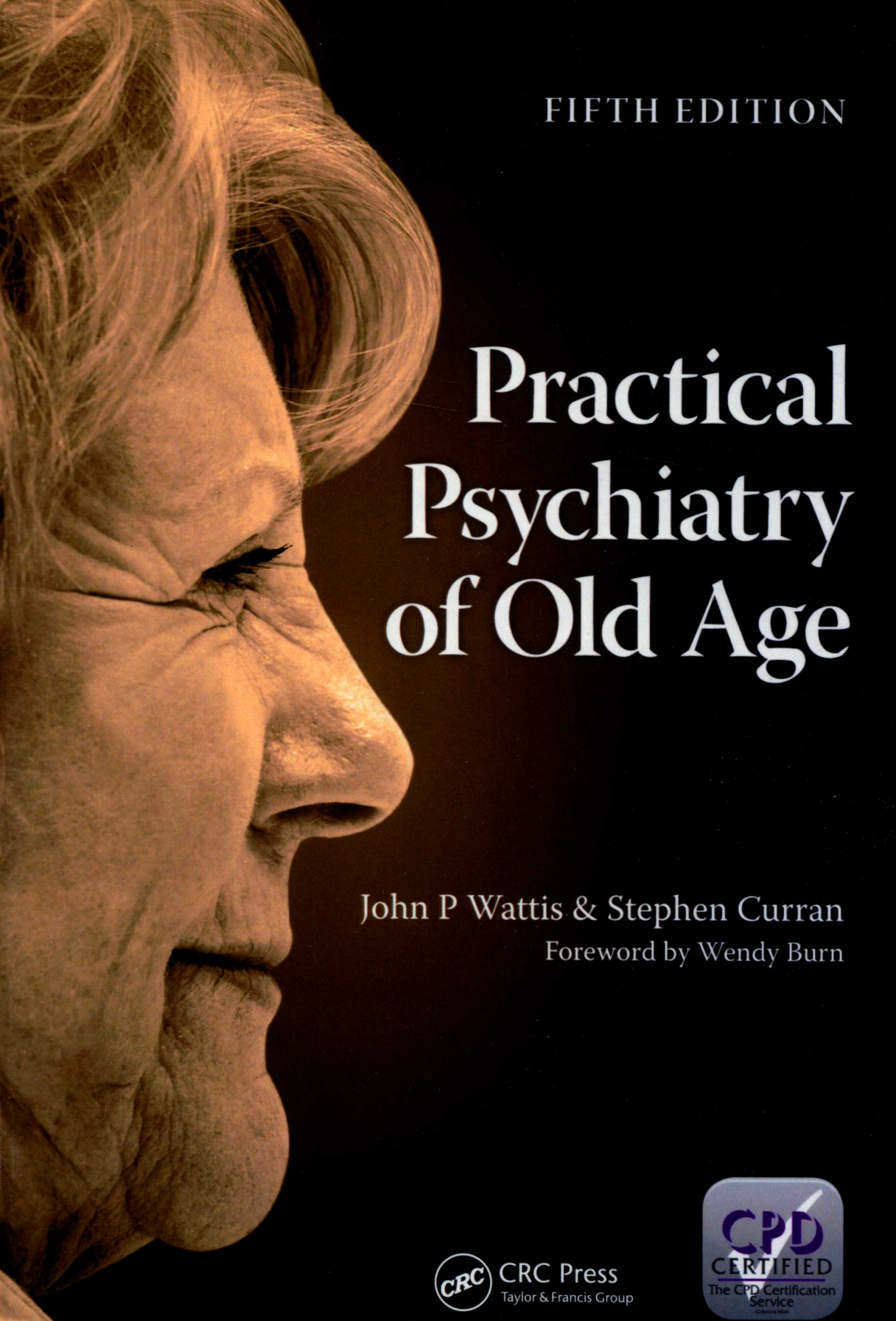
FIFTH EDITION
Practical Psychiatry of Old Age
John P Wattis & Stephen Curran
Foreword by Wendy Burn
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Practical Psychiatry of Old Age

Fifth edition

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PRACTICAL PSYCHIATRY OF OLD AGE

Foreword to the fifth edition

I am delighted that there is now a fifth edition of *Practical Psychiatry of Old Age* and that I have been asked to write an introduction.

I first came across this book very early in my professional life when I worked for John Wattis. This was in the early days of old age psychiatry as a specialty, and John was one of those who inspired me to make my career in it. I can still remember my excitement on recognising a patient who had been the subject of one of the case vignettes in the book.

Practical Psychiatry of Old Age has stayed with me throughout my working life and I have used it more than any other reference book. As its title suggests it contains practical and accessible advice for the busy clinician, backed by a solid knowledge of the research literature. Each new edition has reflected the changes in the specialty that have occurred in assessment, treatment and the way that services are organised. I return to it again and again, sometimes to check basic facts, sometimes to help in the preparation of teaching or assessment and sometimes purely out of interest. I always find understandable, lucid explanations and the information is clearly and helpfully set out.

Stephen Curran became involved from the third edition. I have known him since he was a trainee and had the pleasure of being his trainer at one point. Apart from his clinical experience and natural wisdom, Stephen brings an excellent knowledge of psychopharmacology in practice and experience gained in his role as chair of the Royal College of Psychiatrists' Memory Services National Accreditation Programme advisory group. He also has a particular interest in resistant depression in old age and forensic work with the elderly.

The fifth edition has been updated to include modern NICE advice on the tiered approach to managing depression, with an expansion of information on psychological approaches and an update on psychopharmacological matters. Care pathways are covered, and the recent changes to the way in which services are organised are included.

This is a book light enough to be read for pleasure but heavy enough to be used as a clinician's main textbook. I recommend it to anyone of any discipline who works with the elderly and wants their knowledge to be sufficient to ensure that they provide the optimum care for older people with psychiatric problems.

Wendy Burn BM MMedSc FRCPsych
Dean, Royal College of Psychiatrists
January 2013

Foreword to the fourth edition

Not many books make it to a fourth edition. This is a commendation in itself. Of those that do, the epithet 'classic' is likely to be attached. So it is my privilege to undertake the foreword to this classic textbook.

The specialty of psychiatry as applied to older people may be a relative newcomer compared with other branches of medicine, but it has enjoyed vigorous growth over the past 20 years, spurred on by demographic changes in most developed societies. New technologies, such as medication for dementia, have not only helped patients directly but have had an important impact on the seriousness with which conditions like dementia are regarded. In an interesting reversal of dualistic thinking which has pervaded medicine, new concepts such as 'vascular depression' have brought together findings from brain imaging with those from observations of mood, behaviour and psychosocial experience. Around the globe, organisations such as the International Psychogeriatric Association and the Section of Old Age Psychiatry of the World Psychiatric Association are championing service development, teaching and research. There has probably never been a better time to practise in this specialty.

Integral to this endeavour is dissemination of the knowledge base that constitutes the specialty. *Practical Psychiatry of Old Age* is a major contributor to this. If I had to emphasise one word in the book's title it would be 'practical'. The two authors are clinicians who have devoted their professional lives to the practical care of older people with mental ill health. I can picture them returning after an assessment in a patient's home thinking 'that will make a great case history for the book'. Paradoxically, the term 'practical' can have slightly negative connotations – the mere fixing of problems, unacademic, not having much depth. It is important then to note that the immensely practical approach of this book is underpinned by a strong evidence base which the two authors, both of whom have robust academic credentials, have clearly weaved throughout the fabric of the contributions.

In a textbook which is comprehensive in scope, it is vital that the authors have a grip on 'quality control'. Not only is this apparent but they have made clear from the earliest chapter and throughout the book that they are serious about treating the whole person. So theory and practice are expertly melded but there are also important insights regarding ethical dilemmas, societal values and spiritual concerns. The overall 'feel' of this book then is one of expert knowledge within a compassionate, humane and holistic framework.

This book will appeal to a wide readership – from those who want general information on the major mental health problems of later life to specialists who want to refresh and update their knowledge.

Robert Baldwin DM FRCP FRCPsych
Consultant Old Age Psychiatrist and Honorary Professor
at the University of Manchester
Manchester Royal Infirmary
March 2006

Preface

When the first edition of this book was published, old age psychiatry in the UK was in its infancy and the senior author was a newly appointed consultant. Now, 30 years on, things have changed almost beyond recognition. Some of the changes have been welcome. There are many more old age psychiatrists and many more multidisciplinary teams. Other changes have been less welcome, including the virtual abolition of NHS-funded long-term care for people with severe dementia. Some things have, despite changes in the organisation of services, remained depressingly familiar, like the still too frequent examples of neglect and abuse in the care of old people.

One thing remains certain: old people with mental health problems require compassionate and competent services. This edition seeks to bring up to date our clinical primer for doctors and others caring for old people with mental health problems. We have incorporated many changes in clinical and organisational areas. We hope we have retained the emphasis on good diagnosis, care and management combined with an emphasis on the importance of showing old people that we value them by relating to them in a respectful way.

John P Wattis
Stephen Curran
January 2013

About the authors

John Wattis was appointed Visiting Professor of Psychiatry for Older Adults at Huddersfield University in 2000. Before this he was responsible for pioneering old age services in Leeds, where he worked as a Consultant and Senior Lecturer for nearly 20 years. He completed his psychiatric training in Birmingham and Nottingham, where he was lecturer in the Department of Health Care of the Elderly, which combined psychiatric and medical teams. He has management experience as Medical Director of a large community and mental health trust. He is a former Chairman of the Faculty for Psychiatry of Old Age at the Royal College of Psychiatrists, and the committee that advises on the higher training of doctors in general and old age psychiatry. He has published research on the development of old age psychiatry services, alcohol abuse in old age, the prevalence of mental illness in geriatric medical patients, and outcomes of psychiatric admission for older people. He has written or edited a number of books and contributed numerous chapters in the area of old age psychiatry.

Stephen Curran works as Consultant Old Age Psychiatrist in Wakefield, and was appointed a Visiting Professor at Huddersfield University in 2001. He graduated in psychology before studying medicine and then worked as a Research Fellow and Lecturer in Old Age Psychiatry at the University of Leeds. His research interest is in psychopharmacology in older people with mental illness, particularly the pharmacological management of depression and early detection of Alzheimer's disease. He has numerous research publications to his credit, and has co-authored and co-edited a number of books.

Together, John and Stephen have contributed to undergraduate and postgraduate teaching both of doctors and of those in other disciplines. Their approach to healthcare for older people is founded on three principles:

1 recognition of the importance of *good relationships* between individuals and between different health and social care providers
2 firm commitment to the need to develop and integrate evidence-based practice
3 an emphasis on the need for creativity in improving treatment and services.

They are committed to a multidisciplinary and inter-agency approach to healthcare of the elderly that sees mental health and illness in the context of physical health and social pressures.

Acknowledgements

We gratefully acknowledge the work undertaken by Mike Church and Carol Martin, co-authors of the first two editions, some of which is retained or reflected in this fifth edition. We are also indebted to Shabir Musa, Arun Devasahayam and Jayanthi Devi Subramani, for allowing us to use part of their contribution to *Practical Management of Dementia (2nd edition)* as the basis for the section on legal issues in Chapter 10.

We would also like to thank Gill Nineham for help and advice given over many years, and Jenny Monk for her work on the revised manuscript for this edition.

To our families –
for their patience with us whilst we have been working on this book.

Contents

Setting the scene

INTRODUCTION

This chapter sets the scene for the whole book. Those who are eager to address some practical problem such as what to do with a confused or depressed patient in the consulting-room can safely skip it and return to it later.

The pace of change in medicine and society is accelerating. We are in a period of confusion as the 'industrial age' gives way to the 'information age'. We may move into a period of *relative* stability once this has occurred. In the mean time, the busy clinician and the educated consumer have to learn to work *with* constant change. The following are among the most relevant:

- technical progress – molecular medicine, new scanning techniques, new drugs (medications) and new classes of drugs, and new information technology
- the need to develop good practice based on the best available evidence, meeting the challenge of changing the behaviour of clinicians and patients
- improving the interpersonal aspects of clinical practice
- frequent reorganisation as politicians 'modernise' the way services are delivered.

Our understanding of ageing and the issues that surround it has also moved on. In particular, our understanding of the dementing illnesses such as Alzheimer's disease has developed in a number of ways, from the molecular biology to the 'science of the art' of diagnostic practice[1] and interpersonal care.[2] Social and political trends are also influencing *how* services are delivered. These include the following:

- a move from quantitative to descriptive standards of service provision
- a move from public to private funding and provision
- a move from medical dominance to 'stakeholder' or even consumer power (potentially leading to neglect of weaker consumer groups such as old people)

- a move from hospital to community services
- rising inequality in Western societies (especially the USA and the UK).[3]

The changes in the population structure continue. These include not only the 'greying' of the population but also other social and cultural changes with regard to marriage, divorce and parenting. The political context is also changing. In the UK we are moving away from the post-war welfare state, which was dominated by monolithic (some would say 'neolithic') public services, towards a 'mixed economy' of health and welfare provision. This is more able to cope with rapid change, but there may be more risk of vulnerable groups being neglected. Mental health services for older people are a relatively new development both around the world and in the UK.[4] They are children of change, and should be able to thrive in the changing world, though increased emphasis on private provision and consequent fragmentation of services may not serve old people well.

In this chapter we intend to give a brief overview of some of these issues. In particular, we hope to cover the following areas:

- what ageing is – a biological and psychological understanding
- ageing in society – social, cultural and political aspects
- a developmental viewpoint on ageing and its challenges
- the impact of technical advances and 'evidence-based medicine/evidence-based practice' (EBM/EBP)
- the epidemiology of mental disorder in late life
- the development of specialist services for old people with mental disorder and their interface with other services for old people, especially memory services.

WHAT IS AGEING?

Age can be measured in various ways, including the following approaches:

- chronological
- biological
- psychological
- developmental
- social.

A particular individual may well be at different stages on these and other dimensions. These various aspects of ageing are not independent of each other. Psychological and biological ageing interact with each other and with the social and physical environment to produce the complicated picture that we recognise as ageing. We shall now, for the sake of simplicity, describe some of these areas separately.

Biological ageing

Biological ageing can be considered at the level of molecular, cellular, organ, organ-system or whole-organism ageing.

Despite the Bible's 'threescore years and ten', human life expectancy is scientifically indeterminate. We can discuss the average age of populations and the known limit of longevity, but individuals may (and probably will, in due course) survive beyond that apparent limit. However, we are here more concerned with present reality than with any theoretical limit. In the UK in 2011 a man aged 65 years could expect on average to live to 83 years, and a woman of the same age to 85.6 years (*see* Age UK website). Even within the UK there are marked geographical differences in life expectancy.[5]

What determines the age of death and what processes are important? Usually death occurs as a consequence of the inability of the body to deal with some disease process, rather than as a direct effect of ageing. Indeed, one definition of ageing is that it is a progressive change in the organism that leads to an increased *risk* of disease, disability and death. At the *genetic* level, some argue that lifespan is 'pre-programmed', although no direct evidence of this has yet been found. Others argue that errors in protein synthesis, damage to DNA (the genetic coding material of the cell) or chromosomal mutation in tissues that renew themselves may play a part. Certainly cell cultures grown in the laboratory seem to survive for a long but limited time unless they undergo a mutation (e.g. into cancer-like cells) whereby the normal cellular mechanisms that control growth and cell division are no longer active.

Another type of genetic mutation, in the immune system, might result in it starting to attack healthy cells. External factors such as ionising radiation may be responsible for damaging the DNA and producing mutations. Even at this level, attempts to separate internal and external factors may be in vain. At the *cellular and tissue level* some cells (e.g. nerve cells) are not replaceable if they die. However, even nerve cells are able to generate new connections and so, to a limited extent, 'bypass' problems caused by cell death. Other cells are replaced with varying degrees of rapidity in processes that are sensitive to internal feedback mechanisms. Pigments and other products of metabolism may accumulate in cells and extracellular tissue and may potentially cause harm, as may certain heavy metals.

Whatever the underlying mechanisms, we know a great deal about the changes that normally occur in different *organ systems* of the body as they age. Heart disease accounts for most deaths over the age of 65 years. Muscle fibres in the ageing heart are reduced and the pigment lipofuchsin, which first appears in the heart at around 20 years of age, represents over 5% of the muscle fibres in those aged over 80 years. Within wide individual variation there is an average reduction in the pumping performance of the heart. Each individual contraction is slower, probably as a result of changes in the

cellular enzymes that facilitate this action. The reserve capacity of the heart to cope with the stress of vigorous exercise is reduced with increasing age, but is generally still considerable. Changes also occur in the blood vessels, with decreased elasticity in the vessel walls, compounded in virtually all cases by the deposition of fatty atheromatous plaques in the lining of arteries. This loss of elasticity may be one of the reasons why blood pressure tends to increase with increasing age. However, another reason may be only indirectly age related, as obesity tends to be more common in middle age, and is itself a risk factor for high blood pressure, and possibly for later onset of Alzheimer's disease.

In the digestive system, apart from wear and tear on teeth, there are no major consistent changes with ageing. The loss of neurons in the brain is probably only marginal, and although nerve cells do not generally regenerate in humans, they are capable of growing new connections to other nerve cells (synapses). Sensory input to the brain may be reduced by ageing and disease. The eye becomes less able to shift focus, and night vision declines with increasing age. High-frequency hearing loss develops gradually over the age of 50 years. Reflexes are more slowly reactive, and the capacity of the brain to make decisions in complex situations is slightly reduced, apparently largely as a result of intrinsic changes.

Skin shows reduced elasticity and adherence to subcutaneous tissues. With the exception of the female menopause, relatively few changes occur in the endocrine system. There is no decrease in thyroid activity, although there may be reduced utilisation of thyroxine by other cells. Corticosteroid hormones, produced by the adrenal cortex, may show a slight reduction in levels, but the adrenals retain their capacity to react to stress. The production of insulin by the pancreas is undiminished in health, but may be less reactive to changes in blood sugar levels. Male sex hormones gradually decline between the ages of 50 and 90 years, and male sexual activity decreases from around four episodes weekly at age 20 years to around once weekly at 60 years. The majority of this decline appears to occur by the age of 45 years. Of course, the extent to which this is hormonally determined and the extent to which it is a result of social and psychological expectations is not easily determined.

The *body as a whole* changes partly as a result of less effective feedback and control systems. It also changes in composition, with less lean body mass and relatively increased fat and fluid levels. Some of the loss of lean body mass may be due to reduced muscle mass resulting from reduced physical activity. This again emphasises the problems of distinguishing biological ageing from social and psychological factors.

Expectations about health have an important part to play in old people's satisfaction. For example, one study suggested that older people describe

themselves as sufficiently fit if they can carry out the tasks of daily living, even though these may require minimal activity. Levels of fitness in the general population may be much lower than optimal, and many people may be accepting restrictions on their lifestyle unnecessarily.

Psychological understanding of normal ageing

There are many false beliefs about the psychology of human ageing. However, there are some well-established facts. In the area of cognition, for example, research shows that response time slows – that is, it takes longer for older people to process new information. The size of the change is small, but in some circumstances even that may be critical, especially in combination with sensory or motor changes or stress, or when complicated decisions are involved. Many older people compensate by developing skills and strategies. For example, older typists look further ahead when typing and have extra time for processing, thereby maintaining their speed. The slowed reflexes and greater difficulty in decision making in older people, coupled with sensory changes, should make older people less safe drivers. However, again they use experience to compensate (and more than compensate), as the actuaries who set insurance premiums so high for young people clearly understand.

The differences that are found between groups are *statistically* significant, but there are older individuals whose performance matches or exceeds that of younger people. Training older people to use their memories and asking them to perform in areas of special competence allows them to perform as well as younger individuals. Memory for events in the distant past is not necessarily better than memory for recent events, and some of the stories that are retained by individuals may be over-learned and told in an automatic, repetitive way. In normal ageing, the ordinary tasks involving memory (e.g. sending someone a birthday card or remembering that the bath is running) do not decline. Where levels of motivation are high, older people may be better at telephoning someone at a set time, for example, but apparently perform less well when tasks are not regarded as vital. Certainly older people have a tendency to complain that they are more forgetful, particularly of names and the last place in which they put something. Their 'working memories' often have less capacity than those of younger people. However, there is a suggestion that the thinking of old people becomes more context bound and more expertise related, and intuitive, because it is *more* efficient to proceed in this way, thus compensating for reduced capacity.

Chronological age is an inadequate but necessary marker for more important but less easily measured phenomena of biological and psychological ageing.