not been tried

Delirium but not very disturbed—Use common law to admit to care of the elderly ward

Delirium and very disturbed—Use Mental Health Act to admit

Living in squalor but no psychiatric disorder—Use section 47 of National Assistance Act only if risk to public health

Seriously physically ill but no psychiatric disorder—You may not admit compulsorily

Persecutory delusions and very distressed or dangerous to others—Use Mental Health Act to admit

Persecutory delusions but not very distressed or dangerous to others—Unwise to admit at all

Severely depressed and deluded or suicidal—Use Mental Health Act to admit

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Further reading

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Burns A, Harris J. Ethical issues in dementia. *Psychiatr Bull* 1996; 20:107-8

A memorable patient

The patient's best interest?

Making a correct early diagnosis is not always in the best interests of the patient.While working as an emergency medicine registrar in Australia some years ago I saw a 12 year old boy who had been referred to the casualty department. The general practitioner had attempted to drain a scalp haematoma, which had formed after the child had fallen and struck his head. The general practitioner had been unable to stop the bleeding after incising the haematoma.

The bleeding was finally controlled with some difficulty after suturing and pressure dressing. In view of the difficulty experienced in stopping the bleeding the child's clotting profile was checked. This showed him to have abnormal coagulation studies. He was subsequently referred to the regional unit, found to have mild haemophilia A and was treated with factor VIII. He has required factor VIII treatment on several occasions since his diagnosis.

When questioned his mother described other episodes of disproportionate bleeding since infancy. In particular he had bled for up to three days following dental extractions on two occasions and had developed a haemarthrosis of the knee following a minor football injury when aged 7. He had not been investigated on any of these occasions. I was initially critical of the failure to make the diagnosis previously but on reflection I realised that delay in making a diagnosis may have its advantages. He had come to no long term harm from the failure to recognise his condition. Had his diagnosis been made at the time of the initial presentations, by 1987, in common with other Australians with haemophilia, he would have had a 50% chance of being HIV positive.

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We welcome filler articles of up to 600 words on topics such as *A memorable patient, A paper that changed my practice, My most unfortunate mistake,* or any other piece conveying instruction, pathos, or humour. If possible the article should be supplied on a disk.