The Old Age Psychiatry Handbook

A practical guide

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Dedicated to our families, particularly
   Linda and Derek Rodda,
   and
   George and Kathleen Boyce,
   and
   Rodney and Juliet Walker.
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Preface

Old Age Psychiatry is a growing specialty, due to the expanding proportion of the elderly population, the increasing base of knowledge in this area, and the promise of new diagnostic and therapeutic tools that come with an established and vibrant research community.

The majority of psychiatric trainees will spend some time working in old age psychiatry. All General Practitioners will be confronted with the unique management issues arising from psychiatric pathology in elderly patients. Community Mental Health Teams comprise a number of different professionals, each involved in a different aspect of care but working towards a common goal. This book provides a comprehensive but concise overview of psychiatric, medical and practical issues that may arise within the speciality.

In writing this book, we have been guided by the principle of holistic care. Providing the best care for patients involves understanding and addressing their physical and emotional needs from the point of view of the whole individual including their life story, environment, family and friends. This is the challenge, and the privilege, of treating elderly patients.

Note on the text

Where it may break the flow of the chapter, some information (for example tables and assessment scales) has been included in the form of appendices. The aim of this book is to be a concise guide to Old Age Psychiatry rather than a reference text, and as such suggestions for further reading rather than extensive references are given at the end of each chapter.

Joanne Rodda
Niall Boyce
Zuzana Walker
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# 1
## The Assessment of Patients in Old Age Psychiatry

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## Introduction

Assessment of patients in old age psychiatry follows similar principles to that in general psychiatry, the main differences being in the practicalities and emphasis. Multidisciplinary working is central to the process; in many cases the assessment involves a number of professionals and occurs over a period of time.
Referrals

In general, referrals are made to the appropriate Community Mental Health Team (CMHT, see page 222) and the most appropriate action is discussed in a multidisciplinary meeting. Depending on the nature of the referral, the initial assessment may be completed by one or more members of the team, with involvement of other professionals as necessary.

Beginning the assessment

There are a number of things that it is important to establish at the beginning of the assessment which may seem obvious but make things go a lot more smoothly:

- Introduce yourself and make your role clear – some patients may not realise that they have been referred to a psychiatrist.

- Try your best to put the patient at ease (see above).

- Establish what the patient would like to be called (it’s usually best to use Mr/Mrs/Miss if unsure).

- Make sure you know the names of people accompanying the patient and their relationship/roles.

- Ask if the patient would like some time alone without relatives/carers listening (it may be easier to ask at the end, or give the patient the opportunity during the physical examination).

Setting

Assessments usually take place in the patient’s home or in the outpatient clinic, although sometimes it is necessary to assess a patient on a hospital ward.

Domiciliary visits

The patient’s own home is the ideal environment for an assessment, and allows for a more accurate insight into their social situation and level of functioning, for example:

- Is the house clean, well organised?

- Is there fresh food in the fridge?
• Can they make a cup of tea?

• Can they recognise people in photos around their home?

• Is the accommodation safe/appropriate? (For example heating, hot water, stairs, bathrooms, hazards.)

• Are there empty bottles of alcohol?

• Are there boxes of unused medication?

• How much support is available from people living nearby?

Another advantage of a home visit is that friends and family involved in the patient’s care are more likely to be able to attend and give valuable collateral history. This is balanced against the disadvantages of the time necessary for travel, difficulties in performing a physical examination and safety implications for staff. Although the patient may not pose a risk, their environment or other people in the home might. Box 1.1 summarises some important safety and practical procedures.

**Box 1.1 Important safety and practical procedures for domiciliary visits**

Let the patient and their family/carers know when to expect you.

Plan your route in advance and carry a map.

Familiarise yourself with any history of risk that is available.

Make sure someone knows details of the visit and when to expect your return.

Carry a mobile phone.

If you feel threatened, leave immediately.

**Outpatient clinics**

The outpatient clinic is the most convenient setting for assessment from the point of view of medical staff, although there are a number of disadvantages:

• It can be disorientating for the patient to travel, which may lead to a less accurate picture of their mental state and cognitive function.
Friends and relatives are less likely to be able to attend.

Patients often do not have transport.

**Psychiatric wards**

It may be necessary for a patient to be admitted to a psychiatric ward for assessment because:

- The patient is at risk of self-harm, self-neglect or harm to others.
- A longer period of assessment is needed than a brief interview at home or in the clinic.
- Family/carers are not able to manage/cope with the patient.

The disadvantage is that the patient is out of their home environment and so the assessment may still not reflect the true level of functioning. In addition, patients might lose some of their skills and confidence.

**General hospital wards**

Medical and surgical inpatients with acute mental health problems may be referred for liaison assessments on the ward. Before the assessment, read the referral thoroughly and if necessary call the referrer for further information, including any test results pending. It is always worth checking whether or not the patient is already known to psychiatric services, and tracking down the notes if they are.

There are a number of things that you can do to make the liaison assessment go more smoothly:

- Get as much information as you can from the ward nurses.
- Try and arrange for a relative or carer to be present.
- Wards are noisy – find a quiet room where you won’t be interrupted.
- Be prepared to do your own physical examination if you feel it is necessary.
- Ask the patient’s permission to phone relatives for further collateral information if you need it.
- Be prepared to make more than one visit.
In the case of a liaison assessment the psychiatrist is only advising the team looking after the patient of the most appropriate management from a psychiatric point of view. Ultimately, decisions regarding management remain the responsibility of the team looking after the patient.

**The psychiatric history in older patients**

The psychiatric history follows the same scheme as that used in general psychiatry. There needs to be a greater focus on particular aspects, for example social history and assessment of cognition. In addition, much of the history is often obtained from a relative or carer (see page 10). Box 1.2 gives an outline.

---

**Box 1.2  Overview of the psychiatric history**

- Source and details of referral
- Presenting complaints
- History of presenting complaint
  - nature, onset, duration, precipitating factors, impact, risks
- Personal history
  - birth and milestones, childhood, education, employment, relationships
- Family history
- Past psychiatric history
- Social history
  - accommodation, finances, activities of daily living, level of support
- Past medical history
- Medication and allergies
  - note potential interactions and side effects
- Alcohol and drugs
- Forensic history
- Premorbid personality
- Collateral history
History of presenting complaint

As with any psychiatric interview, it’s good to start with an open question (“can you tell me a bit about what’s been happening lately?”).

More focused questions can be used to direct the history and to establish:

- Nature of the problem
- Speed of onset
- Duration
- Possible precipitating factors (e.g. life events, physical illness, medication changes)
- Impact on the patient’s life (e.g. no longer leaves the house)
- The patient’s perception of the problem
- Whether others think there is a problem
- Risks (Table 1.1).

To establish a timeline it can be helpful to relate the onset and changes of symptoms to events like birthdays, Christmas or holidays.

Whilst the patient needs to be able to tell their own story, there are some features that should be screened for, with more detailed questioning where necessary. The nature and range of symptoms experienced by older patients may be different from their younger counterparts.

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Personal history

- Birth and milestones
- Upbringing and significant childhood experiences
- School, higher education and occupational achievements
  - contributes to overall picture
  - gives an idea regarding the patient’s previous level of functioning.
- Relationships, marriage and children
- Life events
- Social network.

Many of the current older generation were affected by the Second World War and may have experienced significant adversity. Separation from carers, interruption of education, loss of parents or a spouse and serving in combat with resulting injuries and psychological traumas are all issues that may affect the presentation of psychiatric illness.

It is always important to put life events in to context, for example being a single mother is generally socially accepted in the UK today, but in the past often had devastating consequences.

Family history

Patients with cognitive impairment might seem muddled about the exact names and relationships of family members, and this in itself is informative. Whether from the patient or a carer, it is helpful to obtain accurate information regarding any family history of medical and psychiatric problems.

Past psychiatric history

Patients often use terms like “nervous breakdown” to describe episodes of mental illness in the past. They might also describe diagnoses such as “schizophrenia” which seem questionable. It is often best to ask a few questions about the exact nature of the illness and its treatment to get a clearer picture.
Social history

Interventions aimed at optimising the social situation are often extremely effective and well received by the patient and their family. The main areas to cover in the social history are:

Accommodation

- Type (independent/warden controlled/residential home/nursing home)
- House or flat?
- Rented or owned? (If rented, private or local authority/housing cooperative?)
- Stairs – are the bedrooms/bathrooms upstairs or down?
- Heating (open fires, gas heaters).

Finances

- Are there financial worries or concerns about exploitation?
- Do they receive any state benefits, for example, in the UK, Attendance Allowance (AA), or Disability Living Allowance (DLA)?
- Do they have insight into their financial situation?
- Who controls the finances and is this a formalised arrangement (e.g. power of attorney)?

Activities of daily living

- Is assistance required and how much?
- Personal hygiene
- Dressing
• Cooking
• Eating/drinking
• Shopping
• Use of transport
• Hobbies and interests (past and present).

**Current level of support**

• Input may be from family, friends, neighbours or paid carers (social services or private). How often do they visit and for how long? What do they do?

• Meals on wheels

• Day centres

• Respite.

**Past medical history**

Ask about any past illness or surgery, as well as current or chronic conditions and cardiovascular risk factors. These may help with diagnosis or may be exacerbating factors.

**Medication**

• If the patient doesn’t bring a list, call the GP surgery.

• The elderly are particularly susceptible to side effects (see Chapter 10).

• Confusion, anxiety, affective disturbance, psychotic symptoms and falls can all be caused or exacerbated by drugs.

Ask about compliance, and whether or not the patient has a dosette box or prompting/help from a carer to take medication. This is also a good time to ask about allergies.
**Drugs and alcohol**

Ask about past and present alcohol consumption and smoking. Recent changes may reflect the underlying mental state. Drug abuse may not be thought of as a major problem in elderly patients, but is worth asking about.

**Forensic history**

Ask about any experience the patient has had of the criminal justice system. Recent arrests, convictions and cautions may be important evidence of new-onset psychiatric illness, or a relapse of manic or schizophrenic illness.

**Premorbid personality**

Premorbid personality is often neglected but can be especially important, for example in the case of disinhibition in frontotemporal dementia.

**Collateral History**

The law allows us to take information regarding a patient from anyone who wishes to offer it but it is always best to ask the patient for his or her permission. Explicit permission from the patient is essential if you are going to give details of their illness to their relatives. If the patient lacks capacity to give their consent then information can be given to relatives/carers if it is in the patient’s best interests. If you are at all unsure, it is best to discuss the issue with a senior colleague.

Ideally, you will be able to take the collateral history in the presence of the patient, allowing the process to be completely transparent. However, it can often be useful to see the patient’s relative alone. For example, the relative may wish to discuss behaviour that is upsetting or embarrassing for the patient.

**The Mental State Examination (MSE)**

The psychiatric history records the symptoms since the onset of illness, whereas the MSE is a snapshot of these symptoms and signs at the time of the interview. In practice, there is considerable overlap between the two. Box 1.3 gives a skeleton plan of the MSE and a more detailed summary is given below.
Box 1.3 Mental State Examination

Appearance and behaviour

Speech

Mood

Thought

Perception

Cognition

Insight

Appearance and behaviour

Awareness

• A reduced level of awareness might reflect effects of physical illness or drugs.

• Rapid fluctuations suggest an acute confusional state.

• Variations in the level of consciousness can also occur in dementia with Lewy bodies.

• The level of awareness will affect performance on cognitive testing.

Appearance

• Personal hygiene: an unkempt appearance and poor personal hygiene suggests personal neglect, although a person might appear well kempt because they are well looked after by a carer.

• Clothing: the state of dress might suggest mania, disinhibition or dressing dyspraxia.

• Environment: on a domiciliary visit the state of the patient’s environment also gives clues (cleanliness, tidiness, empty bottles etc.).
Behaviour

• Eye contact

• Facial expression

• Ability to establish rapport

• Anxiety/agitation/aggression

• General slowing/psychomotor retardation/posture
  – can be suggestive of depression, can also occur in dementia

• Overfamiliarity and disinhibition
  – may be suggestive of mania or frontal lobe problems

• Apparent responses to hallucinations

• Tics, mannerisms and stereotypies, for example:
  – as a feature of schizophrenia
  – hyperorality and repetitive behaviours may occur in frontotemporal and other types of dementia.

Speech

• Rate and quantity, for example:
  – ↓ in depression; can be to the point of appearing to have dysphasia
  – ↑ in mania, although this is not always the case in the elderly
  – ↓ may be due to dysphasia (see below)
  – pressure of speech and poverty of speech may reflect mania or depression respectively.

• Tone: may be normal or monotonous (e.g. depression, Parkinson’s disease).

• Volume, for example:
– ↑ in deafness, disinhibition and mania

– ↓ in anxiety, depression.

• Word finding difficulties:
  
  – dysphasia (impairment of language, note: this is different from impairment of articulation of speech which is called dysarthria and is due to poor muscle coordination)
  
  – language deficits are common in many dementias (e.g. semantic dementia)
  
  – nominal dysphasia (word finding difficulties) occurs early in Alzheimer’s disease.

**Mood**

**Depression**

The current generation of older people may find it difficult to describe their mood. Biological features and somatisation may therefore be more apparent than the psychological features of depression. The assessment of mood also draws from the assessment of behaviour and both subjective (the patient’s) and objective (the clinician’s) accounts are recorded. Table 1.2 gives a list of depressive features to screen for. The 15-item Geriatric Depression Scale (GDS, Appendix 1) is a brief assessment scale that can be completed in the clinic.

Differentiating depression from dementia or bereavement can be difficult; for further information see the later chapters on dementia and mood disorders.

If there is any suggestion of depressed mood, enquiry about suicidal ideation is essential. Older men are one of the highest risk populations for completed suicide.

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