

Psychiatry of the Elderly

Consensus Statement

Abstract J. Wertheimer, Professor for psychogeriatrics at the University of Lausanne and Chairman, Geriatric Psychiatry Section, World Psychiatric Association (WPA) and Dr. J. A. Costa e Silva, Director, Division of Mental Health and Prevention of Substance Abuse (WHO) organized a Consensus Meeting which took place in Lausanne from 05.–07.02.1996. The meeting aimed at the elaboration of recommendations on psychogeriatrics. The meeting was attended by the above mentioned WHO and WPA representatives and also by representatives from the following organisations: International Psychogeriatric Association, International Association of Gerontology, International Union of Psychological Science, Alzheimer's Disease International, International Council of Nurses, International Federation of Social Workers, International Federation of Ageing, World Federation of Occupational Therapists. Further attendants were various experts who participated at the meeting on invitation of Prof. Wertheimer and Dr. Costa e Silva. The discussion was chaired by Prof. H. Häfner (Mannheim). Dr. N. Graham (London) and Prof. C. Katona (Harlow/Essex) acted as co-rapporteurs. The Consensus Statement was unanimously accepted by all participants. It contains recommendations for the development within a field of great future importance with regard to the current and expected global demographic structure and the increasing knowledge about agespecific diseases and general health, social and personal problems of the elderly.

H. Häfner

This document is a consensus statement on Psychiatry of the Elderly jointly produced by WHO and the Geriatric Psychiatry Section of the World Psychiatric Association, with the collaboration of several pertinent NGOs and the participation of experts from countries in several WHO regions

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Foreword

Longevity is one of the characteristics of today's world. The ageing of populations, already in evidence in developed countries, is becoming a reality in less developed countries. In this context, the health problems of the elderly, particularly its psychological dimension, become crucial. Both the well-being of the individual at this point in life and the individual's harmonious integration into society, are at stake.

The increased frequency of mental health problems above the age of 65 which require specific diagnostic, therapeutic and readaptative approaches is at the root of the development of geriatric psychiatry. This discipline has progressively constituted itself since the 1950s, defining its nosographic field, evaluative procedures and organization of care. In view of the ubiquity of this issue, all the health professions are involved. On the one hand it falls within the framework of pluridisciplinary teams and on the other hand each of these disciplines can be individually confronted with psychiatric situations. Hence, geriatric psychiatry becomes a basic discipline for all the socio-medical providers and a speciality for physicians and health workers who devote themselves entirely to the psychiatric care of the elderly.

This implies some overlapping between specialists and nonspecialists in the care of patients particularly between somatic geriatric care and geriatric psychiatry, at the risk of improperly using individual competence. It is therefore indispensable to define the scope of the professions engaged in the care of the elderly. Knowing one's own field as well as those of other disciplines is very necessary for quality cooperation.

It is in the context of demographic aging and the complexity of caring for the elderly that this Consensus Statement was prepared by an interdisciplinary group representing the principal international associations concerned. Its objectives are not only to define geriatric psychiatry but to encourage the development of this discipline for the benefit of the elderly.

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Introduction

The population of old (and particularly very old) people is increasing rapidly throughout the developed and developing world. This reflects improving health and social conditions and is a cause for celebration. Most older people remain in good mental as well as physical health and continue to contribute to their families and to society.

This notwithstanding, some mental illnesses (such as the dementias) are particularly common in old age; other differ in clinical features and/or present particular problems in management. Social difficulties, multiple physical problems and sensory deficits are also common. Appropriate detection and management require specialist knowledge and skills as well as multidisciplinary collaboration.

Priority needs to be given to these mental illnesses which can cause a great deal of stress not only to older people themselves but also to their families. This is aggravated by changing family structures. There is also an increasing number of older people living alone. Appropriate interventions for the major mental illnesses of old age can often either treat them effectively or at least substantially improve the quality of life of patients and their families.

The rise in numbers of older people with mental health problems has necessitated the development of the specialty of psychiatry of the elderly. The emergence of the specialty of psychiatry of the elderly has helped to raise the status of this vulnerable group and has also fostered research which offers hope for better treatment and outlook and provides the opportunity for training students in all health and social care related disciplines.

This summary of the scope of psychiatry of the elderly is intended to promote awareness of mental health problems in older people, to initiate or improve the provision of services and to encourage teaching and research in the area.

Definition and Assessment

Psychiatry of the elderly is a branch of psychiatry and forms part of the multidisciplinary delivery of mental health care to older people. The specialty is sometimes referred to as geriatric psychiatry, old age psychiatry or psychogeriatrics.

Its area of concern is the psychiatry of people of 'retirement' age and beyond. Many services have an age cut-off at 65 but countries and local practices may vary: several specialist services include provision for younger people with dementia. The specialty is characterised by its community orientation and multidisciplinary approach to assessment, diagnosis and treatment.

An elderly patient suffering from mental health problems often has a combination of psychological, physical and social needs. This implies that individual assessment management and follow-up requires collaboration between health, social and voluntary organization and fam-

ily carers. Mental health problems in old age are common and an understanding of the principles involved in their identification and management should be an integral part of the general training of all health and social care workers. Progress in the field must be evidence-based and founded on rigorous empirical research with which practitioners should aim to keep up to date.

Past experience and behaviour may influence whether a person develops mental illness and how such illness presents itself. Multiple losses (death of relatives/friends, declining health, loss of status etc) in old age may be particularly important though many older people remain resilient despite multiple adversity.

The specialty deals with the full range of mental illnesses and their consequences, particularly mood and anxiety disorders, the dementias, the psychoses of old age and substance abuse. In addition, the specialty has to deal with older people who developed chronic mental illness at a younger age. At any rate, psychiatric morbidity in old age frequently coexists with physical illness and is likely to be complicated by social problems. Older people may also have more than one psychiatric diagnosis.

The above factors, together with the biological, social and cultural changes associated with ageing may significantly alter the clinical presentation of mental illness in old age. Current diagnostic systems (ICD-10, DSM-IV etc) do not fully allow for these factors.

The diagnostic approach is essentially similar to that used in other age groups. There are nevertheless some differences. Older people are often frightened by unfamiliar diagnostic investigations. They should have their initial assessment in their home or other familiar setting wherever possible. It is particularly important to obtain a collateral history. Invasive or stressful tests should only be undertaken where their results might alter management or to fulfil family needs for diagnostic answers.

Many mental illnesses in old age can be treated successfully. Some (particularly the dementias) are chronic and/or progressive. Appropriate intervention can nonetheless contribute to improving quality of life.

A diagnostic formulation should emphasise abilities as well as deficits and incorporate the meaning given to the illness by the patient and the family. Both assessment and intervention may involve overlap between professional roles as well as coordination between services.

Treatment

The objectives of treatment may include restoration of health; improving quality of life, minimising disability, preserving autonomy and addressing supporters' needs are equally valid. Treatment must be adapted to the individual patient's need and to available resources. Its delivery usually requires cooperation between the multidisciplinary professionals involved as well as involvement of informal supporters. Early detection and intervention may improve prognosis, and education is required to counteract the therapeutic pessimism of both professionals and patients.

Treatment must pay due regard to individual patient's wishes: dignity and autonomy must be respected. Consent to treatment by patients no longer competent to make such decisions raises important ethical and legal issues.

Older people with mental illness (particularly depression) may take longer to respond to treatment than their younger counterparts. Functional psychiatric illnesses in late life have a high rate of relapse; close follow-up and continued treatment may reduce this.

Older people are particularly vulnerable to side effects of psychotropic drugs. Consideration must also be given to age-related changes in drug handling. Interactions between psychotropic drugs and older patients' comorbid physical illnesses (and their treatment) are also common. Coexistent physical problems in older people with mental illness must be treated; this may facilitate treatment of the mental illness.

Treatments to improve cognitive functioning in people with dementia and/or modify the course of the disease are being actively researched. Vascular dementia may be prevented or slowed by treatments that reduce risk of stroke.

All psychotherapeutic techniques (e.g. supportive, psychodynamic and cognitive/behavioural) may be used with older people. Adaptations may be necessary to take into account any sensory or cognitive deficits.

Therapeutic interventions to encourage autonomy include retraining of practical support and information including social and legal rights' advice to patients and their supporters make an important contribution.

Organization of services

Most older people with mental health problems are cared for by their families and/or friends with support from the primary care team which also provides continuity of care. The primary care team (as well as other service providers) needs to be able to refer to the old age psychiatry service when further opinions and advice are needed and/or for direct specialist care.

The multidisciplinary specialist service in old age psychiatry can include a range of professionals such as doctors, nurses, psychologists, occupational therapists, physiotherapists, social workers and secretarial staff who should meet regularly to coordinate and discuss new referrals and current caseload. The team should have an identified leader.

Initial assessments should wherever possible be in the patient's home; family members and the primary care team should be involved. The assessment should result in the formulation of a care plan and follow-up arrangements with clear objectives, defined responsibilities for multidisciplinary team members and the primary care team (usually with a single designated 'key worker'). This should include the provision of support, information and advice to carers.

In order for the specialist service to work effectively, a range of resources needs to be available and accessible. These include an acute in-patient unit, rehabilitation, day

care, respite facilities and a range of residential care for people no longer able to live in their own homes. Reciprocal availability of advice between psychiatry of the elderly and general medical and (where available) geriatric medicine is important. Links with community facilities are important (e.g. day centres and support groups for carers as well as for patients themselves).

A comprehensive service in psychiatry of the elderly should be patient-centred and achieve sufficient coordination between its elements to ensure continuity of care. The service should be integrated into the health and social welfare system and is dependent upon an adequate social, political, legal and economic framework.

Quality assurance must be a priority within all parts of the service. This is particularly important to ensure respect for the needs and wishes of those older people who are unable to express them fully.

Training

The specialty of psychiatry of the elderly requires a grounding in general psychiatry and in general medicine as well as training in the specific aspects of both psychiatric and medical conditions as they occur in older people. Psychiatry of the elderly should be taught in the variety of settings in which it is practised.

Training schemes for all health and social care workers should include a component on mental health care of older people. Training in mental health care of older people should be offered at both undergraduate level and also during continuing professional development.

Education and information about mental health care of older people should be offered to the general public and to carer groups. The development of appropriate training manuals with culturally appropriate material should be achieved for all groups of professionals and carers.

Research

Research in old age psychiatry covers a wide range including molecular biology, epidemiology, neurochemistry, psychopharmacology, health service research (including evaluation of innovative community projects) and ethics.

Research in this area provides a unique opportunity for crossfertilisation between disciplines, is crucial for the advance of the specialty and may have benefits beyond its domain. Workers in the field need training in research methods as well as time and opportunity to pursue research.

Conclusions

There is already a vast amount of knowledge and expertise related to psychiatry of the elderly. It is hoped that the guidance offered will encourage professionals and politicians to initiate, build up and improve services, training

and research on behalf of the rapidly ageing population worldwide and the associated increase in numbers of older people with mental health problems.

It is important to recognise that in some countries, resources, especially in terms of mental health professionals, are very limited. In these countries it will be necessary to establish sensible priorities for mental health problems of the elderly. We would suggest the following priorities:

1. Teaching of psychiatry of the elderly to primary health care workers.
2. Training of all the existing mental health professionals in the special mental health problems of the elderly.

3. Establishment of multidisciplinary groups to act as resource centres.

It is the responsibility of those multidisciplinary professionals already in the field to put pressure on governments to ensure that reasonable quality and affordable resources are provided to meet the urgent needs of elderly people with mental illness whose physical problems and life circumstances often require special consideration.

There can be no doubt that there is ample justification to support the development of the specialty of psychiatry of the elderly with its own training programmes, career structure and multiprofessional support network.