Psychiatric assessment of the elderly patient

Components
- Appropriate venue for assessment
- Difficulties of assessment
- Components of assessment
- History
- Mental state
- Physical examination

Aims of assessment
- Diagnosis
- Problems
- Further assessment
- Multidisciplinary input

Venue for assessment
- Patient’s Home
- Residential or nursing homes
- Inpatient wards
- Outpatient clinics

Difficulties in assessment- History
Is often taken via a relative or carer
Therefore, always gain permission from the patient

Areas that should be emphasised are
- Enquiries about the activities of daily living
- What effect the illness is having on the carer and family

Psychiatric History
- Presenting complaint- especially cognition and memory
- Activities of daily living- cooking, laundry etc
- Precipitating factors
- Past psychiatric history- diagnosis, admissions (and section status), duration, treatment
- Past Medical History and Past Surgical History
- Medications- especially benzodiazepines and over the counter
- Family history of dementia, depression etc
- Personal history- education, occupational History etc
- Premorbid personality
- Alcohol History- CAGE questionnaire can be useful
- Smoking
- Drug history
- Forensic history- arrests, cautions, sentences, nature
- Social history- friends, isolation
- Housing- ask about independence, sheltered housing, carer

It is always important to consider, especially with elderly patents that:
- Physical illness can be a precipitating factor to psychiatric disorder
- Psychiatric symptoms can be the presentation of a physical illness.
Physical examination
- Impairments of vision, hearing and speech
- Nutrition, self neglect, general health
- Physical Disability
- Pulse and blood pressure
- Hydration status
- Respiratory system
- Cardiovascular system
- Abdominal examination
- Full neurological examination
- ? Per Rectal- constipation common in elderly

Investigations
- Weight
- Temp
- Urine testing
- Bloods, FBC, B12, folate, syphilis serology, U&E, LFTs, TFTs, glucose, serum lithium (if appropriate)
- ? CXR
- Brain imaging in dementia is diagnostic. It is important to rule out other potentially reversible causes of severe cognitive impairment (haematoma, infarction, space occupying lesion)

Mental state examination
- Appearance and behaviour- clothes, cleanliness, manner, sociable, shaking, alert, any impairments in vision or mobility?
- Speech- is it spontaneous, consistent, deaf, dysphasic, demented, delirious, flight of ideas
- Mood- subjective and objective, anxiety
- Affect- euthymic, irritable, constricted, blunted, flat, inappropriate or labile
- Always assess suicidal ideation and risk
- Thought content
- Abnormal beliefs- paranoia, dementia, severe depression, schizophrenia
- Abnormal perceptions- auditory hallucinations (paraphrenia), visual
- Thought form- disordered?
- Cognition- MMSE
- Insight- preserved in early dementia, revert to denial later

Formulation
- History, Mental State Examination, Physical Examination
- Differential diagnosis
- Aetiology
- Management plan
- Prognosis
- ? Complete a cognitive scale and depression scale if appropriate

Cognitive scales
- Affected by education and intelligence, Culture and language
- Severe (floor), Mild (ceiling)
- Abbreviated mental test score (AMTS)- concentrates mainly on the domains of orientation and memory
- MMSE
MMSE
The different domains are-
- Orientation
- Short term verbal memory
- New learning
- Concentration
- Language
- Visuo-spatial
- Praxis

Strengths
- Reliable
- Quick

Weaknesses
- Poor on detecting frontal lobe problems
- May not pick up subtle cognitive abnormalities
- Variation exists because of how it is administered – Essential to use it correctly. Can be minimised if the same assessor is used every time

Other cognitive domains
- Consciousness
- Calculation
- Hallucinations

Presentation in old age
- Core features of psychiatric illness are the same for all ages
- Interaction with physical health and cognitive impairment is important to consider
- Communication difficulties may play a role
- Important but subtle differences in symptomatology

Depression
- 3% severe and 10-15% mild to moderate
- Core features - low mood, biological symptoms and depressive cognitions
- Mood congruent delusions
- Reduced expression of sadness
- Cognitive impairment - “pseudodementia”
- Somatisation is common in the elderly
- Psychomotor agitation or retardation
- Self harm – can be medically trivial

Outcomes in depression
- Similar to younger patients - 2/3 respond to treatment
- Need to treat energetically
- Be aware of under detection in primary care
- Small proportion have poor outcome (when there is coexisting dementia)
- Persisting symptoms
- High mortality
- Deteriorating cognitive function
Mania
- Elevated (or irritable mood), over activity and pressure of speech
- Psychotic symptoms - mood congruent delusions
- Attenuated symptoms
- Behavioural changes - disinhibition and bizarre behaviour (psychotic or impaired)
- Cognitive impairment
- Impairment of insight and judgement

Late onset schizophrenia (paraphrenia)
- Late onset Schizophrenia - 0.5%
- Psychotic symptoms - delusions and hallucinations
- Often female, living alone with sensory deficits
- Personality less affected than early onset schizophrenia
- Fewer negative symptoms
- Less thought disorder

Personality disorder
- Particularly difficult to define in old age
- Behaviours, e.g. anti-social, may be affected by physical changes
- Social expectations of behaviour change can be substantial

Substance misuse
- Most commonly alcohol
- Can present indirectly – with confusion, falls, self neglect and medical complications
- Patients and informants may minimise intake
- Also - benzodiazepine dependence

Further assessment can take place in
- Day hospital
- Respite facilities

The multi-disciplinary team approach is paramount in the management of psychiatric illness
- Nursing needs assessment is necessary to establish the level of care a patient and their family or carers require

Areas to cover include:
- Living circumstances
- Mobility,
- Current Benefits
- Current Allowances,
- Current care packages
- Family support
- Main carer and driving status

Please Note
These notes were written by Dr Rebecca Exley as an F1 doctor in 2009. They are presented in good faith and every effort has been taken to ensure their accuracy. Nevertheless, medical practice changes over time and it is always important to check the information with your clinical teachers and with other reliable sources. Disclaimer: no responsibility can be taken by either the author or publisher for any loss, damage or injury occasioned to any person acting or refraining from action as a result of this information