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Introduction

Geriatric Medicine and Old Age Psychiatry

Rob Wears

The Evolution of Specialties

Geriatric medicine has been defined as 'a branch of general internal medicine that is concerned with the clinical, preventative, remedial and social aspects of illness in old age. The challenges of frailty, complex comorbidity, different patterns of disease presentation, slower response to treatment and requirements for rehabilitation or social support require special medical skills' (1). Geriatric medicine is one of the largest specialties in the United Kingdom (2). The original pioneers of geriatric medicine in the 1940s demonstrated the value of specialised assessment of older adults and defined the problems most often faced by this group of patients. The 'geriatric giants' of instability, immobility, incontinence, intellectual impairment and memory loss, and impaired independence (3) form the basis of the required specialty's skill.

Old age psychiatry developed as a specialty designed to deliver the specialist knowledge and skills needed to provide effective care for older people with mental illness. It recognises the increased prevalence of dementia in this age group, as well as the prevalence of social, psychological, and medical problems in this population (4).

Liaison psychiatry is a subspecialty of psychiatry that acknowledges the importance of recognising and treating mental illness in a general hospital population. It aims to integrate the assessment and treatment of mental disorders into routine care (5). Improvements in providing for mental health problems, including mental health liaison in acute hospitals and dementia care, were placed among the nine 'must dos' for the NHS in the two-year planning guidance of 2017–19 (6). Almost all UK hospitals have access to a liaison psychiatry service (7). This is also the cornerstone of the National Confidential Enquiry into Patient Outcome and Death's 'Treat as One' report (8).

Within the past thirty years many, but not all, liaison psychiatry teams in the United Kingdom have developed services to specifically assess and treat older people (9, 10). Traditionally in UK psychiatry the age of 65 is used as a cut-off point in determining when a person is 'older'; yet some services are delivered according to patient need, for example frailty. The perceived advantage of mental health services for older people is that they have specialist experience in meeting the care needs of a population that often has complex communication, social, medical, and mental health problems (11).

Geriatric medicine and liaison psychiatry teams vary in size and remit from hospital to hospital, but are generally made up of multidisciplinary professionals who, in addition to the geriatrician or psychiatrist, can include specialist nursing staff, healthcare support workers, psychologists, physiotherapists, and occupational therapists.

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Both geriatric medicine and old age psychiatry will tend to attract doctors who have an interest in general medical and psychiatric illness, have good communication skills, and work well in teams. Although these specialties retain a strong hospital focus, both recognise the need to provide expert opinion in the community setting and to work effectively across the traditional divide between primary and secondary care. Clinicians working in these specialties will have the skills required to address the challenges of providing safe and effective health care for an ageing population. In recent years there has been an increasing emphasis on the need to supply all possible 'organ specialists' on in-patient specialty wards, as well as acute physicians with sufficient skills in geriatric medicine to care for older adults with predominantly specialty-defining illnesses complicated by frailty, dementia, and complex comorbidities.

Our Aging Population

There is considerable evidence to support the contention that the UK population is ageing. The Office for National Statistics provides detailed figures that clearly show tremendous changes in the UK population over the past century, and notes that changes in lifestyle, health care, and technology have allowed us to live longer on average than we had done previously. English life tables show that, for a male child born in 1901, the expectation of life was just over 48 years. When the NHS was founded in 1948, around 48 per cent of people died before the age of 65. Now that figure is around 12 per cent, as men and women at 65 are expected to live respectively 18 and 20 more years on average. In 1997, around one in every six people (15.9 per cent) were aged 65 years and over; the proportion increased to one in every five people (18.2 per cent) in 2017 and is projected to reach around one in every four people (24 per cent) by 2037. The Office for National Statistics estimates that by mid-2039 the number of people aged 75 and over would rise by 89.3 per cent, to 9.9 million. The number of people aged 85 and over is projected to more than double, namely to reach 3.6 million by mid-2039; and the number of centenarians is projected to rise nearly six times, from 14,000 in mid-2014 to 83,000 in mid-2039. The situation is further complicated by falling fertility rates in the United Kingdom: these rates have declined from 1.87 children per woman in 2007 to 1.79 in 2016. Thus, at the same time as we are living longer, our declining birth rate tips the overall age structure of the United Kingdom further towards the later-life age groups. The UN demographic yearbook defines the United Kingdom as an ageing society since 1930, when those aged over 65 years reached 7 per cent of the total population. By 2041, the 1960s baby boomers will have aged into their 70s and 80s and by 2069 an additional 7.5 million people aged 65 years and over are projected, by comparison with 2019 figures. This would take the United Kingdom's 65+ age group to 19.8 million people, accounting for 26.2 per cent of the projection population, which would define the United Kingdom as having reached 'super-aged' status (12–15).

This demographic change has significantly impacted the case mix of acute hospitals. Medical specialties in the early years of the NHS tended to focus on short-lived illness usually limited to single-organ pathology, and generally in patients of working age. Recent studies have suggested that now 65 per cent of the people admitted to hospital are over 65 years old and that this population accounts for approximately 70 per cent of hospital bed days (16). Hospital-admitted patient care activity for 2017–18 showed that the age group with the highest number of episodes was the 70–74-year group (1.8 million), which accounted for 7.9 per cent of all episodes for that year (17).

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It is important to note, however, that the ageing population itself does not cause problems for health and social services. Simply put, the problem is not that we are living longer, but rather that we are not getting healthier. People are living longer with a growing number of long-term chronic conditions such diabetes, heart disease, and dementia. It is estimated that by the age of 75 an older adult living in the United Kingdom will have, on average, two long-term conditions. There is often no cure for such conditions, and managing them is more about care than about cure. In addition to surviving longer with a long-term condition, more people nowadays have multiple long-term conditions. The number of people in England with four or more medical conditions is predicted to double between 2015 and 2035, from 9.8 per cent to 17.6 per cent (18). It should be stressed that not all people with multimorbidity are old. Studies have shown a strong link between socioeconomic status and multimorbidity. Patients from disadvantaged areas were more likely to develop multimorbidity ten to fifteen years earlier than those from more advantaged areas (19).

The Scale of the Problem

In 2012, the Royal College of Physicians produced a report entitled 'Hospitals on the edge? The time for action' (20). In the introduction, the report noted: 'All hospital inpatients deserve to receive safe, high quality, sustainable care centred around their needs and delivered in an appropriate setting be respectful, compassionate, expert health professionals. Yet it is increasingly clear that our hospitals are struggling to cope with the challenge of an ageing population and increasing hospital admissions.' This report was followed by a wide-ranging examination of service provision and training within the health service. This culminated in the General Medical Council producing the Shape of Training review in 2013 (21). The review noted that the needs of patients in the United Kingdom were changing and that doctors would be expected to care for patients with chronic illness and multiple comorbidities. There was a recognised need to achieve 'a better balance between doctors who are trained to provide care across a general specialty area and those prepared to deliver more specialised care'. The consensus view was that doctors needed to be better prepared for working in multiprofessional teams and that the service needed more generalists. Since the 1940s, in the United Kingdom this role of 'expert generalist' in medicine has been filled by geriatricians and general physicians. Along with acute physicians and emergency department consultants, these doctors are defined more by a group of patients than by a system or organ disease. These physicians are now seen as having a crucial role in making the acute hospitals work more effectively.

The burgeoning population of older people in hospitals is not spared of mental disorder; in fact the rate of prevalence of most mental disorders in hospitals is higher than community prevalence figures (for details, see chapter 2, on epidemiology) (5). This is relevant because mental illness and its consequences can complicate a person's hospital journey, causing significant distress for the patients, worry for their carers and families, and anxiety among the hospital staff. Perhaps most importantly, hospital outcomes are often worse for people with mental illness in hospital with longer in-patient stays; increased hospital-acquired infections, increased mortality, and increased dependence on care on discharge are frequently cited consequences of admission (5).

It is the role of the liaison psychiatrist to navigate the patient and the hospital teams through this journey, trying both to reduce the impact of mental disorder on the hospital admission and the impact of the hospital admission on the mental disorder.

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Both the geriatrician and the liaison psychiatrist will have a role in signposting on discharge and linking patients with appropriate community services after discharge. In some areas, these clinicians may also be actively involved in the ongoing treatment of these patients in the community.

Frailty and Assessment

In addition to ageing and having multiple medical conditions, we need to recognise the concept of frailty as an entity that has a major role in ill health. Frailty is a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves. This state results in a loss of function, a loss of physiological reserve, and an increased vulnerability to disease and death. Around 10 per cent of people aged over 65 years have frailty, and in those aged over 85 the proportion raises to something between a quarter and a half. People with multimorbidity may not be frail, and people with frailty may have only a single long-term condition. Multiple instruments have been developed in recent years to try to provide a standardised definition of frailty so as to render it objectively measurable (22). Currently there are two broad models of frailty most commonly used. The first, known as the frailty phenotype, is based on a predefined set of patient characteristics (unintentional weight loss, reduced muscle strength, reduced gait speed, self-reported exhaustion, and sedentary behaviour) that, if present, can predict poorer outcomes (23). This model can be applied at the first contact with the person. Generally individuals with three or more of the characteristics listed here are said to have frailty. The second model is known as the frailty index or the cumulative deficit model and assumes an accumulation of deficits from a long checklist of clinical conditions and diseases (24). The original version of the frailty index had seventy items, but shorter versions with as few as twenty conditions have been described. This system requires a detailed clinical assessment of the patient before it can be completed. The two models should be seen as complementary rather than interchangeable. The frailty phenotype model can be applied at the first contact with the patient whereas the frailty index requires a comprehensive geriatric assessment of the patient and can be used for continuous follow-up.

Whichever model is used, the key feature of frailty is the person's loss of physiological reserve, which results in significant illness and prolonged disability from relatively minor triggers. A common method of depicting this scenario is shown in Figure 0.1.

Frailty syndromes usually present in crisis. Frailty is strongly associated with increased use of health and community services (25). In the acute hospital setting, frailty is associated with high readmission and high mortality rates (26). One of the most important skills of the geriatrician is to be able to recognise the underlying problems hidden behind the presenting 'minor' illness. A key component in the geriatrician's ability to identify underlying problems is comprehensive geriatric assessment (CGA). Comprehensive geriatric assessment can be defined as the process of carrying out a multidimensional assessment of an older person's health and well-being, formulating a planned intervention to address areas of concern both to the older person and to his or her family and carers (where applicable), reviewing the older person's progress, and reconsidering the interventions accordingly. It has been shown that a CGA can reduce hospital admissions and readmissions, and also the impact of frailty on the older adult (27).

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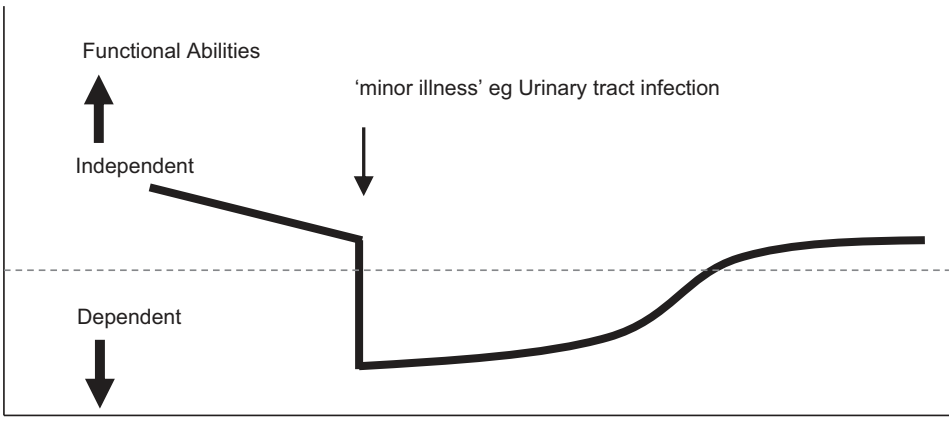

Figure 0.1 The impact of minor triggers on functional ability in frail older people

Comprehensive geriatric assessment also increases the older person's likelihood of survival and of living in his or her own home after an emergency admission to hospital (28). The British Geriatrics Society (BGS) has developed a CGA toolkit for use in primary care (29). Further details can be found in chapter 19.

Embedding comprehensive geriatric assessment in any interaction with a frail older adult is an important strategy; it helps the health service to manage the problems associated with an ageing population. Developing a skilled workforce able to deliver this assessment in the community, in care homes, and in the emergency departments as well as on more traditional geriatric medicine units should be regarded as essential to securing good, patient-centred care in the future.

A similar emphasis should be placed on removing the perceived barriers between physical and mental health services. This is particularly relevant in the management of frail older adults because of the prevalence of significant mental health issues among this population. For example, 29 per cent of older people in hospital will have diagnosable depression (30). It is currently estimated that approximated 850,000 people in the United Kingdom have dementia and that that this figure will rise to 1.6 million by 2040 (31). It is therefore likely that older adults with existing dementia will be admitted to an acute hospital setting even if the dementia is not the primary reason for hospital admission. Forty-two per cent of over 75-year-olds in hospitals are likely to have dementia (32). Once inside the hospital system, the patient with dementia can face a variety of challenges and risk serious adverse outcomes unless the need to provide appropriate care for his or her cognitive issues is recognised as being just as important as the need to provide care for his or her physical illness (33). Sixty-six per cent of patients with dementia admitted to an acute hospital will develop delirium during their hospital stay (34). Even experts can sometimes struggle to differentiate accurately between dementia and delirium, and the two conditions can coexist. Delirium is often poorly recognised and poorly managed in the acute hospital setting. In the United Kingdom, a nationwide audit of forty-five hospitals was carried out in 2018. This audit showed that the regular care team screened only 27 per cent of patients for delirium before the audit assessment.

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Among those found to have it, delirium was recognised only in 34.9 per cent (35). Some older patients present to the acute hospital with delirium, others develop it during the course of their hospitalisation. Delirium can lead to increased lengths of stay in hospital, increased mortality, and increased risk of institutional placement (36). Delirium is preventable in up to a third of cases and early attention to the acutely confused patient can have enormous benefits for both the patient and the hospital.

Although geriatric medicine is a hospital-based medical specialty, one of its attractions to many geriatricians is that it is not confined purely to the hospital setting. Most of the acutely ill older patients require skilled rehabilitation and discharge planning, and are at risk of decompensation and disability if exposed to prolonged hospitalisation. Outside the hospital environment, specialists in geriatric medicine and old age psychiatry seek to work with colleagues in primary care to develop services for older people living with frailty in a variety of settings, including outpatient clinics, community hospitals and other intermediate care settings, and older people's own homes. The British Geriatrics Society has published recommendations for the recognition and management of frailty in community and outpatient settings (37) and advice and guidance on the development, commissioning, and management of services for people living with frailty in community settings (38). For many geriatricians and psychiatrists, the requirement to provide good medical care across a range of settings, together with being granted the privilege of seeing the patient in their own home, is a strong incentive to work within the specialties.

All these facts clearly indicate the need for a workforce fit for the future; and consultant geriatricians and old age psychiatrists are a key part of it.

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Chapter 1

Psychological Well-Being in Later Life

Andrew Papadopoulos

Introduction

Ageing can be considered in three fundamental ways:

First, as a process of physical and cognitive change where such factors as genetics, occupation, lifestyle, environment, diet, mental health, illness, disability, and life events can all have a considerable influence upon how our bodies function and respond to challenges in later life.

Research on biological ageing has identified several factors that influence the aging process. These include: accumulation in the body, over the lifespan, of pathological substances that trigger cell senescence (e.g. atherosclerotic plaques and amyloid proteins); disruption of regulatory pathways (e.g. as a result of frequent inflammatory diseases); mutations in mitochondrial DNA leading to poor energy metabolism; age corruption of the DNA telomeres that affect cell copying processes; and the pre-programmed cessation of stem cell renewal in late life.

Research into cognitive ageing suggests that, while there are wide individual differences in cognitive functioning in later life, people are likely to benefit from established wisdom and pre-existing skills and abilities. However, our speed of information processing, immediate recall, and word-finding ability are all likely to suffer reduced functioning as we age, particularly in those over eighty years of age.

Accordingly, people affected with multimorbidities are likely to experience a greater range of adverse life events and outcomes, including lengthy hospital stays, frequent care transfers, poor quality of life, and increased mortality. Physical multimorbidity is strongly correlated with unplanned admission to hospital, particularly when also associated with existing mental health conditions and socioeconomic deprivation (1).

Second, as a time of particular social and material change and transition in our lives, triggered for example by retirement, loss of loved ones, rehousing, and a satisfactory level of available financial and social resources. Thus, while older adults are often more experienced than younger adults in coping with major life events, they also face some of life's hardest challenges, such as chronic illness, disability, and bereavement. These factors, in addition to social context, cohort differences, and idiosyncratic coping styles, have a significant relevance to the presentation of older people in care settings and to working with them therapeutically (2).

Third, from an existential perspective, in terms of whether we experience our lives as being meaningful or meaningless in relation to our values, activities, interests, level of social inclusion, status, and value within the community, and in terms of our view of our lives as having been accomplished. According to Erikson (3), people are faced with

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a number of psychological tasks throughout their lives, from birth to senescence, that support our personal and social development. These reflect trust, independence, accomplishment, identity, relationship formation and maintenance, contribution to society, and, finally, reflection from the age of 65 years on. This latter task reflects a need to retain one's sense of self-integrity or wholeness by considering one's life as having worth and by being able to accept the regrets in one's life rather than experiencing the sense of despair induced by the thought that one's life has been fruitless, insignificant, or morally deficient.

Within this perspective, how a given society views and responds to its older people plays a major role in the experience of being older and in the meaning we draw from our lives. The lack of meaning and purpose to one's life is a strong predictor of mental health problems, specifically in relation to depression (4), suicidal behaviour (5), and poor recovery from illness in older adults (6).

Drawing upon these perspectives, the term 'successful ageing' has been applied to reflect a field of study that explores predictive processes and mechanisms in late life that promote well-being and an adaptive ability. Rowe and Kahn (7, 8) have developed one of several models of successful ageing and define this as the ability to maintain a low risk of disease and disease-related disability by adopting a healthy lifestyle, high mental and physical functioning, and active engagement in life. Alternatively, Baltes and Baltes (9) suggest that successful ageing reflects our effectiveness at adapting to life's challenges regardless of health status and involves our ability to select and apply what we are good at while compensating for what we are least good at. They call this 'selective optimisation' and 'compensation'. Nevertheless, both the experience of growing older and the factors that influence it in positive and negative ways are complex and multifaceted and show a great deal of variation across individuals. Accordingly, the clinical problems and needs of older people admitted to acute care are often more complex and substantially different from those of younger people. Older people are more likely to experience a combination of multimorbidities as well as general frailty, polypharmacy, financial, social, and mental health problems (10).

In addition to the medical and psychiatric factors that trigger admission to hospital, many problems that affect an older person's well-being and quality of life may have been evident and building in intensity over time. These are often financial, social, or environmental problems, such as social isolation and loneliness, inadequate income or support, caring for other dependent people, struggling to maintain their home, and managing other demands in relation to their interests and activities (11). Accordingly, in assessing and responding to the needs of older people in hospital settings, significant challenges arise for clinicians and other professionals.

Understanding Psychological Well-Being in Older People

The psychology of ageing reflects a complex and often complicated interplay of biological, cognitive, emotional, behavioural, social, cultural, environmental, and economic factors that determine the experience of being older. Hence no single factor can be predictive of well-being and longevity in later life.

In later life, well-being is as much to do with *living a meaningful life* (an existential definition that reflects one's way of being in the world) as it is about *being well* in oneself (a biomedical definition that indicates being free from illness and disability) (12).

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