

## **Report of the UEMS Section for Psychiatry**

### **OLD AGE PSYCHIATRY**

#### The statement of purpose

This document was prepared in order to identify the current patterns of old age psychiatry practice in Europe and to make recommendations for training to facilitate the raising of standards in this clinical area.

#### Background

Europe's population is ageing –17% of the population is over 65. The biggest growth in the next 20 years will be in those over 85. Another demographic change over the last 50 years is the growing proportion of those over 65 living alone. Older age is associated with high rates of depression (12-15%) and the onset of dementia (5% at 65 rising to 20% at 85). These disorders co-occur with physical disease common to this age group which are often relatively poor and marginalised.

The responsibility of care varies across Europe. In more northern countries statutory services are expected to contribute both to domiciliary support and health care. In more southern countries the duty of care falls legally on children. In both, the family, the informal carers, shoulder most of the task.

Physical health care for older people is delivered through primary care and usually from specialists in geriatric medicine. In the UK and Ireland, a similar separate subspeciality has developed for psychiatry of old age. Finland has just disbanded the speciality. For the majority of countries it seems that the general psychiatrist will, if asked, treat older people as part of their service.

Dementia care may take place within neurology, geriatric medicine or psychiatry. There are special aspects of presentation and treatment of the mental illnesses of older people that warrant them to be considered as a specific component in training and a case can be made of some specialisation in care within psychiatry. The attached questionnaire was circulated to assess the possibility of agreement on future directions in the care of older people with mental illnesses.

#### Respondents (20)

Austria (A), Belgium (B), Czech Republic (Cz), Denmark (Dk), Finland (Fin), France (F), Germany (G), Greece (Gr), Hungary (H), Iceland (I), Ireland (Ire), Malta (M), Netherlands (NL), Norway (N), Poland (Pol), Slovenia (Slo), Slovakia (Slk), Spain (Sp), Sweden (Sw), UK.

#### Non-respondents (3)

Italy(It), Portugal (P), Switzerland (CH).

#### Responses

##### *Question 1*

All countries agreed that the trainee's logbook should make it explicit that training should include work with patients over 65 with mental illnesses. All rated this goal as realistic.

#### *Question 2*

Similarly, respondents agreed that there should be mandatory theoretical instruction on the disorders of old age and their management. This goal was realistic.

#### *Question 3*

There was general agreement that trainees should understand that old age patients would be included in any assessment /examination of their training.

#### *Question 4*

There was disagreement about creating old age as an area of special competence for psychiatrists (i.e. creating the idea of some specialisation without the formality). Six countries (B, Cz, Gr, F, Pol, Sp, Sw) reported this as probably or definitely unrealistic or impossible. The reason given (*only 2*) was the impossibility of creating sub specialisation.

#### *Questions 5 to 8*

These questions concerned the practice of such '*special interest*' psychiatrists. In 13 countries, it was thought realistic to have in place in all major training centres psychiatrists with a special expertise in old age, who might set up a service for older patients, be local experts on the best treatment of older people and offer help to GP, medical colleagues, etc. In 3 countries (B, Gr, Sp) this was rated as unrealistic. The remainder gave neutral or mixed responses.

#### *Questions 9 to 12*

These questions referred to the setting up of specific out-patient services or in-patient units for those whose mental disorders began after 65 and those who suffer from intellectual decline. Such services were rated as realistic in 11 countries; largely unrealistic in 3 (Sp, N, Dk). The reason provided being the shortage of experts. The others gave a neutral response.

#### *Questions 13 to 15*

These refer to dementia care establishing a role for psychiatric services in the assessment of patients with non-cognitive symptoms of dementia, management in nursing homes and, in particular, supervising the prescription of major tranquillisers there. Fourteen countries rated these as realistic possibilities. For other countries these were seen as beyond current resources or in the case of nursing home care – taking over the role of the GP.

#### *Questions 16 and 17*

These concerned the future availability of psychological treatments for older people in the community and in residential settings. Ten countries rated this pessimistically, largely due to absence of resources (N, A, Fin, Sw, NL, Sp, F, Dk, Cz, UK).

### Conclusions

A preliminary survey had indicated that in only 5 countries were there psychiatrists recognised as having special responsibility for old age patients (NL, G, M, Ire, UK). Against that background the results of this survey might be seen as encouraging, if it is agreed that old age patients do have special needs and can be lost/discriminated against if included for care in a busy general adult service.

1. There was a consensus that trainees should be obliged to learn both theoretically and practically about the disorders of older people. The assessment of training could also include examination in this area.

2. The majority of countries stated that it would be possible to move to the identification of psychiatrist with special expertise in old age disorders and that there should be one such in all major training centres in their country. Apart from teaching and training, these experts could be seen as local advisors to other service providers about old age disorders.
3. There was less agreement about the possibility of setting up specific services for the old age mentally ill and extending the role of psychiatry in dementia care.
4. Therefore, it should be possible for the European Board of Psychiatry to recommend the mandatory inclusion of old age disorders in the training experience. We could also recommend that member states identify or ask their psychiatrists to self identify those with special interest /expertise in this area. Perhaps a network could be formed to take the subject forward in each country. This would neither be formal creation of a subspeciality nor a prescription from outside on how services to older people are best delivered.

The final draft of the report was circulated to all members of the Section and Board after the Ljubljana meeting in April 2001 with the request to gather feedback from their national psychiatric associations.

At the closing date of 1<sup>st</sup> August 2001 the following organisations sent in their replies:

1. Finnish Psychogeriatric Association
2. Royal College of Psychiatrists, UK
3. Psychiatric Association of Slovenia
4. Association of Maltese Psychiatrists

All were supportive of the document. Only the Finnish Psychogeriatric Association had further comments on the report. These were endorsed by the UEMS Section meeting and may be summarised as follows:

1. Every country should have a number of specialists in old age psychiatry who will provide leadership in research, training and clinical service development.
2. Every country should have one or more specialist units for the management of the mental health problems in old age with a research as well as a clinical agenda.
3. GPs, physicians and other health and social care professionals need training in various aspects of old age psychiatry.

#### Membership of the Working Group

Prof A Mann (Chair), *UK*  
Prof J Furedi, *Hungary*  
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