LAUSANNE
TECHNICAL CONSENSUS STATEMENTS ON

PSYCHIATRY OF THE ELDERLY

This document is a compilation of three previous WHO documents, respectively on:

1. Psychiatry of the Elderly
   (Doc.: WHO/MNH/MND/96.7)

2. Organization of Care in Psychiatry of the Elderly
   (Doc.: WHO/MNS/MNH/MND/97.3)

3. Education in Psychiatry of the Elderly
   (Doc.: WHO/MNH/MND/98.4)

WORLD HEALTH ORGANIZATION
DEPARTMENT OF MENTAL HEALTH
GENEVA
1999

PSYCHIATRY OF THE ELDERLY
A CONSENSUS STATEMENT
DIVISION OF MENTAL HEALTH AND
PREVENTION OF SUBSTANCE ABUSE
WORLD HEALTH ORGANIZATION
GENEVA

PSYCHIATRY OF THE ELDERLY

A CONSENSUS STATEMENT

This document is a consensus statement on Psychiatry of the Elderly jointly produced by WHO and the Geriatric Psychiatry Section of the World Psychiatric Association with the collaboration of several pertinent NGOs and the participation of experts from countries in several WHO regions.

KEY WORDS: psychogeriatrics / elderly people / definition l assessment / treatment / organization of services / training / research / dementia.

DIVISION OF MENTAL HEALTH AND
PREVENTION OF SUBSTANCE ABUSE
WORLD HEALTH ORGANIZATION

GENEVA

1996

PSYCHIATRY OF THE ELDERLY

The Division of Mental Health and Prevention of Substance Abuse is proud to issue this consensus statement on Psychiatry of the Elderly. This statement is a contribution to an area in great need of a common basis and language for its further development and progress.

It is a concrete product resulting from a plan of work established through long-standing collaboration with the World Psychiatric Association (WPA), in this particular case through its Section of Geriatric Psychiatry. The WPA is an NGO in official relations with WHO and we would like to express our deep appreciation for all the Association's efforts towards making this consensus statement a reality. This statement is the final product of a meeting which took place in Lausanne, 5-7 February 1996. We are particularly grateful to Professor J. Wertheimer, Organizer of the Meeting, Professor H. Hafner (Chairperson), and Dr N. Graham and Professor C. Katona (Co-Rapporteurs) for the effort they graciously contributed to this project.

In addition to WPA, several other NGOs participated in this project. We would like to thank Alzheimer's Disease International, the International Association of Gerontology, the International Council of Nurses, the International Federation of Social Workers, the International Psychogeriatric Association, the International Federation on Ageing, the Interndti0ndl Union of Psychological Science and the World Federation of Occupational Therapists, as well as the experts indicated in the List of Participants (see Annex) for their decisive participation during the elaboration and finalization of this consensus statement.

The main interests behind the production of this document are two-fold: on the one hand, to reach a degree of consensus on concepts and terminology, and on the other hand, and more importantly, to contribute to the improvement of the living conditions of elderly people with mental disorders and their families.

Dr. J. A. Costa e Silva Director
Division of Mental Health and Prevention of Substance Abuse
World Health Organization

FOREWORD

Longevity is one of the characteristics of today's world. The ageing of populations, already in evidence in developed countries, is becoming a reality in less developed countries. In this context, the health problems of the elderly, particularly its psychological dimension, become crucial. Both the well-being of the individual at this point in life and the individual's harmonious integration into society, are at stake.

The increased frequency of mental health problems above the age of 65 which require specific diagnostic, therapeutic and readaptative approaches is at the root of the development of geriatric psychiatry. This discipline has progressively constituted itself since the 1950s, defining its nosographic field, evaluative procedures and organization of care. In view of the ubiquity of this issue, all the health professions are involved. On the one hand it falls within the framework of pluridisciplinary teams and on the other hand each of these disciplines can be individually confronted with psychiatric situations. Hence, geriatric psychiatry becomes a basic discipline for all the socio-medical providers and a speciality for physicians and health workers who devote themselves entirely to the psychiatric care of the elderly.

This implies some overlapping between specialists and no specialists in the care of patients particularly between somatic geriatric care and geriatric psychiatry, at the risk of improperly using individual competence. It is therefore indispensable to define the scope of the professions engaged in the care of the elderly. Knowing one's own field as well as those of other disciplines is very necessary for quality cooperation.

It is in this context of demographic aging and the complexity of caring for the elderly that this Consensus Statement was prepared by an interdisciplinary group representing the principal international associations concerned. Its objectives are not only to define geriatric psychiatry but also to encourage the development of this discipline for the benefit of the elderly.

Professor J. Wertheimer
President
World Psychiatric Association
Geriatric Psychiatry Section

CONSENSUS STATEMENT ON PSYCHIATRY OF THE ELDERLY

Introduction

The population of old (and particularly very old) people is increasing rapidly throughout the developed and developing world. This reflects improving health and social conditions and is a cause for celebration. Most older people remain in good mental as well as physical health and continue to contribute to their families and to society.

This notwithstanding, some mental illnesses (such as the dementias) are particularly common in old age; others differ in clinical features and/or present particular problems in management. Social difficulties, multiple physical problems and sensory deficits are also common. Appropriate detection and management require specialist knowledge and skills as well as multidisciplinary collaboration.

Priority needs to be given to these mental illnesses which can cause a great deal of stress not only to older people themselves but also to their families. This is aggravated by changing family structures. There is also an increasing number of older people living alone. Appropriate

interventions for the major mental illnesses of old age can often either treat them effectively or at least substantially improve the quality of life of patients and their families.

The rise in numbers of older people with mental health problems has necessitated the development of the specialty of psychiatry of the elderly. The emergence of the specialty of psychiatry of the elderly has helped to raise the status of this vulnerable group and has also fostered research which offers hope for better treatment and outlook and provides the opportunity for training students in all health and social care related disciplines.

This summary of the scope of psychiatry of the elderly is intended to promote awareness of mental health problems in older people, to initiate or improve the provision of services and to encourage teaching and research in the area.

Definition and Assessment

Psychiatry of the elderly is a branch of psychiatry and forms part of the multidisciplinary delivery of mental health care to older people. The specialty is sometimes referred to as geriatric psychiatry, old age psychiatry or psychogeriatrics.

Its area of concern is the psychiatry of people of “retirement” age and beyond. Many services have an age cut-off at 65 but countries and local practices may vary: several specialist services include provision for younger people with dementia. The specialty is characterised by its community orientation and multidisciplinary approach to assessment, diagnosis and treatment.

An elderly patient suffering from mental health problems often has a combination of psychological, physical and social needs. This implies that individual assessment management and follow-up requires collaboration between health, social and voluntary organizations and family carers. Mental health problems in old age are common and an understanding of the principles involved in their identification and management should be an integral part of the general training of all health and social care workers. Progress in the field must be evidence-based and founded on rigorous empirical research with which practitioners should aim to keep up to date.

Past experience and behaviour may influence whether a person develops mental illness and how such illness presents itself Multiple losses (death of relatives/friends, declining health, loss of status etc) in old age may be particularly important though many older people remain resilient despite multiple adversity.

The specialty deals with the full range of mental illnesses and their consequences, particularly mood and anxiety disorders, the dementias, the psychoses of old age and substance abuse. In addition, the specialty has to deal with older people who developed chronic mental illness at a younger age. At any rate, psychiatric morbidity in old age frequently coexists with physical illness and is likely to be complicated by social problems. Older people may also have more than one psychiatric diagnosis.

The above factors, together with the biological, social and cultural changes associated with ageing may significantly alter the clinical presentation of mental illness in old age. Current diagnostic systems (ICD-10, DSM-IV etc) do not fully allow for these factors.

The diagnostic approach is essentially similar to that used in other age groups. There are nevertheless some differences. Older people are often frightened by unfamiliar diagnostic investigations. They should have their initial assessment in their home or other familiar setting wherever possible. It is particularly important to obtain a collateral history. Invasive or stressful tests should only be undertaken where their results might alter management or to fulfil family needs for diagnostic answers.

Many mental illnesses in old age can be treated successfully. Some (particularly the dementias) are chronic and/or progressive. Appropriate intervention can nonetheless contribute to improving quality of life.

A diagnostic formulation should emphasise abilities as well as deficits and incorporate the meaning given to the illness by the patient and the family. Both assessment and intervention may involve overlap between professional roles as well as coordination between services.

Treatment

The objectives of treatment may include restoration of health; improving quality of life, minimising disability, preserving autonomy and addressing supporter~ needs are equally valid. Treatment must be adapted to the individual patient's needs and to available resources. Its delivery usually requires cooperation between the multidisciplinary professionals involved as well as involvement of informal supporters. Early detection and intervention may improve prognosis, and education is required to counteract the therapeutic pessimism of both professionals and patients.

Treatment must pay due regard to individual patient's wishes; dignity and autonomy must be respected. Consent to treatment by patients no longer competent to make such decisions raises important ethical and legal issues.

Older people with mental illnesses (particularly depression) may take longer to respond to treatment than their younger counterparts. Functional psychiatric illnesses in late life have a high rate of relapse; close follow-up and continued treatment may reduce this.

Older people are particularly vulnerable to side effects of psychotropic drugs. Consideration must also be given to age-related changes in drug handling. Interactions between psychotropic drugs and older patients' comorbid physical illnesses (and their treatment) are also common. Coexistent physical problems in older people with mental illness must be treated; this may facilitate treatment of the mental illness.

Treatments to improve cognitive functioning in people with dementia and/or modify the course of the disease are being actively researched. Vascular dementia may be prevented or slowed by treatments that reduce risk of stroke.

All psychotherapeutic techniques (e.g. supportive, psychodynamic and cognitive / behavioural) may be used with older people. Adaptations may be necessary to take into account any sensory or cognitive deficits.

Therapeutic interventions to encourage autonomy include retraining in daily living skills and improving safety at home. Provision of practical support and information including social and legal rights' advice to patients and their supporters make an important contribution.

Organization of services

Most older people with mental health problems are cared for by their families and/or friends with support from the primary care team which also provides continuity of care. The primary care team (as well as other service providers) needs to be able to refer to the old age psychiatry service when further opinions and advice are needed and/or for direct specialist care.

The multidisciplinary specialist service in old age psychiatry can include a range of professionals such as doctors, nurses, psychologists, occupational therapists, physiotherapists,

social workers and secretarial staff who should meet regularly to coordinate and discuss new referrals and current caseload. The team should have an identified leader.

Initial assessments should wherever possible be in the patient's home; family members and the primary care team should be involved. The assessment should result in the formulation of a care plan and follow-up arrangements with clear objectives, defined responsibilities for multidisciplinary team members and the primary care team (usually with a single designated 'key worker'). This should include the provision of support, information and advice to carers.

In order for the specialist service to work effectively, a range of resources needs to be available and accessible. These include an acute inpatient unit, rehabilitation, day care, respite facilities and a range of residential care for people no longer able to live in their own homes. Reciprocal availability of advice between psychiatry of the elderly and general medical and (where available) geriatric medicine is important. Links with community facilities are important (e.g. day centres and support groups for carers as well as for patients themselves).

A comprehensive service in psychiatry of the elderly should be patient-centred and achieve sufficient coordination between its elements to ensure continuity of care. The service should be integrated into the health and social welfare system and is dependent upon an adequate social, political, legal and economic framework.

Quality assurance must be a priority within all parts of the service. This is particularly important to ensure respect for the needs and wishes of those older people who are unable to express them fully.

Training

The specialty of psychiatry of the elderly requires a grounding in general psychiatry and in general medicine as well as training in the specific aspects of both psychiatric and medical conditions as they occur in older people. Psychiatry of the elderly should be taught in the variety of settings in which it is practised.

Training schemes for all health and social care workers should include a component on mental health care of older people. Training in mental health care of older people should be offered at both undergraduate and postgraduate level and also during continuing professional development.

Education and information about mental health care of older people should be offered to the general public and to carer groups. The development of appropriate training manuals with culturally appropriate material should be achieved for all groups of professionals and carers.

Research

Research in old age psychiatry covers a wide range including molecular biology, epidemiology, neurochemistry, psycho-pharmacology, health service research (including evaluation of innovative community projects) and ethics.

Research in this area provides a unique opportunity for cross-fertilisation between disciplines, is crucial for the advance of the specialty and may have benefits beyond its domain. Workers in the field need training in research methods as well as time and opportunity to pursue research.

Conclusions

There is already a vast amount of knowledge and expertise related to psychiatry of the elderly. It is hoped that the guidance offered will encourage professionals and politicians to initiate, build up and improve services, training and research on behalf of the rapidly ageing population worldwide and the associated increase in numbers of older people with mental health problems.

It is important to recognise that in some countries, resources, especially in terms of mental health professionals, are very limited. In these countries it will be necessary to establish sensible priorities for mental health problems of the elderly. We would suggest the following priorities:

1. Teaching of psychiatry of the elderly to primary health care workers.

2. Training of all the existing mental health professionals in the special mental health problems of the elderly.

3. Establishment of multidisciplinary groups to act as resource centres.

It is the responsibility of those multidisciplinary professionals already in the field to put pressure on governments to ensure that reasonable quality and affordable resources are provided to meet the urgent needs of elderly people with mental illness whose physical problems and life circumstances often require special consideration.

There can be no doubt that there is ample justification to support the development of the specialty of psychiatry of the elderly with its own training programmes, career structure and multi-professional support network.

ANNEX
Consensus meeting on Psychogeriatrics
Organized by the World Psychiatric Association, Section of Geriatric Psychiatry
Co-sponsored by the World Health Organization
Lausanne, 5 - 7 February 1996
List of participants

Professor E. W. Busse
International Association of Gerontology
Duke University Medical Center
Durham, NC, USA

Professor E. Chiu
Academic Unit for Psychiatry of Old Age
Mont Park Hospital Campus
Melbourne, Australia

Mrs A: F. Dufey
Clinique La Source
Lausanne, Switzerland

Ms I. Hoskins
International Federation on Ageing
Chambésy, Switzerland

Rev. C. A. Hume
World Federation of Occupational Therapists
Edinburgh, Scotland

Professor C. Katona
(Co-Rapporteur)
Professor of Psychiatry of the Elderly
Princess Alexandra Hospital
Harlow, Essex, England

Mr Tesfamicael Ghebrehiwet
International Council of Nurses
Geneva, Switzerland

Dr N. Graham (Co-Rapporteur)
President-Elect
Alzheimer's Disease International
Department of Psychiatry
Royal Free Hospital
London, England

Professor H. Hafner (Chairperson)
Zentralinstitut für seelische
Gesundheit
Mannheim,Germany

Professor J-M.Léger
Head, SHU de Psychiatrie Adultes
CHS Esquirol
Limoges, France

Professor R. Levy
President
International Psychogeriatric Association
Institute of Psychiatry
London, England

Ms A. O'Loughlin
International Federation of Social Workers
Dublin, Ireland

Dr N. Martin
Secretary-General
International Federation on Ageing
Montreal, Québec, Canada

Professor J. Wertheimer
President
World Psychiatric Association
Geriatric Psychiatry Section
Service Unirversitaire de Psychogériatrie
Prilly, Switzerland

Professor G. d'Ydewalle
Secretary-General
International Union of Psychological Science
Department of Psychology
University of Leuven
Leuven, Belgium

Secretariat
Dr J. M. Bertolote
Mental Disorders Control
Division of Mental Health and
Prevention of Substance Abuse
World Health Organizafion
Geneva, Switzerland

Dr V. Camus
Service Universitaire de Psychogériatrie
Prilly, Switzerland

Dr C. de Mendonça Lima
Service Universitaire de Psychogériatrie
Prilly, Switzerland

Dr P. Schwed
Service Universitaire de Psychogériatrie
Prilly, Switzerland

Dr J. A. Costa e Silva Director
Division of Mental Health and
Prevention of Substance Abuse
World Health Organization
Geneva, Switzerland

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PROGRAMME ON MENTAL HEALTH

ORGANIZATION OF CARE IN PSYCHIATRY OF THE ELDERLY

A TECHNICAL CONSENSUS STATEMENT

DIVISION OF MENTAL HEALTH AND PREVENTION OF SUBSTANCE ABUSE

WORLD HEALTH ORGANIZATION WORLD PSYCHIATRIC ASSOCIATION

GENEVA

ORGANIZATION OF CARE IN PSYCHIATRY OF THE ELDERLY:

A TECHNICAL CONSENSUS STATEMENT

This is a technical consensus statement on the organization of care in psychiatry of the elderly, jointly produced by the Geriatric Psychiatry Section of the World Psychiatric Association and WHO, with the collaboration of several other NGOs and the participation of experts from countries in several WHO Regions.
It is the final version of a previous draft issued under reference MSA/MNHMIND/97.1.

KEY WORDS: psychogeriatrics / elderly people / care / organization of services / mental health care.

Division of Mental Health and Prevention of Substance Abuse
World Health Organization World Psychiatric Association
Geneva, 1997

SERVICES FOR THE ELDERLY WITH MENTAL DISORDERS

I am pleased to support the distribution of this technical consensus statement on the organization of services for the elderly with mental disorders. It is a second document in a planned series of three, developed by a group of representatives of non-governmental organizations and the World Health Organization during a meeting organized by the Geriatric Psychiatry Section of the Word Psychiatric Association and hosted by the Lausanne University Psychogeriatrics Service, held in Lausanne, Switzerland, 14-18 April 1997.

The importance of this subject is indicated by the number and quality of NGOs who sent representatives to the meeting and tater endorsed the final text. These NGOs include some of the most relevant organizations interested in this area, and to which we are deeply grateful: Alzheimer's Disease International (and its local branch, the Swiss Alzheimer Association), the International Council of Nurses, the International Federation of Social Workers, the International Psychogeriatric Association, the International Union of Psychological Science, Medicus Mundi Internationalis and the World Federation for Mental Health.

Our appreciation goes to Professor Jean Wertheimer, Professor of Psychogeriatrics at the Lausanne University and President of the Geriatric Psychiatry Section of the World Psychiatric Association, who organized and hosted the meeting; to Professor Raymond Levy, President of the International Psychogeriatric Association, who chaired the meeting; and to both Dr Nori Graham, President of Alzheimer's Disease International, and Professor Cornelius Katona, from the University College London Medical School, who excelled in producing the final report of the meeting; The text of the statement produced by the meeting has been sent to all member societies of the World Psychiatric Association for comments. Dr José Manoel Bertolote, from the World Health Organization's Mental Disorders Control Unit, was responsible for the final editing of this document. We gratefully acknowledge a grant from Pfizer Pharmaceuticals Group for the printing and distribution of this document.

It is our hope now that, through the implementation of the principles included in this document, the lives of the elderly with mental disorders and of their carers will be brighter and better.

Dr. J. A. Costa e Silva
Director Division of Mental Health and Prevention of Substance Abuse
World Health Organization

INTRODUCTION

I am very grateful to the Section on Geriatric Psychiatry of the World Psychiatric Association and its Chairman, Professor J. Wertheimer for agreeing to take a leading role in the development of a consensus of opinion on several issues in the development of health care for the elderly with mental disorders.

The proportion of the population reaching old age is growing in developed and developing countries and the resources available to deal with health care for this group of people are becoming more and more restricted. it is necessary therefore to develop strategies of care that will be both effective and rational. The first step to their formulation must be an examination of scientific evidence and a unanimous statement about the most desirable course of action by those most concerned with the implementation of such strategies - the organizations representing the

health and social service professionals, governmental agencies, patients and non professional carers.

The Geriatric Section of the WPA has approached this task by inviting representatives of leading nongovernmental organizations and of the World Health Organization to meet and produce a draft of three consensus statements - the first dealing with the limits of the field of concern for the psychiatry of old age, the second addressing the organization of services for the elderly with mental disorders, and the third presenting views on research and training in relation to the management of these disorders. The participation of international organizations such as the International Psychogeriatric Association, Alzheimer's Disease International, the International Federation of Social Workers, the International Union of Psychological Science, the World Federation of Mental Health and Medicus Mundi Internationalis made this a truly international effort. The first two texts produced by this group have been widely circulated to individual experts for comments and suggestions. In addition, they have been forwarded to the Member Societies of the World Psychiatric Association in some 80 countries and their views and opinions have also been taken into account in finalizing the texts. The third text of the series will be produced in early 1998 using the same procedure.

It is my hope that the other Sections of the World Psychiatric Association will follow the example set by the Section on Geriatric Psychiatry. The development of consensus statements is one of the explicitly stated goals of the WPA - a goal that has never been of greater importance for psychiatry than now at a time when the prevalence of mental disorders is growing worldwide and when psychiatry has acquired the knowledge and techniques to deal with them in an effective manner.

Professor N. Sartorius
President
World Psychiatric Association

A CONSENSUS STATEMENT ON THE ORGANIZATION OF PSYCHIATRIC SERVICES FOR THE ELDERLY

Care of older people suffering from mental disorders is growing in importance, at the same time as life expectancy is increasing. The latter phenomenon, which is already a significant reality in developed countries, will progressively end up playing an important role in developing countries as well. The implications of this increased longevity are widespread and will greatly affect our society which must adapt itself to the political and socio-economic environment, while at the same time adhering to rigorous ethics that protect the individuals, whatever their age.

It is with full awareness of the interests at stake, that this consensus statement has been prepared by representatives of the primary professional organizations concerned with mental health of the elderly. This document, which is a follow-up of a first Consensus Statement on Psychiatry of the Elderly, gives the broad outlines of the organization of care for the aged. It is intended to be sufficiently flexible to allow local adaptations of the basic principles.

Psychiatry of the Elderly is a complex discipline, confronted with intricate problems pertaining not only to mental health and behavior, but also to physical health and relational, environmental, spiritual and social matters. The situations which this discipline is facing are thus closely linked to the family nucleus, the local customs and culture, the general organization of Public Health and social assistance. The organization of care in Old Age Psychiatry must be worked out along the perspectives of the Primary Health Care Strategy of the WHO (Declaration of Alma Ata, 1978), focus on the patients and their families, and yet be integrated into the medical and social network designed for the population in general and the elderly in particular. However, this integration must not be synonymous with dilution and loss of specificity. On the contrary, since

collaboration is necessary, it is therefore indispensable that competences, specific care and structures adapted to Old Age Psychiatry, be solidly developed. Care of the elderly requires a strong contribution from Old Age Psychiatry.

Professor J. Wertheimer
Chairman
Geriatric Psychiatry Section
World Psychiatric Association

ORGANIZATION OF CARE IN PSYCHIATRY OF THE ELDERLY: A TECHNICAL CONSENSUS STATEMENT

The World Health Organization and World Psychiatric Association have recently produced a consensus statement on the scope of psychiatry of the elderly (WHO. Psychiatry of the elderly: a consensus statement. (Doc.: WHO/MNH/MND/ 98.7). Geneva, WHO, 1996).

. That consensus statement defines the specialty of psychiatry of the elderly as a branch of psychiatry that forms part of the multidisciplinary delivery of mental health care to older people. In order to fulfil the scope of psychiatry of the elderly we need recommendations as to the organisation of care within it.

The objectives of this document are to:

- promote debate at the local level on the mental health needs of older people and their care givers;
- describe the basic components of care to older people with mental disorders, and their coordination;
- stimulate assist and review the development of policies, programmes and services in psychiatry of the elderly according to the framework of the WHO Primary Health Care Strategy (2 WHO. Alma-Ate 1878 Primery Health Care. Geneva, WHO, 1978); and
- encourage the continuous evaluation of all policies, programmes and services to older people with mental disorders.

This document is intended for use by all those involved in the development and implementation of policies, programmes and services for promoting the mental health of older people. It is therefore expected that this document will be widely distributed.

1. GENERAL PRINCIPLES

Good health and life of good quality are fundamental human rights. This applies equally to people of all age groups and to people with mental disorders

All people have the right of access to a range of services that can respond to their health and social needs. These needs should be met appropriately for the cultural setting and in accordance with scientific knowledge and ethical requirements.

Governments have a responsibility to improve and maintain the general and mental health of older people and to support their families and carers by the provision of health and social measures adapted to the specific needs of the local community.

Older people with mental health problems and their families and carers have the right to participate individually and collectively in the planning and implementation of their health care.

Services should be designed for the promotion of mental health in old age as well as for the assessment, diagnosis and management of the full range of mental disorders and disabilities encountered by older people

Governments need to recognise the crucial role of non-governmental agencies and work in partnership with them

Preparing for increasing life expectancy and ensuing health risks calls for significant social innovations at the individual and societal level, which must be founded on a knowledge base drawn from contributions by, and collaboration among, the medical, behavioural, psychological, biological and social sciences.

In developing countries it may be difficult to provide resourcs for the provision of care. This, however, does not invalidate the aims of helping the elderly by the application of the principles listed above and the specific principles that follow.

2. SPECIFIC PRINCIPLES

Good quality care for older people with mental health problems is:

Comprehensive
Accessible
Responsive
Individualised
Trans-disciplinary
Accountable
Systemic

A comprehensive service should take into account all aspects of the patients physical, psychological and social needs and wishes and be patient-centred.

An accessible service is user-friendly and readily available, minimising the geographical, cultural, financial, political and linguistic obstacles to obtaining care

A responsive service is one that listens to and understands the problems brought to its attention and acts promptly and appropriately

An individualised service focuses on each person with a mental health problem in her / his family and community context. The planning of care must be tailored for and acceptable to the individual and family, and should aim wherever possible to maintain and support the person within her/his home environment.

A transdisciplinary approach goes beyond traditional professional boundaries to optimise the contributions of people with a range of personal and professional skills. Such an approach also facilitates collaboration with voluntary and other agencies to provide a comprehensive range of community orientated services.

An accountable service is one that accepts responsibility for assuring the quality of the service it delivers and monitors this in partnership with patients and their families. Such a service must be ethically and culturally sensitive.

A systemic: approach flexibly integrates all available services to ensure continuity of care and coordinates all levels of service providers including local, provincial and national governments and community organisations.

3. CARE NEEDS

PREVENTION

There are several specific circumstances within the psychiatry of old age where preventative strategies may be useful. Vascular dementia may be prevented by appropriate measures that reduce risk of cerebrovascular accident. These include identification of those at high risk of CVA (screening for hypertension and atrial fibrillation, early identification and good control of diabetes), low-dose aspirin and encouragement towards healthy lifestyle (diet, exercise, non smoking). Similarly depression may be prevented by facilitating meaningful social contact and recognising circumstances that increase individual risk (bereavement, social isolation, institutionalisation, poverty). Encouraging continued social and intellectual activity in old age may protect against both depression and dementia. Recognition of impending carer burnout and provision of appropriate support can prevent crises of care.

EARLY IDENTIFICATION

Early identification of mental disorders of old age (such as depression, dementia, delirium, delusional disorders, anxiety disorders, alcohol and substance abuse and dependence) may facilitate access to services and effective management and reduce stress both for the individual and the carer(s). Abrupt change in behaviour or personality should alert the clinical team to the possibility of treatable mental disorder. Carers and families are in the best position to recognise such change. Screening (e.g., MiniMental State Examination for dementia, Geriatric Depression Scale for depression) may have a role but requires training in true case recognition as well as in administration of screening instruments.

COMPREHENSIVE MEDICAL AND SOCIAL ASSESSMENT (INCLUDING DIAGNOSIS)

Wherever possible, initial assessment should be in the individual's home environment. All care professionals should be trained in comprehensive initial assessment and good record keeping. The purposes of such assessment are to identify problems (including practical difficulties), resources and needs (from the points of view of the individual and the care network), to make a working diagnosis and to generate an initial management plan (which may include further assessment or specialist referral). A diagnostic formulation is important both to allow rational care planning and to inform patients and carers as to the current situation, management options and outlook. Timely referral as appropriate (to hospital specialists, social services, voluntary organisations etc.) is integral both to the initial assessment and to subsequent management (see below).

MANAGEMENT

Management is more than treatment in the medical sense. A coherent and comprehensive care plan should critically review diagnoses and address the individual's physical, psychological, social, spiritual and material needs as well as specific psychiatric diagnoses. The needs of the carer network and of the local community must also be addressed. Progress must be monitored in follow-up and risk of relapse considered. Prophylactic treatment may play an important role. The primary goal of management is, as far as possible, to maintain or improve the quality of life of patients and their carers while respecting their autonomy. Quality management also includes special care for dying persons and their families.

CONTINUING CARE, SUPPORT AND REVIEW OF THE INDIVIDUAL AND CARER(S)

Patients with severe mental illness, particularly those with dementia, may need considerable support in maintaining self-care and activities of daily living. In some cases continuous supervision may be necessary. The ability of informal carers to meet these needs, and the resultant burdens on carers need to be monitored closely and emerging problems addressed promptly. Practical and regular help with household and personal care may considerably enhance quality of life. Counselling and emotional support for carers may play a crucial role. A proactive approach is more efficient as well as more humane than one that is crisis-driven. Emerging physical problems may require active medical treatment.

INFORMATION, ADVICE AND COUNSELLING

Patients and carers need easy access to readily understandable and accurate information concerning diagnosis, management options and implications and available support resources. Educating patients and carers and promoting discussion are important components in care planning which may facilitate compliance, particularly in the context of long-term prophylaxis. A systematic multidisciplinary approach to record keeping and information sharing (within the confines of confidentiality) is highly desirable.

REGULAR BREAKS (RESPITE)

The provision of breaks from caring may be crucial in enabling informal carers to continue in their caring role. Such respite may take many forms and should be as flexible and responsive as possible to individual needs and circumstances. Respite may be required at different times of day or night and may be offered both in the patients home and in appropriate alternative settings such as day centres, day hospitals and residential facilities. Using scarce residential facilities for respite rather than exclusively for continuing care may increase their effectiveness considerably.

ADVOCACY

The legal rights and financial and other personal interests of such patients must be protected. Some other people with mental disorders (particularly those with dementia) may not be able effectively to represent their interests, manage their affairs or agree to what is proposed for them. This is particularly problematic for patients who are alone and where there is a conflict between individual and family interests. Patient advocates (who have neither a carer nor a service provider role for the patient concerned) may be important, as may reference to advance directives.

RESIDENTIAL CARE

Though care should be provided in patients' homes as long as possible, It must be recognised that care in an alternative residential setting may be the only way of meeting patients' needs effectively or avoiding intolerable carer burden. Such care will always be necessary, particularly for people who have no relatives available or willing to look after them.

SPIRITUAL AND LEISURE NEEDS

Older people with mental health problems need the opportunity to express and discuss spiritual needs and observe their religious practices. Meaningful and appropriate recreational and leisure activities may contribute substantially to quality of life. Appropriate provision and support in these areas should be considered in both community and residential settings.

4. DESCRIPTORS OF COMPONENTS OF SERVICES.

The components of services can be summarised in Figure 1, which portrays the concept that individual patients, together with family and carers are surrounded by care services ; these are flexibly interlocking, overlapping and integrated to provide an unified system for continuing care and best possible quality of life. Structural obstacles are minimised, as represented by the dotted lines of the figure, enabling the smooth movement of the patient from one service component to another as changing circumstances require.

This section describes the components which can be put into place to address the care needs described in the previous section.

The following components ideally should be the responsibility of specialised teams of trained health care professionals working in psychiatry of the elderly. Where there is a scarcity of trained staff and of resources it will be necessary to use ad hoc solutions in order to provide the necessary components -while trying to fully develop services.

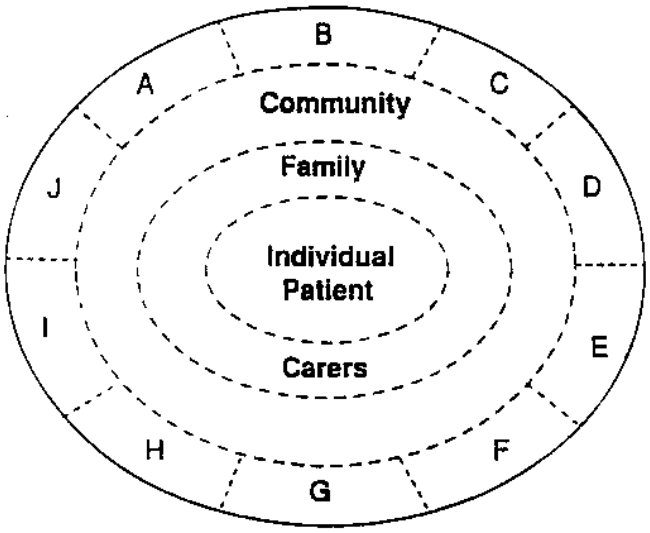

Figure 1: Surround with care

A. Community Mental Health Teams (CMHTs) for Older People

The lead in organising the following components of the service should ideally be taken by Multidisciplinary Specialist Teams working in psychiatry of the elderly. The CMHT may consist of doctors, psychiatric nurses, psychologists, social workers, therapists, secretaries. Referral to the CMHT is usually from primary care. One of the main responsibilities of the CMHT is the specialist assessment, the investigation and the treatment of people in their home setting. In situations where such personnel are not available, the responsibility may be taken by general psychiatric or geriatric medicine teams.

B. Inpatient services

Acute inpatients units need to provide specialist assessment and treatment for the full range of mental disorders. This may in some cases include rehabilitation before return to the community.

C. Day hospitals.

This is an acute service which offers assessment and treatment to older people who can be maintained at home supported by the multidisciplinary team. The day hospital team could include doctors, nurses and therapy staff. Transport may need to be available.

D. Out-patient services

These provide assessment, diagnosis and treatment for people fit enough to live in the community and get to and from the hospital base. Out-patient services should be close to the in- and day-patient units. They may involve subspecialty clinics (e.g., memory or mood disorder clinics) and mobile clinics.

E. Hospital Respite Care

Hospital beds may be used to provide a respite service for people with chronic and severe mental illness and difficult associated behavioural problems in order to give their carers a break and enable care at home to continue as long as possible.

F. Continuing Hospital Care

Care for life in a hospital setting may be required for people with chronic and severe mental illness and difficult associated behavioural problems. Such care should be provided in as relaxed and homey an environment as possible, with carers encouraged to participate.

G. Liaison Services

Consultations and/or liaison services should be provided between facilities for elderly people with mental disorders and those serving general and geriatric medicine, general psychiatry, residential facilities and social agencies. This relationship should be of a reciprocal nature.

H. Primary Care

The primary care team has the initial responsibility for identifying, assessing and managing mental health problems in older people. The decision to refer to the CMHT is usually made in primary care.

I. Community and social support services

Services (both formal and informal), to enable the elderly person to remain at home. This includes a range of activities (home care, day care, residential care, respite care, self-help groups etc) provided by voluntary or government/social services.

Respite facilities. A range of short term, time limited, in-the-home and out-of the home services (residential services, other carers, day programmes) to support the carers.

Residential care. For those patients whose physical, psychological, and/or social dependencies make living at home no longer possible, a spectrum of residential facilities should be provided. These range from supported accommodations with low level supervision, medium level care facilities, to full nursing facilities. These should be organised to achieve the best possible quality of life.

J. Prevention

The mental health team for the elderly should engage in the prevention of relapse of disorders by careful follow up. They should also identity the risk factors for mental disorders in the elderly (e.g. hypertension, alcohol and substance abuse) and ensure these are effectively managed by appropriate medical, social strategies.

Within each service, preventative activities need to be coordinated in collaboration with relevant public health and other health care professionals. These may include educational activities to improve early identification of mental health problems by carers, families and primary care personnel in the community.

5. CONCLUSIONS

This document is not meant to be either totally comprehensive or prescriptive. Detailed descriptions of methods of treatment and care, for example, have not been included in this statement. Treatment and care are consistently evolving in the light of advances in research and services have to be continuously evaluated to ensure that they follow these advances of knowledge. New structures may well be required to enable new treatments to be used successfully.

This statement identifies care needs of older people with mental disorders and some of the ways by which these are currently met in some parts of the world. Where this is not the case, the consensus is that it is urgent that people responsible for health care policy development and implementation take note of the requirements cited and act accordingly,

Responsive action should lead to the development, appropriate to local conditions, of the components of services which will adequately address these needs.

Such components should be integrated and co-ordinated to serve older people with mental health problems and their carers and should be supported by adequate resources.

The attainment of the best possible quality of life of elderly people with mental disorders and their carers is paramount and is the ultimate guiding principle in organisation of care.

Good services should always be under-pinned by good research, evaluation and training. These will be dealt with in subsequent consensus reports, the next of which will discuss exclusively the question of teaching and training in the specialty of psychiatry of the elderly.

Consensus Meeting on Organization of Care In Old Age Psychiatry
Organized by the World Psychiatric Association, Section of Geriatric Psychiatry
Co-sponsored by the World Health Organization
Hosted by the Lausanne Universily Psychogeriatrics Service
Lausanne April 14 - 16 1997

List of participants

Alzheimer's Disease International
Dr Nori Graham, President
(Co-Rapporteur)
London, England

Swiss Alzheimer Association
Mr Oskar Diener, General Secretary
Yverdon-les-Bains, Switzedand

International Council of Nurses
Ms Anne-Françoise Dufey
Lausanne, Svàtzerland

International Federation of Social Workers
Ms Anne O'Loughlin
President, Irish Association of Social Workers
Dublin, Ireland

Lausanne University
Psychogeriatrics Service
Dr Vincent Camus
Lausanne, Swiáeriand

Dr Carlos de Mendonça Lima
Lausanne, Switzerland

Medicus Mundf Internationalis
Dr Kojo Koranteng
Basel, Switzerland

International Psychogeriatric Association
Prof. Raymond Levy, President (Chair)
London (England)

International Union of
Psychological Science
Prof. Kurt Pawlik, Past-President Hamburg,
Germany

World Federation for Mental Health
Ms Beverly Benson Long, President
Atlanta, USA

Dr John R.M. Copeland
Liverpool, England

World Health Organization:

Dr José Manoel Bertolote
Mental Disorders Control
Division of Mental Health and Prevention of
Substance Abuse
Geneva. Switzerland
Dr Juliet Dube-Ndebele
Consultant, Regional Office for Africa
Harare, Zimbabwe

Dr Helmut Sell
Regional Advisor, Health and Behaviour

Regional Office for South-East Asia
New Delhi, India

World Psychiatric Association
Prof. Norman Sartorius, President
Geneva, Switzerland
Prof. Jean Wertheimer, Chairperson
Geriatric Psychiatry Section (GPS)
Lausanne, Switzerland

Prof. Oluwafemi Agbayewa Member, GPS
Vancouver, Canada

Prof. Edmond Chiu Member, GPS
Melbourne, Australia

Prof. Cornelius Katona (Co-Rapporteur)
Member, GPS
London, England

Prof. Jean-Made Léger Member, GPS
Limoges, France

Secretariat
Mrs Suzanne Scheuner
Mrs Tina Anderson

DEPARTMENT OF MENTAL HEALTH

EDUCATION IN PSYCHIATRY OF THE ELDERLY

A TECHNICAL CONSENSUS STATEMENT

DIVISION OF MENTAL HEALTH AND PREVENTION OF SUBSTANCE ABUSE

WORLD HEALTH ORGANIZATION WORLD PSYCHIATRIC ASSOCIATION

GENEVA

EDUCATION
IN PSYCHIATRY OF THE ELDERLY

A TECHNICAL CONSENSUS STATEMENT

This document is a technical consensus statement jointly produced by the Geriatric Section of the World Psychiatric Association and WHO, with the collaboration of several NGOs and the participation of experts from different Regions.

It is intended to provide a basic guide for all those involved in the development and implementation of education in the fields of mental health and mental health promotion for older persons.

KEY WORDS: psychogeriatrics / elderly people / training / health education / mental health care.

CONSENSUS STATEMENTS ON PSYCHIATRY OF THE ELDERLY

The publication of this document represents the culmination of three years of work jointly developed by WHO and WPA, particularly through its Geriatric Psychiatry Section. Of course we are very proud of it and hope it will receive the same attention and have the same impact as those of the first consensus statements.

The innovative operational model through which this document was arrived at is indeed already interesting on its own. Although an initiative primarily from WPA, several other NGOs, some of the most relevant ones to the area of Psychiatry of the Elderly were also involved, thus setting a standard which cannot be ignored in future similar exercises. In addition, the meetings for deliberations were hosted by the Psychogeriatric Services of the University of Lausanne, which is a WHO Collaborating Centre for Research and Training in Psychogeriatrics. The private sector was also involved, since it was financially supported by a generous grant from Pfizer Pharmaceuticals, Pfizer, Inc.

We would like to express our gratitude to all institutions Involved as well as to those who participated in the conference, and who are named in the Annex. Our particular appreciation goes to the two Co-Chair of the meeting, Prof J. Wertheimer and Prof T. Arie and to the Co-Rapporteurs, Dr N. Graham and Prof C. Katona.

Dr J. M. Bertolote
Department of Mental Health
World Health Organization

FOREWORD

Psychiatric troubles are particularly frequent in old age. They are becoming predominant with demographic aging and raise important questions in terms of public health policies. The challenge is already of concern in developed countries since several decades. It is starting to be so also in developing ones, with life expectancy increasing progressively.

Psychiatric problems in the elderly have very complex causes and consequences, implicating among others, brain and physical diseases, personality factors, social situation. They are matter of prevention, treatment and rehabilitation. They are found both in the community and in institutions (general and psychiatric hospitals, long stay facilities, outpatient departments, day care centres, etc.) They consequently concern a wide range of persons including, apart from patients, the public in general, relatives, professionals involved and political and administrative representatives.

Two previous consensus statements produced guidelines on Psychiatry of the Elderly and on the Organization of Care in Psychiatry of the Elderly. This third one focuses on Education. This point is evidently crucial for the dissemination of knowledge, experience and practice in this field. The topic is diverse, going from biology of aging to clinical aspects and to sociological considerations. The public varies from lay people to professionals from difl'erent horizons. The aim is to propose wide guidelines favouring an education of good quality, taking into account the complexity of the subject to teach and of the public concerned. This consensus statement reflects the views brought by representatives of the main international associations involved in psychiatry of the elderly.

Professor J. Wertheimer
Chairman - Geriatric Psychiatry Section
World Psychiatric Association

1. INTRODUCTION

The World Health Organization and the World Psychiatric Association have recently published two consensus statements on the scope of psychiatry of the elderly and organization of services in psychiatry of the elderly.

The first consensus statement described the specialty of psychiatry of the elderly and made several recommendations with regard to training and education (1).

- The specialty of psychiatry of the elderly requires a grounding in general psychiatry and in general medicine as well as training in the specific aspects of both psychiatric and medical conditions as they occur in older people. Psychiatry of the elderly should be taught in the variety of settings in which it is practised.

- Training schemes for all health and social care workers should include a component on mental health care of older people. Training in mental health care of older people should be offered at both undergraduate and postgraduate level and also during continuing professional development.

- Education and information about mental health care of older people should be offered to the general public and to carer groups. The development of appropriate training manuals with culturally appropriate material should . be achieved for all groups of professionals and carers.

The second statement described the organization of services in psychiatry of the elderly and emphasized the need of all concerned for appropriate education, training and information (2).

Both Statements take account of pronouncements by the United Nations and the World Health Organization bearing on health and access to health care (3-6).

This third statement explores educational issues in greater detail. Its objectives are to:

- promote development and action on these issues at every level (local, regional, national and international) for all those concerned;
- promote an understanding on these issues and encourage positive attitudes;
- describe an approach to, and a core content for educational programmes;
- indicate the variety of groups to whom education should be offered;
- encourage the evaluation and continuous updating of all these activities.

2. PRINCIPLES

Education in this field should follow modem principles of adult education. It should:

- offer clear learning objectives centred on the learner's needs;
- ensure that learners are actively involved in their learning;
- address attitudes and skills as well knowledge;
- be appropriate for the context and culture of the learner;
- be systematically evaluated;
- be ready to challenge assumptions and acknowledge controversy where it exists;
- respect the spirit of the relevant recommendations from the UN and the WHO.

3. NEEDS

It is necessary to consider to whom education should be offered, what should be taught and teaching methods.
Education for whom:

- health and social care professionals - undergraduate, post-graduate and continuing education;
- health and social service managers;
- other care workers who constitute the bulk of care staff, especially in longer-stay institutions, community and primary health care;
- family carers, neighbours and others;
- voluntary workers;
- people in professions not specifically related to health but on whose work the mental disorders of old people impinge (e.g. lawyers, policemen, journalists, clergy, architects and designers);
- public policy makers;
- the general public.

What to teach?

The people concerned with this field range from professionals (generalists and specialists) to the lay public. It is obvious, therefore that the needs and levels of different groups will vary widely. Nevertheless there is basic information which is common to the needs of all. What follows is a core curriculum primarily derived from the learning needs of health professionals. Attitudes, knowledge and skills are embodied in different degrees in each of the items on the following list.

- The processes of ageing in individuals.
- Demography, economics and politics of ageing societies.
- Epidemiology, pathology, clinical features, assessment, diagnosis, treatment and management of the mental disorders of old age emphasizing the features which differ from similar conditions in younger people.
- The physical disorders and impairments of function which commonly occur in old age.
- The special significance in old age of the interdependence of mental, physical and social factors.
- Prevention and health promotion including recreational and spiritual issues.
- Ethical and legal issues.
- Planning, provision and evaluation of services in different settings. · Carers: needs and support.
- End of life issues.
- Multidisciplinary team work.
- Interviewing and communication skills.
- Fostering of positive attitudes, insight into the reasons for negative attitudes, and realistic expectations.

Teaching methods

Guiding principles:

- Many who work with the elderly do so under pressure and may feel they have no time to teach. Every activity of a service is a fruitful educational opportunity, ranging from a visit to old persons in their own homes to a meeting of a service planning committee.

- Formal education should fit with different learning styles. The best way of accomplishing this is to make a variety of different teaching formats available for learners. These may include large and small group teaching, tutorials and seminars.

- Carers and users of the service can make a significant contribution to multidisciplinary groups.

- Education for multidisciplinary groups can facilitate team work and dispel inter-professional misperceptions.

- Teaching thrives on association with research and encourages critical thinking in learners. Where appropriate, learners should themselves participate in research.

Media (radio, television, newspapers, etc.) - including materials which range from documentaries to dramas - are excellent ways to educate patients, caregivers, the public and professionals groups. Already available information and educational materials which are culturally appropriate should be used and further developed.

Information technology offers innovations such as distance-based education, video conferencing, internet, CD ROM programmes and computer teaching modules. These are also useful.

Evaluation

Evaluation of teaching is always desirable and depends on prior setting of learrung objectives. Accepted methods of evaluation need to be applied. Aspects for evaluation may include:

- Satisfaction of the learners with the teachers and the course content.
- Measurable change in knowledge, skills and attitudes.
- Improvement in patient outcomes.

4. CONCLUSIONS

There has been considerable growth in awareness worldwide of the importance of the mental health of older persons, especially in countries experiencing rapid population ageing. In some countries psychiatry of the elderly is a recognised specialty.

The importance of effective education for all those involved with the care of older persons with mental disorders is now widely acknowledged. While a great deal has already been achieved including the development of excellent teaching resources, there remains a pressing need in many situations for the establishment and implementation of teaching programmes. Improved access to existing resources should be facilitated through international exchange and continuing research.

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ANNEX

Consensus Meeting on Education in Psychiatry of the Elderly
Organized by the World Psychiatric Association Section of Geriatric Psychiatry
Co-sponsored by the World Health Organization
Hosted by the Lausanne University Psychogeriatrics Service
Lausanne, 14-16 May 1998

List of participants

Alzheimer's Disease International
Dr Nori Graham, President
(Co-Rapporteur)
London, England

International Council of Nurses

Ms Anne-Françoise Dufey
Lausanne, Switzerland

Canadian Academy of Geriatric Psychiatry

Dr. Ivan Silver
Toronto, Canada

International Federation on Aging

Dr Bjarne Hastrup,
Copenhagen, Denmark

International Federation of Social Workers

Ms Anne O'Loughlin
Dublin, Ireland

International Association of Gerontology

Prof. Gary R. Andrews
Flinders, Australia

International Association of Universities of the Third Age

Mrs Christine Wong
Paris, France

International Psychogeriatric Association

Dr Jean Philippe Bocksberger
Geneva, Switzerland

Lausanne University Psychogeriatrics Service (Lausanne, Switzerland)

Dr. Italo Simeone
Dr. Vincent Camus
Dr. Carlos Augusto de Mendonça Lima

Medicus Mundi Internationalis

Dr Kojo Koranteng
Basel, Switzerland

World Federation for Medical Education

Mr Lars Gustafson
Lund, Sweden

World Psychiatric Association

Prof. Jean Wertheimer (Co-Chair)
Lausanne, Switzerland

Prof. Tom Arie (Co-Chair)
London, England

Prof. Edmond Chiu
Melbourne, Australia

Prof. Cornelius Katona (Co-Rapporteur)
London, England

Secretariat
Mrs Suzanne Scheuner
Mrs Tina Anderson

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