National Council for the Elderly

Mental

Disorders in

Older Irish

People:

Incidence,

Prevalence

and Treatment

NATIONAL COUNCIL FOR THE ELDERLY

The National Council for the Elderly was established in January 1990 in succession to the National Council for the Aged which began in June, 1981. The terms of reference of the Council are:

To advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister, and in particular on

- *measures to promote the health of the elderly,*
- *the implementation of the recommendations of the Report, **The Years Ahead - A Policy for the Elderly**,*
- *methods of ensuring co-ordination between public bodies at national and local level in the planning and provision of services for the elderly,*
- *ways of encouraging greater partnership between statutory and voluntary bodies in providing services for the elderly,*
- *meeting the needs of the most vulnerable elderly,*
- *ways of encouraging positive attitudes to life after 65 years and the process of ageing,*
- *ways of encouraging greater participation by elderly people in the life of the community,*
- *models of good practice in the care of the elderly, and*
- *action, based on research, required to plan and develop services for the elderly.*

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MENTAL DISORDERS IN OLDER IRISH PEOPLE:
INCIDENCE, PREVALENCE AND TREATMENT

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MENTAL DISORDERS IN OLDER IRISH PEOPLE: INCIDENCE, PREVALENCE AND TREATMENT

By

Fiona Keogh
and
Anne Roche

NATIONAL COUNCIL FOR THE ELDERLY

REPORT NO. 45

This Report has been prepared by
Ms. Fiona Keogh and Ms. Anne Roche of the Health Research Board

for

THE NATIONAL COUNCIL FOR THE ELDERLY
CORRIGAN HOUSE
FENIAN STREET
DUBLIN 2

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Foreword

This study on mental disorders in older Irish people is a further contribution to work by the National Council for the Elderly on the health and well-being of older people. In the past the Council has concentrated on the physical health of older people. In this report we focus on the mental health of older people and examine the treatments available to those with mental disorders.

It is clear that while most older people are in good mental health a significant number suffer from a mental disorder at any one time. The majority of those with a mental disorder will continue to function independently in the community, but many will require support from community care services to do so. In addition, some older people, particularly those with severe dementia, will usually require institutional care.

By gathering together the available information on prevalence, incidence and treatment in one report, the authors have provided valuable information for the planning and development of mental health services for the elderly. While there is no evidence that older Irish people have an abnormally high prevalence of mental disorders by international standards, the Council believes that attention to this area is urgently required. The report highlights the need to strengthen the community care services, a need which the Council has consistently recognised in previous reports. The report also highlights the need to develop specialist services in old age psychiatry. The Council hopes that developments in old age psychiatry will be hastened by the publication of this report.

On behalf of the Council I would like to thank the authors of the report, Fiona Keogh and Anne Roche of the Health Research Board. In addition, I would like to thank Dr. Dermot Walsh of the Health

Research Board for the advice and support he has given to the authors, and to thank the Council's Research Officer, John Browne, for writing Chapter Eleven of the report.

I would also like to thank the members of the Consultative Committee for their advice to the researchers at a number of meetings and through correspondence, and for their assistance to the Council in formulating its views on this report. I would particularly like to thank Dr. Margo Wrigley, Consultant Psychiatrist in the Psychiatry of Old Age with the Eastern Health Board for chairing the Committee. The other members were, Ms. Mary Courtney, Mr. Stiofán de Burca, Dr. Mary Hynes, Ms. Geraldine Kelly, Ms. Margaret McDonald, Ms. Catherine Mc Nelis, Ms. Margaret Murphy, Ms. Mary O'Mahony, Mr. Michael O'Riordan, Ms. Teresa Peacock, Dr. Sheelagh Prosser, Dr. Louis Ramsay, Mr. Michael Shasby, Mrs. Lillian Sullivan and Dr. Cillian Twomey.

Finally, I would like to thank our Secretary, Bob Carroll, and our Research Officer, John Browne, for overseeing the project on the Council's behalf. I also thank our Projects Officer, Trish Whelan, for her work in preparing the report for publication and Ms. Céline Kinsella, Ms. Fionnghuala Ní Néill and Ms. Carol Waters for their secretarial support throughout the course of the project.

Michael White
Chairman
October 1996

National Council for the Elderly Comments and Recommendations

Introduction

1. The National Council for the Elderly is aware of the growing interest in the mental health of older people, and of the large amount of information on the subject which exists in both published and unpublished form. Concise reviews are essential both to consolidate previous work and to direct new research. This research aims to provide such a review, by gathering together in one publication, the information which exists on the incidence, prevalence and treatment of mental disorders in older Irish people.

2. The Council wishes to make a number of comments and recommendations based on issues arising from the report, mostly relating to the treatment of mental disorders in old age. It is obvious from the report that care provision in this sector is extremely complex and requires multiple options to meet different needs. It is also obvious that care provision differs greatly across the country, and that policies for the future are unlikely to lessen these differences.

3. The Council is aware, however, that the following comments and recommendations are no substitute for a comprehensive and integrated national strategy for old age mental health services. The Council believes that such a plan is urgently needed, given the pace of developments over the last decade. These developments include:

- *Planning for the Future* (1984)
- *The Years Ahead* report (1988)
- *The 1991 Nursing Homes Act*
- The Health Strategy document *Shaping a Healthier Future* (1994)
- The development of old age psychiatry services in four districts

- The 1995 White Paper on Mental Health *A New Mental Health Act*.

Over this period we have also become aware of the growing size of the elderly population. *The Council therefore recommends that a national strategy for the future of mental health services for older people be developed by the Department of Health in consultation with all concerned parties in this area.* Such a strategy should provide clear national guidelines for future developments, integrating, and where necessary, superseding the influences identified above.

Demographic context

4. There were 402,924 persons aged 65 years and over living in the Republic of Ireland according to the 1991 Census, representing 11.4 per cent of the general population (Central Statistics Office 1993). The Central Statistics Office estimates that the older population had increased to 412,500 persons by 1995 (Central Statistics Office 1996).

5. All recent demographic projections foresee significant growth in the numbers of older people in Ireland during a period when the overall State population is expected to remain stable. The latest projections prepared for the Council indicate that the elderly population will grow by almost 120,000 persons in the period 1991-2011. The proportion of older people aged 80 years or more, is expected to increase from 19 per cent to 24 per cent, a rise of 51,071 persons, in this period (Fahey 1995). This age group has by far the greatest incidence and prevalence of dementia disorders such as Alzheimer's Disease.

6. It is also clear that people with a mental handicap, for a variety of reasons, are living much longer than in the past. This population has an earlier ageing process and is therefore more likely to develop

dementia at an early age. People with a mental handicap are also more likely to develop additional handicaps such as epilepsy.

7. Relatives and friends are a vital source of care for the dependent elderly (Fahey and Murray 1994). Policy makers should not assume however, that the current levels of social contact and care will continue to exist in the future. The large size of kin networks among the present elderly is the result of a number of distinct demographic factors which may never occur again. The important factors were a high marital fertility rate during the child-bearing years of today's elderly, new historically low rates of mortality among their children and, from the 1960s onwards, low emigration rates and high marriage rates among those children in their adult years. The combination of these factors was unique; other demographic trends indicate that a decreased level of family support will be available to older people in the future (Blackwell *et al.* 1992).

8. Firstly, both the size and number of Irish families is decreasing due to falling fertility and marriage rates. Secondly, the proportion of married women in the labour force has increased and is expected to continue increasing. In the period 1981-1991, for example, the labour force participation rate of married women in the 35-39 year age group increased from 15.6 per cent to 32.3 per cent. This rate is projected to increase to 65.0 per cent by the year 2006 (Central Statistics Office 1995). This is likely to reduce the amount of time, especially during the day, available for care of relatives. The labour force participation rate for single women is falling, but not at a rate to compensate for the increase among married women. Thirdly, increased urbanisation and geographic mobility mean that the distance that people live from their relatives is likely to increase, making contact and caring arrangements more difficult.

Incidence

9. Irish information on the incidence of mental disorders in older people is very poor. We have little data on the number of community residing older people that annually develop particular disorders to a level that would warrant clinical intervention. Nor is there detailed information on the number of such cases that contact psychiatric and non-psychiatric community services. Without this information we have no firm basis for planning the annual requirements of specialist and non-specialist services. It is also impossible to accurately measure the number of older people who do not receive professional help for their condition.

10. The poverty of incidence data will not be remedied by one study. *The solution lies in the development of information systems to routinely collate the activities of all health and social care services in a particular district, whether at the community care, acute hospital, psychiatric hospital or long-stay unit level. These systems would be patient-focused and integrated to allow the tracking of individual patients through various care sectors.* In essence, we are advocating the model used so successfully by the the National Psychiatric In-Patient Reporting System (NPIRS) and psychiatric case registers to record the activities of the psychiatric services. The NPIRS system is used throughout this report as a proxy for true incidence data. With a more comprehensive system we would have a true record of the incidence of new cases receiving care at some level. Although the development of these systems would be a major undertaking, it should be borne in mind that most of the relevant data is already collected and analysed for disparate information systems.

Prevalence

11. Information on the overall prevalence of mental disorders is also far from ideal and it too would benefit from a patient-centred integrated information system. Where information is available it

confirms a large psychiatric morbidity among older people. The best estimate is that between 20 and 25 per cent of older Irish people have a mental disorder of some kind at any one time. Roughly five per cent of those over 65 years suffer from severe dementia. There is no evidence to date that older Irish people have a higher or lower prevalence of mental disorders compared to international figures. Nor is there consistent evidence that particular disorders are more prevalent than in other countries.

12. In absolute terms there are roughly 100,000 older Irish people with a mental disorder of some severity. If this prevalence figure remains constant in the near future, and if recent population projections are accurate, there will be 120,000 older persons with a mental disorder by 2011. The equivalent figures for severe dementia are 20,000 persons now and 25,000 persons in 2011. It is possible that these figures may be lower if significant improvements in the physical health of older people occur or if advances in medical science lead to improved treatments for some disorders. So far however, the prevalence of mental disorders has shown remarkable stability across time and in different countries. *In the absence of better information, future service provision should be based on these estimates.*

Public and professional attitudes

13. While public and professional attitudes to old age and mental disorders are improving, education is still required to reduce the stigma and misunderstanding surrounding some disorders. The large disparity that is often found between the number of people diagnosed by formal services and the community prevalence of, for example, depression, may be caused in part by these problems.

14. A major difficulty is that mental disorder is often perceived as a sign of weakness of character. This stigma inhibits sufferers from

seeking help. It may also prevent carers of older people from seeking help for their dependent friends or relatives. This attitude is also evident in some care professionals who may be unwilling to diagnose a mental disorder to prevent embarrassment. This may be compounded by a misunderstanding of the nature of old age on the part of care professionals. Many perceive mental disorders as a natural part of growing old, because of the ageing process or because of negative life changes in old age that lead to declining quality of life. As a result, they may be unwilling to initiate a comprehensive treatment package.

15. The reality is that apart from dementia, there is little evidence linking mental disorders and the ageing process. There is also much evidence that quality of life as experienced by older people is as high on average as that experienced by younger age groups. While it is true that losses in some areas (e.g., retirement and bereavement) are to be expected in old age, the effects of these losses are not always permanent, nor do they always have a negative effect on overall life quality (Browne *et al.* 1994).

16. *The Council recommends that a comprehensive public education programme on the nature of mental disorders in old age be undertaken by the health boards in conjunction with the Department of Health and other relevant agencies such as AWARE, the Alzheimer Society of Ireland and the Mental Health Association of Ireland. This programme should have the following aims:*

- to enable older people to identify mental disorder in themselves or other older people
- to familiarise younger relatives, friends or carers of older people with mental disorders in old age

- to explain the biological, social and psychological roots of mental disorders so that older people may understand that these problems are not a negative reflection on their character
- to explain the potential benefits of receiving treatment for a mental disorder.

17. *An equivalent programme for care professionals should also be undertaken. The professionals to be targeted should include general practitioners, public health nurses, social workers, psychiatric nurses, occupational therapists, physiotherapists and nursing home staff. Again the health boards should be the lead agencies, in conjunction with relevant professional bodies.* In addition to the above aims, this programme should highlight the rewards of working with older people and encourage professionals to use as broad a range of treatment options as possible. Too often, care professionals avoid working with older people, or minimise their contact, as they perceive the cases to be 'difficult' with little hope of a positive outcome. This attitude must be eliminated if older people are to have access to the full range of treatment options for their conditions.

18. *The Council would urge that the above programmes have a particular focus on suicide in old age.* Unfortunately, the suicide of an 80 year old is often seen as less regrettable than the suicide of a 20 year old. This common wisdom holds that the older person had lived their life while the younger person's life was left unfulfilled. A further problem is that suicide is often thought of as a natural response to certain aspects of old age such as poor health and bereavement. These common sense assumptions are dangerous, as they may affect the way older people view their own deaths, and put them more at risk for choosing suicide. The attitudes of formal and informal caregivers may also be affected, with efforts at suicide prevention in older people given a lower priority. The Council rejects the notion that

suicide should be implicitly accepted as a natural choice for certain categories of older people.

Training

19. *The Council believes that the ability to detect mental health problems such as depression and dementia should be a part of the training of all care professionals so that treatment can be delivered as early as possible. General practitioners and public health nurses in particular should be able and willing, as part of a routine assessment or ongoing care programme, to screen for mental disorders using the simple measures that are available. A training programme to achieve this should be organised by the Irish College of General Practitioners and An Bord Altranais.*

20. Such a training programme would not only hasten the delivery of appropriate treatment but also, in the case of dementia, enable certain legal steps to be taken. General practitioners are often asked to make a judgement about the mental competence of older people so that their testamentary capacity to make wills can be assessed. If dementia is detected at an early stage it is more likely that the patient will be judged competent, and be able to settle their legal affairs to their own satisfaction.

21. *The training programme should place special emphasis on older people who live alone. Without regular contact with others, mental disorders such as depression and dementia may develop unnoticed in older people who are already vulnerable and isolated, and who may be unaware of the problem themselves. Early detection is vital therefore, if serious and even tragic consequences are to be avoided.*

Co-ordination

22. Older people can easily become the victim of professional divisions, divisions between different service programmes within the health boards or divisions between services provided by different care teams or agencies. *At community level it is particularly important that primary care teams, psychiatric care teams and, to some extent, medicine for the elderly services, are well co-ordinated. It is also vital that the community care professionals have co-ordinated procedures for the use of secondary care services. Access points to services such as day care centres, acute psychiatric and medical services, and long-stay facilities must be identified at a local level and criteria for gaining access specified.*

23. Specific co-ordination structures are required for older people with a mental handicap. People with a mental handicap are likely to require a range of services because of the multiple problems that develop as they age. In addition to the mental handicap services, the person will also require primary health care to deal with minor mental and physical problems, and may need consultant-led specialist services for major problems. *The Council would urge that clear guidelines governing the treatment of older people with a mental handicap be drawn up by the health boards. These should specify points of access and criteria for referral to the various services required.*

24. The reports, *Planning for the Future* (1984) and *The Years Ahead* (1988) sought to assist the process of co-ordination by advocating a district organisation of all services for the elderly. Districts would contain a general population of 25-30,000 with roughly 3,000 people over 65 years of age. The district boundaries for elderly services and psychiatric services would map onto each other. This would enable a small, territorially based, multidisciplinary team to ensure that decision making in relation to the elderly would

take place as near as possible to those affected by the decision. Within each sector a comprehensive psychiatric service would be provided.

25. Some progress in the alignment of sector boundaries has been made in recent years but the process is far from complete. *The Council would urge that the establishment of integrated service districts be hastened along the lines advocated by The Years Ahead report.* It would also like to refer to the experience of two pilot projects on the co-ordination of services for the elderly at local level (Browne 1992). The pilot projects testify to the difficulty of establishing local area teamwork without the fullest backing and resources from higher managerial levels. For local area organisation to work it is essential, in short, that there be an ethos of co-ordination promoted by policy makers which filters down through all levels and agencies. The recent *Strategic Management Initiative* for the public sector has also recognised and advocated this ethos.

Carers of older people with mental disorders

26. The burden caused by dementia is very high on carers. In a recent study, interviews were carried out with 100 carers of elderly dementia/ Alzheimer's Disease sufferers. The study found that carers' needs for respite care, practical and medical support, advice and training information, financial support and counselling were not met (Ruddle and O'Connor 1993). *The report recommended that a particular service provider should be designated as a case manager who would take responsibility for the assessment of needs and the planning and delivery of services and supports. It also recommended that carers themselves should be involved in planning and decision making. The Council endorses these recommendations.*

27. The Council has long argued that the current provision of community care services is inadequate to deal with the needs of older

people and their carers. *Major investment is needed in all services, but the following areas are of particular importance to carers:*

- *24 hour a day, seven days a week community services*
- *specialised day centres for people with severe dementia with transport to the centres available when needed*
- *day hospitals capable of treating older people with mental disorders, again with transport when needed*
- *flexible respite care services, capable of accepting patients at short notice, for day or night care*
- *day sitting services.*

28. *In many cases the degree of care needed amounts to full-time care. Where the caring task therefore amounts to constant care, the Council is of the view that a special constant care allowance should be made available, funded by the Department of Health. This allowance would be distinct from the means-tested Carer's Allowance which is, in effect, a form of income maintenance. The new allowance would be based on the implicit cost of the care provided by the carer, which would in most cases be borne by the statutory authorities if the patient were transferred to long-stay care.*

29. *The Council has also advocated the need for a Dementia Services Information and Development Centre in Ireland (National Council for the Elderly 1993). This centre would provide a number of important services to carers and service providers for persons with dementia. Its functions would include:*

- *the establishment of a database on services and other information which is linked to all health boards*
- *the provision of personal advice (perhaps in the form of a helpline)*
- *improvement of communication*
- *identification of service gaps*

- co-ordination of services
- provision of staff support
- improvement of the status of those working with people with dementia
- development of a common language to be used with regard to dementia
- organisation of training and information on training
- maintenance of a record of completed and ongoing research
- piloting research projects and carrying out evaluations
- promotion of public awareness of dementia issues
- provision of models of good practice
- provision of information on planning.

A similar centre in Scotland has proved very successful on a limited budget.

Old age psychiatry services

30. The need to develop old age psychiatry services in Ireland has been well argued over the past decade. In *Planning for the Future* (1984) the role of a specialist old age psychiatry service was acknowledged. The report stated that psychogeriatricians should be appointed in the larger cities. Initially three such consultant posts were to be created in the Dublin area, with further posts to follow elsewhere, based on the experiences gained there.

31. Comhairle na nOspideal, in a discussion document on long-term institutional care, in 1985, emphasised the urgent need to initiate a properly organised service headed by trained consultants. It recommended that three posts of consultant psychiatrist with a special interest in the care of the elderly should be created, two in Dublin and one in Cork. It added, "The foregoing recommendation represents nothing more than a beginning towards the development of a properly

organised specialist service for the elderly with mental impairment" (1985).

32. *The Years Ahead* report in 1988 lent its support to these recommendations stating that, "as a matter of urgency" specialists should be appointed in Dublin and Cork, "to develop a model service and to promote high standards in the care of the elderly mentally ill" (p. 160).

33. The Council is concerned at the slow rate of progress in the appointment of consultant psychiatrists in the psychiatry of old age. There are currently four old age psychiatrists, three in Dublin and one in Limerick. The Council believes that consultant-led old age psychiatry should be at the core of the development of mental health services for older people. The specialist assessment, rehabilitation and treatment services offered by these consultants, and the ancillary services they develop are recognised as a model for good practice. It is inequitable then that only four districts in the country can avail of these services.

34. *In the absence of a feasibility study on the establishment of a national old age psychiatry service, the Council would recommend that the Royal College of Psychiatrists (Jolley and Wattis 1994) planning norm of one consultant in the psychiatry of old age per 10,000 elderly be adopted.*

Long-stay care

35. Estimating the number of older people with mental disorders in long-stay care is extremely difficult. This is due firstly to the high number of different institution types which cater to patients with similar medical and social profiles. It is also due to the poor quality of information arising from the Department of Health's 1995 Survey of Long-Stay Units. This survey does not allow for an exact estimation

of the number of older people with particular mental disorders in long-stay care. The figures that are available are likely to be a considerable underestimate. *The Council recommends that future surveys of long-stay units provide more detailed information on the medical, psychological and social status of residents to remedy this situation.*

36. Despite the poor quality of information, it is possible to derive some conclusions about the current situation. Firstly, it is clear that the number of older long-stay residents of psychiatric facilities is falling. Secondly, the level of psychiatric morbidity in other long-stay units such as geriatric hospitals and nursing homes is high. Thirdly, it is likely that many older people who are no longer considered for long-stay care in psychiatric facilities, particularly those with dementia, are now long-stay residents of non-specialist facilities, particularly nursing homes.

37. While the Council naturally welcomes the reduction in the numbers of older people resident in psychiatric institutions, it is concerned about the appropriateness of the current residential settings available. Many of these long-stay settings do not offer access to specialist ongoing assessment and treatment services. Often, the only treatment option available is pharmacological, with no access to other treatments such as behaviour therapy, counselling or reminiscence therapy. Thus, some older people in long-stay care with treatable problems are not receiving the best care possible.

38. It is clear from the report that the supply of designated community residential beds for older people is very low. *In a context where patients are being resettled from psychiatric institutions into the community or not being accepted in the first place, there is an urgent need to:*

- *Increase the supply of housing and hostel accommodation for older patients suitable for discharge to the community.*
- *Ensure that older people who are left behind in psychiatric facilities are not left in buildings with falling standards of care as younger patients are discharged. If older patients are to remain, these buildings must be adapted to their needs in accordance with established principles of good design and environment.*
- *Increase the supply of long-stay beds in non-psychiatric facilities dedicated to the care of older people with dementia.*

39. The Council is also concerned that the criteria for entry to various facilities are not clear and vary significantly from health board to health board. One health board, for example, has almost twice the number of patients with a mental disorder in long-stay units compared to another health board. This is in part due to historical variations in the type of facilities available, but is also linked to different admission policies across the health board regions. *For the sake of equity, the Council recommends that national guidelines for the placement of older patients with mental disorders in long-stay care be established. These guidelines should take into account the level of behaviour disturbance present in the patient, their physical health and their different life circumstances. At local level, these criteria would then be translated into clear policies for admission to various facilities.* This process would also highlight where shortages in the provision of accommodation exist.

Mental health promotion

40. *The 1995 White Paper on Mental Health proposed to place a statutory duty on health boards to promote mental health. This obligation is to be welcomed, and will hopefully translate into meaningful efforts for mental health promotion.* The Council wishes to emphasise the many benefits that mental health promotion may have on older people. Mental disorders in older people are often

misconstrued as having an inevitable and untreatable course (e.g., the dementias). The reality is that early detection of dementia is vital if the quality of life of both patient and carer is to be maximised. Another misperception is the notion that functional mental disorders such as depression are extensions of psychiatric problems experienced earlier in adulthood. In reality it is common for disorders such as depression to make their first appearance in old age. The identification of older people at-risk for mental disorders is an essential activity therefore, if the mental health of older people is to be improved.

41. *Future health promotion programmes should take account of the strong links that exist between psychological well-being and physical health status (Fahey and Murray 1994).* These programmes should focus not only on preventing illness but also on psychologically preparing the elderly for future changes in health status through promoting the use of successful coping mechanisms.

42. *The implicit role of the voluntary sector in promoting mental health is already significant and should also be acknowledged. Social events, social contact and a range of related services are regularly provided voluntarily. Such networks might be developed and given a focus by a defined policy at health board level.*

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CHAPTER ONE

Introduction

This research aims to gather together in one publication the information which exists on the incidence, prevalence and treatment of mental disorders in older Irish people. Information on this topic exists in both published and unpublished form. Government agencies, academic researchers and others all possess data which either lie in archives, are on computers or are published only in specialist media. At the same time, new research in the area is being completed. It seems prodigal to reproduce studies to gain information which already exists, and unfortunately this often happens. Concise reviews are essential both to consolidate previous work and to direct new research.

The overall aim of the study is to collect information on the number of older people (i.e., those over 65 years) who develop mental disorders each year (incidence), the number who suffer from these disorders at any one time (prevalence) and the treatments for these disorders that older people receive. The National Council for the Elderly is mandated to advise the Minister for Health on all aspects of ageing and the welfare of the elderly, either on its own initiative or at the request of the Minister. This research will highlight areas of concern for future action in the areas of mental health promotion and will also provide valuable information for the planning and development of mental health services for the elderly.

A comprehensive literature review using Medline (a computerised database of published articles and papers on all medical topics) provided us with research papers from the Irish and international arena, while health board and government agency reports offered us information on current Irish practices in terms of service use and

availability. While there are few studies concerning the level of mental disorder in the general population or in general practice in Ireland, we are fortunate in having good quality data on psychiatric service use in this country, extending back over a period of many years, enabling us to study mental disorder in ways which many other countries cannot. Computerised databases such as the National Psychiatric In-Patient Reporting System (NPIRS), the Three County Psychiatric Case Register (TCCR - Westmeath, Roscommon and Carlow), St. Loman's Hospital (West Dublin) Psychiatric Case Register and the Hospital In-Patient Enquiry (HIPE) system were all accessed to provide data on incidence and prevalence rates. The Danish Case Register, based in Aarhus, also kindly co-operated and provided us with similar data in order to make international comparisons. This register collects information on all in-patient and out-patient contacts with the psychiatric services in the whole of Denmark (population approximately five million). While the structure of the health services is not the same in Denmark and Ireland, service use data of the type collected in case registers is rarely available and some comparisons between the information from the two countries can be made with the proviso that they are based on contacts within the psychiatric services. A large number of voluntary groups and interested individuals were also contacted to provide more detailed information regarding their specific service provision.

1.1 Mental disorders in late life

Mental health problems are one of the most important causes of disability in old age (Dewey *et al.* 1993). Community surveys carried out in Ireland (Lawlor *et al.* 1994), the UK (Copeland *et al.* 1987a), and elsewhere (Robins *et al.* 1984), suggest that between 19.3 per cent and 28.5 per cent of the population aged 65-years and over suffer from an identifiable psychiatric disorder. These rates suggest a high level of disorder, warranting particular attention. While the process of ageing can bring some problems in terms of physical and mental

health, these problems are not inevitable, nor is it impossible to treat mental health problems that may arise.

Mental health problems in late life can range from a minor anxiety state to a disabling dementia, but depression is considered to be the most common mental disorder in the elderly, affecting from 13 to 23 per cent (Lawlor *et al.* 1994). While many mental disorders are common to all age groups, there are disorders which are specific to people over 65 years. For example, Alzheimer's Disease and other dementias occur almost exclusively in older people and the occurrence of dementia increases with age. Estimates of dementia from over 50 international studies of people over 65 years report between two and 14 per cent suffering from dementia with most estimates being around the five per cent level (Anthony and Aboraya 1992). Results from international studies show that while approximately five per cent of people over 65 suffer from dementia, about 20 per cent of those over 80 years have dementia (Mortimer 1983).

1.2 Diagnosis and treatment of mental illness in older people

Anyone can become mentally ill, at any point in their lives. There are some illnesses which begin mainly in young adulthood, such as schizophrenia, and some which begin mostly in old age, such as Alzheimer's Disease. While many illnesses or disorders are essentially the same for all age groups, there are some differences between younger and older people in the diagnosis and treatment of mental illness. Before treatment can be administered the mental disorder must be recognised and diagnosed. This can give rise to particular problems where older people are concerned. Some studies estimate that as many as 50 per cent of cases of mild or moderate depression in older people are missed by general practitioners (Goldberg and Huxley 1980). When the disorder has been diagnosed, treatment options can then be considered. There is some

evidence that the wide range of treatment options available for common conditions such as depression may not be considered for older people. Brodaty *et al.* (1993) found that people over 65 were offered drug treatment more often and psychotherapy less often than younger age groups. While it may be overstating the case to suggest that discrimination exists against older people when it comes to diagnosis and treatment of mental disorders, it is certainly the case that serious gaps in the understanding of mental disorders in older people exist. This report will try to highlight these gaps and recommend ways in which they might be addressed.

1.3 The elderly population in Ireland

In 1991, there were 402,900 people aged over 65 years in Ireland, constituting 11.4 per cent of the population (Table 1.1). It is projected that this group will make up 14.1 per cent of the population by the year 2011, or over 520,000 (Fahey 1995). This is an increase of almost 30 per cent. Even more important in health terms is the projected increase in the very old. The number of people aged 80 and over is expected to increase from 79,000 in 1991 to 130,000 in 2011, an increase of almost two-thirds.

Table 1.1: Population by selected age groups and gender, Ireland 1991.

	65-74		75+		Total 65+		All ages
	Number	% over-65s	Number	% over-65s	Number	% total population	Number
Male	110,139	27.3	63,586	15.8	173,725	4.9	1,753,418
Female	129,938	32.3	99,237	24.6	229,175	6.5	1,772,301
Total	240,077	59.6	162,823	40.4	402,900	11.4	3,525,719
% total population	6.8		4.6		11.4		100

Source: Census 1991, Central Statistics Office.

1.4 Mental health services

Changes are taking place in the delivery of psychiatric services in Ireland that have implications for the care of the elderly mentally ill. The Department of Health report on the future development of the psychiatric services in Ireland, *Planning for the Future* (1984), recommended that psychiatric services become more community based, with less reliance on in-patient hospital care. To address the particular needs of older people with mental illness, four services for the psychiatry of old age have been established and more are planned. We have little information as yet concerning the impact of these changes on the elderly mentally ill. This report hopes to address some of the gaps in our knowledge.

The increased interest in mental health issues in the elderly has taken place in the context of considerable advances in specialities such as neurobiology, psychiatry and psychology. Progress in understanding the nature and progression of Alzheimer's Disease is particularly noteworthy. While the progress being made in other areas may not be as dramatic, the state of our knowledge is advancing steadily.

If we are to meet the health and social care needs of an increasing population of older people, our services need to be efficient, effective and appropriately delivered. The first step in planning these services is to understand the nature of mental illness among older people, and the issues and concerns around these conditions. It is also important to have some estimate of the level of psychiatric morbidity in this population. Furthermore, it is necessary to review the treatments, services and practices currently available. This report will address these issues.

1.5 A model of ageing

In order to tie together the different pieces of evidence and information obtained from a wide variety of sources it is useful to have

a 'model' of ageing. It is now widely accepted that mental disorders, including the dementias, are bio-psycho-social phenomena (Kahn 1971). Thus, they arise from some combination of biological, psychological, social and environmental factors, and their understanding requires an integration of these perspectives. It is important to differentiate between biological, psychological and social processes of ageing. For example, an individual's physical health or other biological factors may have more of an influence on their mental health than chronological age.

- Senescence or normal ageing brings about physical and psychological changes in the individual, and these provide an important background for considering mental disorders in older people.
- Co-morbidity or the co-occurrence of physical illness and mental disorder is common in people over 65 years. For example, depression can occur after stroke, and anxiety is frequently seen accompanying heart or respiratory problems. Many commonly used medications can affect mood or thinking. Since medical illnesses can present with many components, both physical and psychological, and since age-related changes can also influence these same issues, the tasks of diagnosis and treatment in older people need special attention.
- There are specific mental illnesses which occur in old age such as Alzheimer's Disease. The likelihood of having Alzheimer's Disease increases with age, so that those aged over 80 are more likely to develop the disorder than those aged 70 and so on. Increases in life expectancy mean that more people are living to a very old age and so we might expect to see more 'late life mental illnesses'.
- Increases in life expectancy have occurred across the whole population. This means, for example, that individuals with a life-long disorder such as Down's Syndrome, or those who developed

a mental disorder in early adulthood, such as schizophrenia, are living to old age.

Thus, there are mental disorders which are acquired as people grow older, and others which individuals 'bring with them' into old age. Mental illnesses and disorders in late life, arising from these different sources, will be described.

1.6 Concepts of mental health and mental illness

Mental health is a broader notion than simply the absence of mental disorder. This term implies that the individual functions in positive ways, attaining some 'ideal norm' of mental health. While operational definitions of positive mental health are not well established, some attempt can be made to list the qualities or characteristics which typify good mental health. A subjective sense of well-being is usually one of the prominent features of positive mental health. Other characteristics include positive self-esteem and a sense of being accepted, the ability to form reciprocal affectionate relationships, having a good level of 'self-knowledge', having an efficient perception of reality, and having an enthusiasm for living and an ability to meet the demands of the day. This list is not exhaustive and we are still not sure just what constitutes good mental health. At a clinical level however, this orientation towards mental health encourages a balanced consideration of the individual's strengths as well as weaknesses or symptoms. It is also interesting to note that many of these features, such as self-knowledge, are those which develop over time and are likely to be present in older people; such a description of mental health would suggest that the older one gets, the more one's mental health improves.

It is equally difficult to describe what is meant by mental illness or mental disorder. Many attempts have been made to define these terms and there is much debate surrounding their use. The term

mental illness is generally used to describe some disturbance in either brain functioning or in brain physiology (i.e., the structure of the brain) which results in observable signs and symptoms that are 'abnormal'. Using this definition in its narrowest form some believe that since many mental disorders have no demonstrable physical pathology they are not, in fact, illnesses (e.g., Szasz 1961). Others believe that psychological or environmental processes are the primary causes of mental disorder (Bandura 1969, Ullman and Krasner 1975). As evidence concerning the interaction of physical, psychological and environmental factors in the development and expression of mental illness slowly accumulates, the term 'mental disorder' is often used as a looser term which describes some observed abnormalities without prescribing a physical cause. DSM-IV (the Diagnostic and Statistical Manual of Mental Disorders 4th Edition - American Psychiatric Association 1994) defines mental disorder as, "a clinically significant behaviour or psychological syndrome or pattern that occurs in a person that is associated with present distress ... or disability ... Whatever its original cause, it must currently be considered a manifestation of a behavioural, psychological or biological dysfunction in the person" (p. xxi). This definition also specifies that understandable responses to particular events such as bereavement, do not constitute mental disorder.

In order to treat individuals and to define more carefully what constitutes specific diagnoses, conventional operational definitions of mentally disordered states are used. Current diagnostic systems are the International Classification of Disease (ICD 9; World Health Organisation 1988) and DSM-IV. Throughout this report the terms mental illness and mental disorders will be used to describe a lack of mental health. The term 'acute' describes illness of recent onset and 'chronic' refers to long-standing illness.

1.7 Incidence and prevalence

In describing the occurrence of a disease or disorder in a population two terms are generally used, 'incidence' and 'prevalence'. Incidence is a count of all the *new cases* of a disorder arising in a particular period in the population at-risk (e.g., all adults or those over 65). Incidence is usually reported on an annual basis and rated to the population base (e.g., one per 100, 10 per 1,000, 100 per 10,000 and so on). Prevalence is a count of *all cases* of a particular disorder and is reported in the same way. Thus, prevalence figures include the incidence figure and are always higher than the incidence rate. The use of rates, be they percentages or rates to 10,000 or 100,000 population, enables us to compare occurrence across different populations. For example, reporting the number of people affected by a particular illness in the eight health boards in Ireland would not allow us to compare across them. The use of rates however, allows us to do this. Incidence and prevalence figures allow us to describe the distribution of illness in a community, changes in its rate of occurrence and, if the information is available, the demographic and social factors associated with the illness or disorder. In this report, age specific rates to 10,000 population are normally used.

Describing a disorder in terms of incidence and prevalence also focuses attention on the overall occurrence of the disorder and not just those cases that have reached the specialist services. In psychiatry particularly, only a small proportion of cases ever consult a specialist and fewer still are admitted to hospital. However, this differs according to specific disorders. For example, with depression the 'iceberg' model is often used to illustrate the fact that the bulk of this particular disorder either remains undetected or is treated at the primary care level, with only the very 'tip of the iceberg' being referred to specialist services.

The most reliable way to measure the incidence and prevalence of a disorder is to select a random sample of a well defined population. A valid, standardised measure is then required which will accurately report on true cases that exist in the population. In order to have reliable estimates of incidence and prevalence, large numbers of individuals must be surveyed. This type of research is time consuming and expensive and is infrequently undertaken. The use of different measures in different studies means it is difficult to compare the results obtained. For example, if a particular questionnaire is used that measures very general *symptoms* of depression, such as a depressed mood, a lack of enjoyment in things or a feeling of hopelessness, the result will probably be a very high prevalence figure. This is because these symptoms can occur quite often as isolated and short-lived feelings in many people without necessarily meaning they have clinical depression.

At the other extreme, if very strict criteria are used to measure only groups of symptoms that have lasted for a defined period of time and with a defined severity, a much lower prevalence figure will be obtained because there are fewer people who meet the criteria of a clinical depression. Thus, when rates of depression and other disorders are being examined, it is important to consider how these were measured and if this measurement is reliable. While these issues make it more difficult to find reliable studies and to compare them, international studies have been conducted and some Irish work has been carried out which can be used to provide estimates of the incidence and prevalence of mental disorder at the community level.

Another way to examine the occurrence of disorders is to examine the use of particular services which treat the problem, for example, out-patient clinics or hospitals. This provides a picture of a specific set of cases (usually the more serious ones) which reach the specialist services through a variety of pathways. Comprehensive data usually

exist on the activities of in-patient services and are therefore more widely used.

1.7.1 The National Psychiatric In-Patient Reporting System (NPIRS)

Ireland is fortunate in having good quality databases which have recorded this type of information for several years. The National Psychiatric In-Patient Reporting System (NPIRS) has been running since 1965 and collects information from private and public psychiatric hospitals and units around the country, with a 96 per cent coverage rate. All admissions to and discharges from these facilities are notified to the Health Research Board. Data on diagnoses and various socio-demographic variables are also collected. The diagnostic system used is ICD and two diagnoses can be recorded on both admission and discharge. The data are collated and analysed for presentation annually, the most recent report being that for 1994 (Keogh and Walsh 1995). The data from the NPIRS that will be reported in subsequent chapters refers to *first* and *all* psychiatric admissions for a particular year. *All* admissions include first admissions and is also a record of all other admissions to psychiatric hospitals and units. The number of first admissions in a year is lower than the number of all admissions as some people are admitted more than once. The admissions' figures from the NPIRS do not include patients who have been in hospital for more than one year. By definition the number of *first* admissions does not include re-admissions and so can be used as a proxy incidence measure. Approximately 27 per cent of all admissions to psychiatric hospitals and units in any one year are first admissions.

1.7.2 Psychiatric case registers

The Health Research Board also administers the *Three County Case Register (TCCR)* and is involved in the administration of the St. Loman's Hospital Psychiatric Case Register which covers West

Dublin. The TCCR began in 1973 with counties Carlow, Westmeath and Roscommon. These counties were chosen as they represented a broad range of psychiatric service use and socio-demographic population structure. County Carlow has not been part of the register since 1990 and so the figures from the TCCR in this report include only Westmeath and Roscommon. A psychiatric case register is a specific type of information system which records the contacts made with the psychiatric service by patients who live in a defined geographical area. Thus, it covers not only in-patient admissions, but also psychiatric out-patient contacts, visits by community psychiatric nurses and other contacts with psychiatric services. This type of database is very useful for epidemiological research for two reasons. It is patient centred, that is each patient is registered only once on the system when they first come into contact with the psychiatric service, so there is no double counting. It is also longitudinal, that is a record of contacts for each patient is kept for as long as they stay in the psychiatric service, so if someone comes in contact in 1980 they will stay on the system until they are discharged from the service. Both case registers have been operating since 1973 and the areas covered were specifically selected to contain a representative sample of both the urban and rural populations of Ireland. In contrast to the data from the NPIRS, which is event based (i.e., all admissions), data from the two case registers is person based, so that the data reported in subsequent chapters denotes all individuals in contact with the psychiatric service within the case register area.

1.8 Estimating the incidence and prevalence of mental illness

Goldberg and Huxley (1980 and 1992) describe a framework for what has been called 'the pathway to psychiatric care', that is, how individuals are defined as mentally ill and eventually reach the psychiatric services. They use this framework to organise epidemiological data about mental illness at different points along the pathway to psychiatric care (see Table 1.2).

This framework refers to the total adult population (all those aged 15 and over), and the estimates of prevalence are obtained from a variety of comparable studies from a number of countries. While the figures are not specific to Ireland, or to the elderly in Ireland, they do provide us with estimates of the rate of mental illness we might expect at the different levels in our community. This will help us to interpret the Irish data and the data relating to persons aged over 65 years.

Table 1.2: Five levels and four filters on the 'pathway to care' with estimates of annual prevalence rates at each level for the total adult population (all those aged 15 years and over).

Level	Setting	Estimated prevalence	Filter to next level
1	The community	260-315 persons per 1,000 per year	Illness behaviour
2	Primary care attendees (total mental morbidity)	230 persons per 1,000 per year	Ability to detect disorder
3	Mental illness identified by general practitioners ('conspicuous psychiatric morbidity')	101.5 persons per 1,000 per year	Referral to mental illness services
4	Mental illness services	23.5 persons per 1,000 per year	Admission to psychiatric beds
5	Psychiatric in-patients	5.7 persons per 1,000 per year	

Source: Goldberg and Huxley, 1980 and 1992.

At community level, psychiatric morbidity is estimated at 260-315 cases per 1,000 adults per year. Such cases are likely to be found in community surveys and are generally less severe cases of mental disorder. At this level of illness the first filter on the pathway is encountered, that is, the manifestation of illness behaviour which is seen in attendees at primary care. Psychiatric morbidity for all adults at this level is estimated at 230 per 1,000 per year.

From this group the general practitioner will detect and identify a mental disorder in only a proportion. Individuals who go through this

second filter constitute the group with 'conspicuous psychiatric morbidity' which is estimated at being approximately 101.5 cases per 1,000 adult population per year. It is at this point that a third filter on the pathway to care is encountered - the decision by the general practitioner to refer an individual to specialist mental illness services. If the individual is referred, they encounter level four where the total morbidity in the mental illness services is estimated at 23.5 cases per 1,000 per year. Within the mental illness services the fifth filter is encountered, that is admission to psychiatric beds. The prevalence of psychiatric in-patients (level five) is estimated at being 5.7 per 1,000 per year.

To summarise, this framework predicts that in the adult population in any one year there will be approximately 26-31 per cent of people living in the community with a mental disorder, mostly with mild problems. Of those that attend primary care services, approximately 23 per cent will have a mental disorder. General practitioners will identify approximately 10 per cent as having a mental disorder and will refer about two per cent of these to the psychiatric services. Less than one in 100 will be admitted to a psychiatric hospital.

While this framework has been very useful in providing estimates for the total prevalence of mental illness and in describing the means by which individuals progress along the pathway of care, it has some limitations. Firstly, this pathway is not the only way an individual comes to the attention of the psychiatric services. They might, for example, be physically ill and attend a general hospital where a psychological problem is noted and the individual is referred to the psychiatric service by this route. However, the numbers in the framework estimate all individuals affected by mental illness, regardless of how they come into contact with the service at the different levels. Secondly, the picture for specific groups in the population can be quite different to that described in the framework.

For example, estimates of prevalence in females only or in males only would show quite different numbers. Similarly, a model of the prevalence of disorder for those over 65 years would show different numbers. The picture for certain mental disorders can also be quite different. For example, for those individuals diagnosed with schizophrenia, almost all would be in contact with either level four or five at some stage of their illness. For some milder neurotic conditions however, they may never be formally identified, and while they would be encountered in a community survey they would never be included in the figures at level four or five of this model. Thus, the majority of mental illness reported in community surveys has never been seen by the mental illness services (levels four and five) as the filtering processes along the way are selectively permeable to more severe disorders.

In applying such a framework to the elderly population, specific characteristics of this population are important. In *Planning for the Future* (1984) a distinction was made between three groups of the 'elderly mentally infirm' as follows:

1. Elderly patients with functional mental illness, that is those people aged over 65 years who develop a psychiatric illness, such as depression, for the first time (or relapse following earlier illness).
2. Elderly patients with dementia.
3. Elderly patients with long-standing psychiatric illness, that is those individuals who may have developed a long-term illness (e.g., schizophrenia) in their youth, who then move into old age. Older long-stay psychiatric patients are also part of this group.

An overall prevalence rate of mental illness in the elderly will, by definition, include all patients in these categories. An incidence rate will only include new cases of dementia and functional mental illness that arise in a particular time period, and will not include those in

category three. In terms of the numbers of individuals over 65 years with a mental illness, the rate of patients in category one will be quite low and their needs will be very different to those patients in categories two and three, who are greater in number and who will generally require a very different level and type of care.

1.9 Pathways to care for older people with mental disorders

In order to describe the different levels of care available and how people might move between them, Figure 1.1 shows an illustrative model of the possible pathways to care and the type of services required for older people with dementia. For the purpose of clarity, only the usual routes between services are shown.

The filtering of patients between geriatric medicine and the psychiatric services will depend on the predominant problem the individual has and its severity. For most individuals the pathway will be from primary care with general practitioners and support services in the community, to acute geriatric or psychiatric care or both, and then on to long-stay care if necessary. However, people may be referred directly from primary care to long-stay care and other pathways might also be appropriate for other individuals. The model would also be somewhat different for other disorders such as depression.

Figure 1.1: Illustrative model of possible pathways to care and services for older people with dementia.

1.10 The diagnosis of mental disorders

While issues concerning the concepts, definitions, classification and diagnosis of different psychiatric disorders are important, they will not

be discussed at length in this report. The definition of mental illness can be seen to be hierarchical with single symptoms, of depression for example, at the lowest level. These symptoms can be grouped into syndromes, that is, a group of symptoms which tend to group together and re-occur in association with each other. Finally, a clearly defined and standardised description of a disorder or 'disease' is laid down which more specifically describes the symptoms and features which constitute a particular disorder and distinguish it from another. The International Classification of Diseases (ICD; World Health Organisation 1988) or the Diagnostic and Statistical Manual of Mental Disorders (DSM; American Psychiatric Association 1987, 1994), constitute this level of diagnostic classification.

Problems around the classification and diagnosis of a mental disorder generally arise because of the differences in establishing the existence of a mental problem as opposed to a physical problem. If a doctor is concerned that an individual has diabetes, a blood test can be performed and the existence (or not) of diabetes can be confirmed definitively. If the problem is one of depression however, the doctor must ask a series of questions and weigh up the responses to these questions in the context of everything else they know about the individual. A structured questionnaire such as the Beck Depression Inventory (Beck and Worthen 1972) can be used in addition to this procedure to help determine the severity of a depressive episode, but there are no definitive tests to show whether an individual has depression or not. Problems can arise because doctors differ on how they will examine patients. A doctor may elicit symptoms that another may not, or interpret them differently, or differ on how they define or classify a disorder, leading to differences in the rates they report for these disorders. In this way, the different means of classifying and measuring disorders used in different studies can have a bearing on the results they report. A further problem is that certain measures may be designed for a specific group of people, such as

those in hospital, and this measure may not be so useful for people living in their own homes in the community.

The way in which samples of individuals are selected can also lead to differences in results, so that a study which selects only people living in the community will miss those in hospitals or nursing homes, and vice versa. In this report the measurement and methodology of the various studies reported will usually not be included in order to avoid unnecessary technical detail. Instead, reliable studies of a comparable nature are reported wherever possible.

The International Classification of Diseases (ICD) is used in Ireland to classify mental illnesses. There are over 150 diagnoses relating to mental disorders in this system. They are summarised here, with a brief description, for ease of reporting (Table 1.3). Each of these groups of disorders will be more fully explained in the coming chapters. The individual ICD codes which go to make up these categories are summarised in the Appendix.

The latest version of this system, ICD 10, only came into use in 1994. Much of the data in this report predates this and uses the ICD 9 system and so this diagnostic system is employed in this report.

1.11 Outline of the report

Depression and dementia are the most common mental disorders among older people and these will be examined in detail in Chapters Two and Three. Other disorders such as schizophrenia, neuroses and alcohol dependence will be described in Chapters Four, Five and Six. Separate chapters for Mental Handicap (Seven) and Suicide (Eight) are included. Each chapter has a similar structure, with a general introduction to the disorder and a discussion of the special features of this disorder in older people (if any). This is followed by Irish data on the incidence and prevalence of the disorder.

Table 1.3: ICD 9 diagnostic groups and descriptions.

Summary groups	Description
Organic psychoses	A collective term for illnesses with an organic or physical cause. Psychosis is a term used to describe when an individual is out of touch with reality. Most illnesses in this group constitute some form of dementia and this is how they will be described throughout the rest of the report.
Schizophrenia	A form of psychosis. In schizophrenia the individual's thinking and perceptions are distorted.
Other psychoses	Schizophrenia-type illnesses such as paranoid states and short lived psychotic reactions to stressful situations.
Depressive disorders	The individual feels low spirited and this feeling is severe, prolonged and out of proportion to external circumstances. Also known as affective disorder.
Mania	The individual feels elated and is full of energy, overactive and needs little sleep. He/she can also be very agitated and irritable. This is another form of affective disorder.
Neuroses	Includes such disorders as anxiety, panic disorder and phobias. The common feature is a feeling of fear and apprehension which is severe and out of proportion to external circumstances.
Personality disorders	A set of behaviour patterns which are significant deviations from the way the average individual acts and relates to others.
Alcoholic disorders	Alcohol dependence and abuse.
Drug dependence	Addiction to or dependence on both prescription and 'street' drugs.
Mental handicap	Includes disorders such as Down's Syndrome.

Source: ICD 9.

International data on incidence and prevalence is presented with comparisons to the available Irish data. The main findings, conclusions and points of interest are presented at the end of the chapter. The whole area of diagnosis or mis-diagnosis and the ensuing treatments on offer will be explored, as will current treatment settings (Chapter Nine) and the use of acute services (Chapter Ten). Mental disorders in long-stay care settings will be described in Chapter Eleven and mental health promotion is covered in Chapter Twelve. The findings and conclusions are outlined in Chapter Thirteen, along with the recommendations resulting from the study.

Affective Disorders: Depression and Mania

Depression is an emotional state characterised by feelings of sadness, loneliness, rejection, failure, hopelessness or a combination of these feelings. Depression as a psychiatric disorder or mental illness is distinct from feelings of 'the blues', when these feelings are severe, prolonged and out of proportion to prevailing circumstances. Depression, along with anxiety, is probably the most prevalent mental disorder in the general population. The most recent community study in the UK (Meltzer *et al.* 1995) of the population aged 16 to 64 years reported 77 cases per 1,000 of mixed anxiety and depressive disorder, and 21 cases per 1,000 with a depressive episode. Dichotomous classifications of depression have often been used, such as neurotic versus psychotic depression, or 'endogenous' versus 'reactive', but the presentation of depression is usually more complex. For the purposes of this chapter, a range of depressive disorders are included, from the milder to the more severe (see Appendix for details of the ICD 9 diagnostic groupings), and descriptive terms such as 'endogenous' are avoided.

2.1 Depression in older people

Many epidemiological studies have shown that depression is the most common mental disorder in the elderly (Blazer *et al.* 1988), and some studies have found that the risk of developing depression increases with age (Schwab *et al.* 1973). Blazer *et al.* (1991) carried out a survey of 4,163 adults aged 65 and over living in five communities in the US and found that the association between age and depressive symptoms was positive and statistically significant. However, they argued that factors other than age may contribute to the observed relationship between age and depression. These correlates of depressive symptoms have been described as functional disability.

chronic illness, social support, lower income and cognitive impairment. When these factors were controlled in this survey, the positive association between age and depressive symptoms disappeared. These findings confirm those of Kennedy *et al.* (1989), who found a hierarchy of characteristics associated with substantial levels of depressive symptoms which included illness, disability, isolation, bereavement, and poverty. O'Hara *et al.* (1985) in a rural study found that poor health and inadequate social support were associated with depressive symptomatology. Thus, while there is an association between age and depression the accumulated evidence suggests that it is not age *per se* which influences the development of depressive symptoms, but other factors in the individual's environment.

2.2 Diagnosing depression in older people

The symptoms of depression do not differ substantially according to the age of the sufferer, but there are certain clinical features of depression which are more common in the elderly. There can be an increase in the frequency of physical complaints in older depressed people and there is also some evidence that this group are more likely to experience weight loss and are less likely to report feelings of worthlessness or guilt (Blazer 1989). Cognitive deficits such as memory loss, apathy and distractibility can also be features of depression in the elderly (Kaplan and Sadock 1990). A further difficulty in the diagnosis of depression in older people is that depression can mimic dementia and can co-occur with dementia, which complicates both disorders and makes diagnosis difficult. A depressive disorder with very severe cognitive disturbance is known as pseudodementia (Kiloh 1961) as it 'mimics' the dementia syndrome, but this is relatively uncommon. Much more common is the co-occurrence of both depression and dementia. One study from the US reported a 23 per cent prevalence of depression in Alzheimer's Disease patients in an out-patient clinic (Reifler *et al.*

1982). Several studies have found that depression in the community dwelling elderly is under-diagnosed and under-treated by general practitioners. Goldberg and Huxley (1980) reported that at community level only 50 per cent of mild to moderately depressed elderly patients are recognised as so by their general practitioner. An Irish study reported various factors that may contribute to the under-diagnosis by general practitioners of depression in the elderly (Lawlor 1995). Especially at the milder end of the spectrum, factors such as medical illness, bereavement and somatisation (i.e., the presentation of physical complaints as depression) can make it very difficult to successfully diagnose depression. It is somatisation in particular that tends to obscure depression from the general practitioner.

Even when depression has been identified, less than 20 per cent of older people are prescribed a specific treatment (anti-depressants or psychotherapy). MacDonald (1986, UK) found that general practitioners missed only a small number of cases of depression in patients over 65, but more importantly, they intervened or gave treatment in only 10 per cent of these patients. Tylee and Katona (1996) suggest that possible reasons for this gap between the recognition and treatment of depression in older patients may be due to 'erroneous and ageist beliefs' that depression is understandable in old age, that older people are too frail to tolerate physical treatments, or general practitioners may feel lacking in experience in initiating treatment of depression in older patients. It may also be that the roles and expectations of older people make them reluctant to recognise and report psychological symptoms.

2.3 Assessment of depression in older people

The diagnosis and management of mental health problems is facilitated by a thorough assessment of the individual. This can be carried out initially by the general practitioner who may then refer the individual on to the psychiatric services. Alternatively, an older

person may come into contact with the specialist services following a crisis. While the assessment carried out on any new referral to the psychiatric services does not necessarily differ across varying age groups, there are particular issues that are important to the assessment of depression in particular, and mental illness in general, among older people. The environment or living conditions of the older person can have an impact on their mental health and so it is very useful for the initial assessment to be carried out in the person's own home. This also presents the opportunity of interviewing the carer or relatives of the elderly person who can provide a collateral account of the problem. *Planning for the Future* (1984) recommended that, "Consideration should be given to the many possibilities for assessing elderly persons. These include assessment at primary care level, at out-patient clinics, domiciliary assessment by a member of the psychiatric team and assessment in the general hospital" (p. 89), although it was noted that domiciliary assessment was preferable.

Because of the prevalence of physical illnesses in this population, it is also important that a complete physical examination be carried out. Symptoms of depression can be among the initial presenting symptoms of physical illness or conversely, the presence of physical conditions can themselves cause depressive symptoms. Physical problems can also influence the outcome or prognosis of depression (Freyne and Wrigley 1995). Busse (1973) lists specific modifications to the diagnostic or assessment procedures that take account of the special needs of elderly persons, including the use of active enquiry, the slow pacing of interviewing, paying attention to non-verbal communication and the evaluation of activities of daily living.

2.4 The incidence of depression in older Irish people

Almost all the epidemiological studies concerning the elderly are prevalence studies. Very few describe the incidence of mental disorders in this group and there are no Irish incidence studies.

However, there is information available from the case registers and data from the NPIRS, which represents new cases of depression as they come into contact with the specialist services.

Table 2.1 shows the one year incidence of depression classified by age and gender from the Three County Case Register (TCCR), obtained from an average of five years¹. The incidence rate of depression per 10,000 total population is 9.9. The rate for those aged 65 and over is slightly higher at 10.1. The age group 65-69 has the highest rates among the over-65s as a whole. The rate is higher for females than for males in all age groups.

Table 2.1: Incidence of depression by age group and gender. One year average: Westmeath and Roscommon. Rates per 10,000 population.

	Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	7.9	17.7	15.5	9.8	2.4	4.7	8.0	7.9
Female	12.0	20.8	16.6	23.5	14.9	13.3	12.0	12.0
Total cases	90	10	7	6	2	1	26	116
Rate	9.9	19.3	16.0	17.1	9.4	10.2	10.1	9.9

Source: TCCR 1989-1993.

The incidence of depression in West Dublin is very similar to that in the TCCR area, for the total population and for those over 65 years (Table 2.2). The rate is highest in the 75-79 age group and interestingly, while the rate for females is higher than that for males in the under-65s, in those over 65 this is reversed and the rate is higher for males. The number of cases of depression in those over 65 from the two case registers is quite small and care must be taken when extrapolating from them. However, the rate from the two areas is remarkably similar.

¹ Because the numbers of new cases in the age groups each year are quite small there can be large variations from year to year. Using an average of the figures over five years helps to 'smooth out' these variations.

Table 2.2: Incidence of depression by age group and gender. One year average. West Dublin. Rates per 10,000 population.

	Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	5.9	10.9	12.5	11.5	2.9	19.3	11.1	6.3
Female	12.2	9.6	8.6	12.1	8.3	6.2	9.4	12.0
Total cases	214	7	5	4	1	1	18	232
Rate	9.1	10.2	10.2	11.9	6.5	9.4	10.0	9.3

Source: St. Loman's Dublin, Psychiatric Case Register 1989-1993.

An examination of the first contact referrals to the North Dublin Psychiatry of Old Age Service in one year revealed 61 cases with depression, a rate of 22 per 10,000.

All first admissions to psychiatric facilities are recorded as such on the NPIRS, although this does rely on the accuracy of recording at local level. The first admission rate for patients over 65 years for depression was almost twice that for the rest of the population in 1994 (see Table 2.3) indicating that the risk of first-time hospitalisation for people over 65 with depression is much higher than for those under 65 years.

The overall rate of admissions for depression for those over 65 years declined from 13.5 to 11.5 over the 10 years from 1984 to 1994 (Table 2.3). The largest drop was in the 65-69 age group, from 15.6 to 10.1 first admissions per 10,000. Those aged 75 years or more showed a slight increase in the rate of admissions however, with the largest increase in those aged 85 years or more. The rate for people aged less than 65 years decreased from 6.7 to 5.1.

Table 2.3: First admissions to psychiatric hospitals and units for depression by age group. 1984 and 1994. Numbers and rates per 10,000 population.

	Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
1984								
Number	2,050	209	163	71	43	13	499	2,549
Rate	6.7	15.6	15.8	10.4	10.6	5.7	13.5	7.4
1994								
Number	1,600	132	136	113	57	27	465	2,065
Rate	5.1	10.1	12.4	13.4	11.6	9.2	11.5	5.9

Source: NPIRS 1984 and 1994.

2.5 The prevalence of depression in older Irish people

2.5.1 Depression in the community

An important Irish study of mental disorders in older people has been carried out recently in Dublin (Lawlor *et al.* 1994). This study examined 450 elderly community dwelling people selected from a general practitioner practice list and used AGE CAT (Copeland *et al.* 1987a) to diagnose a variety of psychiatric conditions. AGE CAT is a computerised diagnostic system with well established reliability and validity. This study found that 13.1 per cent of people over 65 in this urban community had a diagnosable depression. The inclusion of 'subcases' of depression, that is, those individuals who had a variety of depressive symptoms but who would not be diagnosed as having depression, showed that a further 9.7 per cent of elderly people in this community had depressive symptoms. A combination of cases and subcases showed that at any one time 22.6 per cent or more than one in five of the elderly people in this urban community suffered from depression to varying extents. The picture was slightly different for the sexes and for different age groups (see Table 2.4). Overall, there were slightly more men with depression than women (13.7 per cent versus 12.8 per cent). This is contrary to most of the reported literature on depression which generally shows an excess of females

over males (Bebbington *et al.* 1981). The distribution in this study might reflect characteristics specific to this sample. The highest rate for women was in the age group 65-69, where a substantial 39.4 per cent had significant depression. Although the numbers were small, the lowest rate for both sexes was in the 80-84 year group and overall there was no evidence of an increase in the prevalence of depression with age.

Table 2.4: AGECAT cases of depression in Irish community dwelling elderly by age group and gender. Numbers and percentages.

Age (years)	Male		Female		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
65-69	5	11.1	13	39.4	18	14.1
70-74	6	17.1	14	15.4	20	15.9
75-79	6	18.1	8	12.7	14	14.7
80-84	1	7.7	6	11.1	7	10.4
Total over 65	18	13.7	41	12.8	59	13.1

Source: Lawlor *et al.* 1994.

A study of 617 people over 64 years on the General Medical Services list in the South Eastern Health Board (1996) used the Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983) to determine levels of anxiety and depression. Nine per cent of this sample had a positive score for depression (10 per cent of men and eight per cent of women). One-fifth of those who had a positive score for depression/ anxiety had received treatment for these conditions from their general practitioner in the previous four weeks.

2.5.2 Depression in the psychiatric services

Table 2.5 shows a prevalence rate of depression of 79.3 per 10,000 population over 65 years as measured by the TCCR. This is higher than the rate for those under 65 years (53.5). The rates for females in

both age groups were higher than for males. In those over 65 years, females had more than twice the rate of depression compared with males (106.1 for females versus 49.2 for males).

Table 2.5: Prevalence of depressive disorder by age group and gender. 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	240	38	278
	Rate	46.5	49.2	46.9
Female	Number	298	92	390
	Rate	61.0	106.1	67.8
Total	Number	538	130	668
	Rate	53.5	79.3	57.2

Source: TCCR 1993.

2.5.3 Depression in psychiatric in-patients

In 1994 there were 26,687 admissions to Irish in-patient psychiatric facilities. People aged 65 years and over constituted 15.7 per cent of all admissions. The diagnostic category depression accounted for 7,149 of all admissions, and those over 65 made up 26 per cent of this group. Table 2.6 shows the numbers of admissions and rates per 10,000 population for selected age groups for the years 1984 and 1994. These figures show that the rate of admission for those aged over 65 years is consistently over twice that for the admissions for all ages. The rate for the under 65 group is consistently lower than the rate of the population as a whole. Thus, the elderly are at much greater risk of admission for depression than younger people. Examining the admissions for those over 65 in 1994 in more detail shows that the highest admission rate is for those aged 70-74 years at more than two and a half times the national admission rate. The lowest is for those aged 85 years and over. The admission rates for most age groups are lower in 1994 compared to 1984, the largest

reduction being seen in the 75-79 age group. However, admission rates for those aged 80-84 years and 85 years or more have increased.

Table 2.6: All admissions to psychiatric hospitals and units for depression by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
1984	Number	6,114	750	652	286	122	27	1,837	7,951
	Rate	20.0	56.0	63.2	70.7	30.2	11.8	49.8	23.1
1994	Number	5,320	613	582	402	164	68	1,829	7,149
	Rate	17.0	46.9	53.2	47.8	33.3	23.1	45.4	20.3

Source: NPIRS 1984 and 1994.

The 1994 admission figures are examined in greater detail in the tables below. Table 2.7 shows the numbers and rates of all admissions for depression by age and marital status.

Table 2.7: All admissions to psychiatric hospitals and units for depression by age group and marital status. 1994. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Single	Number	2,237	183	157	116	42	28	526	2,763
	Rate	12.0	67.0	66.3	62.8	36.9	40.4	59.9	14.1
Married	Number	2,396	221	229	116	47	10	623	3,019
	Rate	20.7	29.9	44.7	37.3	35.7	21.7	36.6	22.7
Widowed	Number	250	182	185	165	71	29	632	882
	Rate	53.7	61.5	53.8	47.8	28.8	16.2	44.8	47.0

Source: NPIRS 1994.

Single people aged 65 and over consistently had higher admission rates than either married or widowed people. This is somewhat at variance with the admissions for the under 65 group and with the

picture nationally, which shows by far the highest rates of admission for widowed people.

The picture for all admissions classified by gender (Table 2.8) shows the pattern that has been seen nationally for many years (Keogh and Walsh 1995), where women have a much higher rate of admission than men. This pattern is maintained for women over 65 years for each of the five year age groups.

Table 2.8: All admissions to psychiatric hospitals and units for depression by age group and gender. 1994. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	Number	2,264	222	178	128	45	13	586	2,850
	Rate	20.6	36.4	36.2	35.8	23.7	14.6	33.7	22.4
Female	Number	3,056	391	404	274	119	55	1,243	4,299
	Rate	28.2	56.0	67.2	56.7	39.2	26.8	53.8	37.2

Source: NPIRS 1994.

2.5.4 Depression in other institutional settings

The prevalence studies referred to above, which have been carried out in different settings, from the community to psychiatric hospitals, necessarily exclude the small proportion (approximately five per cent) of older people who are in nursing homes or other long-stay care facilities. O'Neill *et al.* (1991) carried out a study on residents in a sample of nursing homes and found that 30 per cent of these nursing home residents had a positive depression score on the Geriatric Depression Scale, and that 16 per cent of residents rated as positive for both cognitive impairment and depression. More detail on the prevalence of mental disorders in long-stay care settings is provided in Chapter Eleven of this report.

2.6 International data on the incidence of depression

Table 2.9 presents a summary of three incidence studies for depressive symptoms in the elderly. Phifer and Murrell (1986) surveyed 1,233 community dwelling subjects aged 55 years and older and reported a six month incident rate of 5.4 per cent. Kennedy *et al.* (1990) reported a 24 month incident rate of 11 per cent in their sample of 1,457 community dwelling subjects aged 65 and over. Callahan *et al.* (1994) found an incidence rate of 11.7 per cent among primary care attenders. There is a degree of consistency in the incident rates reported with the 12 month incident rate for depressive symptoms being around 10-11 per cent. This would represent the milder type of depressive disorder which would probably be short lived and remit without much intervention. The incidence rate for 'cases' of depression or clinical depression is much lower. The ECA studies² from the US reported an incidence rate of major depression for patients aged 65 and older of just under one per cent (Van Marwijk *et al.* 1994). There are no comparable Irish data on the rate of new cases of depression among older people in the community.

Table 2.9: International studies of the incidence of depressive symptoms in those aged over 65.

Study	Sample size	Incidence rate (%)
Phifer and Murrell (1986) 6-month incidence	1,233	5.4
Kennedy <i>et al.</i> (1990) 24-month incidence	1,457	11.0
Callahan <i>et al.</i> (1994) 9-month incidence	1,171	11.7

The incidence rate of depression in Denmark, as measured by contacts with the psychiatric services, is lower than the rates from the Irish case registers (5.9 per 10,000 compared to 10.0 in West Dublin and 10.1 in the TCCR area). However, the difference between the

² The 'Epidemiological Catchment Area' (ECA) studies were a series of large scale surveys which covered over 17,000 community residents in five US sites.

under and over 65 age groups is larger in Denmark, with the rate for those over 65 (5.9) being three times that for those under 65 years (1.8).

Table 2.10: Incidence of depression in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	Number	324	43	35	22	21	5	126	450
	Rate	1.5	4.0	3.8	3.4	5.0	2.1	3.8	5.3
Female	Number	471	81	94	82	60	31	348	819
	Rate	2.2	6.6	8.0	8.6	8.0	5.1	7.4	9.6
Total	Number	795	124	129	104	81	36	474	1,269
	Rate	1.8	5.4	6.2	6.5	4.2	4.2	5.9	2.4

Source: Danish Case Register 1993.

2.7 International data on the prevalence of depression

2.7.1 Depression in the community

Many studies have been carried out examining the prevalence of depression in the adult population but unfortunately many specifically exclude those over 65 years. For example, a major survey recently carried out in the UK to estimate the prevalence of psychiatric morbidity, included over 12,000 adults aged 16 to 64 years (Meltzer *et al.* 1995). Those aged under 16 years and over 65 years were excluded because a survey of these groups "would require specialised sampling, interviewing and assessment procedures" (p. 2). General population studies have used a variety of measures to estimate prevalence and have examined rates of depressive symptoms, depressive disorder and major depression, all of which result in different rates for depression in the community. In this section, studies using similar methodology and diagnostic criteria have been selected and examined in order to identify patterns and trends. A series of studies has used AGE CAT (Copeland *et al.* 1987a) as a

diagnostic measure of depression. Using AGECAT Copeland *et al.* found a prevalence rate of cases of 11.2 per cent in their study in Liverpool, with a total rate of depressive symptoms of 22.0 per cent and found very similar rates in their follow-up study three years later (1992). Lobo *et al.* (1995) in a study of 1,080 elderly people in Spain found a prevalence rate of 9.1 per cent at the case level and 10.5 per cent at the subcase level. These studies compare to the rate in the Irish study (Lawlor *et al.* 1994) which reported rates of 9.7 per cent of cases of depression and a subcase level of 12.9 per cent.

Studies using very strict diagnostic criteria have found low rates of depression in the elderly. A surprising finding from the ECA studies in the US was that the lifetime rate of any disorder declined with age, with lower rates being found among elderly people. This pattern of decreasing lifetime rate was particularly pronounced for affective disorders (depression). For men and women respectively, the lifetime rates were six per cent and 11 per cent for 18-29 year olds, seven per cent and 15 per cent for those aged 30-44 and thereafter declined to four per cent and nine per cent in the 45-64 age group and two per cent and three per cent for those aged over 65 years (Weissman *et al.* 1991). These results were found across the five study sites. The ECA studies used very strict diagnostic criteria which probably accounts for the lower prevalence rates reported by this series of studies compared to others using different measures.

2.7.2 *Depression in primary care*

Studies of the general population show that six to 10 per cent of all patients visiting general practitioners for any reason have a major depressive syndrome. However, despite its high prevalence, general practitioners fail to diagnose major depression in their patients up to 50 per cent of the time (Zung *et al.* 1993). One of the larger studies carried out on general practitioner attenders was designed to estimate the prevalence of depressive symptoms in a consecutive series of

primary care users across the US (Zung *et al.* 1993). The overall prevalence of clinically significant depressive symptoms for all ages reported was 20.9 per cent. The prevalence of moderate to severe depressive symptoms in those aged 65 years and over was 13.9 per cent (Table 2.11).

Table 2.11: Prevalence of depression among primary care users aged over 65 years.

Study	Sample size	Prevalence of major depression
Callahan <i>et al.</i> (1994): CES-D Scale	1,171	17.1
Van Marwijk <i>et al.</i> (1994): GDS Cut-Off (11) and Zung Self-Rating	384	21 17
Zung <i>et al.</i> (1993): Zung Self-Rating	10,027	13.9
Turrina <i>et al.</i> (1994): DSM	255	22.4

The highest prevalence rate of major depression for this setting, 22.4 per cent, was that identified by Turrina *et al.* (1994) in Italy which the authors believed may have been due to good performance by general practitioners in identifying illness.

2.7.3 Depression in the psychiatric services

Table 2.12: Prevalence of depression in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	Number	1,639	218	176	110	61	20	585	2,224
	Rate	7.3	20.4	19.1	16.9	14.5	8.2	17.7	25.0
Female	Number	3,173	509	551	475	265	127	1,927	5,100
	Rate	14.7	41.5	47.0	49.9	35.5	20.8	41.0	55.6
Total	Number	4,812	727	727	585	326	147	2,512	7,324
	Rate	10.9	31.7	34.8	36.5	27.9	17.2	31.4	14.1

Source: Danish Case Register 1993.

The prevalence rate of depression in Denmark as measured by all contacts with the psychiatric services is 31.4 per 10,000 (see Table 2.12) for those over 65, which is lower than that from the Irish case register (79.3 per 10,000, see Table 2.5). The same pattern of higher rates in females than males is seen in data from the Irish and Danish case registers.

2.8 Mania

Mania is a mood or affective disorder. Affective disorders concern abnormalities of mood, the most familiar being depression which is essentially a sustained lowering of mood.

Mania, on the other hand, is a persistent elevation of mood associated with mental and physical overactivity. Full-blown mania is not seen very commonly as help is usually sought and treatment started before it can develop. Hypomania, is similar to, but not as severe as a manic episode. Sometimes an individual has a combination of manic episodes and depressive episodes. This is known as bipolar affective disorder.

People with mania or hypomania have an abundance of energy and this is made evident by racing thoughts, their speech which is often rapid and 'non-stop' and their decreased need for sleep. Sometimes inappropriate or disinhibited behaviour is observed, especially in social interactions or sexual behaviour. The affected individual can indulge in spending sprees, for example buying three or four cars or ordering expensive items and equipment that can never be paid for. Because of this type of behaviour, people with mania or hypomania are at considerable risk and can cause great distress to their families. However, this condition can be treated using a drug called lithium which is effective in most patients (Chou *et al.* 1993). If patients are maintained on lithium this can also prevent a recurrence of manic episodes. Because lithium can take some days to take effect and

symptoms may be quite severe, other drugs are often used in combination with lithium to good effect to produce more rapid symptom remission. Hospitalisation is almost always required for someone who is manic but because of the nature of the condition, the individual will often refuse this. In these cases, involuntary detention is required. In Ireland in 1994, mania accounted for 18 per cent of all involuntary admissions (Keogh and Walsh 1995).

2.9 Mania in late life

Mania, like depression, can occur at any stage in life. People over 65 years who present with mania may be experiencing their first manic episode with no history of depression or bipolar disorder, or they may have had previous episodes of depression which are now being followed by a manic episode. There is some evidence that mania manifests differently in later life, and that these cases may be relatively mild (Slater and Roth 1977). These authors, reporting from clinical experience, noted that euphoria in older manic patients usually did not have the 'infectious' quality seen in younger patients, and that hostility and resentment were notable features. Perhaps not surprisingly, the agitation and excessive behaviours seen in younger patients are not often seen in older patients with mania (Young and Falk 1989). There is also further evidence from a more recent prospective study of mania in old age (Broadhead and Jacoby 1990), that mania is milder in older patients.

Important symptoms in older patients are disorientation and delirium (Slater and Roth 1977). Some studies have also reported evidence of cognitive dysfunction in older patients with mania (Young and Jain 1988) and some association has been noted between first presentation of mania in late life and cerebral disorder (Stone 1989). There has been very little reported on relapse of mania in older patients. Young and Jain (1988) noted that over 2-3 years, 58 per cent of the bipolar patients over 65 years in their sample required re-hospitalisation.

While lithium is also the treatment of choice for mania in late life, a significant concern in this group is the toxicity of lithium. In patients of any age, lithium can accumulate in the blood and cause damage to organs such as the kidneys. For this reason all patients taking lithium have regular blood tests to monitor their lithium levels. However, older patients metabolise drugs differently than younger patients and particular care has to be taken with a drug as potentially toxic as lithium.

2.10 Mania in older Irish people

2.10.1 Incidence

Table 2.13 shows a very low incidence of mania in those over 65 in the TCCR area.

Table 2.13: Incidence of mania by age group and gender. One year average. Westmeath and Roscommon. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	1.2	0.4	1.4	0.5	1.1
Female	0.6	0.8	0.0	0.3	0.5
Total cases	8	<1	<1	1	9
Rates	0.9	0.6	0.6	0.4	0.8

Source: TCCR 1989-1993.

Table 2.14: Incidence of mania by age group and gender. One year average. West Dublin. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	0.5	1.5	0.0	1.1	0.6
Female	0.7	0.9	1.7	1.2	0.8
Total cases	15	1	<1	2	17
Rates	0.6	1.1	1.1	1.1	0.7

Source: St. Loman's Dublin, Psychiatric Case Register 1989-1993.

Table 2.14 shows that the West Dublin case register has also recorded a very low incidence rate with only two cases of mania in those aged 65 years or more.

Table 2.15 shows figures for first admissions to psychiatric in-patient facilities for mania for the years 1984 and 1994. In 1984 the figures for those over 65 were considerably higher than those for the under-65s. This pattern has settled somewhat in 1994 with the rate for the under and over 65 groups being very similar. The rate for those over 75 seems high. It is possible that this, and the high rates seen in 1984 are due to diagnostic anomalies.

Table 2.15: First admissions to psychiatric hospitals and units for mania by age group, 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	457	64	30	94	551
	Rate	1.5	2.7	2.3	2.6	1.6
1994	Number	458	40	18	58	516
	Rate	1.5	1.7	2.3	1.4	1.5

Source: NPIRS 1984 and 1994.

2.10.2 Prevalence

No cases of mania in those in the community over 65 years were found in the only prevalence study carried out in Ireland (Lawlor *et al.* 1994). Once again, we must rely on data concerning contacts with the psychiatric services, both case registers and admissions to psychiatric in-patient facilities, in order to obtain some estimate of the number of individuals over 65 who might be affected.

Although the numbers according to the TCCR are small (44 cases among those over 65) the rate per 10,000 population of contacts with the psychiatric services for mania was higher in the over-65s compared to the under-65s (Table 2.16).

Table 2.16: Prevalence of mania by age group and gender. 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	51	21	72
	Rate	9.9	27.2	12.1
Female	Number	54	23	77
	Rate	11.0	26.5	13.4
Total	Number	105	44	149
	Rate	10.5	26.8	12.8

Source: TCCR 1993.

The rate of all admissions to psychiatric facilities is also higher in the over-65s, although this rate has decreased in 1994 compared to 1984, while the rate in those under 65 years has increased in the same period (Table 2.17). It seems that older patients with mania (and the behaviour problems that can be associated with mania) are not being admitted to psychiatric hospitals as often as before.

Table 2.17: All admissions to psychiatric hospitals and units for mania by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	1,968	374	108	482	2,450
	Rate	6.4	15.8	8.2	13.1	71.1
1994	Number	2,329	297	103	400	2,729
	Rate	7.5	12.4	6.3	9.9	7.7

Source: NPIRS 1984 and 1994.

2.11 International data on mania

2.11.1 Incidence

There is limited international information regarding the incidence of mania in late life. The only studies available concern 'treated populations' that is, those in contact with the psychiatric services.

Some studies (Clayton 1981 and 1986) conclude that the risk of mania declines, or at least does not increase with age. However, others (Eagles and Whalley 1985) have reported a gradual increase with age in first admissions of manic patients to psychiatric hospitals in Scotland. This increase was sustained past the age of 70. The first contact rates from Denmark (Table 2.18) show similar rates across age groups.

Table 2.18: Incidence of mania in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	42	7	6	13	55
	Rate	0.2	0.4	0.5	0.4	0.6
Female	Number	50	7	7	14	64
	Rate	0.2	0.3	0.3	0.3	0.5
Total	Number	92	14	13	27	119
	Rate	0.2	0.3	0.4	0.3	0.2

Source: Danish Case Register 1993.

Data from the two Irish case registers and from the NPIRS also show little difference between those over and under 65 years, although the numbers are very small. In the light of contradictory evidence from international studies and the Irish data available, it seems the only conclusion to be drawn for the moment is that the incidence of mania in late life is low at less than one case in 10,000.

2.11.2 Prevalence

Prevalence data for mania in late life reflect both patients with recurrent early life illness and patients with late onset illness. Fogarty *et al.* (1994) in a prevalence study of mental illness in the community found no cases of mania in those over 65. Lawlor *et al.* (1994) in their study in Dublin also reported no cases of mania in those over 65 in the community.

Prevalence studies from samples in contact with the psychiatric services report rates of 4.9 per cent (Yassa *et al.* 1988 a,b) to six per cent (Roth 1955). Data from the Danish case register report low prevalence rates of less than one per cent in those over 65 (Table 2.19). Comparable Irish rates from the TCCR and NPIRS suggest rates of 0.3 per cent for those in contact with psychiatric services and an all admission rate of 0.1 per cent for those over 65.

Table 2.19: Prevalence of mania in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	460	65	24	89	549
	Rate	2.1	3.3	1.8	2.7	4.8
Female	Number	700	87	36	123	823
	Rate	3.2	3.6	1.6	2.6	5.9
Total	Number	1,160	152	60	212	1,372
	Rate	2.6	3.5	1.7	2.6	2.6

Source: Danish Case Register 1993.

2.12 Summary

2.12.1 Depression

Irish data on the incidence of depression based on contacts with the psychiatric services is very consistent, with rates of around 10 per 10,000 from the two case registers and a first admission rate of 11.4 per 10,000 from the NPIRS. This would suggest approximately 400 new cases of depression in people over 65 years coming into contact with the psychiatric services annually. However, data from the North Dublin Psychiatry of Old Age Service recorded 60 first contacts with their service for depression in 1994, approximately double the rate from the two case registers. Thus, relying on contact data from the generic psychiatric services alone probably yields an underestimate of the number of new cases of depression that a psychiatry of old age service might see. This highlights the previously mentioned difficulty

of using service utilisation figures. The specialist service caters specifically for those over 65 years and sees approximately twice as many new cases of depression as the generic adult psychiatric service. The different figures are not indicative of a different incidence of depression but rather the different availability and accessibility of these services.

Incidence rates from international studies of older people in the community report rates of one per cent for severe depression and 10 per cent for milder depression or depressive symptoms. The figures from the case register would suggest that only one-tenth of new cases of depression come into contact with the psychiatric services. There is no information currently available to indicate if the remainder are treated by their general practitioners or if they remain untreated.

The easiest way to summarise the Irish data on the prevalence of depression in those over 65 is to draw on the Goldberg and Huxley model described in Chapter One of this report. Table 2.20 below shows the available Irish data and the extrapolated numbers based on the total population over 65.

Table 2.20: Estimates of the prevalence of depression in those over 65 from Irish data. 1994.

Level	Irish data	Extrapolated to total population over 65
Level 1: The community	1,310 per 10,000	52,793
Levels 2 and 3 : General practitioner attenders	900 per 10,000	36,270
Level 4: Psychiatric services	79 per 10,000	3,184
Level 5: Psychiatric hospitals	45 per 10,000	1,814

The hierarchical nature of detected depression is seen quite clearly with most cases found in the community and fewest being admitted to

hospital. Residents of other institutions are not included in this model, although an Irish study on nursing home residents suggests that 30 per cent have some level of depression.

Data from international studies report very similar rates of depression at the community level and approximately 14-18 per cent of general practitioner attenders with depressive symptoms. The Danish rate of 31 per 10,000 older people in contact with the psychiatric services for depression is less than half the Irish rate and may reflect different patterns of service use in the two countries.

The rate of both first and all admissions to psychiatric in-patient facilities has decreased in the 10 years 1984 to 1994, by as much as 22 per cent for first admissions. While some of the new cases of depression may have been diverted into the psychiatry of old age services, only two were in operation at the time of writing and only account for a small proportion of cases. We have no reliable information on where the one-fifth of new cases of depression in the over-65s, who are not being admitted to hospital, are now being treated. Some may be transferred to nursing homes or other residential facilities if long-term care is required.

2.12.2 Mania

The numbers of new cases of mania in people over 65 in Ireland are quite small, approximately one in 10,000, which would result in about 40 new cases of mania in contact with the psychiatric services in any one year. The prevalence of mania in late life, as estimated from psychiatric service contact data, shows approximately 1,000 people over 65 with this diagnosis, with about 400 admissions to psychiatric hospitals in any one year. The international data on mania in late life are also sparse but the Irish numbers are largely in keeping with estimates from international sources.

CHAPTER THREE

Dementia

Unlike depression which can occur at any time in life, dementia is predominantly a disorder of later life with its prevalence and incidence rising sharply with advancing age. 'Dementia' is a term used to describe a group of organic, or physically based, mental disorders which produce the dementia syndrome in older adults. The term 'syndrome' here refers to a group of signs and symptoms that cluster without a specific known causative disorder. Most dementias have an insidious or gradual onset and become progressively worse over time. The dementia syndrome is due to a disease of the brain, usually of a chronic or progressive nature, in which there is disturbance of several brain functions, including memory, thinking, comprehension, orientation, language and judgement. These types of disturbances are collectively known as cognitive impairments and are usually accompanied by deterioration in emotional control and social behaviour.

One of the symptoms which is probably the first to be noticed is deterioration in memory. This is not the occasional difficulty in remembering names that is sometimes noticed with increasing age, but the inability to remember the names of common everyday items, the day of the week or month of the year, and even, in later stages, the names of family and loved ones. This forgetfulness can be potentially very dangerous, as in cases where gas might be left on or a fire left untended. However, dementia does not just involve severe memory impairment. Other symptoms that can be causes of concern for carers are wandering (especially at night), and neglect of personal hygiene or diet. Explosive outbursts of emotion can also be common. Dementia can result in a previously able and independent individual becoming totally dependent, and this can have huge implications for

family members who have become carers. Dementia can also bring about changes in the individual that feel like a loss to the family, such as failure to recognise them or remember the life they shared, and perhaps this is the most distressing result of dementia.

Of the 70 or more causes of dementia, the most common by far is Alzheimer's Disease, which accounts for 50-60 per cent of all cases in those over 65 years. While Alzheimer's Disease and other dementias can occur in those under 65, it is uncommon and the vast majority occur in those over 65. The other common form of dementia is multi-infarct dementia, resulting from infarction of the brain due to vascular disease. This is when a series of minor strokes in the brain, which individually may not be very disabling to the individual, can lead to a build-up of damage in the brain that results in a dementia syndrome. Multi-infarct dementia accounts for another 20 per cent of cases of dementia. Dementia can also occur in a number of illnesses including Parkinson's Disease, Lewy Body Disease, Creutzfeldt Jakob's Disease and Huntingdon's Disease. The cognitive disorder associated with chronic alcoholism is also a type of dementia (Lishman 1981).

Alzheimer's Disease and vascular dementia constitute the majority of cases of dementia. However, in many studies estimating the incidence or prevalence of dementia, no distinction is made between these different types. In the remainder of this chapter the collective term 'dementia' will be used.

3.1 Why is dementia important?

The prevalence of dementia is high, affecting approximately five per cent of those over 65. Prevalence increases with age, five per cent of people aged 65-69 having dementia compared to about 20 per cent of those aged over 80. The population of Ireland is ageing, with a 29.5 per cent increase in the number of people over 65 predicted between

1991 and 2011. Thus the number of people in Ireland over 65 will increase from the current figure of 402,900 to over a half a million (521,700). Even more importantly, the number of 'old elderly' (those aged 80 and over) is expected to increase by roughly two-thirds (Fahey 1995). It is among this group, that the prevalence of dementia is highest (Jorm *et al.* 1987).

A study by the National Council for the Elderly (O'Connor and Ruddle 1988) estimates that over 66,000 older people received some level of care from family members, one-quarter of whom were also aged over 65. Of the carers surveyed, 29 per cent had been caring for more than 10 years; one-third believed that their health had suffered because of caring demands and stresses, and emotional strain was common; over half (57 per cent) reported having felt completely overwhelmed at times because of worry or concern for the older person. Increases in the older population, and the resultant large numbers of people affected by dementia, will have important implications for the provision of care, particularly that provided by carers in the home. A comprehensive range of support services is required to facilitate care in the home. O'Connor and Ruddle (1988) recommended improvements and expansion of many services, including respite care, home help services, day care services and the provision of information and counselling for carers.

The projected increase in the older population, coupled with the high prevalence of a disabling mental disorder in this group has important implications for health services, particularly for the provision of long-stay care. There is little information on the financial implications of this, although a recent study estimated that the costs of Alzheimer's Disease in England were in excess of St£1 billion per annum (Fenn and Gray 1993). The average projected increase in health expenditure over the next 50 years is 30 per cent, of which 20 per cent will be used in the care of the elderly. As this is an average

figure, those countries with a greater proportion of people over 65 will see greater increases (OECD 1987).

3.2 Diagnosis and assessment

A detailed examination of a patient with suspected dementia is required as there are no specific diagnostic tests to enable a clinician to make a diagnosis of dementia. It is also important to interview an 'informant' or close relative whenever possible to provide evidence of deterioration in cognitive functioning as this is a central feature of the diagnosis of dementia. Clinical diagnosis can be supplemented through the use of scales such as the Mini-Mental State Examination (MMSE; Folstein *et al.* 1975) or the Clifton Assessment Procedure for the Elderly (CAPE; Pattie and Gilleard 1979). Numerous psychometric tests can also be used to assess the degree of cognitive impairment or disturbance. Scales such as the Hachinski Scale (Hachinski *et al.* 1975) can be used to assist in the further classification of the dementia into Alzheimer's Disease or multi-infarct dementia.

The diagnosis of Alzheimer's Disease is generally a 'diagnosis of exclusion'; that is, when other possibilities are firmly ruled out the likelihood is that the patient is suffering from Alzheimer's Disease. The diagnostic process for dementia usually begins with the observation of poor cognitive performance or some type of cognitive disturbance. Recent-onset cases are further considered as possible cases of dementia. The cognitive disturbance can be due to a number of causes, and alternatives such as delirium or depression have to be ruled out. The diagnostic process can then continue to classify further the type of dementia involved.

A further difficulty in diagnosing dementia is the co-occurrence of other disorders such as depression and anxiety. Depression occurs in about 25 per cent of dementia sufferers (Grob 1993). It is important

that its presence be noted as it can respond well to anti-depressant therapy (Hebenstreit *et al.* 1991). Wands *et al.* (1990) found that 16 per cent of dementia sufferers in their sample had definite anxiety and 22 per cent had possible anxiety. These co-existing complaints can make the dementia appear worse than it is but they are also amenable to treatment and will usually resolve if treatment is given. Accurate identification and diagnosis of cases is important so that a treatment and care plan can be initiated which will be most suited to the needs of the individual.

3.3 Does the prevalence of dementia increase with age?

The observation that the prevalence of dementia increases with age has led to a discussion as to whether dementia is 'age related', that is a disease distinct from the normal process of ageing that occurs within a specific age range, rather than an 'ageing related' disorder that is caused by the ageing process itself. Huppert and Brayne (1994) propose that there is a continuum, with 'normal ageing' at one extreme, moving through gradations of cognitive disturbance, through to dementia at the other extreme.

Three important meta-analyses (studies which provide a synthesis of the results from a number of previous studies) of the prevalence of dementia have been carried out which address the link between ageing and dementia. Firstly, Jorm *et al.* 1987 showed that the prevalence of dementia did indeed increase with age and that the effect of age was consistent with a doubling of prevalence every five years. Using the available data Jorm *et al.* predicted a prevalence rate for dementia of 62 per cent at the age of 95. One problem with this analysis is that very few of the studies included had data for people aged over 80. Thus, estimates of the prevalence of dementia in the very old were projections from the lower ages on the assumption that earlier trends would continue. The second study (Ritchie *et al.* 1992) showed somewhat different results. A similar relationship between

age and prevalence was seen as that in other studies, with the rate doubling every six years from age 60. However, at higher ages the prevalence of dementia seemed to level off, especially over age 85, such that the prevalence of dementia at age 95 in this study was reported as 39 per cent. However this study also suffered from having too few numbers in the over 80 age group. In order to clarify some of the contradictions between these two studies the final meta-analysis concentrated on the prevalence of dementia in the 'oldest old' (Ritchie and Kildea 1995). This study confirmed that the prevalence rate of dementia does increase exponentially with age to begin with, but that the rate of increase falls from around 80-84 years. Thus the prevalence rate of dementia at age 95 reported in this study was 40 per cent. The prediction that everyone will have dementia if they live long enough is not borne out by this study.

This debate is not just a theoretical discussion of statistics. As we have already noted, the outcome of this discussion has several important public health implications in terms of health service provision for this group. Thus, an estimate of 40 per cent of this group of very old requiring care versus 62 per cent is quite considerable. Also, research into dementia may take a very different course if it is viewed as ageing related (i.e., inevitable with greater age) than if it is viewed as age related (i.e., a pathological or disease process with a specific age range being at highest risk).

3.4 The incidence of dementia in older Irish people

There is no information on the incidence of dementia at the general community level or at the primary care level in Ireland. Any figures obtained from contacts with the psychiatric services are likely to be a significant underestimate of the incidence of dementia as many new cases are referred to geriatric medicine in acute general hospitals and may never come into contact with the psychiatric services. This differs according to the services available in specific areas. For

example, in North Dublin, where a psychiatry of old age service covers a population of 27,000 over 65 years, 177 new cases of dementia were seen in 1994. This is many times greater than the incidence figure from the case registers.

Table 3.1: Incidence of dementia by age group and gender. One year average. Westmeath and Roscommon. Rates per 10,000 population.

	Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	0.2	4.6	3.6	3.7	4.7	0.0	2.4	0.6
Female	0.1	2.2	3.5	6.4	9.3	2.7	2.8	0.7
Total cases	1	2	2	2	1	>1	7	8
Rates	0.1	3.4	3.6	5.1	7.3	1.7	2.6	0.7

Source: TCCR 1989 -1993.

Table 3.1 shows the one year incidence of dementia for Westmeath and Roscommon, which was 2.6 per 10,000 population over 65 years. The incidence was slightly lower for males (2.4) than females (2.8). The incidence for those aged under 65 years was almost zero. For those five year age groups over 65 the Irish rate showed a steady increase, from 3.4 cases per 10,000 in the 65-69 group to 7.3 in the 80 to 84 group. The 85 years and over group showed only 1.7 cases per 10,000. This small number of new cases of dementia in the 'old old' is somewhat at odds with the reports in the literature and may indicate that an increased number of dementia patients are resident in non-psychiatric institutions such as nursing homes (see Chapter Eleven).

A similar incidence rate is seen in the West Dublin case register of 2.0 per 10,000 over 65, and increasing rates with increasing age (Table 3.2).

Table 3.2: Incidence of dementia by age group and gender. One year average. West Dublin. Rates per 10,000 population.

	Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	0.3	0.0	2.9	1.4	5.7	0.0	1.6	0.4
Female	0.1	0.5	2.6	2.6	4.1	4.1	2.2	0.2
Total cases	4	<1	1	1	1	<1	4	8
Rate	0.2	0.3	2.7	2.2	4.7	3.1	2.0	0.3

Source: St. Loman's Dublin, Psychiatric Case Register 1989-1993.

Table 3.3 shows the first admissions to psychiatric in-patient facilities for two years, 1984 and 1994. There has been more than a 50 per cent decrease in first admissions for dementia over the 10 year period. The rate per 10,000 population over 65 was 16.0 in 1984 and 7.2 in 1994, and a similar decrease is seen across all the age groups. This is probably due to policy changes in admission practices recommended in *Planning for the Future* (1984) rather than any reduction in the incidence of dementia. As with the figures from the case register, a clear pattern of increasing incidence with increasing age is seen, from 3.2 per 10,000 in the 65-69 age group to 15 in the 80-84 age group. This is maintained at the same level (15 per 10,000) in the 85 years and over age group.

Table 3.3: First admissions to psychiatric hospitals and units for dementia by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
1984	Number	133	91	146	149	145	60	591	724
	Rate	0.4	6.8	14.2	21.8	35.8	26.1	16.0	2.1
1994	Number	73	42	65	64	74	44	289	362
	Rate	0.2	3.2	6.0	7.6	15.0	15.0	7.2	1.0

Source: NPIRS 1984 and 1994.

A clear pattern of increasing incidence of dementia with increasing age is seen, both in the figures from contacts with psychiatric services and the first admissions to psychiatric hospitals. A crude application of the case register incidence figures to the current population over 65 suggests that approximately 150-200 new cases of dementia will come into contact with the psychiatric services each year. However, as the population ages this will increase, as there is a higher rate of new cases in the older age groups. Also of note is the 55 per cent reduction in first admissions to psychiatric hospitals for dementia.

3.5 The prevalence of dementia in older Irish people

3.5.1 *Dementia in the community*

The study of Lawlor *et al.* (1994) on the prevalence of mental illness at the community level in Ireland, previously discussed in Chapter Two of the report, also reported on the prevalence of dementia. Table 3.4 shows the distribution of cases of dementia diagnosed by AGECAT in a sample of community dwelling people over 65 years.

Table 3.4: AGECAT cases of dementia in Irish community dwelling elderly by age group and gender. Numbers and percentages.

Age (years)	Male		Female		Total	
	Number	Per cent	Number	Per cent	Number	Per cent
65-69	2	4.4	0	0	2	1.6
70-74	1	2.9	5	5.5	6	4.8
75-79	1	3.1	1	1.6	2	2.1
80-84	4	30.8	3	5.6	7	10.4
85-89	0	0	8	32.0	8	25.8
90+	0	0	0	0	0	0
Total over 65	8	6.1	17	5.4	25	5.5

Source: Lawlor *et al.* 1994.

Thus, people in nursing homes or other institutional care were not included. This may account for the slightly unusual distribution of

cases, for example, none in females aged 65-69, and the small number of cases in females aged 75-79. The prevalence of dementia for all those over 65 was higher for males (6.1 per cent) than females (5.4 per cent) with an overall rate of 5.5 per cent. These figures also show a pattern of increasing prevalence with increasing age, with 15.1 per cent of those in the sample aged over 80 years diagnosed as cases of dementia.

3.5.2 *Dementia in primary care*

There is very limited data concerning the prevalence of mental health problems generally in primary care attenders in Ireland, although there are some data on dementia. A study in 1988 (O'Neill *et al.*) screened a random sample of 244 patients over 65 from two general practices for cognitive impairment. The Folstein Mini Mental State Examination (MMSE, Folstein *et al.* 1975), adapted for an Irish population, was used. While a rating of cognitive impairment from the MMSE does not equate with a diagnosis of dementia it is strongly correlated with dementia (Anthony *et al.* 1982). The prevalence of dementia in this group was found to be 16 per cent. Prevalence increased with age, with 43 per cent of those over 80 having positive scores for dementia. More recently the Irish College of General Practitioners (1995) carried out a *Care of the Elderly Study*. All patients over 75 years who took part in this study were given the Abbreviated Mental Test Score. Although this test is not ideal for use with non-hospitalised patients, it is a short test that is useful for general practice assessment of cognitive function. This study found that 28 per cent of general practice attenders over 75 years scored below the cut-off, indicating 'abnormal cognitive functioning'. A further, more detailed testing of the 28 per cent of individuals would be required to determine what, if any, problems they might have. However, the results from both studies suggest that a considerable proportion of general practice attenders over 75 years may have dementia, and this warrants further investigation.

3.5.3 Dementia in the psychiatric services

The prevalence of dementia among attenders at psychiatric services in Westmeath and Roscommon is shown in Table 3.5. The rate in females over 65 years is three times that of males, with the rate for all people over 65 years being 21.4 per 10,000 population.

Table 3.5: Prevalence of dementia by age group and gender. 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	11	8	19
	Rate	2.1	10.4	3.2
Female	Number	10	27	37
	Rate	2.0	31.1	6.4
Total	Number	21	35	56
	Rate	2.1	21.4	4.8

Source: TCCR 1993.

3.5.4 Dementia in psychiatric in-patients

The numbers and rates of all admissions to psychiatric in-patient facilities are shown in Table 3.6. As with the first admission figures in Table 3.3, the prevalence of dementia in psychiatric hospitals has also decreased over the 10 years 1984 to 1994 by approximately 50 per cent. The rate of admissions for dementia in those over 65 years was 27.4 per 10,000 population in 1984 compared to 13.6 in 1994, and this rate increased with age. As previously noted, this probably reflects changes in admission policies rather than a reduction in the prevalence of dementia. *Planning for the Future* (1984) recommended that, "the practice of routinely admitting demented patients to psychiatric hospitals should be discontinued" (p. 89). The substantial decrease in admissions for dementia in the 10 years following publication of this report is probably due to a policy change in admitting such patients.

Table 3.6: All admissions to psychiatric hospitals and units for dementia by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
1984	Number	389	163	299	246	212	91	1,011	1,400
	Rate	1.3	12.3	29.0	35.9	52.4	39.6	27.4	4.1
1994	Number	239	96	129	115	141	65	546	785
	Rate	0.8	7.3	11.8	13.7	28.6	22.1	13.6	2.2

Source: NPIRS 1984 and 1994.

3.5.5 Dementia in other institutional settings

Another Irish study (O'Neill *et al.* 1991) examined over 400 residents in nursing homes and screened for cognitive impairment using the MMSE. The results suggested a 58 per cent prevalence of cognitive impairment among nursing home residents. While the presence of cognitive impairment does not necessarily mean a dementia is present, it is likely to be present in a substantial proportion of cases. This result would suggest a very high prevalence of cognitive impairment and possibly dementia in this population (see Chapter Eleven of the report for more detail).

Two very similar studies were carried out in the Clare (Boland and Hennessy 1993) and Limerick (Clinch and Hickey 1992) catchment areas of the Mid-Western Health Board. All patients over 65 years in all hospitals in the two areas (both acute and continuing care) were assessed using the MMSE. Fifty of the 192 patients in acute hospital (26 per cent) had significant cognitive impairment. Of the 362 patients in continuing care beds, 206 (57 per cent) showed significant cognitive impairment. In total, the prevalence rate of cognitive impairment was 46 per cent in hospitalised patients over 65 years.

3.6 International data on the incidence of dementia

3.6.1 Dementia in the community

There have been few incidence studies of dementia carried out. One of the difficulties is the importance of covering all the people in the desired age group in a particular area, as some may be in institutional care. If they develop dementia in this setting they would be missed by a study that looked solely at those who lived in their own homes in the community. Table 3.7 shows the results of four international incidence studies.

Table 3.7: International incidence rates of dementia by gender in selected older age groups. Percentages.

Study	Age group	Male	Female	Total
<i>Sweden</i> Aevårsson and Skoog 1996, community and residential	85+	6.1	10.3	9.0
<i>New York, US</i> Aronson <i>et al.</i> 1991, community residents	75+	3.0	3.6	3.4
<i>UK</i> Paykel <i>et al.</i> 1994, people on general practitioner lists (including residential)	75+	3.2	4.8	4.3
<i>UK</i> Morgan <i>et al.</i> 1993, people on general practitioner lists (not including residential)	75+ 85+	0.9 0.0	2.1 2.2	1.7 1.7

The problem of excluding those patients in institutional care can be seen in the differing UK rates obtained in the Morgan *et al.* (1993) study compared to the Paykel *et al.* (1994) study (1.7 versus 4.3). The studies do seem to confirm that incidence is higher in older age groups. For the over 65 group as a whole, the incidence of dementia is around 1-1.4 per cent per year (Bordeaux, Dartigues *et al.* 1992; Cambridge, Brayne *et al.* 1992; Liverpool, Copeland *et al.* 1992; Nottingham, Morgan *et al.* 1993). As there are no Irish studies concerning the incidence of dementia in the community we assume that the rates obtained in these studies would apply to Ireland.

3.6.2 Dementia in the psychiatric services

The incidence of dementia in Denmark for those over 65, as measured by first ever contacts with the psychiatric service, is 8.7 per 10,000 population. This rate shows the pattern reported in the literature, of substantial increases with each five year age group. The highest rate was for those over 85 (17.7) which is over five times that for the 65-69 group (3.1). Males had a slightly higher incidence than females (9.7 versus 7.9). These rates are higher than the rates from the two Irish case registers (2.6 and 2.0 per 10,000) for those over 65. The highest rates by age group in the Irish registers were for the 80-84 group and females had higher rates than males in both. Data from psychiatry of old age services suggest that the incidence figures from the case registers are probably gross underestimates of true incidence. The differences observed between the Danish and Irish case register figures probably reflect differences in referral patterns and service use in the two countries rather than real differences in the incidence of dementia.

Table 3.8: Incidence of dementia in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	Number	212	40	72	74	84	52	322	534
	Rate	0.9	3.7	7.8	11.3	19.9	21.3	9.7	10.7
Female	Number	118	31	57	81	105	99	373	491
	Rate	0.5	2.5	4.9	8.5	14.1	16.2	7.9	8.5
Total	Number	330	71	129	155	189	151	695	1,025
	Rate	0.8	3.1	6.2	9.7	16.2	17.7	8.7	2.0

Source: Danish Case Register 1993.

3.7 International data on the prevalence of dementia

3.7.1 Dementia in the community

Table 3.9 shows the prevalence of dementia in people over 65 in the community from a number of studies which used similar samples,

methodology and means of measuring mental illness, namely the AGE CAT programme (described in detail in Chapter Two). The results from these studies show that somewhere between 2.2 per cent and 6.7 per cent of males and 5.4 per cent and 10.1 per cent of females suffer from dementia. Between 4.3 per cent and 8.3 per cent of the total population over 65 suffer from dementia in any one year. Other community studies have shown how the prevalence of dementia increases with age, and although these studies did not use the same methodology there is some consistency to the rates reported. The rates for those aged 85 and over from four studies were 23 per cent in the Netherlands (Heeren *et al.* 1991), 23.9 per cent in New York (Aronson *et al.* 1991), 25.4 per cent in Germany (Fichter *et al.* 1995) and 30 per cent in Sweden (Skoog *et al.* 1993). The results from the Irish AGE CAT study (Lawlor *et al.* 1994) shows the same pattern and very similar rates, with a prevalence rate of 5.5 per cent for all over-65s and 23 per cent for all those aged over 85 years.

Table 3.9: Prevalence of dementia in studies using the AGE CAT methodology. Percentages.

Study	Male	Female	Total
Copeland <i>et al.</i> 1987a (UK, Liverpool), people on general practitioner list aged 65+	2.7	6.8	5.2
Copeland <i>et al.</i> 1987b (US, New York), community sample aged 65+	5.7	10.1	8.3
Copeland <i>et al.</i> 1987b (UK, London), people on general practitioner list aged 65+	2.2	5.4	4.3
Lobo <i>et al.</i> 1992 (Spain, Zaragoza), community and residential aged 65+	6.7	8.0	7.4

3.7.2 Dementia in the psychiatric services

The prevalence of dementia in Denmark (Table 3.10) as measured by contacts with the psychiatric services is 17 per 10,000 population over 65 years. The rates for males and females are very similar and a pattern of increasing prevalence with increasing age is seen, with a rate of eight per 10,000 in the 65-69 group compared to 28 in the 85+ group. The prevalence rate from the TCCR is 21.4 per 10,000 aged

65 and over (see Table 3.5), which is somewhat higher, and the Irish rate for females is considerably higher than for males (31.1 versus 10.4).

Table 3.10: Prevalence of dementia in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-69	70-74	75-79	80-84	85+	Total 65+	All ages
Male	Number	907	90	133	130	148	82	583	1,490
	Rate	4.1	8.4	14.5	19.9	35.1	33.6	17.6	21.7
Female	Number	556	93	162	182	182	157	776	1,332
	Rate	2.6	7.6	13.8	19.1	24.4	25.7	16.5	19.1
Total	Number	1,463	183	295	312	330	239	1,359	2,822
	Rate	3.3	8.0	14.1	19.5	28.2	28.0	17.0	5.4

Source: Danish Case Register 1993.

3.8 Summary

International data on the incidence of dementia in older people in the community suggest a rate of 1.0 to 1.4 per cent. There are no comparable Irish figures, although data from psychiatric services contacts suggest a low contact rate of 2.6 and 2.0 per 10,000 population and a first admission rate to psychiatric hospitals of 7.2 per 10,000. This first admission rate shows a 55 per cent decrease from 1984 to 1994, probably as a result of the recommendations in *Planning for the Future* (1984), that patients with dementia should not be routinely admitted to psychiatric hospitals.

An extrapolation of the international rates to the total population of the over-65s in Ireland would suggest about 4,000 new cases of dementia in the general community population each year. Calculating service use according to case register and NPIRS figures presents an interesting issue. The reported rates from these sources would suggest approximately 100 new cases coming into contact

with the psychiatric services nationally and around 300 first admissions to psychiatric hospitals. However, information from psychiatry of old age services shows 177 new cases of dementia referred to one service alone last year. Thus, the availability of these specialist services seems to be addressing a gap in the existing general psychiatric services, and enables those cases in the community to receive specialist care. Another gap in services for new cases of dementia is that of in-patient psychiatric care. The 55 per cent reduction in first admissions to these facilities over the last 10 years cannot have been addressed by psychiatry of old age services as only one has been in operation since 1989 and another one since 1991. There is no information regarding where these cases are now treated.

A summary of the Irish prevalence data on dementia is presented in Table 3.11 below. The Irish prevalence rate of dementia in the community of 5.5 per cent is comparable to international estimates which range from 4.3 per cent to 8.3 per cent.

Table 3.11: Irish data on the prevalence of dementia in those aged over 65.

	Irish data	Extrapolated to total population over 65
Level 1: The community	550 per 10,000	22,165
Levels 2 and 3: General practitioner attenders	1,600 per 10,000	64,480
Level 4: Psychiatric services	21 per 10,000	846
Level 5: Psychiatric hospitals	14 per 10,000	564

The rate for general practice attenders denotes 'abnormal cognitive functioning' which does not necessarily equate with dementia. This may explain why these figures are quite high. The figures concerning contact with the psychiatric services are low, reflecting the reduction

in admissions for this group over the last 10 years. Prevalence rates for other services are 58 per cent of nursing home residents and 46 per cent of acute hospital patients over 65. This last rate in particular is very high and warrants further investigation.

This extrapolation of figures represents a crude estimate of possible levels of dementia in the population. It is important to take into account the projected population growth in the over 65 population if these figures are to be used for planning future service provision. Of particular importance for dementia is the difference in prevalence at different age groups, such that prevalence in those over 80 is around 20 per cent compared to five per cent in all those over 65. It is this oldest group which is also predicted to have the largest proportional increase in population.

Schizophrenia and Other Psychoses

Schizophrenia is probably one of the best known but least understood mental disorders. Contrary to popular belief it is not a condition of 'split personality' or multiple personality. Schizophrenia is a form of psychosis, 'psychosis' being a general term for conditions where there is a severe impairment of mental functioning, such that the individual finds it difficult to stay in touch with reality. It is now generally recognised that schizophrenia is a disorder which affects the chemistry of the brain resulting in distortions in thinking and perception. Emotions and behaviour are also usually affected. The symptoms which characterise schizophrenia can be grouped into positive symptoms and negative symptoms. Positive symptoms include hallucinations, delusions and thought disorder. Hallucinations can occur in all of the senses although auditory hallucinations, where the individual hears voices or other noises, are the most common. Delusions are false beliefs that are strongly fixed and cannot be shaken, despite evidence to the contrary. For example, an individual may think people want to harm him/ her or that there is a conspiracy against him/ her. Thought disorder occurs when an individual's thoughts are so completely jumbled that concentration is severely affected and the individual finds it difficult to even complete a sentence. Negative symptoms include withdrawal, lack of emotion and self neglect. Sometimes the person with schizophrenia only rarely has positive symptoms and more commonly becomes very withdrawn and begins to neglect him/ her self. The individual may also show a 'blunted affect' that is, a very limited emotional expression, as if no emotion is felt at all. Other psychoses include a number of conditions that have some of the features of schizophrenia but are generally short lived psychotic episodes in response to an event in the individual's environment. The numbers in this category

of disorder are quite small and so most of this chapter will concentrate on schizophrenia with occasional mention of the category of other psychoses.

Schizophrenia is usually treated with drugs called neuroleptics, the earliest of which were developed in the 1950s. These drugs are very effective in about one-third of people with schizophrenia, and somewhat effective in another third. The most recently developed anti-psychotic drugs are reported to be effective, particularly in treating patients who have not responded to other anti-psychotic drugs (Kane 1992) and in treating negative symptoms (Marder and Meibach 1994). Schizophrenia usually develops in adolescence and early adulthood, when incidence is highest. An Irish study (Kendler *et al.* 1993) found that the average age of onset was 25.6 years and this is in keeping with data from international studies which show that approximately 50 per cent of cases of schizophrenia have an age of onset of 25 years (Kaplan and Sadock 1990). However, because schizophrenia is a long-term condition, the prevalence of schizophrenia among older people is quite high. Although mortality among those with schizophrenia is higher than in the general population, many people with schizophrenia live to old age.

International studies suggest that approximately one per cent of the total population develop schizophrenia, and a study of the incidence of schizophrenia in Ireland (Ni Nuallain *et al.* 1987) reported a similar estimate of between 0.8 per cent and 1.8 per cent depending on the diagnostic criteria.

4.1 Schizophrenia in late life

While the onset of schizophrenia is usually in early adulthood, the term 'late onset schizophrenia' is used to describe a form of schizophrenia with an onset between the ages of 40 and 60 years (Bleuler, 1943). Kraepelin (1919/1971) applied the diagnosis

'paraphrenia' to patients who developed psychosis in later life. Confusion has arisen over the term paraphrenia which is used by some to denote 'late onset schizophrenia' and by others to denote delusional disorders starting after age 60 (Roth 1955). Although the diagnosis of paraphrenia was recognised in ICD 9 it is not included in ICD 10. Here the term 'late onset schizophrenia' will be used to describe schizophrenia which begins in late life. In a discussion of schizophrenia and people over 65, there are two groups in whom we are interested:

- those who have a 'late onset schizophrenia', that is, develop this condition when they are over 65 years. The numbers in this group are very small but we need to know the incidence (the number of new cases) and the prevalence
- those who have 'early onset schizophrenia' and are now in old age. This is a prevalence group only, that is, by definition there are no new cases.

These two groups are distinct as the presentation of the illness is often quite different and the clinical and care needs of these two groups of patients are different, even though they all have the 'same' condition.

The first group consists of those cases of late onset schizophrenia, including those patients who either develop schizophrenia in later adulthood or who present for the first time with schizophrenia in later adulthood. Late life schizophrenia is becoming increasingly important both epidemiologically and clinically, as the number of older persons in the population increases. In general however, there is a dearth of published data on late life schizophrenia (Jeste 1993).

The second group is those patients with early onset schizophrenia who are now in late life. Gurland and Cross (1982, US) estimate that about one per cent of the elderly population has schizophrenia. The

majority of these older schizophrenia patients are those with early onset illness. It has previously been believed that schizophrenia had a progressive and deteriorating course, that is, that patients got worse as time went by. Thus, it might be expected that schizophrenia patients in their old age would have more symptoms and more impairment generally than at any earlier point in their lives. However, in their review of the very sparse literature available on the outcome of early onset schizophrenia in late life, Belitsky and McGlashan (1993) concluded that deterioration in schizophrenia is usually limited to the first five or 10 years of illness. Winokur *et al.* (1987) reported that in old age, patients with schizophrenia suffered less from positive symptoms and more from negative or passive symptoms. As a result, a different type of management is usually required for older patients. In one of the longest follow-up studies of schizophrenia, Ciompi (1980) reported that almost half (49 per cent) of patients were considered to have a favourable outcome, 27 per cent having achieved complete social remission, some after many years of severe illness. In the patients they followed up, it was noted that social adjustment was still relatively compromised, many remaining dependent and withdrawn. Hafner (1996) reports that symptoms and functional impairment do not differ clearly in early and late onset schizophrenia but that the social course shows clear differences because of the different social development in individuals in early adulthood compared to mid-life.

4.2 The incidence and prevalence of schizophrenia and other psychoses in older Irish people

4.2.1 Incidence

We have no data on the number of new cases of schizophrenia that might arise in the community population of people aged over 65. However, data are available from the case registers and the NPIRS system, where we can examine first contacts with, and first admissions to psychiatric facilities to provide an estimate of incidence. Tables 4.1

and 4.2 show the average one year incidence of schizophrenia in the TCCR area and in West Dublin. The number of cases is very small (only four in both case register areas) giving rates of 1.3 in Westmeath and Roscommon and two per 10,000 in West Dublin.

Table 4.1: Incidence of schizophrenia by age group and gender. One year average. Westmeath and Roscommon. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	2.1	1.7	2.1	1.1	1.9
Female	1.6	4.0	0.0	1.5	1.6
Total cases	17	3	1	4	21
Rates	1.9	2.9	0.9	1.3	1.7

Source: TCCR 1989-1993.

Table 4.2: Incidence of schizophrenia by age group and gender. One year average. West Dublin. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	2.2	1.9	4.2	2.6	2.2
Female	1.2	1.7	1.3	1.5	1.3
Total cases	40	2	2	4	44
Rates	1.7	1.8	2.2	2.0	1.8

Source: St. Loman's Dublin, Psychiatric Case Register 1989-1993.

The incidence of other psychoses was zero for males and 1.8 for females over 65, and all cases were in the 65-80 age group.

The incidence of schizophrenia in the over-65s in 1994 nationally, as measured by first admissions to psychiatric hospitals is very similar to that from the case registers at 2.0 per 10,000 (Table 4.3). The overall rate for over-65s was slightly higher in 1984 which might reflect a change in the recording of first admissions or in the diagnostic practice rather than any real decrease in the incidence rate.

Table 4.3: First admissions to psychiatric hospitals and units for schizophrenia by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	1,118	83	29	112	1,230
	Rate	3.6	3.5	2.2	3.0	3.6
1994	Number	784	49	31	80	864
	Rate	2.5	2.0	3.9	2.0	2.5

Source: NPIRS 1984 and 1994.

The number of first admissions for other psychoses is low and has not changed in the last decade, with only nine admissions in those over 65 in 1984 (a rate of 0.2 per 10,000 population) and 11 admissions in 1994 (a rate of 0.3 per 10,000 population).

4.2.2 Prevalence

Table 4.4 shows the prevalence of schizophrenia in the TCCR area as measured by contacts with the psychiatric service. The rate for those over 65 (45.1 per 10,000) is higher than that for those under 65 years (37.9 per 10,000) reflecting the fact that many people with schizophrenia live to old age.

Table 4.4: Prevalence of schizophrenia by age group and gender. 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	226	33	259
	Rate	43.8	42.8	43.7
Female	Number	155	41	196
	Rate	31.7	47.3	34.1
Total	Number	381	74	455
	Rate	37.9	45.1	38.9

Source: TCCR 1993.

Unlike the first admissions in Table 4.3, the rate of *all* admissions for schizophrenia over the 10 years has not changed significantly (Table 4.5). The rate of all admissions for the over-65s is 13.4 per 10,000 population, compared to an admission rate of 16.3 for the under-65s. We would not expect to see any large differences between the age groups here as the older age groups include both the early and late onset cases and the prevalence of schizophrenia is roughly the same across the whole population. There has been no substantial change in the all admission rate for schizophrenia in any age group between 1984 and 1994. The all admissions rate does not include those patients who might have been in hospital for the entire year or more (as they were not admitted in that year). These patients are included in the census of psychiatric hospitals and units as those resident at the end of each year:

Table 4.5: All admissions to psychiatric hospitals and units for schizophrenia by age group, 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	5,740	433	86	519	6,259
	Rate	18.7	18.3	6.5	14.1	18.2
1994	Number	5,093	412	126	538	5,631
	Rate	16.3	17.2	7.7	13.4	16.0

Source: NPIRS 1984 and 1994.

The number of all admissions to psychiatric facilities for other psychoses has not changed considerably in the 10 year period examined in any age group. Those over 65 had 33 admissions in 1984 (a rate of 0.9 per 10,000 population) and 32 in 1994 (0.8 per 10,000 population).

4.3 International data on the incidence of schizophrenia

There are few incidence studies on late onset schizophrenia but the few that have been reported show fairly consistent results. Kay

(1972) in a study of schizophrenia and other psychoses in a sample aged over 65, reported incidence rates of 1.0-1.5 per 10,000 in males and 2.0-2.5 per 10,000 in females. Holden (1987), examining late paraphrenia reported a rate of 1.7-2.4 per 10,000 population and the most recent study (Castle and Murray 1993) reported an incidence rate for schizophrenia of 1.3 per 10,000 population aged 65 and over. The incidence rates of 2.0 and 1.3 per 10,000 over 65 from the Irish case registers are very consistent with these rates, even though they are obtained from different sources, one being community rates and the other being service contact rates. The figures from the Danish case register are also very similar to the Irish, at 1.7 per 10,000 population in the over-65s (see Table 4.6), although their incidence rates for the under-65s are somewhat lower than the Irish.

Table 4.6: Incidence of schizophrenia in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	266	22	23	45	311
	Rate	1.2	1.1	1.7	1.4	2.6
Female	Number	144	32	58	90	234
	Rate	0.7	1.3	2.5	1.9	2.6
Total	Number	410	54	81	135	545
	Rate	0.9	2.2	0.9	1.7	1.0

Source: Danish Case Register 1993.

4.4 International data on the prevalence of schizophrenia

There are very few prevalence studies of late onset schizophrenia using community samples and most use hospitalised samples. Parsons (1964) in a community study of people over 65 in Wales, reported a prevalence rate for late paraphrenia of 1.7 per cent. The Epidemiologic Catchment Area (ECA) study from the US reported a prevalence rate of 0.2 per cent for schizophrenia in over-65s (Keith *et al.* 1991).

In a review of the literature on late onset schizophrenia, Harris and Jeste (1988) noted that 23 per cent of patients with schizophrenia could be considered to have a late onset of illness (generally onset after 40 years). Around 14 per cent of this group first manifested the illness after age 60.

It would seem that the prevalence of schizophrenia or schizophrenia type disorders (i.e., late paraphrenia) is around one per cent of the population over 65. This is in keeping with the well established rate of schizophrenia in the general population which is also one per cent.

Table 4.7: Prevalence of schizophrenia in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	6,395	139	62	201	6,596
	Rate	28.6	7.0	4.7	6.1	34.7
Female	Number	3,674	276	198	474	4,148
	Rate	17.0	11.5	8.6	10.1	27.1
Total	Number	10,069	415	260	675	10,744
	Rate	22.9	9.5	7.2	8.4	20.7

Source: Danish Case Register 1993.

The prevalence rate of schizophrenia in Denmark, as measured by contacts with the psychiatric service (Table 4.7) is 8.4 per 10,000 population over 65. This is considerably lower than the Irish rate from the TCCR of 45.1 per 10,000 (Table 4.4), reflecting a much higher rate of service contact in the over-65s with schizophrenia in Ireland.

4.5 Summary

Available Irish data would suggest that the rate of new cases of schizophrenia in those over 65 (late onset schizophrenia) is between one and two per 10,000 population, and this is supported by the

international literature. This would extrapolate to approximately 40 to 80 new cases of late onset schizophrenia in the total population over 65. These numbers of new cases of functional psychiatric illness could be catered for within existing psychiatric services.

The prevalence rate of schizophrenia in the population over 65 is estimated to be around one per cent internationally and Irish data would support this. The psychiatric admission rate for older people with schizophrenia is broadly similar to that of those under 65 years, although studies of schizophrenia in later life would suggest that fewer positive symptoms are experienced at this stage of the illness. The issue of whether these admissions are appropriate in terms of acute care, or whether alternative treatment and residential options such as hostels should be readily available for this group is one which requires further study.

Prevalence rates necessarily include early onset cases who are now in old age. Those patients with early onset schizophrenia tend to remain in the care of the psychiatric service which has usually cared for them. Many of these patients are residing in long-stay accommodation. The needs of these patients are different to those of younger patients with schizophrenia, in terms of physical and social care and this should be taken into account in a consideration of service provision for this group.

Neuroses and Personality Disorders

This chapter examines two separate forms of mental disorder: neuroses and personality disorders.

5.1 Neuroses

Neurosis is a widely used term which has a variety of meanings both in everyday language and in relation to mental disorders. The term 'neurotic' is often used to describe someone who is very 'highly strung' and nervous. However, 'neurosis' is more properly used as a general term to mean minor mental illness or to describe a specific disorder which may be a common reaction to stress. An individual with a neurosis is still in touch with reality (differentiating the disorder from psychosis) and has no physical or organic cause for his/ her problem. The individual's behaviour may be substantially affected but remains within socially acceptable limits. While neuroses are termed 'minor mental illnesses', neurotic disorders can be very distressing and disabling to the individual concerned and to his/ her family. The common disorders which fall under the heading neuroses are anxiety disorders, phobias and obsessive-compulsive disorders.

Anxiety disorders occur when the fear response to stress (which is normal in some circumstances) stays with the individual, causing him/ her to feel anxious all the time. The fear will also increase so that it is out of proportion to the particular set of circumstances. Symptoms include feelings of fear and apprehension, muscle tension resulting in headache, chest pain or backache, and other symptoms such as breathlessness, palpitations, diarrhoea, sweating and tremor.

Panic disorder is characterised by bouts of severe anxiety which are unpredictable. This condition is also known as 'panic attacks' and

can be very disabling as the affected individual can begin to avoid certain situations for fear of having an attack and bringing attention to him/ her self. Mixed anxiety and depressive disorder are diagnosed when mild symptoms of both anxiety and depression occur together, neither one dominating the clinical picture.

Phobic anxiety disorder or phobias arise when fears about specific situations or items become very intense and/ or out of proportion to the threat they represent. This fear cannot be reasoned away and the individual has no real control over it. Ultimately the individual avoids the situation which provokes the anxiety and this can result in serious consequences. For example, in agoraphobia, the fear is in relation to being outdoors, at the shops, in crowds, on public transport and so on, in such a way that the affected individual can become completely housebound and dependent on others.

The variety of neurotic disorders are quite common in the general adult population, about two to four per cent of the population are affected by general anxiety disorder and another one to four per cent by phobias (Kessler *et al.* 1994). Women outnumber men in these disorders. Anxiety disorders are very treatable, usually with psychological therapies such as behaviour therapy and relaxation training, anti-anxiety drugs (anxiolytics), or a combination of both.

5.2 Neurotic disorders in late life

While depression and dementia are regarded as the most 'important' mental disorders in later life, because they are both common and disabling, Sheikh *et al.* (1988, US) contend that anxiety is also important, as it affects about 10-20 per cent of people over 65 years. More recently, Sheikh (1992) concludes that, "anxiety remains probably the most under-addressed psychiatric problem of old age" (p. 410).

Like the other disorders we have reviewed neurotic disorders and anxiety disorders in old age present problems in terms of being recognised and treated. This may be accounted for by the fact that up to 65 per cent of neuroses in older people are unrecognised by general practitioners (Williamson *et al.* 1964). It can also happen that neurotic symptoms in those over 65 are dismissed as 'being reasonable for their age' or just an integral part of growing old (Lindsay *et al.* 1989). Neurotic disorders in this group of patients can often present with physical symptoms as the central component, thus making it easier for the underlying anxiety to be missed and the physical symptoms to be treated instead (McDonald 1973).

While up to one-fifth of cases of anxiety will recover spontaneously (Larkin *et al.* 1992), it is important that anxiety in older people is diagnosed and treated. Anxiety is distressing, can adversely affect quality of life and can result in increased dependence in an otherwise healthy and previously independent individual. This loss of independence can further impact on the individual's quality of life. However, anxiety is very amenable to treatment, often at the primary care level.

5.3 The incidence and prevalence of neuroses in older Irish people

5.3.1 Incidence

There are no data on the incidence of neuroses in the general population over 65 in Ireland. Tables 5.1 and 5.2 present incidence rates of neuroses by age group and gender as measured by contacts with the psychiatric services in the TCCR and West Dublin case register areas. The number of new cases of neuroses in those over 65 is very small, two in the TCCR and eight in the West Dublin case register. Both numbers and rates are considerably lower in those over 65 compared to those under 65 years.

Table 5.1: Incidence of neuroses by age group and gender. One year average. Westmeath and Roscommon. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	2.1	0.8	0.0	0.3	1.7
Female	2.7	2.8	0.5	1.2	2.4
Total cases	22	2	<1	2	24
Rates	2.4	1.8	0.3	0.8	2.0

Source: TCCR 1989-1993.

Table 5.2: Incidence of neuroses by age group and gender. One year average. West Dublin. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	5.5	3.9	2.5	3.4	5.4
Female	9.9	5.7	2.5	4.4	9.4
Total cases	181	6	2	8	189
Rates	7.7	4.9	2.5	4.0	7.5

Source: St. Loman's Dublin, Psychiatric Case Register 1989-1993.

The rate of first admissions for neuroses in 1994 for the over 65 group was 1.3 per 10,000 population (Table 5.3).

Table 5.3: First admissions to psychiatric hospitals and units for neuroses by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	519	58	43	101	620
	Rate	1.7	2.5	3.3	2.7	1.8
1994	Number	602	35	19	54	656
	Rate	1.9	1.5	2.4	1.3	1.9

Source: NPIRS 1984 and 1994.

Further study would be required to firmly establish the reasons for the decrease in first admissions. This shows a reduction of over 50 per cent on the rate of admissions for 1984 (2.7), while the rate of first

admissions for the under 65 group shows an increase over the same period. The decrease in first admissions for those over 65 could be due to a number of factors. It may be that older people with neuroses are not being referred and/ or admitted to psychiatric hospitals. It is also possible that a change in recording first admissions or in diagnostic procedure has occurred, but since the figures for those under 65 years have remained largely the same this is not likely.

5.3.2 Prevalence

There are some Irish studies which have addressed anxiety among older people living in the community. Lawlor *et al.* (1994) reported a prevalence rate of 1.1 per cent for cases of anxiety as diagnosed by AGECAT. However, a considerable proportion of the sample (13.7 per cent) had symptoms of anxiety and were classified as 'subcases'¹. While no cases of phobia were seen, four per cent were classified as subcases, and only one subcase of obsessive-compulsive disorder was identified. A study in the North Western Health Board region (O'Connor 1989) of 283 community dwelling people aged 70 or more reported a prevalence rate of 11.7 per cent for depression and anxiety, although a non-specific measure designed for the purposes of the study was used. The medical and social needs of people over 75 in a general practice population in Donegal were surveyed (Mee and O'Callaghan 1990) and showed 12 per cent with anxiety/ depression, similar to the prevalence rate found in the North Western Health Board study. The South Eastern Health Board recently conducted a study in 1995 of 617 people aged over 64 randomly selected from the General Medical Scheme list and found that 11 per cent had a positive anxiety score on the Hospital Anxiety and Depression Scale (Zigmond and Snaith 1983). Slightly more women than men had anxiety (12 per cent versus nine per cent). Only 21 per cent of all those who had a positive anxiety/ depression score had received

¹ AGECAT assigns a confidence level to the diagnosis derived from the system. Those at levels 3, 4 and 5 are denoted 'cases', that is, the symptoms form a recognisable diagnostic pattern. Levels 1 and 2 are 'subcases', which means there are symptoms present but they are insufficient to merit a clinical diagnosis.

treatment for these disorders from their general practitioner in the previous four weeks.

Fahey and Murray (1994) used the 12 item General Health Questionnaire (GHQ, Goldberg 1972) in a survey of 909 people aged 65 years or more which assessed the health and social circumstances of this sample. The GHQ does not assess specific disorders but does rate 'general distress' which is recognised as being very similar to anxiety. The scores from the GHQ have a threshold level, commonly referred to as the 'GHQ Stress Threshold', with those above the threshold classified as distressed and those below classified as 'normal' or non-distressed. For the 12 item GHQ the stress threshold score is three or more (Fahey and Murray 1994). Table 5.4 summarises the results from the GHQ.

Table 5.4: Proportion of community sample scoring over the GHQ stress threshold (over-65s).

Sub-groups	Percentages
All over-65s	23
All men over 65	18
All women over 65	27
All aged 65-69	20
70-79	22
80+	30
Physical illness also present	37
No physical illness present	11
Married	19
Widowed	28
Single	23

Source: Fahey and Murray 1994.

These results suggest that 23 per cent of all those over 65 years experience significant symptoms of 'psychological distress'. The prevalence is higher in women than in men and increases steadily with increasing age. Distress is also greatest in people who are not married, with widowed people showing the highest scores within the

marital status category. Perhaps not surprisingly, those who had a physical illness had the highest proportion scoring over the GHQ threshold at 37 per cent.

Table 5.5: Prevalence of neuroses by age group and gender, 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	43	5	48
	Rate	8.3	6.5	8.1
Female	Number	51	12	63
	Rate	10.4	13.8	10.9
Total	Number	94	17	111
	Rate	9.4	10.4	9.5

Source: TCCR 1993.

The prevalence rates of neuroses from the TCCR (Table 5.5) show greater similarity for the under- and over-65s than the incidence rates. The rate in both age groups is higher for females compared to males.

Table 5.6: All admissions to psychiatric hospitals and units for neuroses by age group, 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	1,313	205	107	312	1,625
	Rate	4.3	8.7	8.1	8.5	4.7
1994	Number	1,492	125	46	171	1,663
	Rate	4.8	12.4	6.3	4.2	4.7

Source: NPIRS 1984 and 1994.

The rate of admissions to psychiatric in-patient facilities has halved for those over 65 for the 10 year period 1984 to 1994 from 8.5 to 4.2 admissions per 10,000 population (Table 5.6), bringing them into line with the rates for the under-65s.

5.4 International data on the incidence of neuroses

The incidence rate of neuroses from a community dwelling sample of people over 65 in the UK (Larkin *et al.* 1992) using the AGE CAT methodology was 4.4 per 1,000 population per year (44 per 10,000). There are no comparative incidence figures for neurotic disorders in an Irish general population sample, although contact rates with the psychiatric service in Ireland reveal a much lower rate of 0.8 to 4.0 per 10,000.

Table 5.7: Incidence of neuroses in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	91	3	2	5	96
	Rate	0.4	0.2	0.2	0.2	0.6
Female	Number	268	25	7	32	300
	Rate	1.2	1.0	0.3	0.7	1.9
Total	Number	359	28	9	37	396
	Rate	0.8	0.6	0.2	0.5	0.8

Source: Danish Case Register 1993.

The incidence rates of neuroses in those over 65 in Denmark is 0.5 per 10,000 population (Table 5.7), which is lower than both of the Irish case register rates. This may reflect a difference in treatment setting with more cases in Denmark being treated by services not recorded on the register such as psychotherapy, while cases in Ireland attend the local psychiatric service.

5.5 International data on the prevalence of neuroses

The prevalence of all neurotic disorders from the general population study of Larkin *et al.* (1992) was 11 per cent and nine per cent in the two years of study, with rates for separate categories of disorder of; 4.0 per cent for anxiety, 1.1 per cent for phobias and nought per cent for panic disorder. Another UK study (Lindsay *et al.* 1989) reported one

month prevalence rates which were somewhat similar with 3.7 per cent for anxiety, 10 per cent for phobia and nought per cent for panic disorder. The rate for anxiety disorders from the only Irish prevalence study in an elderly population was 1.1 per cent (Lawlor *et al.* 1994) which would seem to be an underestimate. However, the inclusion of subcases gives a rate of around 14 per cent which is similar to the above studies.

As with the incidence rates, the prevalence rate of neuroses in the over-65s in the Danish case register, at 1.8 per 10,000 population (Table 5.8), is much lower than that from the TCCR, probably reflecting different treatment settings, as noted previously.

Table 5.8: Prevalence of neuroses in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	237	11	3	14	251
	Rate	1.1	0.6	0.2	0.4	1.5
Female	Number	754	95	32	127	881
	Rate	3.5	4.0	1.4	2.7	6.2
Total	Number	991	106	35	141	1,132
	Rate	2.3	2.4	1.0	1.8	2.2

Source: Danish Case Register 1993.

5.6 Summary of data on neuroses

Irish and international data seem to suggest that the incidence rate of neuroses in the over-65s is between 0.5 and four per 10,000 population. This low rate of new cases would extrapolate to approximately 20-160 cases nationally each year. The prevalence rate of neuroses in the community from Irish studies reflects the different types of measures used. Clinical cases of anxiety seem to be around one to four per cent, using both Irish and international findings. These are the cases which might be expected to come into

contact with the psychiatric services. However, equally important in terms of the everyday quality of life of older people is the amount with symptoms of anxiety and 'psychological distress' which occur in around 23 per cent of Irish people over 65. While these symptoms may not satisfy clinical criteria for diagnosis, they nevertheless represent a considerable rate of distress in our older population. These symptoms can impinge on everyday life significantly, but are also those most amenable to intervention. Two strongly related factors are loneliness/ isolation (as reflected in the high rate for widowed and single people) and physical illness. Measures taken to tackle these factors, would not just address the immediate problem (e.g., the physical illness) but would also play an important role in reducing distress and anxiety in people over 65.

5.7 Personality disorders

Personality is a term with which everyone is familiar but which is difficult to define. It is generally used to refer to those aspects of a person's behaviour, thinking and emotional reactions which are enduring and predictable and which uniquely characterise the individual. The personality of each individual is shaped by an interaction between biological/ genetic factors and environmental factors, specifically social interaction. Personality influences the individual's response to a variety of situations and conditions, including illness. For example, associations have been found between certain types of personality and heart disease (Thoresen and Powell 1992). It is also likely that an association exists between certain personality types and specific psychiatric conditions (Cohen and Hart 1994), although there is limited evidence for this.

The definition of personality disorder is also difficult, not least because it relies on differentiating between 'normal personality' and 'abnormal personality'. Since personality is essentially different in each individual, the concept of normality is difficult to establish. The

essential features of the ICD 10 definition of personality disorder are deeply ingrained and enduring behaviour patterns, manifesting themselves as inflexible responses to a broad range of personal and social situations. They represent either extreme or significant deviations from the way the average individual in a given culture perceives, thinks, feels and particularly relates to others. Thus an individual with antisocial personality disorder typically shows an unconcern for the feelings of others, a disregard for social norms, rules and obligations, an incapacity to experience guilt and learn from experience, a very low tolerance for frustration and a low threshold for the discharge of aggression, and a marked proneness to blame others or offer plausible explanations for the behaviour that has brought them into conflict with society (Gelder *et al.* 1996). While many of these features may be modified and somewhat less pronounced by the time an individual reaches old age, personality disorder in older people can often be regarded as the type of 'eccentricities' or 'difficulties' which are expected in stereotypical approaches to older people.

The assessment of personality disorder might include the use of personality inventories as well as a detailed clinical interview. These inventories are psychological tests which assist in the assessment of personality disorder. The classification of personality disorder is largely descriptive and is based upon the identification of clusters of personality traits. For example, features of paranoid personality disorder include being suspicious, sensitive, mistrustful, argumentative, stubborn and self-important. International studies show that the prevalence of personality disorder in the general population is around six to nine per cent (Kaplan and Sadock 1990).

Because the definition of personality and therefore personality disorder is centred on the concept of enduring traits of human behaviour, some psychiatrists hold the view that personality disorders

are untreatable. However, medication may have some role in alleviating stress or symptoms of anxiety. Behavioural techniques and counselling can help the individual to deal with frustration to avoid aggressive displays. People with personality disorder are also admitted to psychiatric hospitals although there is considerable debate over whether personality disorder is a mental disorder. In light of this it is proposed to explicitly exclude personality disorder from the definition of mental disorder in the White Paper *A New Mental Health Act* (Department of Health 1995). Thus individuals with personality disorder will not be involuntarily admitted to a psychiatric hospital. However, older people with personality disorder can be very isolated and marginalised, often neglect themselves and usually refuse treatment or any contact with the psychiatric services (Pitt 1982). This can result in difficulties in treating and caring for this small though vulnerable group of people.

5.8 Personality disorders in late life

The view that personality disorders become less severe with age is widespread (Cohen and Hart 1994). Blazer *et al.* (1988) found that the prevalence of antisocial personality disorder declined with age. These authors note that the ICD 10 diagnostic definition is expanded upon by DSM-III-R (the American diagnostic system) to suggest that personality disorders, "are often recognisable by adolescence or earlier and continue throughout most of adult life ... they often become less obvious in middle or old age" (p. 335). Tyrer and Seivewright (1988) similarly suggest that, "personality disorders seen in early adult life do not present in anything like the same degree. if they present at all, in the elderly" (p. 119). As yet there is a lack of firm evidence to suggest that this is or is not the case, although Tyrer and Seivewright (1988) and Solomon and Hellon (1981) suggest that specific types of personality disorders such as antisocial and histrionic may improve over time, others such as obsessional and paranoid may not.

Organic factors can be important in the nature or presentation of personality disorders in those over 65. A number of neurologic diseases, which are common in later life, and other damage to the brain can lead to disturbances of personality (Sadavoy and Fogel 1992). For example, Alzheimer's Disease can aggravate antisocial or histrionic personality traits (Fogel and Eslinger 1993). Because of the nature of the disorder older people can often refuse services (both psychiatric and general medical) which they might need and this can be problematic (Pitt 1982). There has been a limited amount of work on the integration of those individuals with personality disorder into an institutional environment, suggesting that these individuals can remain isolated and that institutional life may exacerbate symptoms of anxiety, agitation or paranoia (Bennett 1983). There is equally very little known on the effect of the person with personality disorder on the institution, as these individuals can often be quite disruptive (Sadavoy and Dorian 1983).

5.9 The prevalence of personality disorders in older Irish people

As described in the above introductory paragraphs, personality disorder is a life-long, or at least long-standing disorder, and so a discussion of the incidence of personality disorder in later life is not relevant. There are no studies concerning the prevalence of personality disorder in Ireland, either in the general population or in the older population. The only data that exist are those concerning contacts with the psychiatric services and in-patient admissions. Table 5.9 below shows the prevalence of personality disorder in Westmeath and Roscommon as measured by contacts with all parts of the psychiatric services, for both sexes for 1993. This shows that the prevalence of personality disorder in those over 65 in contact with the psychiatric services is very low, with only three cases in 1993.

Table 5.9: Prevalence of personality disorder by age group and gender. 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	29	1	30
	Rate	5.6	1.3	5.1
Female	Number	25	2	27
	Rate	5.1	2.3	4.7
Total	Number	54	3	57
	Rate	5.4	1.8	4.9

Source: TCCR 1993.

Table 5.10 shows the same pattern of prevalence of personality disorder as measured by admission to psychiatric in-patient facilities. Prevalence is much higher in those under 65 years and the number of admissions for those over 65 is very low and shows no significant change over the 10 year period from 1984 to 1994.

Table 5.10: All admissions to psychiatric hospitals and units for personality disorder by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	1,270	45	14	59	1,329
	Rate	4.1	1.9	1.1	1.6	3.9
1994	Number	1,397	43	28	71	1,468
	Rate	4.5	5.2	2.8	1.8	4.2

Source: NPIRS 1984 and 1994.

5.10 International data on the prevalence of personality disorders

The Epidemiological Catchment Area (ECA) study found a prevalence rate of 0.8 per cent for personality disorder in those older than 65 years (Robins *et al.* 1984), although this is probably an underestimate due to the questionnaire used, and Swanson *et al.*

(1994) reported a prevalence rate of 0.3 per cent in community dwelling elderly. In a detailed analysis of personality disorder in later life using data from the ECA study, Cohen and Hart (1994) reported an overall prevalence rate for any personality disorder of 6.6 per cent in those aged over 55 years. Older subjects were significantly less likely than younger subjects to have any personality disorder.

Table 5.11 shows the prevalence of personality disorder by age and gender in Denmark, as measured by contacts with the psychiatric services.

Table 5.11: Prevalence of personality disorder in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	2,431	42	6	48	2,479
	Rate	10.9	2.1	0.5	1.5	12.3
Female	Number	3,683	111	36	147	3,830
	Rate	17.0	4.6	1.6	3.1	20.2
Total	Number	6,114	153	42	195	6,309
	Rate	13.9	3.5	1.2	2.4	12.1

Source: Danish Case Register 1993.

These figures show a much lower prevalence of personality disorder in those over 65 compared to those under 65 years, with a higher prevalence in females in all age groups. The same pattern is seen in the Irish case register data (Table 5.9) although the prevalence in both age groups is lower and even the Irish rate of psychiatric admissions is lower. Interestingly, the rate in females is higher than males in Denmark and also in Ireland, although most reports in the literature show higher rates of personality disorder in males. In a study by Kastrup (1985) the same finding was seen. In first time admitted psychiatric patients over 65 years, 0.7 per cent of the males and 2.8 per cent of the females had a diagnosed personality disorder.

Comparable rates of personality disorder in first time admitted patients in Ireland are 0.7 per cent for males and 1.3 per cent for females.

5.11 Summary of data on personality disorders

In summary, the lack of data concerning the prevalence of personality disorder in those over 65 precludes drawing any firm conclusions. However, the limited data that are available show the same general pattern in Ireland as that seen elsewhere, that is, a very low rate of personality disorder in older people. In spite of this, personality disorder can represent a very significant problem because of the intractable nature of the disorder and the lack of treatments for it. Individuals with personality disorder can represent a significant management problem in sheltered/ institutional environments. It would be particularly useful to have data concerning this in order to estimate the impact of people with personality disorder on institutional environments.

Alcohol and Drug Abuse and Dependence

Alcohol abuse is a considerable public health problem with international studies reporting a prevalence of approximately 13 per cent in the adult population (Kaplan and Sadock 1990). Overall alcohol consumption per adult in Ireland increased by 83 per cent between 1960 and 1991, and personal expenditure on alcohol in 1991 was about £1.76 billion (Conniffe and McCoy 1993). However, Irish alcohol consumption on a per capita basis is among the lowest in Europe, being less than half that of France or Spain. There is also a high proportion of abstainers in Ireland, estimated at around 20 per cent of the adult population (Conniffe and McCoy 1993). Thus, the Irish reputation for drinking is not necessarily borne out by statistics on consumption. However, alcohol abuse causes many problems not just to the user, but to their family and to society in general, in terms of accidents and other health related consequences. Walsh (1980) estimated the cost to the Irish exchequer of alcohol abuse and this has been updated to 1988 costs (Conniffe and McCoy 1993) to be in excess of £190 million per annum.

While it is generally accepted that the rate of heavy drinking decreases and the rate of abstinence increases with age (Adams *et al.* 1990; Mishara and Kastenbaum 1980), alcohol abuse nevertheless remains an important problem in later life. Drug abuse is much less common in people over 65, although it may become an increasingly important problem in the future as the population ages and the cohort of people who abused drugs 30 years ago or more become older and eventually move into old age. The abuse of prescription drugs is also a cause for concern. However, because rates are so low, particularly in Ireland, drug abuse will be dealt with briefly at the end of this chapter.

6.1 Alcohol abuse and dependence

The definition of dependence is the same, whether the patient is young or old or whether the agent is legal or illegal. Dependence is chronic and progressive, characterised by continuous or periodic uncontrolled use of a drug despite related social, physical, emotional and legal consequences (Jeurgens 1994). Alcohol is the most commonly and widely used drug. The disorders associated with alcohol abuse and dependence can generally be divided into two groups:

- disorders related to behaviour associated with alcohol (alcohol abuse/dependence)
- disorders related to the direct effects of alcohol on the brain (including intoxication, withdrawal, delirium and dementia).

6.2 Alcohol abuse in late life

Gupta (1993) reports that the incidence of alcohol abuse among older people is increasing, possibly as a result of an age-cohort effect. This suggests that increasing alcohol consumption and its related problems might be anticipated for those entering their 60s in the 1990s (Glynn *et al.* 1985). There are several issues relating to alcohol consumption and alcohol dependence which are particularly relevant to those over 65 years. Certain biological risk factors are important as this group shows increased sensitivity to the effects of most drugs, including alcohol. Alcohol can also increase the symptoms of other disorders common in later life, including cognitive impairment, heart and respiratory related illnesses and can cause malnutrition (Gupta 1993). There are also psychosocial risk factors which are important to a consideration of alcohol abuse in those over 65. Major loss events represent a common stress in this group and other stresses can also be present such as debility or disablement, and lack of money. These and other stresses can contribute to alcohol abuse problems. Subjective symptoms of chronic physical illness such as pain and

insomnia, and the presence of a psychiatric problem such as anxiety or depression can all contribute to alcohol abuse (Atkinson *et al.* 1992), and the use of alcohol can also mask disorders such as depression.

The presence of alcohol problems in older people can often be under-recognised. The signs and symptoms of alcohol abuse can be subtle or can mimic symptoms of other late life illnesses making diagnosis difficult (Atkinson 1990). Professional biases and other social factors can also act so that alcohol abuse in people over 65 is 'missed' (Atkinson *et al.* 1992). Gupta (1993, US) estimates that only 10 to 20 per cent of older alcoholics are known to health care professionals. An Irish study on new referrals to a psychiatry of old age service (Farragher *et al.* 1994) reported that of those with alcohol problems, about half were not identified prior to referral.

6.3 The incidence of prevalence of alcoholic disorders in older Irish people

6.3.1 Incidence

There are no Irish figures on the incidence of alcoholic disorders in the general population or in that part of the population over 65 years. Studies to determine either the incidence or prevalence of alcoholic disorders in any section of the community are particularly difficult because of the different levels of problems, for example, problem drinking, alcohol abuse, alcohol dependence and so on, and because of the reluctance of people to admit to any problem at all with alcohol and to underestimate their consumption. Reliance on service use figures, both psychiatric and general medical services, is therefore more common when trying to estimate the incidence or prevalence of alcoholic disorders.

As with many other disorders we have considered, there are two groups of people with alcohol problems in whom we are interested:

people who develop the problem in late life, and those who have had a problem for many years and still have it when they reach old age. There tends to be many more males than females with long-term alcohol problems and this will be seen when the prevalence figures are examined (Tables 6.4 and 6.5). However, new cases of alcohol abuse arising in old age seem to be greater in women than men. In a six month prospective study of new referrals to a psychiatry of old age service in Dublin (Farragher *et al.* 1994), 15 per cent of new referrals to the service were found to suffer from alcoholism. The average age of these patients was 76 years and most (65 per cent) were women. Depression was the most common alcohol related psychiatric problem, followed by dementia. Loneliness was an important contributory factor in almost half of these patients.

A pattern of equal incidence rates for alcoholic disorders between males and females is seen in the figures from the TCCR (Table 6.1), although there is a large gender difference in similar figures from West Dublin (Table 6.2).

Table 6.1: Incidence of alcoholic disorder by age group and gender. One year average. Westmeath and Roscommon. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	10.5	7.1	2.7	3.4	9.0
Female	11.2	6.8	2.2	3.1	9.3
Total cases	98	7	2	9	107
Rate	10.8	7.0	2.4	3.2	9.1

Source: TCCR 1989-1993.

These tables show the average one year incidence of alcoholic disorders by age and gender, as measured by contacts with the general psychiatric services in the relevant areas. The pattern of contacts for alcoholic disorders from the case registers and those seen in specialist services (as evident from the results of the Farragher *et al.*

study) is quite different, both in numbers and gender composition. The case register figures show only a small number of new cases of alcoholic disorders in those over 65 years, (nine cases, a rate of 3.2 per 10,000 population). This rate is about one-third of those under 65. The same pattern is seen in the figures from the Dublin case register, although there is a lower rate of four cases or two per 10,000.

Table 6.2: Incidence of alcoholic disorder by age group and gender. One year average. West Dublin. Rates per 10,000 population.

	Under 65	65-74	75+	Total 65+	All ages
Male	6.4	4.6	2.5	4.0	6.3
Female	1.7	0.9	0.4	0.7	1.6
Total cases	95	3	<1	4	99
Rate	4.1	2.5	1.1	2.0	4.0

Source: St. Loman's Dublin, Psychiatric Case Register 1989-1993.

The rate of first admissions to psychiatric hospitals (Table 6.3) for the over 65 group is also about half that for those under 65 years and decreases with age. There has been a decrease in first admissions for alcoholic disorders of around one-third for all age groups over the 10 years 1984 to 1994. This may be due in part to the development of community alcohol services and the referral of people to these services rather than psychiatric hospitals.

Table 6.3: First admissions to psychiatric hospitals and units for alcoholic disorder by age group. 1984 and 1994. Numbers and rates per 10,000.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	2,332	114	31	145	2,477
	Rate	7.6	4.8	2.4	3.9	7.3
1994	Number	1,596	76	23	99	1,695
	Rate	5.1	3.2	2.9	2.5	4.8

Source: NPIRS 1984 and 1994.

The report *Planning for the Future* (1984) recommended that, "the emphasis on the management of alcohol related problems should be on community based intervention rather than on specialist in-patient treatment" (p. 118).

6.3.2 Prevalence

The number of cases of alcoholic disorder in those over 65 is low (29) compared to those under 65 (193), although the rate per 10,000 population for both age groups is similar (see Table 6.4). The male/female difference in alcoholic disorders can be seen quite clearly in both age groups with the rate for males in either age group being at least five times that for women.

Table 6.4: Prevalence of alcoholic disorder by age group and gender. 1993. Westmeath and Roscommon. Numbers and rates per 10,000 population.

		Under 65	Total 65+	All ages
Male	Number	162	25	187
	Rate	31.4	32.4	31.5
Female	Number	31	4	35
	Rate	6.3	4.6	6.1
Total	Number	193	29	222
	Rate	19.2	17.7	19.0

Source: TCCR 1993.

Alcoholic disorders are a considerable problem for the older age group, with 478 admissions to psychiatric hospitals in 1994 (Table 6.5). Only the more serious cases of alcoholic disorder are likely to be admitted to a psychiatric hospital, with many cases also being admitted to acute general hospitals. Thus, the prevalence of cases in the general community is probably considerably higher than the rates reported here.

Table 6.5: All admissions to psychiatric hospitals and units for alcoholic disorder by age group. 1984 and 1994. Numbers and rates per 10,000.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	6,632	480	81	561	7,193
	Rate	21.6	20.2	6.1	15.2	20.9
1994	Number	5,053	386	92	478	5,531
	Rate	16.2	16.1	5.7	11.9	15.7

Source: NPIRS 1984 and 1994.

6.4 International data on the incidence and prevalence of alcoholic disorders

International comparisons of psychiatric service use by people with alcoholic disorders show considerable differences between the Irish psychiatric services and most other European services, with Irish admission rates being considerably higher (Walsh 1987).

Table 6.6: Incidence of alcoholic disorder in Denmark by age group and gender. 1993. Numbers and rates per 10,000

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	604	20	5	25	629
	Rate	2.7	1.0	0.4	0.8	3.5
Female	Number	237	17	3	20	257
	Rate	1.1	0.7	0.1	0.4	1.5
Total	Number	841	37	8	45	886
	Rate	1.9	0.8	0.2	0.6	1.7

Source: Danish Case Register 1993.

The incidence rate, as measured by contacts with the psychiatric services, is considerably lower in Denmark, for people over and under 65 years (Table 6.6). However, rather than reflecting real differences in the level of the problem, this probably reflects the difference in service use within the two countries. People with alcohol problems tend to be treated outside of the psychiatric services in Denmark.

This pattern is also seen in the prevalence figures from Denmark, which show low levels of psychiatric admission for alcoholic disorders (Table 6.7). However, the difference between the age groups is consistent across countries, with those under 65 having a much higher incidence and prevalence than those over 65 years.

Table 6.7: Prevalence of alcoholic disorder in Denmark by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	3,246	77	9	86	3,332
	Rate	14.5	3.9	0.7	2.6	17.1
Female	Number	1,361	52	11	63	1,424
	Rate	6.3	2.2	0.5	1.3	7.6
Total	Number	4,607	129	20	149	4,756
	Rate	10.5	2.9	0.6	1.9	9.2

Source: Danish Case Register 1993.

Estimates from the ECA study in the US (Myers *et al.* 1984) of alcohol dependence in those over 65 years range from 3.0-3.7 per cent for males and 0-0.7 per cent for females. This study was carried out in the general community and used very strict diagnostic criteria, therefore probably underestimating the true prevalence. Another US study of all hospital discharges under the Medicare programme (Adams *et al.* 1993) found a prevalence rate of 48.2 per 10,000 population for alcoholic disorders in those over 65. This is higher than the Irish rate of 11.9 per 10,000 although this only includes psychiatric hospitals. In another study of medical admissions of 539 patients over 65 (Mangion *et al.* 1992), 7.8 per cent were identified as alcohol abusers. Finally of the 205 people over 65 attending an emergency department in a US study (Adams *et al.* 1992), 14 per cent were alcohol abusers.

6.5 Drug abuse and dependence

There is almost no descriptive or epidemiological data on prescription drug abuse and illegal drug use in those over 65. Findings from the few studies that have been carried out show that the manifestation of prescription drug dependence in patients over 65 is different to that of younger patients. The source of most drugs used by this population is their doctor. Older patients use fewer illicit drugs and fewer types of drugs (Solomon and Stark 1993). This study also found a high rate of psychiatric co-morbidity in older patients, 85 per cent having another psychiatric diagnosis compared to 36 per cent of younger patients. The older patients were also more likely to have a history of memory loss, sleep disturbance, and diminished ability to perform activities of daily living.

The diagnosis of prescription drug abuse is often missed in people over 65 and subsequently these patients are not referred for treatment (McInnes and Powell 1994). The reasons for this are many. The negative consequences of drug abuse are subtle (Jeurgens 1994) and confusion regarding addiction may also occur because the problem may have developed as a complication of drug therapy begun at an earlier age for physical or psychiatric complaints. Patients also may not accept the diagnosis of addiction because they are taking drugs that have been prescribed, and because of the stigma associated with drug problems.

Because of the under-diagnosis of drug dependence the little epidemiological data that are available are likely to be underestimates of the problem. Data from the Irish case registers show no new cases of drug abuse in those over 65 and only one prevalence case in 1993. There were 21 admissions to psychiatric hospitals for drug dependence in the over-65s in 1994, a rate of 0.5 per 10,000 population. Data from international studies showed five per cent of the caseload of a community agency for those over 65 in Washington

was for prescription drug abuse, and 70 per cent of these cases were women (Jinks and Raschko 1990). No cases of drug dependence in those over 65 were found in a community sample in Canada (Russel *et al.* 1994).

6.6 Summary

Approximately two to three new cases of alcoholic disorders per 10,000 population over 65 come into contact with the psychiatric services in Ireland each year and around 2.5 first admissions per 10,000 over 65 occur nationally for this problem. The incidence of alcoholic disorders in the over-65s is about half that of the under-65s. These figures suggest that approximately 80-120 new cases of alcoholic disorders in those over 65 make contact with the psychiatric services nationally, with a further 80 first admissions to psychiatric hospitals. However, a study of new referrals to a psychiatry of old age service in Dublin over a six month period showed a rate of 24 new cases per 10,000 population. Thus, the use of rates from the generic psychiatric services (i.e., from the case registers) underestimates the potential demand for specialist services.

While the rate of new cases in those over 65 is lower than in the under-65s, alcoholic disorders are quite prevalent in the older population, with only slightly lower prevalence rates seen in the over-65s compared to the under-65s. Case register figures show a contact rate of 17.7 per 10,000 population over 65 for this problem, in effect over 700 older people in contact with the psychiatric services for alcoholic disorders. There is a significant gender difference for alcoholic disorders with prevalence rates in males being at least twice those of females, although incidence rates show an equal gender distribution if not greater rates for females. Alcohol abuse can be a significant problem for older women. In these cases it can often mask another problem such as loneliness, depression or anxiety and this underlying problem will often also require some form of treatment.

However, estimates of alcoholic disorders in older people derived from psychiatric service contact figures probably represent an underestimate of the problem, as many cases are in contact with general medical services and do not come to the attention of the psychiatric services. Many more probably remain undetected in the community, or at least do not come to the attention of the health services.

Differences in service use, particularly psychiatric in-patient admission for alcoholic disorders in other countries make it difficult to make international comparisons. Per capita consumption of alcohol in Ireland is lower than in many European countries although our psychiatric services contact rates are much higher, as evidenced by the figures from the Danish case register.

Drug abuse in the elderly usually involves prescription drugs. It is difficult to estimate the extent of this problem, as it is often unrecognised and undiagnosed. Figures from psychiatric services contacts show it to affect only a very small number of people over 65 in Ireland.

CHAPTER SEVEN

Mental Handicap

Mental handicap (also referred to as mental retardation, learning disability or developmental disability) is defined as a condition of arrested or incomplete development of the mind, which is characterised by the impairment of skills during infancy and early development, that contributes to the overall level of intelligence (Cohen and Hart 1994). The condition can result from genetic disorders or be acquired (e.g., as a result of brain trauma or infection). Mental handicap is defined in terms of intelligence quotient (IQ) scores (Grossman 1983). An IQ of 69 to 55 denotes mild mental handicap, an IQ of 54 to 40 denotes moderate mental handicap, an IQ of 35 to 25 denotes severe mental handicap and an IQ of less than 25 denotes profound mental handicap. The prevalence of mild to profound mental handicap in Ireland is less than one per cent (Mulcahy *et al.* 1996).

Mental handicap is not a mental illness, but for largely historical reasons, has fallen within the remit of the psychiatric services in this country. This is changing now, with special services for those with mental handicap being established and people with such disabilities being moved from psychiatric hospitals to more appropriate accommodation, although individuals with both a mental handicap and mental illness are treated in psychiatric hospitals. In the past, a chapter concerning mental handicap would not have been included in a report dealing with people in old age. However, a considerably larger number of persons with mental handicap live to old age than was previously the case (Seltzer 1992), and it is clear that these individuals will become a growing proportion of the older population (Janicki and Wisniewski 1985).

The definition of 'old age' in relation to mental handicap is problematic. Definitions based on age alone are not useful because some subgroups of the population with mental handicap age prematurely, for example, those with Down's Syndrome (Evenhuis 1990). Most studies of older persons with mental handicap have used 55 years as the lower age boundary in an attempt to include at least some of those who age prematurely (Seltzer 1992). This is the age limit which will be used in this chapter when referring to 'old age'.

There are two separate issues to be addressed in this chapter, first, the prevalence of mental handicap by age in order to obtain estimates of the numbers of affected individuals, and second, the prevalence of mental illness in these individuals.

7.1 The prevalence of mental handicap in Ireland

We are fortunate in having good data in Ireland on the prevalence of mental handicap. The Medico-Social Research Board (MSRB) carried out censuses of mentally handicapped persons in 1974 and in 1981. More recently the Department of Health established a computerised National Mental Handicap Database in 1995. Preliminary results have just been published and show that there are 27,193 mentally handicapped persons on the new database. With a number of cases excluded pending validation, the prevalence of moderate, severe and profound mental handicap is 4.11 per 1,000 total population, with a prevalence rate of 2.02 per 1,000 recorded for those aged 55 years or more.

Table 7.1 below shows the numbers and prevalence rates of moderate, severe and profound mental handicap combined by age group for the years 1974, 1981 and 1996. These figures show the ageing of this population with rates of those in the younger age groups generally decreasing over the three years shown, while rates in the age groups 20-34, 35-54 and 55 years and over have increased.

Table 7.1: Intellectual disability database. Numbers with moderate, severe and profound mental handicap by age group. Rates per 1,000 population. Ireland. 1974, 1981, 1996.

Age (years)		1974	1981	1996
0-4	Number	431	332	341
	Rate	1.36	.97	1.25
5-9	Number	1,650	1,384	1,087
	Rate	5.20	3.95	3.41
10-14	Number	1,627	1,580	1,347
	Rate	5.45	4.70	3.87
15-19	Number	1,384	1,865	1,548
	Rate	5.17	5.88	4.62
20-34	Number	2,956	3,888	4,801
	Rate	5.48	5.35	6.30
35-54	Number	2,148	2,268	3,998
	Rate	3.46	3.53	4.95
55+	Number	1,060	987	1,375
	Rate	1.71	1.51	2.02
All ages	Number	11,256	12,304	14,497
	Rate	3.77	3.56	4.11

Source: Mulcahy et al. 1996.

7.2 Mental illness in people with mental handicap

The problems of detecting mental illness in people with mental handicap are many, with a general lack of the specialist measures and specialist training required to assess this. Psychiatric diagnosis can be difficult if the person also has a mental handicap as these individuals are likely to find it difficult to express their emotions verbally (Moss and Patel 1993). Nevertheless studies have been carried out which provide estimates of the number of cases of mental disorder in people with mental handicap. In the MSRB census of mental handicap in the Republic of Ireland in 1981 (Mulcahy and Reynolds 1984), data were collected on the presence of a 'psychiatric syndrome' in the

population covered. These returns showed that 15.8 per cent of the mental handicap population had a psychiatric syndrome and this was severe in five per cent of the total population. A survey carried out by the Eastern Health Board in the West Dublin/ North Kildare area (Conlon 1987) covered 2,690 individuals with mental handicap. One-fifth of the total sample had behaviour problems, and almost half (43 per cent) of those with severe or profound handicap were reported as having behaviour problems. Campbell and Malone (1991, US) reported prevalence rates for mental illness in people with mental handicap in the range of 14 per cent to 67 per cent depending on the type of population studied and the criteria for determining mental illness. If behaviour disorders are included, the prevalence of mental illness in general is high, with a large proportion of the diagnoses being personality disorders (Moss and Patel 1993). The prevalence of psychosis and neurosis is quite low, being approximately eight to 10 per cent (Heaton-Ward 1977, UK).

7.3 The prevalence of mental illness in older Irish people with mental handicap

The Irish 1981 census of mental handicap noted that the relative proportion of those with a psychiatric syndrome increased with age as can be seen in Table 7.2 below. One-third of those aged over 55 years had a psychiatric syndrome compared to an average for all ages of 15.8 per cent.

Psychiatric service use statistics, such as those available from the TCCR and the NPIRS provide some indication of the level of psychiatric service use by those with mental handicap. Contacts with the psychiatric services are low with only 10 individuals over 65 recorded by the TCCR in 1993, a rate of 6.1 per 10,000 population. The overall rate of admissions to psychiatric hospitals for people with mental handicap is also quite low and is only 0.6 per 10,000 for those over 65 (see Table 7.3 below).

Table 7.2: Presence of psychiatric syndrome by age group. 1981 mental handicap census.

Age (years)		Psychiatric syndrome			Total mental handicap
		Severe	Minor	Total	
0-19	Number	239	756	995	11,160
	Per cent	21	6.8	8.9	
20-34	Number	412	700	1,112	6,348
	Per cent	6.5	11.0	17.5	
35-54	Number	309	594	903	3,548
	Per cent	8.7	16.7	25.5	
55+	Number	198	429	627	1,923
	Per cent	10.3	22.3	32.6	
All ages	Number	1,158	2,479	3,637	22,979
Total	Per cent	5	10.8	15.8	100 %

Source: Mulcahy and Reynolds 1984.

Table 7.3: All admissions to psychiatric hospitals and units for mental handicap by age group. 1984 and 1994. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
1984	Number	436	12	5	17	453
	Rate	1.4	0.5	0.4	0.5	1.3
1994	Number	456	18	4	22	478
	Rate	1.5	0.7	0.2	0.6	1.4

Source: NPIRS 1984 and 1994.

A recently published Irish study (Tyrell *et al.* 1996) reports on a sample of 76 individuals with Down's Syndrome over the age of 35 years. Six cases of dementia were found in this population, a prevalence rate of 7.9 per cent. This is low in comparison with international studies which have reported prevalence rates of 15-45 per cent (Prasher and Krishnan 1993). The authors of the Irish study conclude, "the presence of a population of adult learning disabled

patients with dementia will have major implications for the development of services for the learning disabled, and the earlier the presence of dementia is recognised, the better the services can be utilised" (p. 53).

7.4 International data on the prevalence of mental handicap

Although Mulcahy and Reynolds (1984) reported increasing prevalence of psychiatric syndrome with increasing age, when older age groups are examined in detail a slightly different pattern is seen. Day (1985), in a study of hospital residents and admissions to a psychiatric unit (all with mental handicap) showed a progressive fall in the proportion of people with mental illness as a function of age. The proportion of people with mental illness fell from 49 per cent in those 40-49 years to 30 per cent in those 50-59 years with further falls to 25 per cent in those 60-69 years and 17 per cent in those 70 and over.

Table 7.4: All contacts with the psychiatric services in Denmark for mental handicap by age group and gender. 1993. Numbers and rates per 10,000 population.

		Under 65	65-74	75+	Total 65+	All ages
Male	Number	163	6	2	8	171
	Rate	0.7	0.3	0.2	0.2	1.0
Female	Number	151	6	1	7	158
	Rate	0.7	0.3	0.0	0.1	0.8
Total	Number	314	12	3	15	329
	Rate	0.7	0.3	0.1	0.2	0.6

Source: Danish Case Register 1993.

Rates of contact with the psychiatric service in Denmark (Table 7.4 above) are low for those over 65 (0.2 per 10,000 population) compared to 6.1 per 10,000 in the TCCR. This most likely reflects differences in service use between the two countries.

7.5 Summary

The prevalence of moderate, severe and profound mental handicap in Ireland is 4.11 per 1,000 total population. This population is ageing and the prevalence of moderate, severe and profound mental handicap in people over 55 has increased from 1.71 in 1971 to 2.02 in 1996. This increase is attributed to improvements in medical care and improvements in living conditions in the general population. This growing population of older people with mental handicap will result in increased demand for full-time residential places and increased pressure on day services. There is also a need for specialist programmes tailored to meet the needs of this group, for example retirement programmes for those who work in sheltered workshops. Increasing numbers of people with mental handicap are surviving into old age and will therefore be vulnerable to the physical and social problems that can be associated with old age.

Irish data show that approximately 33 per cent of those over 55 years with mental handicap also have a psychiatric disorder. A recent Irish study reported a prevalence rate of dementia in those with Down's Syndrome of eight per cent. However, the use of psychiatric services by those with mental handicap is quite low. This may be because individuals with a psychiatric problem are treated or maintained within their mental handicap service. The recently published discussion document on *Mental Health Needs of Persons with Mental Handicap* (Department of Health 1996) recommended that, "minor mental health problems among persons with mental handicap should be dealt with at the level of primary health care, for example, by members of the mental handicap team or the person's general practitioner" (p. 46). It is also recommended that cases of more severe disturbance should be referred to consultant-led specialist services for treatment programmes, both home based and in special units. The lack of specialist services for individuals with mental handicap and a serious mental health problem can lead to crisis

situations. While some believe that these individuals should be referred to generic psychiatric services, the Department of Health discussion document argues that persons with mental handicap have very specialised medical and mental health needs which require a specialised response from services which understand their needs. While this discussion document refers to persons of all ages with mental handicap, the issues raised and recommendations made apply equally to older persons with mental handicap and mental health problems. Many of the needs of this specific group can be met within their existing residential provision. However, there are resource implications arising from the increasing numbers of elderly people with mental handicap, particularly for appropriate residential units and extra staffing as dependency increases.

CHAPTER EIGHT

Suicide

Concern about the increasing level of suicide in Ireland are being expressed by many sections of the community. Suicide among the young, the old, the mentally ill and those in prison is increasingly reported by the media. This growing concern prompted the establishment of a Task Force on Suicide in November 1995 by the Department of Health, whose objective is to implement a national suicide prevention strategy. Suicide is a very public expression of distress and an increase in suicide is seen as an expression of the increased stresses in our society and the difficulties some individuals may have in coping with them. A particular concern has been expressed about the increase in suicide among the young. A recent Eastern Health Board report *Child Care and Family Support Services* (1996) highlighted the number of teenage suicides in the country, where in 1994, 25 teenagers between 15 and 19 years took their own lives. However, the increase in young suicides, particularly among young males, should not obscure the fact that this has been matched by an increase in suicide in older males too, particularly those over 65 years. According to Bowers (1994), "suicide among the elderly often attracts little public attention, an indication that perhaps the death was understandable and due to the problems many people face in old age: bereavement of a spouse, failure to adjust to retirement, physical illness often resulting in admission to hospital and the psychological pain of loneliness" (p. 47).

8.1 Suicide in Ireland

In earlier chapters we have often noted the lack of data available on a variety of mental health topics. Suicide is an exception to this and Irish figures on suicide are available over many years, with a breakdown by age, so that a detailed consideration of suicide in those

over 65 years can be undertaken. Before this can be done however, there are two issues that are important to any discussion of suicide in Ireland: the under-reporting of suicide and whether there has been a real increase in suicide.

8.2 The under-reporting of suicide

There is considerable evidence that suicide was significantly under-reported in Ireland in the past. Walsh and McCarthy (1966) found a 50 per cent difference between the official suicide rate and that obtained in their study for the years 1954 to 1963. In a further study of suicide in Dublin from 1964-68, they found a four fold difference between the official rate of 1.4 per 100,000¹ and the rate arising from a more detailed study of 5.3 per 100,000. A further investigation into coroner's reports from 1900-1904 and a comparison with records from 1964-1968 revealed a 'constancy' in under-reporting of around four to one ('clinical' versus 'legal' suicide). This problem of under-reporting was cited for figures as recent as 1989 (Kirwan 1991) in a rural population, with an official rate of 7.1 per 100,000 compared to a study rate of 18.0 per 100,000. Clarke-Finnegan and Fahy (1983) also found under-reporting in Galway in 1978, where the official rate of 5.8 per 100,000 contrasted with their findings of 13.1 per 100,000.

However, a study of suicide in Kildare (Walsh *et al.* 1990) covering the 10 year period from 1978 to 1987, reported a very similar official rate of 5.6 per 100,000 to that arrived at through detailed study of 5.9 per 100,000. This has been confirmed by a recent study of the same area examining suicide over the five years 1988-92 (Walsh *et al.* 1995). The official suicide rate and that obtained from the study of coroner's records matched very closely for the five years concerned. Daly and Kelleher (1987) also found official suicide rates in Cork recorded over a six year period to reflect their findings for the same

¹ As the numbers of suicides are small, rates used in this chapter will be to 100,000 population instead of 10,000.

period. The general consensus is that the official reporting of suicide in Ireland is now much more reliable.

8.3 Is suicide increasing in Ireland?

Allied to this issue of under-reporting is that of whether there was an increase in the suicide rate in Ireland over the last number of years. In his review of a century of suicide in Ireland, covering five year periods from 1864-68 to 1964-68, Walsh (1976) indicated an increase in suicide for the first part of the century followed by a decrease in the 25 years up to 1968. However, an addendum to this paper indicated that the number of suicides had increased in 1969, 1970 and 1971 and a study of suicide from 1968-1976 (Walsh 1978) reported a steady rise in suicide over the period resulting in a two fold increase. This increase occurred in both sexes, for all age groups and for all causes of death. Most of the increase was deemed to be 'real', that is, not simply a change in practice of the coroner. Further confirmation of the increasing rate of suicide comes from Walsh *et al.* (1995) which shows that the suicide rate in Kildare has doubled from seven per 100,000 in 1988 to 14 per 100,000 in 1992. Kelleher *et al.* (1996a) also conclude that Irish suicide rates reveal a true increase since the late 1970s.

8.4 Suicide in older Irish people

The first study of suicide in older people in Ireland was that of Walsh and McCarthy (1965) who studied all suicides in the city and county of Dublin from 1954 to 1963. Of the 314 cases in the entire study, 103 (32.5 per cent) were 60 years of age or over. Particular care was taken to study the records of the Dublin City and County Coroners of every sudden death over the 10 year period to evaluate the possibility that the death was self-determined, irrespective of the verdict returned by the coroner. As Table 8.1 shows, the rate of suicide as expressed per 100,000 population was highest in the group aged 60-69.

**Table 8.1: Suicide in those aged over 60. Dublin 1954 to 1963.
Numbers and rates per 100,000 population.**

		60-69	70-79	80+
Male	Number	40	10	4
	Rate	18.8	9.1	12.8
Female	Number	24	12	0
	Rate	8.0	6.6	0.0
Total	Number	64	22	4
	Rate	12.7	7.6	4.3

Source: Walsh and McCarthy 1965.

Males in each age group had a considerably higher rate than females. The official Dublin suicide rate in this period was just under half the rate reported by Walsh and McCarthy. This study found that 37 per cent of these suicides lived alone, only three per cent had made previous suicide attempts and the central city areas showed the highest suicide rates. In 50 per cent of cases there was evidence of a pre-existing mental health problem and 55 per cent had seen a doctor within three months of their death. In 12 per cent of cases that doctor was a psychiatrist and 22 per cent of the sample had previously been in a psychiatric hospital. Even though this 'validated' suicide rate was twice that officially reported, it was still among the lowest in a comparison with other European and 'Western World' countries, only the official rate for Northern Ireland being lower.

The most recent information concerning suicides among the over 65 population in Ireland is that of Kelleher *et al.* (1996a). This study reports a considerable increase in suicide rates in men between the years 1976 and 1993. As Figure 8.1 shows, among four groups: (i) males aged 15 to 24 years, (ii) males 65 years and over, (iii) females aged 15 to 24 years and (iv) females 65 years and over, older males had the highest suicide rate. It is only in the last few years that the suicide rate of young males has exceeded the rates for older males.

Figure 8.1: Suicide rates of young and old. Irish males and females 1977-1992.

Source: Kelleher et al. 1996.

The rates for both groups of males show a steady increase from 1976-1992 resulting in a doubling of the rate for older males. The rates for the two groups of females are consistently lower and show no significant increase over the same time period. As with the pattern seen for males, the rate for older females has been higher than that for younger females for the time period studied.

If we examine the rates for those over 65 years in more detail (see Figure 8.2), it is clear that there are differences in the rates for 'young' old (those aged 65-74 years) and 'old' old (those aged 75 years and over). The higher suicide rate is among the young old and for most of the three year periods from 1976 to 1993 the rate for this group was more than twice the rate for those aged 75 and over.

Figure 8.2: Irish male 'young' old and 'old' old suicide rates.

Source: Kelleher et al. 1996

8.5 Methods of suicide

Methods of suicide used by the elderly in Ireland have shown little change. Walsh and McCarthy (1965) in their analysis of 90 suicides in Dublin in those aged 60 and over, reported that 82 per cent had used either hanging, drowning or poisoning methods. Kelleher *et al.* (1996a) show that hanging, drowning and poisoning account for 85 per cent of the suicides in those over 65 from 1976-1993. There is a significant gender difference in methods used, with hanging being up to four times more common in men, and poisoning being used approximately three times more often by women.

In order to carry out a more detailed investigation of possible causes and correlates of suicide the method termed 'psychological autopsy' is often used. This involves obtaining information from the coroner's report, from friends and relatives of the deceased, from the individual's general practitioner and local hospital patient reports, if available.

In a psychological autopsy study of 100 Cork suicides, there were 12 cases aged over 65 years (Kelleher *et al.* 1996a). Of the six women in this group, all were known to have been depressed. Another two had alcohol related problems and one had also abused a prescription drug. All had been married but three were widowed not long before they died. Two women had significant physical illnesses and one had made a previous suicide attempt. The picture for men however was very different. Five of the six men were never married. Three men lived alone and two lived in hostels for the homeless. Three were known to suffer from depression and one was also an alcoholic. Two of the men had made previous suicide attempts.

The above profiles conform very closely to the body of literature on suicide. Factors associated with suicide in the elderly include declining physical health which often involves loss of independence and chronic pain, recent bereavement of a loved one, alcohol and drug abuse, and social isolation and loneliness. Depression is present to some degree in the majority of elderly suicides. The depression may be as a result of the above factors, but may also be a long-term condition that has been present throughout adulthood (Stillion *et al.* 1989). Many of these risk factors can be reduced through appropriate medical, social and psychiatric intervention.

8.6 Latest suicide rates in Ireland

1994 is the most recent year for which national suicide figures are available from the Central Statistics Office (1995). These figures show that 38 people over 65 years committed suicide in that year. 25 males and 13 females. Of the 24,541 deaths from all causes that occurred to those over 65 in 1994, 6.5 per cent were due to suicide.

8.7 International data on suicide

It has often been noted that the official suicide rate in the Republic of Ireland has been the lowest in Europe and one of the lowest in the world (Walsh and McCarthy 1966).

Table 8.2 shows a breakdown of suicide by gender and age for Ireland, England and Wales, and Denmark for 1977 and 1978. This table shows that Ireland has the lowest rates for both males and females for all age groups, particularly for those aged over 65.

Table 8.2: Ireland, England and Wales, and Denmark. 1977 and 1978. Suicide by age group and gender. Mean rates per 100,000 population.

	Ireland		England and Wales		Denmark	
Age (years)	Male	Female	Male	Female	Male	Female
15-24	6	3	7	4	12	6
25-34	12	5	12	5	29	16
35-44	8	6	13	8	43	22
45-64	11	7	15	11	53	35
65+	6	3	19	12	51	31
Total	9	5	13	8	38	24

Source: Walsh et al. 1984.

One of the most widely documented facts about suicide is that its risk increases as a function of age (Vaillant and Blumenthal 1990). There is however, some difference between countries and between the sexes within countries. Some countries have their suicide peak between the ages of 24 and 35 years, for example in the US, whereas in other countries suicide rates continue to rise until mid-life, roughly between 45 and 54 years of age, for example in Denmark. Men aged 75 years and over have the highest suicide rates in almost all countries, although for women the highest suicide rates are found at a considerably younger age. There is a high correlation (i.e., a strong

association) between suicide and age in most countries studied by Diekstra (1993). In 12 of the 14 countries he studied, the correlation between the suicide rate and age among males ranged from 0.78 to 0.91, with exceptions being Iceland with a correlation of 0.51 and Ireland with a very low correlation of 0.26. For women, in 11 of the 14 countries studied, the correlations ranged from 0.77 to 0.98, with the three exceptions being Iceland, Norway and Finland.

Table 8.3: Rate of suicides per 100,000 population in 1985 and 1986 by age group and gender. International comparisons.

Country	Male			Female		
	15-29	30-59	60+	15-29	30-59	60+
Belgium	22.7	38.6	85.8	6.5	21.3	26.2
Denmark	24.3	47.1	72.5	9.9	30.4	29.5
England & Wales	10.5	16.7	19.9	10.5	7.6	17.7
France	22.7	41.5	93.7	6.3	16.2	26.2
W. Germany	19.7	32.3	59.2	6.6	12.6	23.1
Hungary	33.5	98.3	156.9	11.3	29.7	65.7
Ireland	15.9	15.9	16.1	1.2	6.3	5.1
Mexico	4.3	4.1	9.6	1.4	0.9	0.7
Netherlands	10.0	17.7	37.7	5.4	11.9	12.5
New Zealand	19.6	18.5	33.1	6.0	7.0	6.1
Scotland	15.8	23.4	21.1	3.4	7.0	10.4
US	22.6	23.6	43.4	4.7	7.6	6.5
Venezuela	10.9	13.4	23.4	10.9	2.7	2.7

Source: Diekstra 1989.

Table 8.3 above shows comparative suicide rates from different countries for three age groups. As previously noted, Ireland has one of the lowest suicide rates for both males and females in all three age groups. In most countries the highest rate is in males over 60.

8.8 Parasuicide

Parasuicide or attempted suicide is the subject of a major World Health Organisation (WHO) study (Schmidtke *et al.* 1996). This study uses the ICD 10 definition of parasuicide, "an act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour, that ... will cause self-harm" (p. 328). Like suicide, parasuicide is a phenomenon that is also on the increase. Unlike suicide, there is little data available on the prevalence of parasuicide in Ireland or elsewhere. This is mainly because the collection of such data is very difficult, involving the monitoring of all hospital casualty departments and the careful definition and discrimination of cases of attempted suicide, for example, deliberate self-poisoning would have to be separated out from accidental self-poisoning and so on. The epidemiology of parasuicide is quite different to that of suicide. The peak age for parasuicide, both in terms of absolute numbers and in rates per 100,000 population, is between 15 and 44 years with the rates being particularly high in the youngest age group. There also tends to be an excess of female over male cases, with nine out of 10 countries in a WHO study reporting this (Platt *et al.* 1992).

8.9 Parasuicide in Ireland

The data available on parasuicide suggest that casualty referral of the elderly following non-fatal deliberate self-poisoning is a rare event. An early study on attempted suicide in Dublin (McCarthy and Walsh 1975) reported that only 11 per cent of their sample of attenders at casualty departments following a suicide attempt were aged over 65 years. In Cork city in 1982 there were only two cases, both women, and in 1988 there were 12 cases, eight women and four men. In 1995 only one man was referred (Kelleher *et al.* 1996b). A recent study of deliberate self-poisoning in a Dublin hospital (Coakley *et al.* 1994) examined 467 admissions for deliberate self-poisoning over four years. Most were aged 15-24 and only seven were over 65 years.

8.10 International data on parasuicide

A recent study of attempted suicide in Belgium (van Herringen and Jannes 1993) reported a decrease in the attempted suicide rate from 1986-1990 for both males and females. The average age of males attempting suicide increased, while the average age of females attempting suicide remained similar throughout the five year study period. Data examined by age groups showed that the rates decreased in younger age groups, while the rates in elderly males increased. A study on attempted suicide in Kentucky by Frierson (1991) reported that 5.3 per cent (95 people) of the 1,800 cases studied were among people aged over 60 years. He suggests that parasuicide is qualitatively different in older people compared to younger people. Figures on parasuicide are dominated by young people who, it is thought, are not so much attempting to kill themselves, but are engaging in suicidal gestures. Older people who attempt suicide mean to kill themselves, evidence of planning and premeditation being strong. It is generally due to problems such as lack of co-ordination or impaired judgement that they fail.

Although the evidence on parasuicide, both Irish and international is limited, it unfortunately seems to be the case that when older people want to commit suicide they are successful more often than not.

8.11 Summary

Excellent data on suicide in Ireland exist, with both annual national figures collected by age group and many studies carried out. While suicide may have been under-reported in the past, it seems that reporting now accurately reflects the rate of suicide in the country. Suicide in Ireland has been increasing since the 1970s, with the greatest increases seen in males, particularly males over 65 years, although in recent years the rate for young males has overtaken that of older males. Over 80 per cent of older people choose to commit suicide by hanging, drowning or self-poisoning. Particular risk

factors for suicide in older people as revealed by Irish studies are the presence of a physical health problem and living alone. A proportion also had pre-existing psychiatric disorders and had been in contact with a health professional within three months of their death. This contact with primary health care services represents one of the best opportunities for preventing suicide. However, it can be very difficult to detect suicidal intent and judge the seriousness of this intent. Further training for primary health care professionals might increase the effectiveness of contacts in this regard. Very little data is available on parasuicide but what little is available suggests a low rate of parasuicide in the elderly.

The international data on suicide also show high and increasing rates in older people, although Ireland has very low rates in comparison with many countries. There is little comfort in this fact, particularly in the light of ever increasing numbers of suicides in this country in all age groups. The establishment of the Special Task Force on Suicide by the Department of Health is to be welcomed and special attention needs to be focused on preventing suicide in older people. This specific topic is discussed in detail in Chapter 12, although some points are worth repeating here. There is reliable information on the factors associated with suicide in older people which might enable effective prevention strategies to be put in place. These include declining physical health which often involves loss of independence and chronic pain, recent bereavement of a loved one, alcohol and drug abuse, and social isolation and loneliness. Depression is present to some degree in the majority of elderly suicides. The depression may be as a result of the above factors, but may also be a long-term condition that has been present throughout adulthood (Stillion *et al.* 1989). Many of these factors can be managed if not alleviated, through appropriate medical and psychosocial interventions. Limiting access to the methods of suicide used by older people is difficult as most cases involve hanging or drowning. A general

evaluation of attitudes toward suicide among older people is also required, so that every suicide is seen as regrettable, not just those in younger people. We should work towards a situation where solutions are available to problems in life other than the taking of one's own life.

CHAPTER NINE

Treatment of Mental Disorders in Older People

This chapter describes the variety of treatment settings that now exist for the elderly mentally ill, with a section on the White Paper *A New Mental Health Act* (Department of Health 1995) and its consequences for the elderly. The second part of the chapter deals with the range of treatment options that are available for different mental disorders.

9.1 Treatment settings

Since the publication of *Planning for the Future* (1984) the range of treatment settings for psychiatric patients has expanded from the traditional hospital and out-patient clinic to include a variety of 'community settings', such as day hospitals and day centres. The patient's own home is now also recognised as a treatment setting with doctors and nurses visiting and treating patients in their own homes in several services around the country. While patients over 65 are usually treated within this range of psychiatric services there has also been an expansion in specialist services in old age psychiatry. Four services have now been established and more are planned. Within these services, facilities such as day hospitals are specifically for those over 65 years.

When an individual develops a mental disorder their first point of contact with the health services is usually with their general practitioner. As described in the introductory chapter, most mental illness is treated at this level without the individual ever being referred on to specialist services and the general practitioner will usually treat this level of illness with medication and/ or psychotherapy or counselling. However, if the general practitioner considers that more specialist care is appropriate, he or she refers the individual for an out-

patient appointment in the local psychiatric service. There, the person is seen by a psychiatrist who assesses him/ her and initiates treatment depending on the severity of the problem. Some individuals may only have this one contact with the psychiatric service and return to their general practitioner for treatment. If the person remains in the psychiatric service he/ she may continue at out-patient level, may have psychotherapy or other forms of intervention, or may be admitted to a day hospital for more intensive treatment. At some point in his/ her illness, the person may also require in-patient admission although this is rarely the case. Sometimes an individual's progress through the psychiatric system may be much more rapid and he/ she may 'skip' several steps. For example, a general practitioner may see someone who is very ill and refer him/ her immediately for admission to a psychiatric hospital or unit.

The psychiatric service in Ireland is based on catchment areas and sectors and people are treated in the psychiatric facilities available within their catchment area. The community psychiatric care team usually consists of a consultant psychiatrist with one or more registrars, psychiatric nurses, community psychiatric nurses (CPNs), and some input from social workers, occupational therapists and psychologists as not all services have full-time staff in these positions. There are approximately 152 CPNs, 50 psychiatric social workers and 38 psychologists working in the psychiatric services. Members of the psychiatric team liaise with the patient's family, general practitioner and other primary care workers such as public health nurses (PHNs), the community care team, voluntary groups and any others involved in the care of the individual. The structure and function of these teams is in accordance with that outlined in *Planning for the Future* (1984) which recommended multi-disciplinary, community-oriented, sector based teams providing comprehensive psychiatric care.

The services for old age psychiatry which have been established operate slightly differently, as they are able to tailor their services to the special needs of the elderly mentally ill. For example, following referral by a general practitioner, the first assessment is generally carried out in the patient's own home. This domiciliary assessment is usually conducted by a doctor and/ or a CPN and enables them to see the patient functioning at home. Further treatment can then be initiated on the basis of this assessment, for example, attendance at a day hospital within the service.

While there is a considerable amount of data relating to in-patient treatment, the fragmentation of services unfortunately leads to less comprehensive data collection on community services. Nevertheless, there is sufficient information to provide a picture of the treatment settings available to elderly patients and the use of these facilities by this patient group. Although the emphasis in *Planning for the Future* (1984) is on developing alternatives to in-patient treatment, in-patient admission remains an important feature of the treatment of mental illness in the elderly. The in-patient treatment setting will be described first, followed by alternative or community facilities.

9.2 In-patient treatment

There are 28 psychiatric hospitals and 13 psychiatric units in general hospitals around the country which operate on a catchment area basis. Psychiatric hospitals are gradually being replaced by psychiatric units in general hospitals. There are also eight private psychiatric facilities around the country which do not operate on a catchment area basis.

The most recent year for which in-patient admission figures are available is 1994. In order to make some comparisons with services over time, data from 10 years ago are used (1984 - the year *Planning for the Future* was published). In 1994 there were 26,578 admissions to Irish psychiatric hospitals and units (Keogh and Walsh, 1995).

Sixteen per cent (4,195) of these admissions were for people aged over 65 years. Table 9.1 shows a breakdown of these admissions by age group and type of in-patient facility for 1984 and 1994.

Of all in-patient admissions in 1994 for all age groups, 55 per cent were to health board psychiatric hospitals, 30 per cent to acute general hospital psychiatric units and 16 per cent to private psychiatric hospitals.

**Table 9.1: In-patient psychiatric admissions for 1984 and 1994.
Percentage of admissions to three different hospital types.**

Hospital type	Under 65		65-74		75+		Total 65+		All ages	
	1984	1994	1984	1994	1984	1994	1984	1994	1984	1994
Health board psychiatric hospital	69.1	56.2	67.8	46.7	70.7	47.0	68.6	46.8	69.0	54.7
Acute general hospital psychiatric unit	15.6	28.8	18.1	34.4	14.8	31.3	17.2	33.4	15.9	29.6
Private psychiatric hospital	15.3	15.0	14.1	18.9	14.5	21.7	14.2	19.8	15.1	15.7
Total	100	100	100	100	100	100	100	100	100	100
Number	24,185	22,383	3,369	2,788	1,276	1,407	4,645	4,195	28,830	26,578

Source: NPIRS 1984 and 1994.

For the over 65 group however, only 47 per cent of admissions were to health board psychiatric hospitals, with 33 per cent to units and 20 per cent to private hospitals. Within the over 65 age group there were also differences in admissions. These are most marked for admissions to private hospitals where 22 per cent of admissions for the over 75 group are to private psychiatric hospitals. Thus there are considerable differences between admissions to different facilities according to age, with more admissions in the older age groups occurring to units and private hospitals.

This pattern has changed considerably over the last few years as is evident when admissions for 1984 and 1994 are compared. For the over 65 group, admissions to health board hospitals have decreased by 22 per cent. The largest changes are in the 75 and over age group whose use of health board hospitals decreased by 24 per cent. There has been a corresponding increase in the use of general hospital psychiatric units over the same six year period by all age groups, with the largest increase again in the 75 and over age group. Admissions to private hospitals for those over 65 have increased by six per cent. While these figures reflect a general change in the use of in-patient facilities in all age groups the difference across ages is most marked for the use of private hospitals. Over the 10 year period examined, admissions to private hospitals for those under 65 have not changed, remaining at 15 per cent. However, for the over 65 group, admissions to private hospitals have increased from 14 per cent to 20 per cent. This change in the use of psychiatric in-patient facilities by those over 65 has important implications, particularly for health insurance and the funding of in-patient psychiatric care.

Table 9.2 shows the average length of time spent in hospitals for different age groups in the years 1984 and 1994. The pattern across age groups shows that older age groups consistently had longer episodes than the under 65 group, and that within the over 65 group, length of stay increases steadily with age. In 1994 for example, the length of stay for those under 65 was 24 days and for those aged 85 years or more was 40 days. Over the 10 year period, length of stay in hospital has decreased for all age groups although the decrease in over-65s as a whole has been small (43 days compared to 41) compared to the under-65s (34 days to 25).

Table 9.2: Average length of stay in hospital (in days) by age group. 1984 and 1994.

Age (years)	Days in hospital	
	1984	1994
Under 65	32	24
65-69	39	30
70-74	43	32
75-79	49	37
80-84	49	37
85+	47	40
Total 65+	43	41
All ages	34	25

Source: NPIRS 1984 and 1994.

9.3 Involuntary admissions

Table 9.3 shows the proportion of involuntary admissions by age group and shows that the proportion of involuntary admissions made for the over 65 age group has decreased from 16.5 per cent in 1984 to 12.1 per cent in 1994. This decrease may be related to the decrease in admissions for different diagnostic categories such as dementia; that has been observed in previous chapters.

Table 9.3: Involuntary in-patient admissions. Percentage by age group. 1984 and 1994.

Age (years)	1984	1994
Under 65	83.5	87.9
65-74	10.3	7.5
75+	6.2	4.5
Total 65+	16.5	12.1
All ages	3,555	2,906
Total	100	100

Source: NPIRS 1984 and 1994.

These figures on involuntary admissions highlight an issue which will soon change due to the proposed introduction of new mental health legislation in the next year. Currently, patients are treated under the *Mental Treatment Act 1945* which provides the statutory framework for the detention of people with mental disorder and the administration of the psychiatric services. Under this Act, people are admitted to a psychiatric hospital as a voluntary patient or if admitted involuntarily, as a temporary patient or as a person of unsound mind (PUM). A temporary patient is admitted and detained for treatment without his or her consent and is defined as, "suffering from a mental illness which is believed to require not more than six months suitable treatment for recovery" (p. 41) or "an addict who is believed to require at least six months preventive and curative treatment" (p. 41). A temporary patient is discharged if he or she recovers sufficiently to no longer require detention but may be further detained for an initial period of up to six months. This may be renewed for periods of up to six months for a maximum of two years in total. A PUM is a patient who requires detention for care and protection and who is unlikely to recover within six months. An individual admitted as a PUM may be detained for an indefinite period.

Under the proposed legislation the criteria for involuntary detention are broadly that an individual may be involuntarily admitted if they are suffering from a mental disorder and that because of this mental disorder they are a danger to themselves or others, or that their judgement is impaired to such a degree that a failure to admit would lead to a serious deterioration in their condition.

The important point, particularly in relation to the elderly, is in the definition of mental disorder, which in the 1995 White Paper is defined as, "mental illness, significant mental handicap and severe dementia" (p. 21). Severe dementia for the purposes of involuntary admission is further defined as, "a deterioration of the brain which

significantly impairs intellectual function affecting thought, comprehension and memory and which is associated with severe psychiatric or behavioural symptoms such as severe physical aggression" (p. 21). These conditions will be further defined so that a mental infirmity alone will not be grounds for detention. In the case of those individuals suffering from a severe dementia, the new Act proposes that they should be detained in centres specialising in the care of such persons. The new legislation also proposes to provide for an adult care order, which could be used to protect mentally disordered persons who are being abused, neglected or exploited. These individuals may not specifically need psychiatric care but they may require general treatment and care and the adult care order will provide for this.

A further change which is particularly relevant to the care of the elderly, is that concerning Wards of Court. Dementia sufferers (except in the earlier phases of the process) are mentally incompetent, which means they cannot take responsibility for themselves or their assets. In these circumstances such individuals are often made Wards of Court. This complex procedure results in a person being appointed to manage the ward's affairs while the high court takes charge of the property of the ward. Under the terms of the *1945 Mental Treatment Act*, a Ward of Court cannot be detained in a psychiatric hospital except under an order made by the President of the High Court. This resulted in slow and ponderous procedures if such a person required to be involuntarily admitted. The new legislation proposes that Wards of Court be subjected to the same procedures governing admissions as other persons. The Powers of Attorney Bill 1995, will introduce an enduring power of attorney which will enable people to make provision for the management of their affairs by a relatively simple procedure in the eventuality that they become mentally incompetent.

In general, the proposed new mental health legislation appears to tackle many issues which are of specific concern to elderly people and which were inadequately addressed by the 1945 Act. However, concerns about this new legislation have been expressed, particularly in relation to the impact on psychiatric services (Wrigley 1995). In particular, the need for treatment, as opposed to the need for care, should be carefully defined, in order to ensure that those who need care receive it in an appropriate setting, which is not necessarily an acute psychiatric treatment setting.

9.4 Out-patient treatment

Most in-patient treatment for functional or acute psychiatric illness is now of a short duration and these individuals are more generally followed up and treated in an out-patient setting. Figures collected by the Inspectorate of Mental Hospitals (Department of Health 1995), show that in 1994 there were 17,808 psychiatric out-patient clinics held around the country with approximately 125,093 attendances. Unfortunately, these figures are not broken down by age, so we cannot say what proportion of these visits were made by those over 65 years. However, data from the Three County Case Register (TCCR) show that of all those in out-patient care in 1993, just over half (51 per cent) were aged over 65 years.

9.5 Day hospitals and day centres

Although the distinction between day hospitals and day centres can be blurred, especially when the two services are provided from one facility, a day hospital generally provides acute treatment to patients, often as an alternative or adjunct to in-patient admission. Day centres for older people tend to have more of a social function. Several studies have shown that day hospital treatment is at least as effective as in-patient treatment and that treatment in a day hospital may have additional benefits such as improved social role performance (Creed *et al.* 1989b and 1991).

Unfortunately, these studies have only selected patients aged 18-65 for treatment so that the effectiveness of day hospital treatment for patients over 65 years remains unproved. However, a recent Irish study of a day hospital in the psychiatry of old age has addressed this shortcoming (Corcoran *et al.* 1994) and reported some interesting results. Of the 98 patients with a functional psychiatric illness (i.e., disorders other than dementia), 71 per cent were treated in the day hospital and with home visits without recourse to in-patient admission at all. Twenty-five per cent were admitted to hospital and this was significantly lower than the average admission rate. The patients admitted to hospital tended to be more physically ill than others. Overall, the clinical outcome for the patients with functional illness was good with significant decreases in psychiatric symptoms seen by discharge. Treatment in the day hospital also enabled patients to retain their independence and maintain their community supports.

This study also examined 139 patients with organic psychosis or dementia. The majority (63 per cent) entered residential care eight months on average after the initial referral. While this finding reflects the difficulty of managing patients with advanced dementia in the community, there were very positive aspects to the availability of a day hospital facility for these patients. Attendance at the day hospital facilitated thorough assessment and treatment so that only those patients with irremediable illness entered residential care. Even more importantly, the day hospital acted as a permanent supportive facility for 21 per cent of attenders with advanced dementia who attended for an average of 18 months. However, the authors noted that the lack of local day centres required patients to be kept for longer in the day hospital, thus occupying places that might have benefited other patients.

A further initiative in day treatment has been the development of day care centres by the Alzheimer Society of Ireland and other voluntary

groups to provide the type of ongoing support required by dementia sufferers and their carers. There are currently six 'full-time' day centres operated by the Alzheimer Society around the country and eight 'part-time' centres. Two more centres are being developed. Over 400 patients attend these centres each week providing valuable respite to their carers.

The Inspectorate figures for 1994 show that there were approximately 1,147 day hospital places and 1,788 day centre places around the country. Again there was no breakdown as to the use of these facilities in terms of age but case register figures from 1993 show that 31 per cent of attenders at these facilities were over 65 years, representing a rate of 97 per 100,000 population. There are now three day hospitals specifically for the elderly in Ireland, with over 800 people attending in 1995. These day hospitals provide a service only to people within their specific catchment areas. This currently covers approximately 60,000 people over 65 or 15 per cent of the overall elderly population.

9.6 Home care and domiciliary visits

Community psychiatric nurse (CPN) visits to patients at home have been a feature of the psychiatric services for some time now. Within a catchment area service, CPNs have a broad role which involves visiting patients to monitor their well-being and symptoms, and to offer support and advice on symptom management. CPNs also monitor patients medications and side-effects and play an important role in patient compliance with medication. As CPNs see patients in their own homes, they, of all the psychiatric team, probably have the most contact with the patients' families and carers. In this way the CPNs offer support and advice to families and keep them in contact with the psychiatric team. CPNs also liaise and co-operate with other agencies, both voluntary and statutory, such as general practitioners, public health nurses (PHNs) and meals-on-wheels, in order to link the

patient and family to other services from which they might benefit. Within a psychiatry of old age service, CPNs undertake many tasks but special emphasis has been placed on domiciliary assessment of the elderly mentally ill. There have been several reports from the US of the under-use of community based services for people with dementia following discharge from hospital and before placement in residential care (Spear and Herzberg 1995). CPNs can act as a vital link between in-patient and community services and can support the family in caring for the patient at home. Figures from the TCCR show that the rate of patients over 65 who received domiciliary visits (from CPNs) in 1993 was 24 per 10,000, compared to a rate of 12 per 10,000 for those under 65 years. However, within a psychiatry of old age service the rate of visits by CPNs is much higher, with over 5,500 home visits being made by two full-time and one half-time CPNs in the North Dublin service in 1994, a rate of 1,964 visits per 10,000 population over 65. This reflects the high demand for domiciliary monitoring and intervention in a psychiatry of old age service. Other members of the psychiatric team such as occupational therapists, psychologists and social workers also provide care and specific intervention programmes in the individuals own home, as well as other care settings.

As has been noted at several points throughout this report, the bulk of mental illness is treated at the primary care level, without recourse to specialist psychiatric services. Thus, general practitioners provide care to the majority of people over 65 with a mental disorder. PHNs and other community care services also provide care in the community for this group of people. Unfortunately, there is a lack of information regarding the types of disorder treated in primary care and we have no way of describing in any detail, the enormous contribution made by general practitioners, PHNs and other community care services to the care of the elderly mentally ill. The other group which make an inestimable contribution to the care of the elderly are their family and

friends, the 'informal carers'. An Irish study (O'Connor *et al.* 1988) estimates that over 50,000 people over 65 are cared for within their own homes, and that almost 50 per cent of these have a medium to high level of dependency because of a mental disorder. Thus, most care for older people with a mental illness is provided in the person's own home by his/ her family and relatives.

9.7 Treatment options

The most distressing signs and symptoms of mental disorders can generally be very well managed by medication, and when used in conjunction with other treatments like psychotherapy, they can be effective in preventing a recurrence of the illness. The emphasis on treatment in psychiatry is important because many symptoms of mental disorder can now be managed very effectively.

Generally speaking, the variety of treatments that are used to treat mental illness in people under 65 can also be used to treat those over 65. Issues relating to the accurate and early diagnosis of disorders (particularly dementia and depression) have been dealt with in earlier chapters, but it is worth noting that other mental illnesses can co-exist with dementia and with physical illness which highlights the importance of thorough assessment in order to successfully diagnose a mental disorder. This initial assessment is best carried out in the individual's usual environment (e.g., at home). A thorough assessment of both the patient and their carer (if appropriate) forms the basis of a treatment and care plan which is tailored to the specific needs of the individual. This care plan can then be systematically implemented.

A comprehensive care plan usually includes a range of treatments involving different care settings and different mental health professionals. The variety of treatment options to treat mental disorders can be broadly categorised into biological and

psychological. Treatment with psychotropic medication or pharmacologic treatment (i.e., medication which acts on brain processes) are in the biological category. A wide variety of drugs are now available to treat mental illnesses and those available in Ireland are similar to those available worldwide. The types of treatment that come under the psychological category include the various psychotherapies and behaviour therapy. The availability of these treatments in Ireland is not as widespread as elsewhere, mainly because of the lack of suitably trained personnel to carry out these therapies. For example, there are approximately 1.1 psychologists per 100,000 population in the mental health services in Ireland compared to 5.8 per 100,000 in the UK.

In this chapter, the treatment options available to treat depression and dementia will be outlined in some detail, not just because they are the commonest mental disorders in the elderly, but because many of the treatments and treatment principles apply to most mental disorders. For example, different medications are widely used in the treatment of mental disorders, but issues such as prescribing the most appropriate and effective drug for each individual and concerns over patients' compliance with medication are common to all disorders, from dementia and schizophrenia to depression and anxiety. Similarly with behavioural treatments¹, Newton and Lazarus (1992) concluded that these interventions provide a promising approach to understanding and treating not just behavioural problems but also many of the psychiatric and physiological problems experienced by the elderly. Problems amenable to the behavioural approach include depression and anxiety, and behaviour problems such as wandering, agitation and the socially inappropriate behaviour that is common in Alzheimer's Disease and related disorders.

¹ A specific type of treatment programme designed for each individual and systematically implemented to bring about change in an individual's behaviour.

Similarly, psychotropic medication can be successfully used to treat many mental disorders in old age. However, psychotropic drug treatment for older patients requires an understanding and awareness of several age related factors that influence the effects of these drugs:

- high prevalence of concomitant physical illness,
- increased likelihood of the use of multiple drugs (polypharmacy) and the consequent potential for harmful drug interactions,
- increased sensitivity of the ageing central nervous system to the effects of psychotropic drugs, and
- alterations in the ageing body's ability to bind, distribute and dispose of psychotropic drugs.

All these factors affect therapeutic as well as adverse reactions.

9.8 Treatment of depression

Even when depression is recognised and diagnosed in the elderly, effective treatment is not always undertaken (Lawlor 1995). MacDonald (1986) found that general practitioners had no difficulty in recognising depression in the elderly who attended surgery, but that these cases tended not to be referred to psychiatric services or treated with anti-depressants. That under-treatment is a problem is also suggested by other studies. Gurland *et al.* (1983) found that only 14 per cent of their London sample who had 'pervasive depression' were prescribed anti-depressants; Sharma and Copeland (1989) reported that only four per cent of their Liverpool sample were on anti-depressants prescribed by their general practitioners; and Livingstone *et al.* (1990) found that only 13 per cent of 'cases of depression' were prescribed anti-depressants. It seems that the value of treatment for older people with mild to moderate depression is not always recognised (Liffe *et al.* 1991). Part of the reluctance to treat may relate to a lack of awareness of treatment options. Lawlor (1995) suggests that depressive symptoms may be considered

'understandable' in terms of the individual's physical condition, or that depressive symptoms are regarded as part of the normal ageing process, with this process being seen as one of decline. He notes that primary care physicians appear to place great weight on the understandability factor and will opt not to treat depression in these instances, although it has been detected and diagnosed. In the context of poor social, physical or emotional circumstances, many of these depressions are viewed as 'untreatable' by the general practitioner.

However, depression is treatable in patients over 65 (Reynolds 1994). Once diagnosed, there are three principal therapeutic approaches employed in the management of depression: pharmacologic therapy, electroconvulsive therapy, psychological and social interventions.

9.8.1 *Pharmacologic therapy*

Numerous pharmacologic options, including tricyclic anti-depressants (TCAs), monoamine oxidase inhibitors (MAOIs) and the newer anti-depressants, selective serotonin re-uptake inhibitors (SSRIs), are available for treating depression in elderly patients. Trials have shown that both TCAs (Davis and Glassman 1989) and SSRIs (Dunner *et al.* 1992) are effective in treating depression in the elderly. However, older people metabolise anti-depressant drugs more slowly than younger people and are less tolerant of side-effects. Certain adverse effects of drugs, while they may be minor in younger patients, may be serious in the elderly. For example, increased levels of TCAs can lead to a worsening of mental state, delirium, falls and physical injury, notably hip fractures (Ray *et al.* 1987). The SSRIs have also been shown to be very effective anti-depressants and are effective in treating severe depression in older patients (Bocksberger *et al.* 1993). However, these new anti-depressants are quite expensive and this is a consideration when prescribing, particularly for general practitioners with the advent of drug budgeting. Anti-depressant drugs are used as

the first line treatment for severe depressive illnesses in late life, often in conjunction with some of the treatments outlined below.

9.8.2 Electroconvulsive therapy (ECT)

ECT is another option used in the treatment of depression among the elderly, particularly when there has been no response to anti-depressant drugs and where the person has biological symptoms such as severe anorexia or is actively suicidal. According to Benbow (1992), most studies indicate that 70-80 per cent of depressed elderly people selected for ECT respond well. Karlinsky and Shulman (1984), demonstrated ECT to be a safe and effective treatment in elderly patients.

9.8.3 Social and psychological approaches to the treatment of depression in late life

Traditional teaching has been that older people do not respond well to psychological treatments (Post 1985). However, Church (1986) believes that psychological therapy can be adapted to take account of issues surrounding the normal ageing processes and advocates a flexible and pragmatic approach to the treatment of depression in later years. A variety of models has been used with the depressed elderly (Lazarus 1989).

Psychotherapy is useful in patients whose depression appears to be related to adverse life events (such as bereavement) and severe ongoing psychosocial difficulties. Control studies have demonstrated that outcomes resulting from the use of both cognitive and behavioural approaches are superior to placebo treatment (Blazer 1989). Psychotherapy can be very usefully applied as an adjunct to pharmacologic therapy both to facilitate the patients' recovery and to aid in reintegrating him/ her into everyday life and to prevent relapse.

Family issues have been identified as important in many referrals to old age psychiatry services (Ratna and Davis 1984). Interest in family therapy for later life families has been growing, and its use for the treatment of depressive illness has been described by Benbow (1990). Other forms of counselling and support groups may be complementary to physical measures (i.e., drugs) taken to prevent relapse. Counselling related to specific issues such as bereavement or poor self-esteem is also beneficial.

One issue of great interest in the treatment of depression in older people is how it compares to the treatment given to younger patients, as there is a perception that older people are 'discriminated against' in terms of being offered a narrower range of treatment options than younger people. Brodaty *et al.* (1993) compared the types of treatment for depression administered to different age groups (see Table 9.4) and found some evidence for this. They found that patients over 60 were more likely to receive ECT and psychotropic medication than younger patients. Likewise, older patients were less likely to receive psychosocial therapy such as cognitive therapy, social skills and assertiveness training, family therapy and individual therapy. However, a study of 180 patients aged 60 to 98 years in the US showed lower drop-out rates from therapy than in younger patients (Mosher-Ashley 1994), indicating a willingness on the part of older patients to take part in psychotherapy. In an earlier study in a general practice setting, Brodaty *et al.* (1982) found that older people with minor psychological disorders were less likely than younger patients to receive psychosocial treatments. This may indicate a bias on the part of the physicians towards offering such treatments to the elderly, or it may suggest that the older patient is less inclined to avail themselves of such treatment, although Mosher-Ashley's findings would not support this. In view of the evidence that these types of treatment are equally effective in older people it is important that mental health professionals are made aware of this and encouraged to

offer psychosocial treatments to this patient group. General practitioners can also be encouraged to refer their patients for these treatments.

Table 9.4: Treatment received in first year of care by age group for patients with a diagnosis of depression. Numbers and percentages.

Type of therapy	18-39		40-59		60+	
	N	%	N	%	N	%
ECT	2	2	7	9	23	37
Mood drugs	69	66	52	68	55	90
Other psychotropic drugs	71	68	58	75	55	90
Psychosocial	76	73	53	69	31	51
Individual/ family therapy	61	59	43	56	20	33
Social skills/ cognitive therapy	47	45	36	47	15	25

Source: Brodaty 1993.

9.8.4 Continuation and maintenance therapy

Depression in those over 65 years has a tendency to recur, the risk of recurrence being greatest among patients with onset of depression after 60 years (Zis *et al.* 1980). Thus, most elderly patients will benefit from maintenance therapy that ensures remission, prevents recurrence, and goes some way to ensuring optimal quality of life for these patients. However, a serious obstacle to adequate treatment, particularly in maintenance therapy is patient compliance. As many as 70 per cent of elderly patients take only 50-75 per cent of their prescribed dose of anti-depressants (National Institutes of Health 1992). This is probably true of all psychotropic medication. Compliance can be enhanced by attention to side-effects and the use of measures to treat or reduce unpleasant side-effects. Other factors associated with patient compliance during therapy include involving and supporting family members in treatment, collaboration with the general practitioner and patient education to enable re-integration into the community (Reynolds 1994). These factors apply to the

therapeutic options for many mental disorders in the elderly, not just depression.

9.8.5 Treatment of depression in Alzheimer's Disease

The co-existence of dementia and depression in patients presents a particular challenge that is important to address as this is associated with a degradation in quality of life, greater burden on patients and care-givers, and increased likelihood of early placement in long-stay care (Reynolds 1994). The co-occurrence of depression and dementia symptoms is not uncommon with approximately 20-40 per cent of cognitively impaired older people exhibiting depressive symptoms (Wragg and Jeste 1989). While some report that treatment with tricyclic anti-depressants is effective, the evidence is inconclusive (Reifler *et al.* 1989). Using the newer anti-depressants, Hebenstreit *et al.* (1991) demonstrated highly significant improvements in 762 older patients with unspecified dementia who were also depressed. While the co-occurrence of dementia and depression can make both appear worse, the depression is treatable and this can have considerable benefits in improving the patients' well-being and manageability.

9.9 Treatment of dementia

Until recently dementia was largely ignored and no treatment offered until a crisis occurred involving the affected individual and/ or his/ her family, at which point the patient was admitted to a local institution, usually a psychiatric hospital. It is often thought that dementia is uncontrollable and unmanageable but this is not the case (Wrigley 1993). Ancill (1993) has described the, "therapeutic nihilism that occurs when physicians are asked to deal with patients with Alzheimer's Disease ... who present with dysfunctional behaviour" (p. 87). These beliefs can result in a reluctance on the part of many psychiatric and general medical hospitals to admit people with dementia. The changes in mental health services generally have resulted in fewer beds being available for admissions. There is also

increased pressure on acute medical beds. Many health care professionals working with older people have noted that the pressure on beds can add to the unwillingness on the part of services to admit an individual with dementia to acute facilities as they may remain there for some time (personal communication 1996). In this scenario it is the family and relatives of the dementia sufferer who shoulder the burden of care. Many families wish to be involved in caring for their relative with dementia, but the lack of support they receive in terms of day care or respite care can result in relatives becoming less involved. In answering the question, "what can be treated in Alzheimer's Disease?" Briggs (1993) responds that "sufferers and their carers require the integrated provision of a diagnostic service, community support and institutional care of a high standard" (p. 54). He places the general practitioner in the central role of orchestrating a comprehensive medical and social response to a dementing patient. The general agreement is that a very broad view of what constitutes treatment is required when responding to dementia.

9.9.1 Drug treatments for cognitive symptoms

Until recently, Alzheimer's Disease was seen as an untreatable condition. However, in 1993 Tacrine became one of the first drugs approved by the US Federal Drug Administration for the treatment of Alzheimer's Disease. Tacrine acts to correct a deficit of a chemical in the brain. Analysis of clinical studies and reports of long-term use of Tacrine indicate that 30-55 per cent of patients with Alzheimer's Disease may respond positively (Eagger and Harvey 1995). However, this drug has a high incidence of side-effects, some of which are quite serious, resulting in discontinuation in some patients. The drug is also not effective in all patients. Tacrine has not yet been licensed for use in Ireland. However, it represents a first step in the development of drug treatments for Alzheimer's Disease and other drugs are currently being developed.

9.9.2 Drug treatments for other symptoms in dementia

The other important use of drug treatments in dementia is to treat associated symptoms such as delusions and hallucinations, depression, insomnia and anxiety. However, O'Neill (1994), in discussing the pharmacologic treatment of Alzheimer's Disease in Ireland, notes that there is not a single adequate study of the benefit of psychotropic medication in Alzheimer's Disease. This is in spite of the fact that behavioural (or psychiatric) symptoms occur in 70-90 per cent of these patients. In reviewing the international literature on the subject he notes that, "the main thrust of research into the therapy of Alzheimer's Disease has concentrated on cognitive aspects of the illness, with a corresponding neglect of behavioural problems" (p. 76). In reviewing the efficacy of anti-psychotic drugs in people with dementia, Raskind and Peskind (1992) noted that efficacy is limited, and adverse effects often complicate treatment. While there are many non-pharmacologic therapies for agitated behaviours and dementia they conclude that the mainstay of therapy for this group of patients continues to be the provision of a safe, secure, and consistent environment, designed to compensate for the problems of the individual dementia patient. A central concern is providing support for the care provider, especially when the dementia sufferer is still residing at home. Self-help groups that have been fostered by the Alzheimer's Society of Ireland can be of great therapeutic benefit to family members and other care providers.

9.9.3 Behavioural treatments

Although drug treatments for alleviating the symptoms associated with Alzheimer's Disease are being developed, most of the treatment for dementia is focused on managing the secondary problems and disabilities associated with the disorder, mostly behavioural and social problems. There is a growing body of literature that suggests that a behavioural approach can be applied to alleviate certain behaviours of dementia patients that have traditionally been considered irreversible

and outside of the realm of intervention (Gugel 1994). An approach outlined by Krazner (1971) focuses on changing behaviour from non-functional to functional through the use of operant conditioning, a specific form of behaviour therapy. Behavioural approaches have been used specifically to deal with the problematic behaviour of patients with Alzheimer's Disease and related disorders. These problem behaviours include behavioural deficits and behavioural excesses as well as inappropriate behaviour. A review of the reported studies suggests that a behavioural approach can be successful in altering specific behaviours of elderly demented patients. Smyer *et al.* (1990), in reviewing the literature on the use of behavioural therapy, concluded that behavioural approaches involving the application of learning principles had been demonstrated to be effective as an intervention technique with the elderly for a variety of problems in a variety of settings. Specifically, studies have been reported in the literature that suggest that a behavioural approach can be applied to ameliorate certain behaviours of dementia patients.

Low activity levels among in-patient populations of elderly have resulted in many researchers attempting to increase participation levels and related behaviours. Cartensen and Ericsson (1986), among others, have successfully increased the frequency of appropriate social interactions in this patient group. In addition, Patterson and Eberly (1983) have reported increases in self-care and social skills using behavioural intervention approaches. The behavioural approach however, has limitations. While one behaviour may be successfully changed these changes have not tended to generalise or 'spread' to other behaviours. Also the altered behaviour may revert to old problem patterns when the treatment programme has terminated. The use of behavioural approaches appears to be limited in nursing home settings (Guy and Morice 1985), possibly because the implementation of these approaches requires not only care-giver training but the consistent maintenance of appropriate environmental

contingencies. Behavioural approaches remain useful however, for the management of demented patients.

9.9.4 Other psychological treatments

The use of psychotherapy has been dismissed by many in the early stages of dementia (Bloom 1993). However, it has been reported that not only do some patients have insight, but some also welcome the opportunity to discuss their distress (Reisberg *et al.* 1982). Psychotherapies can also help to shift the focus away from the disabilities which dementia brings onto the remaining abilities of the individual. Therapies such as reality orientation (Holden and Woods, 1988) and reminiscence therapy (Coleman 1986) attempt to maintain cognitively impaired people in contact with ordinary daily events, and their past lives. Reminiscence therapy uses photographs, music or other aids to stimulate discussion and evoke memories of pleasing past events. It has not been systematically assessed but has been found rewarding by formal and informal carers (Jaques 1988).

9.9.5 Dementia services

While drug treatments for dementia are being developed, the existing structure and type of services available to dementia sufferers is very important. *The Years Ahead* report (1988) highlighted the dearth of services available for those with dementia and recommended the Belfast model of services for people with dementia as an example of good practice. This model emphasises the importance of all the agencies involved in caring for this group of people working closely together, that is, community care, medical care and psychiatric care. This close co-operation ensures a full range of flexible community support, residential care and acute medical, and psychiatric services are available to dementia sufferers and their carers. The model in Chapter One of this report illustrated some of the services required for people with dementia and an outline structure for these services. The essential components of a service for people with dementia include:

- a comprehensive range of support services for people with dementia living at home and their carers, including; general practitioner, public health nurse, home help, social worker and other members of community care team as appropriate, voluntary groups, respite care, both day and residential
- access to psychiatry of old age services which includes; psychiatrist, community psychiatric nurses, other members of the psychiatric care team as appropriate, day hospital, day centre, respite care, admission to psychiatric hospital when appropriate
- access to acute medical care
- access to long-stay residential care which is appropriate to the needs of the individual, such as; nursing homes, community hospitals and welfare homes.

Several other elements are required in order to make such a wide range of services work for the individual. A considerable degree of flexibility in the referral and transfer of patients between the services is required. This is largely reliant on good communication. This can be enhanced by having formal psychiatric liaison services in general medical hospitals and also by some local structure which facilitates the coming together of professionals from the primary care and the two secondary care services.

9.9.6 Environmental interventions

One of the more novel approaches to treatment, especially for those conditions with limited treatment options, is to intervene at the environmental level. For example, well designed surroundings should encourage freedom of movement in a safe environment for ambulant restless people. This would help reduce the need for pharmacological restraint. Regnier and Pynoos (1992) describe 12 environmental and behavioural principles derived from design based research that effect the behaviour and quality of life of cognitively impaired older people in both purpose-built and home environments:

- *Privacy*: Provide opportunities for a place of seclusion from company or observation where one can be free from unauthorised intrusion.
- *Social Interaction*: Provide opportunities for social exchange and interaction.
- *Control, Choice and Autonomy*: Provide opportunities for residents to make choices and control events that influence outcomes.
- *Orientation and Wayfinding*: Foster a sense of orientation within the environment that reduces confusion and facilitates wayfinding.
- *Safety and Security*: Provide an environment that ensures each user will sustain no harm, injury or undue risk.
- *Accessibility and Functioning*: Consider manipulation and accessibility as the basic requirements for a functional environment.
- *Stimulation and Challenge*: Provide a stimulating environment that is safe but challenging.
- *Sensory Aspects*: Changes in visual, auditory and olfactory senses should be accounted for in environments.
- *Familiarity*: Environments that use historical reference and solutions influenced by tradition can provide a sense of familiarity and continuity.
- *Aesthetics and Appearance*: Design environments that appear attractive, provocative and non-institutional.
- *Personalisation*: Provide opportunities to make the environment personal and to mark it as the property of a single, unique individual.
- *Adaptability*: An adaptable or flexible environment can be made to fit changing personal characteristics.

These principles can be selectively applied to different residential settings, from the patients' own home to institutions, in order to improve the living environment and help to mitigate some of the

problems cognitively impaired patients might encounter. They are also not specific to people with dementia and many of these design principles are appropriate to older people in any setting.

9.10 Summary

The different treatment settings available to older people with mental illness have been described. Their use of in-patient psychiatric facilities is different to those under 65, with a greater proportion of older people being admitted to private psychiatric hospitals and acute general hospital psychiatric units (see Table 9.1). For example, in 1994, 56 per cent of admissions for under-65s were to health board psychiatric hospitals, compared to 47 per cent in those over 65, a difference of nine per cent. This different use of in-patient psychiatric facilities is even more apparent when the admission patterns in 1984 are examined. In that year there was no difference in admissions to health board psychiatric hospitals for the under- and over-65s. An examination of admissions to private psychiatric hospitals also reveals differences between age groups. For those under 65 admissions to private hospitals stayed the same from 1984 to 1994 (15 per cent), while there was an increase of six per cent for those over 65. Several factors may have brought about this change. The economic status of older people may have improved in this time so that more can afford the health insurance required to pay for admission to a private psychiatric hospital. It may, in part, reflect the change in admission policy which is evident from the 22 per cent reduction in psychiatric admission rates to health board psychiatric hospitals for over-65s from 1984 to 1994. Whatever the explanation, this changing pattern of use in psychiatric in-patient facilities by those over 65 has important implications, both in terms of alternative in-patient treatment for this group and for the funding of health insurance and in-patient psychiatric care in general.

The proposed mental health legislation has considerable implications for in-patient treatment of the elderly in that mental infirmity alone will no longer be sufficient grounds for involuntary detention, only severe dementia. This legislation also makes provision for adult care orders and simplifies the procedures for involuntarily admitting someone who is a Ward of Court.

Other treatment settings available to older people with mental illness include out-patient clinics, day hospitals and day centres, home care or domiciliary visits. Unfortunately, data concerning the use of these services are not available nationally by age group, thus it is difficult to estimate the availability and use of these services by older people. Extrapolating from available data would suggest that people over 65 are 'over-represented' at out-patient clinics, with possibly as many as half of all out-patient visits being made by this group. Domiciliary visits by CPNs are also an important part of the psychiatric service for older people, as access to day hospitals or day centres can be difficult, particularly in rural areas.

There is no information available regarding the use of day hospitals and day centres in the general psychiatric services by those over 65. Three day hospitals for the psychiatry of old age are currently in operation nationally. These are catchment area based and cover approximately 15 per cent of people over 65 in Ireland. The bulk of care to older people with mental illness is provided by the primary care services and carers within the home. The needs of informal carers and their enormous contribution to the care of older people have been the subject of many Council publications.

The variety of treatment options available to treat mental disorder in older people are described. The most effective and widely available are the various drug treatments. Psychological, social and environmental treatments can also be very effective in treating specific

problems, although these approaches are not used as often for older people as they are for younger people. This may be due to the belief that older people do not benefit from these treatments, although the evidence shows the contrary. It may also be due to the shortage of suitably trained personnel to carry out these treatments.

Specific issues relating to treatment in the elderly are:

- the importance of thorough assessment before diagnosis and treatment, because of the particular problems of concomitant physical and/ or psychiatric illness
- the awareness of age related factors that influence both therapeutic and adverse reactions of psychotropic drugs
- the importance of continuation and maintenance therapy in many disorders and the obstacles to this
- awareness of the fact that in spite of a range of treatments being as effective in older as in younger people, they are not used as often in this group
- the range of diverse treatments that have been found to be effective with older patients but that are not used as frequently as they are with younger patients, particularly psychotherapies
- awareness of treatments such as behaviour therapy and environmental interventions which can provide some level of treatment for those conditions that are not amenable to more traditional therapy.

CHAPTER TEN

Acute Service Use by Older People with Mental Disorders

In this report we have described the type of mental disorders which affect older people and how widespread they are. Between 20 and 25 per cent of the Irish population over 65 years can be affected by a mental disorder at any one time. We have also described the types of treatment and treatment settings available. While we have used psychiatric service contact statistics in many chapters as a proxy measure to describe the incidence and prevalence of mental disorders we have not yet described the use of acute services by older people with mental disorders.

10.1 Policy developments

10.1.1 *Planning for the Future*

Psychiatric service requirements for this group were reviewed in *Planning for the Future* (1984) which noted that, "A comprehensive integrated geriatric service is required to cater for the needs of the elderly, including the demented elderly. This service should incorporate assessment facilities and long-stay accommodation in addition to a wide range of community support" (p. 82).

Among the recommendations of this report were that, "The majority of persons suffering from dementia should be cared for by the primary care service or by the geriatric service. The current practice of routinely admitting demented patients to psychiatric hospitals should be discontinued" and "In general, the psychiatric needs of the disabled elderly should be met by the sector team, but, in densely populated areas, consideration should be given to the appointment of a psychiatrist whose main area of expertise would be the psychiatry of old age" (p. 89). Interestingly, *Planning for the Future* did not

distinguish between patients with dementia with or without behaviour problems, as this is a central factor in determining treatment setting.

In the context of these recommendations, an examination of acute service use by older people with mental illness is warranted. The comparisons between psychiatric admission figures for 1984 and 1994 throughout this report have revealed a 50 per cent decrease in admissions for dementia. Thus the practice of routinely admitting demented patients to psychiatric hospitals does seem to have been discontinued. However, we have no information on who is currently caring for the majority of people with dementia, whether it is the primary care and geriatric services, as recommended by *Planning for the Future*, or whether psychiatrists with expertise in the psychiatry of old age have been appointed to sector teams around the country.

10.1.2 The Years Ahead report

These recommendations were reviewed some years later in *The Years Ahead* report (1988) which acknowledged that functional mental illness in older people should be managed in the same way as younger people, with the majority being treated by their general practitioners with referral to a psychiatric team when necessary. The formation of psychiatric teams servicing sector populations as recommended by *Planning for the Future* was seen as complementary to the organisation of services for the elderly proposed by *The Years Ahead*. However, this report noted, with regard to care for older people with dementia that, "the absence of ... a continuum of care is ... one of the major gaps in services for the elderly at present and one that requires urgent attention" (p. 151).

For those patients with dementia *The Years Ahead* described the 'South Belfast Model' which provides a continuum of services with increasing support as the dependency of the individual grows. Its success is largely due to interdisciplinary co-operation between

general practitioners, the social services department, geriatric medicine and the psychiatric services. A wide range of facilities is also provided with agreed policies for the admission and discharge of patients to different facilities. With reference to services for people with dementia *The Years Ahead* recommended that, "health boards develop day hospitals for the elderly with dementia in the main urban centres, under the direction of psychiatrists with an interest in this field. A norm of two day hospitals places per 1,000 elderly people for the confused elderly has been suggested in Great Britain and we recommend that it be used for planning purposes here" (p. 157). A further recommendation was, "that one of the psychiatrists in the sectors which correspond to a community care area should have responsibility for the care of the elderly with severe dementia" (p. 161), and that psychiatrists with responsibility for the elderly be appointed in Dublin and Cork to develop psychiatry of old age services. *The Years Ahead* report seems to have led to a diffusion of responsibility among those treating older people as a multi-professional approach was recommended without a description as to how this might be brought about.

Currently older people who are acutely mentally ill and who require hospitalisation can receive treatment in three settings:

- psychiatric hospitals and units
- old age psychiatry services
- acute general hospitals

This chapter deals with acute service use, but it should not be overlooked that community psychiatric services are equally important in the treatment of older people with mental disorders. These services are described in Chapter Nine of the present report.

10.2 Acute psychiatric hospital use

The number and rate of admissions to acute psychiatric hospitals and units by age group for 1984 and 1994 are shown in Table 10.1. This table also shows the proportion of admissions accounted for by each age group. In this period the overall rate of admissions has decreased from 837 to 754 per 100,000 for the total population. The proportion of admissions for the over 65 group has changed little, being 16.1 per cent in 1984 and 15.7 per cent in 1994. The rate of admissions for this group has decreased from 1,254 per 100,000 in 1984 to 1,041 per 100,000 in 1994.

Table 10.1: All admissions to acute psychiatric in-patient facilities by age group. Ireland 1984 and 1994. Numbers, percentages and rates per 100,000 population.

Age (years)	IRELAND 1984			IRELAND 1994		
	Number of all admissions	% of all admissions	Rate of admissions per 100,000	Number of all admissions	% of all admissions	Rate of admissions per 100,000
Under 15	91	0.3	9	208	0.8	20
15-19	630	2.2	193	818	3.1	247
20-24	1,883	6.5	682	1,772	6.6	619
25-34	5,834	20.2	1,220	5,373	20.1	1,072
35-44	6,244	21.6	1,736	6,046	22.7	1,434
45-54	5,064	17.6	1,679	4,721	17.7	1,527
55-64	4,457	15.5	1,543	3,445	12.9	1,221
65-74	3,369	11.7	1,421	2,788	10.4	1,159
75+	1,258	4.4	954	1,407	5.3	978
Unknown				109	0.4	
Total	28,830	100	837	26,687	100	754

Source: NPIRS 1984 and 1994.

Table 10.2 presents comparative psychiatric admission rates for Ireland and England. The over 65 group comprised 15.7 per cent of all psychiatric admissions in Ireland in 1994 and 34.3 per cent of all

psychiatric admissions in England in 1993/94. On closer examination, the proportion of admissions for the 65-74 group is quite similar (10.4 per cent in Ireland and 11.9 per cent in England), it is admissions for the 75 and over group which shows the greatest disparity between the two countries (5.3 per cent versus 22.4 per cent). However, as the population structure of the two countries is quite different we really should examine age-specific rates. This reveals that the rate of admissions for the over-65s in Ireland was 1,041 per 100,000 and in England was 999 per 100,000. The rate for the 65-74 group was higher in Ireland (1,159 versus 618) while the rate for those aged over 75 was considerably lower in Ireland (978 versus 1,484).

Table 10.2: All admissions to acute psychiatric in-patient facilities by age group. Ireland and England, 1994 and 1993/4*. Numbers, percentages and rates per 100,000 population.

Age (years)	IRELAND			ENGLAND		
	Number of all admissions	% of all admissions	Rate of admissions per 100,000	Number of all admissions	% of all admissions	Rate of admissions per 100,000
Under 15	208	0.8	20	3,100	1.4	33.1
15-19	818	3.1	247	5,700	2.5	202
20-24	1,772	6.6	619	15,600	7.0	438
25-34	5,373	20.1	1,072	43,100	19.0	553
35-44	6,046	22.7	1,434	35,200	15.7	540
45-54	4,721	17.7	1,527	26,000	11.6	437
55-64	3,445	12.9	1,221	18,600	8.3	386
65-74	2,788	10.4	1,159	26,600	11.9	618
75+	1,407	5.3	978	50,200	22.4	1,484
Unknown	109	0.4				
Total	26,687	100	754	224,100	100	462

*Source: Ireland: NPIRS 1994. England: Health and Personal Social Services Statistics for England. 1995 edition, most recent data from 1993/94.

Another important point in the interpretation of these figures is the total psychiatric admission rate which is considerably higher in Ireland compared to England (754 per 100,000 versus 462). The disparity is greatest in the 45-54 age group, where the Irish rate is more than three times that of the English. In this context of higher overall admission rates in Ireland it would seem that the over 65 group are somewhat 'under-represented' in psychiatric admissions. The admission rate for this group is also decreasing.

Within Ireland there is also considerable variation seen in the admissions for people over 65. Table 10.3 shows the number and rate of all psychiatric admissions categorised by health board area.

Table 10.3: All admissions to psychiatric hospitals and units by age group and health board, 1994. Numbers and rates per 10,000 population.

Health board	65-74		75+	
	Number	Rate	Number	Rate
North Western	241	129.4	78	66.3
Western	321	104.7	168	90.5
Mid-Western	263	118.6	78	59.7
Southern	390	96.8	184	77.6
South Eastern	350	133.4	181	113.4
Eastern	863	128.3	538	131.0
North Eastern	213	104.2	97	85.0
Midland	142	95.6	81	97.4
Non-nationals	5	na	2	na
Total	2,788	115.9	1,407	97.8

Source: NPIRS 1994.

For the 65-74 age group rates vary from 95.6 in the Midland Health Board to 133.4 in the South Eastern Health Board. Even greater variation is seen in the oldest age group (75 years and over) with the

Mid-Western Health Board having the lowest rate (59.7 per 10,000 population) and the Eastern Health Board the highest (131.0 per 10,000 population). While differences in the number of beds in psychiatric hospitals probably accounts for some of the variation it is also possible that different admission policies operate resulting in some of the variance seen.

10.3 Psychiatry of old age services

The first psychiatry of old age service to be established in Ireland was that set up in North Dublin in January 1989. This was established as a pilot project by the Eastern Health Board to provide assessment and management of patients suffering from functional disorders such as depression, and organic disorders such as dementia. The aim of the service is to offer a comprehensive community-oriented psychiatric service to elderly people within a designated catchment area. The total catchment area population is 257,358 of which 27,110 are over 65 years. The service is staffed by a consultant psychiatrist, a senior registrar, three registrars, and an assistant chief nursing officer, two CPNs, an occupational therapist, two part-time psychologists and a secretary. The range of services available include domiciliary assessment by a psychiatrist of all new referrals, out-patient clinics, two day hospitals, psychiatric in-patient beds, extended care beds, respite beds and follow-up of patients following discharge.

A psychiatry of old age service has been operating in the Dublin South Central catchment area since 1991, serving a population of 17,000 over 65. The service is centred in the Martha Whiteway Day Hospital, which is in the grounds of St. Patrick's Hospital. This service is headed by a consultant psychiatrist with a senior registrar and two registrars who rotate between St. James's Hospital and the day hospital. The day hospital is staffed by one nursing officer, one staff nurse and one occupational therapist who work as part of a multi-disciplinary team. Other members of the team include a social

worker and a CPN. A range of services are provided by this team including domiciliary assessment, the day hospital which operates individual care plans, out-patient clinics, in-patient admission, short-term respite care, an alcohol dependence programme, follow-up of patients in the community and a family/ care-givers programme.

A psychiatry of old age service is currently being established in Dublin South East to cover 29,000 people aged 65 years and over in Community Care Areas 1 and 2 of the Eastern Health Board. This service is based in St. Vincent's Hospital, Elm Park and will provide a range of services including domiciliary assessments, out-patient clinics, day hospital care, in-patient care, continuing care facilities and respite care. This service will deal with two major types of referral, people over 65 years with new onset functional psychiatric illness and those over 65 years with an organic mental illness, particularly dementia, who exhibit major behavioural disturbance. This service will be staffed by a team headed by a consultant psychiatrist and will include a senior registrar, an occupational therapist, a psychiatric social worker, a clinical psychologist, nursing staff and a secretary.

There is also an informal service for patients over 65 in North Dublin based in St. Ita's Hospital. There are approximately 200 patients over 65 in St. Ita's and there are four respite beds. Around 150 referrals a year are seen by the consultant in charge.

A psychiatry of old age service for Limerick City and its environs commenced in March 1995. This service includes elements common to comprehensive community services for the elderly including domiciliary visits, an out-patient service, a day hospital, respite care, an elderly mentally infirm unit, a functional mental illness facility and a liaison service to the regional hospital. The service is staffed by a consultant in old age psychiatry, a psychiatric registrar, five nurses and a part-time secretary. Eventually, this service is planned to

provide a regional service to the elderly in the Mid-Western Health Board.

Specialist services in the psychiatry of old age are also planned for some other health boards, while others plan to have care of older people with mental disorders as part of the general adult psychiatric services with no specialist input.

Table 10.4 shows the number of first and re-admissions to the psychiatry of old age services that are currently in operation. These services, and those that are planned, are sector based, thus are available only to people over 65 living in the relevant sector or in the catchment area of the service, resulting in significant inequities in access to services. The existing services cover approximately 60,000 people over 65, which is 15 per cent of the national population over 65.

Table 10.4: Admissions to psychiatry of old age services. 1995.

Admissions	North Dublin	South Central Dublin	Limerick*	Total
New patients	348	135	18	501
Re-admissions	160	99	88	347
Total	508	234	106	848

Source: Psychiatry of old age services in North Dublin, South Central Dublin and Limerick.

* This service commenced midway through 1995.

10.4 Acute general hospital services

The Hospital In-Patient Enquiry (HIPE) system collects data on all admissions to acute general hospitals, achieving 91 per cent coverage in 1994. In that year there were 562,999 admissions recorded, 28 per cent of which were for people aged over 65 years. Of these 156,695 admissions, 1,673 or 1.1 per cent were admissions with a first diagnosis of psychiatric disorder (ICD 9: 290-319), and 8,924 (5.7

per cent) had a second diagnosis of psychiatric disorder. Table 10.5 shows the number of admissions, total bed days and average length of stay of the cases with a first diagnosis of psychiatric disorder, by age group and gender.

Table 10.5: Number of admissions to acute general hospitals with a first diagnosis of mental disorder. Bed days and average length of stay. Age group and gender.

		65-69	70-74	75-79	80-84	85+	Total 65+
Male	Admissions	118	136	198	128	71	651
	Bed days	1,683	1,302	5,189	2,743	1,307	12,224
	Average length of stay (in days)	14.3	9.6	26.2	28.4	18.4	18.8
Female	Admissions	140	194	212	266	210	1,022
	Bed days	2,267	2,492	4,311	7,555	8,192	22,817
	Average length of stay (in days)	16.2	12.5	20.3	28.4	29.5	22.3
Total	Admissions	258	330	410	394	281	1,673
	Bed days	3,950	3,794	9,500	10,298	7,499	35,041
	Average length of stay (in days)	15.3	11.5	23.2	26.1	26.7	20.9

Source: HIPE 1994.

The average length of stay for all admissions over 65 with a first diagnosis of psychiatric disorder was 21 days or three weeks and 35,041 bed days were occupied by 1,673 cases. An analysis of the secondary diagnoses coded for these cases revealed that approximately 20 per cent had no secondary diagnosis, 13 per cent had another psychiatric diagnosis and nine per cent had a social problem recoded as the secondary diagnosis such as 'person living alone'. The remainder had diagnoses of physical disorders, mainly respiratory and heart problems. Any interpretation of the diagnostic data from HIPE, or any database, is dependent on the accuracy and completeness of the diagnostic coding. An additional difficulty in interpreting these data is that patients may have been given a principle diagnosis of a physical problem in order to facilitate their admission to an acute general hospital. However, we can tentatively conclude from these data that of these 1,673 admissions with a primary

diagnosis of psychiatric disorder, at least 40 per cent were admitted solely for a psychiatric disorder, or had an accompanying social problem, that is they were inappropriate admissions to an acute general hospital. Boland and Hennessy (1993) and Clinch and Hickey (1992) in their studies in Clare and Limerick found that 26 per cent of patients in acute hospital beds had significant cognitive impairment.

Hayes *et al.* (1995) examined the utilisation of hospital beds by those over 65 (all diagnosis not just psychiatric) in a Dublin hospital and found that almost one-third (29.1 per cent) of days in hospital were 'inappropriate', that is, these patients were not receiving active care. Social 'risk factors' for inappropriate bed days included marital status of the patient and admission for social reasons. The largest number of inappropriate bed days was due to patients awaiting transfer to another level of care and this factor was also mentioned by Twomey *et al.* (1995) in their study of patient throughput in an acute geriatric unit in Cork.

10.5 What level of service should be provided?

Any discussion of resources for services or 'planning norms' must be tempered with a consideration of local population needs. The eight health board areas have differing age profiles, with, for example, a higher proportion of older people in the North Western region. These norms also represent an ideal for service provision which may not be possible with available resources. Nevertheless, some guidelines are necessary in order to plan levels of service provision. In *The Years Ahead* service norms for the psychiatric services included:

- acute psychiatric assessment beds to elderly population 1.5:1,000
- beds for elderly severely mentally infirm to elderly population 3:1,000
- day hospital places to elderly population 2:1,000

The planning norms for the psychiatric services in general (i.e., not specific to the psychiatry of old age) from the report of the Inspector of Mental Hospitals are:

- in-patient places for new long-stay patients aged over 65 to population over 65 5 : 1,000

The joint report of the Royal College of Physicians and Royal College of Psychiatrists (UK) on *Care of Elderly People with Mental Illness* (1989) noted the key resources for a psychiatry of old age service to a catchment area comprising 20,000 people over 65 to be:

- beds for functional illness 12
- beds for organic illness (short-stay assessment and relief) 20
- beds for long-stay 40-60
- day places for functional illness 10-15
- day places for dementia 40-50
- consultant staffing 1 wte*

(*one whole time equivalent consultant per 10,000)

No evaluation of the above norms has been carried out in the context of the needs of the elderly mentally ill in Ireland. The data required to do this, even at the most fundamental level, are currently not routinely available.

10.6 Summary

The prevalence of mental illness is higher in the over-65s than in those under 65 so we might expect to see heavier use of psychiatric services by this group. However, an analysis of psychiatric admissions shows that over-65s account for only 16 per cent of all admissions and that the rate of admissions for this group has decreased by almost one-fifth since 1984. A comparison with the psychiatric admission statistics for England showed that 34 per cent

of admissions in England were for people over 65. Rates of admission revealed a slightly confusing picture, with the rate of admission for the age group 65-74 years being higher in Ireland while the rate for those aged 75 years and over was higher in England. However, the overall rates of admission are higher in Ireland in all other age groups so it would seem in this context that the rates for the 65 years and over group show an 'under-representation' of this group in psychiatric admission figures. Considerable variation is also seen in admission rates for older people across the eight health board areas in Ireland.

This decrease in psychiatric admissions and relatively low admission rate for those over 65 has not been accounted for by the provision of psychiatry of old age services as only three such services in the country are fully operational. In 1995 the day hospitals in these services catered for approximately 800 people, a rate of 20 per 10,000 population. Only 15 per cent of the population over 65 are currently served by psychiatry of old age services.

People over 65 accounted for 156,695 (28 per cent) admissions to acute general hospitals in 1994. This has increased from 25 per cent in the mid-1980s. While only a small proportion of these admissions were 'inappropriate' in the sense that they had only psychiatric problems, the pressure on acute beds in these hospitals means that these admissions use very valuable and scarce resources.

There is an urgent need for a national evaluation of the provision of services for older people with mental disorders to determine if they are adequate in meeting the prevalence and variety of disorder in this population. A priority should be the appointment of sufficient consultants in the psychiatry of old age to serve the elderly population. Until this is done, considerable inequities will exist in service access across the country. An evaluation of service provision

would also need to build on the projected increase in this population over the next 20 years to ensure that there will be adequate services available. This is essential if the central aim of the Department of Health Strategy in relation to the elderly is to be implemented, that is, to promote independent living and community based care for those over 65.

Mental Disorders in Long-Stay Care Settings

by John Browne

This chapter will examine the prevalence of mental disorders in both psychiatric and non-psychiatric long-stay care settings. While the future development of the Irish psychiatric services is in the direction of community based care, there is a continuing requirement for residential care of the mentally ill. Some older people with a chronic mental disorder require long-stay care within psychiatric facilities, usually in long-stay wards within psychiatric hospitals. These patients are generally suffering from a disorder that requires regular supervision, such as schizophrenia with behavioural disturbance. A substantial number do not require long-stay specialist supervision however, and are placed in non-psychiatric residential facilities. In addition there are many patients in residential care who were admitted for non-psychiatric reasons, such as physical disability, but who have a concomitant mental disorder such as depression or dementia.

11.1 Long-stay psychiatric care facilities

There are two main types of long-stay psychiatric care in Ireland. The first is within the long-stay wards of psychiatric hospitals and units. The second is in community residential accommodation (psychiatric hostels). In addition a small number of patients reside in de-designated psychiatric facilities.

11.1.1 Psychiatric hospitals and units

Information on long-stay residents of psychiatric hospitals and units is readily available in Ireland, as a census of residents is taken regularly. The census reveals that the overall population of these facilities has declined significantly over the last 30 years from 19,801 in 1963 to 5,761 in 1993. This represents a reduction from 70.3 to 16.3

psychiatric patients per 10,000 population. The decline has been brought about mostly by the development of community psychiatric services and community residences and by the de-designation of facilities that were solely for the care of individuals with mental handicap or older people.

There were 3,301 people over 65 years of age in psychiatric hospitals and units on March 31st 1991 (81.9 patients per 10,000 elderly population). This figure includes both long-stay patients and those who have been admitted for a short period only. Table 11.1 clearly shows that older people have the highest rate of psychiatric residence of all age groups. The rate per 10,000 population for people over 75 years was 104.9 in 1991 compared to 6.9 for people aged 20-24 years, for example. This does not indicate a dramatically higher rate of mental disorder in older people. In most cases, the older patients were admitted at a younger age and have 'grown old' in the institution.

Table 11.1: Patients in psychiatric hospitals and units for the psychiatric census 1971, 1981 and 1991. Age group and rates per 10,000 population.

Age (years)	1971	1981	1991
Under 15	2.3	0.7	0.4
15-19	10.9	4.6	3.2
20-24	26.6	14.3	6.9
25-34	48.4	27.5	13.9
35-44	76.0	51.7	24.2
45-54	96.7	79.2	39.1
55-64	131.3	103.7	56.6
65-74	147.2	122.9	74.5
75+	173.6	160.9	104.9

Source: Irish Psychiatric Hospitals and Units Census 1971, 1981 and 1991.

Table 11.1 also shows that the greatest reduction in the rate of long-stay psychiatric institutionalisation has occurred with older age groups. If this trend continues the pronounced imbalance in the age profile of long-stay psychiatric hospital residents is likely to be greatly reduced in coming years.

Of all older patients in psychiatric hospitals and units, 2,641 were resident for more than one year. Table 11.2 shows that the profile of older patients by length of stay has remained very stable over the last 20 years. Long-stay elderly patients are still common, with more than one-third resident for more than 25 years.

Table 11.2: Length of stay in psychiatric hospitals and units for patients aged over 65 years. Percentage for 1971, 1981 and 1991.

Length of stay	1971	1981	1991
Less than 1 year	16	17	20
1-5 years	20	20	19
6-10 years	12	11	11
11-24 years	17	19	16
25 years or more	35	33	34
Total	100	100	100

Source: Irish Psychiatric Hospitals and Units Census 1971, 1981 and 1991.

The 3,301 older people in psychiatric hospitals and units in 1991 had a range of diagnoses, but schizophrenia and dementia (organic psychoses) were the most common (Table 11.3). The number with dementia has decreased in recent years from 24 per cent in 1971 to 17 per cent in 1991. This is as a result of policy changes on the placement of patients with dementia. Otherwise the diagnoses have remained quite stable.

Table 11.3: Percentage of patients resident in psychiatric hospitals and units aged 65 years or more. Three census years and diagnostic category.

Diagnosis	1971	1981	1991
Schizophrenia and other psychoses	45	40	44
Organic psychoses (dementia)	24	21	17
Manic-depressive psychoses*	18	23	22
Mental handicap	7	7	5
Other diagnoses	6	9	12
All diagnoses	100	100	100

Source: *Irish Psychiatric Hospitals and Units Census 1971, 1981 and 1991*.

* The classification of manic-depressive psychoses changed from 1971 to 1981. The categories mania and depression are included in this group for 1981 and 1991.

It is also possible to examine the geographical origin of older people in psychiatric hospitals.

Table 11.4: Older people in psychiatric hospitals and units. Numbers and rates per 10,000 population by health board of origin. 1991.

Health board	65-74		75+	
	Number	Rate	Number	Rate
North Western	92	49.4	38	32.3
Western	346	112.9	271	146.0
Mid-Western	166	74.9	134	102.5
Southern	281	69.8	207	87.3
South Eastern	230	87.7	212	132.8
Eastern	406	60.4	447	108.8
North Eastern	144	70.4	124	108.7
Midland	121	81.5	70	84.1
Non-nationals	6	na	6	na
Total	1792	74.5	1509	104.9

Source: *Irish Psychiatric Hospitals and Units Census 1991*.

Table 11.4 above shows that older people from certain health board regions have a higher likelihood than others of residing in a psychiatric institution. Older people from the Western Health Board have the highest rate in both the 65-74 year old and 75 years or more categories. The South Eastern Health Board region also has high rates. The lowest rates by far are for older people from the North Western Health Board.

Finally, there were 542 older people residing in de-designated psychiatric facilities in 1991. There is no information on diagnosis available for these people.

11.1.2 Community residential accommodation (psychiatric hostels)

There are no centrally collected figures on the age of psychiatric hostel residents. The hostels are not specifically located or designed for older people as they cater for all those with a mental illness who require supported accommodation. This can present problems for older residents with mobility impairments.

The Years Ahead report (1988) recommended that dedicated high support hostels for older people with functional mental illness be provided, with a norm of 1.7 places per 1,000 elderly people. Most health boards have these hostels which have an average size of 10-20 places. In general, however, the places are not dedicated for older people.

The Years Ahead report also recommended that specialist high support hostels for older people with dementia be provided, with a norm of three beds per 1,000 elderly people. Most health boards have not developed these hostels, preferring to provide specialist care in hospitals and dementia units.

11.2 Non-psychiatric long-stay care facilities for older people in Ireland

There are five main types of non-psychiatric long-stay residential care facilities for older people in Ireland. These are (i) health board geriatric homes and hospitals, (ii) health board welfare homes, (iii) health board district or community hospitals, (iv) voluntary geriatric homes and hospitals and (v) private nursing homes. The main source of information on these facilities, and the source that will be used unless otherwise specified, is the survey of long-stay units carried out by the Department of Health. The latest survey refers to the situation on the 31st of December 1994. The figures presented are likely to be a slight underestimate as the survey covers only 429 out of a possible 486 facilities (88 per cent). The non-covered facilities are private nursing homes with the exception of two geriatric units in the Eastern Health Board area. It is also worth noting that some elderly people reside in acute hospital beds for prolonged periods because of the lack of suitable long-stay care facilities. These patients are discussed in Chapter Ten of the report.

Table 11.5 below summarises information about residential care facilities at the end of 1994. These figures reveal that of the 17,170 people in non-psychiatric residential care at the end of 1994 roughly 16,200 were 65 years or more. The true figure for older residents was likely to be closer to 17,000 however, given that the true number of private nursing home residents was around 6,400, of whom 6,200 were elderly.

Most patients are female and aged 80 years or more. Roughly half (50.3 per cent) of all long-stay unit beds are provided by nursing homes. These homes tend to cater for the oldest patients, but do not have the highest dependency profile for residents.

Table 11.5: Long-stay units at 31 December 1994. Number of units, beds and patients by age group and gender.

Category of unit	Units	Beds	Respite beds	Total beds	Patients	% 65+ years	% 80+ years	% female
HB geriatric home/ hospital	44*	5,933	196	6,129	5,579	91.1	53.7	62.3
HB welfare home	36	1,302	52	1,354	1,243	96.5	57.2	61.2
HB district/ community hospital	37	1,706	89	1,795	1,669	93.5	55.3	57.9
Voluntary geriatric home/ hospital	67	3,227	63	3,290	3,087	95.1	66.3	73.7
Private nursing home	245†	5,959	151	6,110	5,592	96.9	68.0	75.2
Total	429	18,127	551	18,678	17,170	94.3	61.0	68.0

Source: Department of Health Survey of Long-Stay Units 1994.

* Does not include two units (James Connolly Memorial Hospital and Cherry Orchard Hospital).

† Does not include a small number of homes.

Table 11.6 shows that the most highly dependent patients are more likely to reside in health board geriatric homes and hospitals or district and community hospitals. These facilities are equipped to deliver a more intensive level of medical care.

Table 11.6: Percentage distribution of patients in long-stay units at 31 December 1994 by level of dependency.

Category of unit	Low	Medium	High	Maximum	Not specified	Total
HB geriatric home/ hospital	8.1	18.9	35.7	36.9	0.5	100
HB welfare home	33.9	34.0	23.1	9.0	0.1	100
HB district/ community hospital	11.6	16.4	31.8	40.3	0.0	100
Voluntary geriatric home/ hospital	21.2	24.3	21.5	26.3	6.8	100
Private nursing home	16.5	23.5	29.3	29.7	1.1	100
Total	15.4	22.2	29.7	31.0	1.7	100

Source: Department of Health Survey of Long-Stay Units 1994.

Before describing the above facilities in detail it is worth noting that very few older people require long-stay care in institutions. According to the 1991 census only 8.5 per cent of the elderly population live in non-private households, which includes both medical and non-medical facilities (Central Statistics Office 1994). When an older person does enter residential care, their stay is usually quite short. Roughly 70 per cent of patients are discharged or die within three months with only 15 per cent of patients staying for more than one year.

11.2.1 Health board geriatric homes and hospitals

This sector includes both geriatric hospitals and homes and long-stay geriatric units within general hospitals. The facilities tend to have a more intensive level of medical care than is provided in other long-stay settings. This is reflected in the staff profile which includes medical officers, paramedics such as physiotherapists and occupational therapists and nurses and attendants (Blackwell *et al.* 1992).

Geriatric hospitals and homes are by far the largest type of long-stay unit for older people with an average of 139.3 beds per institution. The size of the older institutions is a result of policies in the 1950s and 1960s designed to gather all dependent elderly people and the destitute in one 'county home'. Recent policies have attempted to reduce the reliance on large institutions for older people. The old style geriatric hospitals and homes are gradually being reduced in size and the trend for new facilities is towards smaller geriatric units within general hospitals. As a result of this the number of beds in this sector has been falling steadily, from 7,005 in 1988 to 5,993 at the end of 1994.

Prevalence of mental disorders: The 1994 survey of long-stay units does not, unfortunately, provide a definitive analysis of mental

disorders among residents as figures are only provided for the 'principal medico/ social status'. The possible categories are as follows:

1. chronic mental illness
2. chronic physical illness
3. convalescence/ rehabilitation
4. mental infirmity/ dementia
5. physical disability
6. mental handicap
7. social reasons
8. terminal illness
9. other.

Only one option is recorded for each patient. Thus we have no information on patients with concomitant mental disorders. More seriously, the basis for choosing one option over another when two categories are relevant is not clear. The survey also does not provide detailed information on diagnostic categories.

According to the survey, 17.2 per cent of residents in geriatric homes or hospitals suffered from dementia. On the assumption that almost all of these patients are aged 65 years or more, this translates to roughly 950 older people at the end of 1994. This is undoubtedly a significant underestimate. A further 2.8 per cent were resident because of a mental handicap. It is likely that most of these patients are less than 65 years of age. Finally 7.0 per cent were admitted because of a chronic mental illness such as depression. This translates to 356 older patients, but is also likely to be an underestimate of the true prevalence.

11.2.2 *Health board welfare homes*

Welfare homes are homes which were generally run by charitable or religious organisations and have been taken over by the health boards. The homes were designed to provide residential care for those with very low incomes or those who had difficulties in living independently for other social reasons such as living alone in remote areas. The development of welfare homes came about as a result of *The Care of the Aged Report* (1968) which recommended that an alternative to county homes should be provided for dependent older people "where relatives or other suitable persons are not available to provide them with the help they need in their own home" (p. 82). Since *The Years Ahead* report (1988) however, welfare homes are no longer seen as the preferable option for the dependent elderly. The report recommended that welfare accommodation should in future be provided through sheltered housing, boarding-out arrangements, community hospitals and hostels for those with dementia. As a result the number of beds in welfare homes has been falling, from 1,589 beds in 1988 (Blackwell *et al.* 1992) to 1,354 beds in 1994.

Welfare homes are not well equipped to provide high levels of medical or psychiatric care as the facilities were initially designed for people without a mobility problem or a chronic mental disorder. They are also quite small with an average of 37.6 beds per institution, making the provision of high levels of medical support impractical. Despite this, almost a third of patients are in the high or maximum dependency categories according to Department of Health figures (see Table 11.6). This is because the patients have become progressively more dependent as they have grown old within the homes.

Prevalence of mental disorders: A surprisingly high number of people reside in welfare homes because of a mental disorder. The 1994 long-stay survey reveals that 10.7 per cent of residents

(approximately 133 older people) were resident because of dementia, 8.4 per cent (approximately 100 older people) because of chronic mental illness and 2.0 per cent because of mental handicap. Only 34.5 per cent were resident because of social reasons, while 25.6 per cent were present because of a chronic physical illness. There seems therefore to be a very high level of mental and physical disorder among the residents of welfare homes, a conclusion that is strengthened by the large number of patients that are likely to have concomitant disorders. This is despite the fact that these units are not well placed to provide high levels of medical or psychiatric care.

11.2.3 Health board district and community hospitals

District or community hospitals also provide long-stay beds for older people at a local level. District hospitals are local hospitals that are staffed by general practitioners and nurses. Community hospitals are based on a newer model advocated by *The Years Ahead* report (1988), designed to provide a broader range of services. The report recommended that, "existing geriatric hospitals and homes, long-stay district hospitals and welfare homes be developed as community hospitals, where appropriate, providing the following range of services for elderly persons and their carers in each district:

- assessment and rehabilitation of elderly patients
- convalescent care
- day hospital and/ or day care services
- respite care to support caring relatives
- facilities for nursing dependent or terminally ill elderly patients who can no longer be cared for at home.
- information, advice and support for those caring for elderly persons at home" (p. 134).

The term 'district' in *The Years Ahead* report refers to an area with an overall population of 25,000-30,000 people, and about 3,000-3,500 people aged 65 years or more.

District and community hospitals are classified together in the 1994 long-stay unit survey and contain an average of 48.5 long-stay beds. Table 11.6 shows that district/ community hospitals have the highest proportion of patients in the maximum dependency category. They also have the shortest average lengths of stay (based on discharges and deaths) with 85 per cent of patients residing for less than three months. Following *The Years Ahead* report this method of bed provision has become increasingly popular in recent years: in 1988, 1,465 beds were provided by 30 district/ community hospitals (O'Shea *et al.* 1991) compared to 37 units and 1,795 beds in 1994.

Prevalence of mental disorders: District and community hospitals have roughly the same proportion of patients with mental disorders as are seen in geriatric homes and hospitals and in welfare homes. Approximately 224 patients (13.4 per cent) are present because of dementia. A further 100 patients are present because of chronic mental illness (6.4 per cent) and 2.0 per cent of patients have a mental handicap. Again the levels of dementia and functional mental illness are likely to be underestimated by these figures.

11.2.4 Nursing homes

Nursing homes fall into two categories, voluntary homes and private (i.e., commercial) homes. A nursing home is an institution for the care and maintenance of more than two dependent persons (i.e. persons who require assistance with activities of daily living by reasons of physical or mental infirmity). There have been important developments in the provision and regulation of nursing home accommodation in the last few years with the implementation of the *Health (Nursing Homes) Act 1990* and the *Nursing Homes (Care*

and Welfare) Regulations 1993. These require all nursing homes to apply for registration with their health board. To become a registered nursing home the home must reach and maintain certain standards. Only patients in registered homes can receive a subvention from the health board to assist with the cost of nursing home accommodation. The level of subvention depends on both the level of dependency of the patient, their financial means and the circumstances of the patients' immediate family.

Voluntary homes, with 49.1 beds on average, are twice as large as private homes (24.9 beds on average). There seems to have been a slight fall in the total number of voluntary beds available in recent years. In 1994 there were 3,290 beds recorded by the Department of Health compared to 3,509 beds in 1988 (Blackwell *et al.* 1992). The private sector, by contrast, seems to be enjoying a period of rapid growth. Table 11.5 indicates that there were 6,110 beds in private nursing homes at the end of 1994, but the complete figure was closer to 7,000. This compares with 5,552 beds in 1988 (Blackwell *et al.* 1992).

Prevalence of mental disorders: The survey of long-stay units reveals that 23.0 per cent of private nursing home residents were admitted because of dementia, the highest rate for all long-stay units. This may reflect a shortage of public beds for dementia patients. Working from a figure of 6,400 residents, and given that practically all of the dementia patients were elderly, this translates to 1,470 older people. The rate for voluntary homes was 15.5 per cent (478 patients). This is still likely to be an underestimate, as O'Neill *et al.* (1991) reported that 58 per cent of nursing home residents had a cognitive impairment that could be indicative of dementia. Thus, as many as 3,700 older people in private nursing homes, and 1,800 in voluntary homes could have had some form of dementia at the end of 1994.

Private homes are also more likely to admit patients with a chronic mental illness. The official figures are 6.7 per cent (415 older patients) for private homes and 3.3 per cent (97 older patients) for voluntary homes. However, the aforementioned study by O'Neill *et al.* also found that 30 per cent of nursing home residents had depression. If these figures are extrapolated, it is possible that as many as 1,860 older people suffer from depression in private homes, with a further 880 in voluntary homes. Indeed given that depression is only one of a range of mental illnesses, the numbers may be even higher.

The survey of long-stay units reveals that 1.1 per cent of patients in voluntary homes were admitted because of mental handicap. The corresponding figure for private homes is 1.2 per cent.

11.3 Homelessness

One especially vulnerable group of people with special needs are the elderly mentally ill who are homeless. A recent Simon Community report (1992) showed that 20 per cent of the homeless people surveyed were over 65 years of age. A significant proportion of the total group (i.e., all ages) had a psychiatric problem (40 per cent) and 65 per cent were reported to have an alcohol problem. It is not unreasonable to assume that some proportion of the 20 per cent of individuals aged over 65 have a psychiatric problem. This group needs special attention when the housing and accommodation options for the elderly mentally ill are considered.

11.4 Summary

Information on mental disorders in long-stay care varies in quality. The data on psychiatric facilities is, understandably, very good. There were 3,301 people over 65 years of age in psychiatric hospitals or units in 1991. Of these roughly 2,641 had been resident for more than one year. The most common diagnosis is schizophrenia (44 per

cent) followed by depression/ mania (22 per cent) and dementia (17 per cent). A further 542 older people resided in de-designated psychiatric facilities. Perhaps the most striking finding is that older people from certain health board regions have a much higher likelihood than others of residing in a psychiatric facility.

The information for non-psychiatric facilities is not as good which makes the estimation of prevalence figures difficult. The situation is exacerbated by the range of facility types and the lack of a coherent national policy for the placement of older people with mental disorders. There is a pressing need for a review of the procedures used to collect information for the Department of Health survey of long-stay units. A broader range of diagnostic categories and information on concomitant problems would greatly improve the survey. Without this data we must rely on local studies to extrapolate national patterns.

Table 11.7 summarises the information on the numbers of people with chronic mental illness (i.e., any mental disorder other than dementia or mental handicap) or dementia in non-psychiatric long-stay residential care facilities. The figures are those derived in previous sections of this chapter.

It is clear that the rate of mental disorder in long-stay care facilities is much higher than that observed in the community. The number of people with mental disorders in welfare homes is of particular concern given that these facilities were not designed to provide medical or psychiatric care provision. One must also consider the needs of long-stay residents with no psychiatric problems. Many of these residents must consider it unsatisfactory to share their accommodation with mentally disordered persons particularly those with behavioural problems.

Table 11.7: Estimated number of older people in non-psychiatric long-stay residential care with a chronic mental illness or dementia at 31 December 1994.

Category of unit	Number of patients over 65 years	Number with chronic mental illness	Number with dementia
HB geriatric home/ hospital	5,082	356+	950+
HB welfare home	1,200	100+	133+
HB district/ community hospital	1,560	100+	224+
Voluntary geriatric home/ hospital	2,936	97-880+	478-1,800
Private nursing home	6,200 (estimate)	415-1,860+	1,470-3,700

The role of the health boards is vital when discussing mental disorders and residential care. As already noted, a striking range of facilities has been developed across the country to provide residential care. There is considerable variation in levels of provision for these facilities across the health boards, as illustrated by Table 11.8. When interpreting these figures it should be borne in mind firstly that roughly five per cent of beds are occupied by people under 65 years of age and secondly that the population figures relate to the 1991 census.

Each health board region places a different emphasis, for both historical and policy reasons, on different types of care facility. The Eastern Health Board region has a high reliance on nursing home beds. The North Western Health Board region has the highest reliance on district/ community hospitals, as recommended by *The Years Ahead* report (1988). In contrast, geriatric home and hospital beds predominate in the Mid-Western, North Eastern and Midland Health Board regions. The Western Health Board region has the highest bed rate for welfare homes, while the Southern Health Board region seems to have a mix of all the facility types.

**Table 11.8: Long-stay non-psychiatric residential care facilities.
Beds per 1,000 elderly population by health board region at 31
December 1994.**

Health board	HB Geriatric home/hospital	HB Welfare home	HB District/community hospital	Voluntary nursing home	Private nursing home†	Total beds per 1,000 elderly
North Western	na	3.8	28.9‡	6.4	9.3	48.4
Western	18.8	7.4	na	2.2	15.0	43.4
Mid-Western	24.1	3.3	1.8	8.9	18.7	56.8
Southern	10.8	1.9	9.8	7.5	13.1	43.2
South Eastern	18.0	3.8	0.8	6.9	15.1	44.6
Eastern	11.6*	1.5	1.1	13.5	18.6	46.3
North Eastern	23.9	3.2	na	3.4	11.5	42.1
Midland	25.3	6.6	1.8	6.4	11.7	51.8
Total	15.2	3.4	4.5	8.2	15.2	44.5

Source: Department of Health Survey of Long-Stay Units 1994.

* Does not include two units (James Connolly Memorial Hospital and Cherry Orchard Hospital).

† Does not include a small number of homes.

‡ Four units designated as community nursing units.

These variations have important implications for the type of care offered to older people with mental disorders from different parts of the country. This is compounded by the different health board policies on the placement of psychiatric patients. Table 11.9 shows that the percentage of long-stay care patients classified as having a mental disorder varies across the health boards.

At one extreme, the South Eastern Health Board region has the lowest number of long-stay residents with any mental disorder (16.5 per cent). At the opposite extreme, the North Eastern Health Board region has the highest rate for patients with dementia (23.2 per cent), mental handicap (4.1 per cent) and for all mental disorders combined (32.8 per cent). The North Western Health Board region has the highest rate of chronic mental illness among residents (11.0 per cent).

If these figures are accurate it is clear that the type of long-stay care offered to older people with mental disorders varies across the country.

Table 11.9. Percentage of long-stay care patients with mental disorders by health board region at 31 December 1994.

Health board	Chronic mental illness	Mental infirmity/ dementia	Mental handicap	Total admitted for mental disorder
North Western	11.0	15.4	2.0	28.4
Western	6.3	15.7	1.7	23.7
Mid-Western	8.6	18.2	1.6	28.4
Southern	4.7	16.8	1.6	23.1
South Eastern	3.1	11.0	2.4	16.5
Eastern	5.5	21.2	1.0	27.7
North Eastern	5.5	23.2	4.1	32.8
Midland	9.7	18.2	3.1	31.0
Total	6.3	17.9	1.8	26.0

Source: Department of Health Survey of Long-Stay Units 1994.

Finally, the rise in the older population will have obvious implications for this sector. The number of people over 65 years is predicted to rise by almost 30 per cent in the period 1991-2011 (Fahey 1995). More importantly, the number over 80 years is expected to increase by 65 per cent. If a proportionate increase in the need for long-stay care occurs, as many as 5,000 extra beds will have to be provided in the next 15 years. The State is committed to maintaining 90 per cent of people over 75 years of age in their own homes (Department of Health 1994), but this will require a large increase in resources for community care. Hopefully, the attainment of this target will not retard the development of high quality long-stay care facilities, tailored to the individual needs of patients.

CHAPTER TWELVE

Health Promotion

The World Health Organisation placed health promotion and illness prevention at the centre of their agenda with the *Health for All by the Year 2000* programme. The broad aims of this programme, and their relevance to that part of the population over 65 years were crystallised in *The Years Ahead* report (1988) which stated, "health promotion policies aim to add life to years by enabling as many persons as possible to remain healthy and active throughout the years of their life; to add health to life by reducing the occurrence of illness and accidents and to add years to life by increasing the average life expectancy of the individual. A successful policy of health promotion would enable more people to reach old age, reduce the incidence of disease and handicap among the elderly and increase the number of elderly who are healthy and active. On each of these counts, the evidence suggests that there is much room for improvement" (p. 55).

As has been illustrated in the present report, mental health problems in those over 65 are considerable with up to 20 to 25 per cent of older Irish people affected by psychiatric disorders of different degrees of severity at any one time (Lawlor *et al.* 1994). This amounts to about 100,000 of the Irish population over 65 years and this figure can be multiplied several times over if the effects on spouses and close relatives of the affected individuals are included. Because people at this stage of life are more likely to have other health problems, a mental health problem can make a previously independent individual more dependent, greatly increasing the level of care that needs to be provided by health services and other agencies, including the family. There is considerable scope for the amelioration of mental health and other health problems through health promotion generally and through illness prevention specifically.

12.1 The concept of health promotion

Many definitions of health promotion are broad and all inclusive. Perhaps the most useful definition of health promotion, with specific reference to the elderly, is that of Kelleher (1993), "health promotion is a comprehensive term that includes personal development but also any formal environmental change that promotes personal health and well-being. It is a positive concept, implying more than the avoidance of illness, and is fundamentally related to the exercise of personal choice. In the case of older people, it can apply to several different aspects of daily life including preparation for ageing, health maintenance and life-style modification, personal skills development and social change to facilitate health" (p. 13).

12.2 Health promotion policies for older people in Ireland

One of the terms of reference of the Council is to advise the Minister for Health on measures to promote the health of the elderly, and a number of reports have been produced on this issue, the most recent being *Health and Autonomy Among the Over-65s in Ireland* (Fahey and Murray 1994). In the same year *Shaping a Healthier Future* (Department of Health) recommended that priority be given to, "promoting healthy ageing, with the assistance of the National Council for the Elderly and in co-operation with statutory and voluntary bodies involved with older people" (p. 67).

12.3 The concept of illness prevention

The concept of health promotion is also closely linked to that of illness prevention. Disease or illness prevention is traditionally linked to physical illness and most specifically to infectious diseases. Many of the early advances in medicine which contributed to significant increases in life expectancy in the late 19th Century, were due to developments in prevention, most specifically of those infectious diseases such as cholera and smallpox. The importance of prevention has gained currency more recently, particularly in relation to cancer

and heart disease. The traditional public health model of prevention has three levels (Caplan 1964):

- Primary prevention: directed at reducing the incidence or the rate of occurrence of new cases in the community. Examples of this would include identifying specific risk factors for developing a disorder and putting strategies in place to prevent them if possible.
- Secondary prevention: directed at reducing the prevalence of a disorder by reducing its duration. For example, if early signs of a disorder such as depression are seen, effective treatment would be started promptly so that the episode would be as short as possible.
- Tertiary prevention: designed to reduce the severity and disability associated with a particular disorder. Thus, the individual has the illness or disorder, such as dementia, and treatment is initiated to try to reduce the incapacity associated with it.

This model was created with physical illness in mind, and more particularly physical illnesses that had a single, readily identifiable cause. It has been argued that this way of thinking has little relevance to mental illness, where there are multiple causes of illness or disorder, many of which still have yet to be clearly identified. However, Jenkins *et al.* (1994) argue that these arguments only apply, if at all, to primary prevention and that secondary and tertiary prevention are as relevant to psychiatric medicine, as they are to physical medicine and in many cases simply reflect good clinical practice. They believe that primary prevention is also relevant to mental illness and that the multifactorial approach to the cause of disease and to preventive strategies (Bloom 1981) should be adopted.

There has also been some debate about the relationship between mental health promotion and primary prevention. Goldston (1977) believes that mental health promotion programmes are, "primarily educational rather than clinical in conception, their ultimate goal

being to increase people's capacities for dealing with crises and taking steps to improve their own lives". In this chapter we will use the term 'health promotion' to refer to universal strategies applied to the whole of the population (in this case all those over 65), such as the reduction, or cessation of smoking, encouragement of exercise and the maintenance of social contacts.

12.4 Mental illness prevention with older people

As we have outlined in previous chapters, mental illness is a considerable problem in the older section of the population significantly reducing their quality of life and resulting in disability and dependence which leads to heavy use of a range of services. Any success in the prevention of psychiatric disorder in this group will have substantial benefits, not only for the individual, but for the economics of health care delivery (Jolley 1994). The prevention of physical illness is usually the focus of health promotion programmes but an improvement in the physical health of older people may have a significant impact on many psychiatric disorders. In previous chapters it was noted that there are strong links between physical illness and disorders such as depression, dementia, anxiety and alcohol abuse. Fahey and Murray (1994) found that 37 per cent of Irish people over 65 who had a physical illness also showed significant psychological distress. Physical illness and chronic pain have also been noted as risk factors for suicide. Thus, any strategies which can limit the extent of physical illness in old age might also have considerable scope to reduce, or at least lessen the severity of, many psychiatric disorders.

12.5 Strategies for the prevention of specific disorders

12.5.1 Depression and neurotic disorders

At the primary level, prevention of physical illness and programmes to prepare people for the inevitable changes associated with late life such as retirement, and losses by bereavement, should, in theory,

reduce the incidence of depressive mood and other affective changes. Secondary prevention would involve the early detection of people suffering from mood disorders. This could be enhanced by the monitoring of people suffering from ill health, or with specific stresses such as recent bereavement. There is good evidence as to the effectiveness of physical and psychological treatment methods for depression and other neurotic disorders once they have been correctly identified. Tertiary prevention in the form of maintenance therapy and ongoing monitoring helps to prevent relapse and this is associated with decreased morbidity and probably a decreased mortality (Baldwin and Jolley 1986).

12.5.2 Dementia

For symptomatic dementias, primary prevention involves the early detection and treatment of those physical illnesses or other psychiatric disorders which produce a dementia type syndrome. For example, hypertension, or high blood pressure, is known to play an important role in multi-infarct dementia. The treatment and control of high blood pressure may help to reduce the risk of developing this type of dementia. Unfortunately, as the causes of Alzheimer's Disease are not yet fully understood, primary prevention of this disorder is not yet possible. At the secondary and tertiary prevention levels, once the cognitive and other changes associated with any type of dementia have been noted, progression of the disorder can be influenced by providing a good level of general medical care and appropriate management of the social and personal environment of the individual. It is important that treatment is initiated as soon as possible and that individuals are referred for assessment early on in the development of dementia. The referral of patients at the point of crisis can mean the opportunity for some treatments has passed and others may be more difficult to initiate.

There are several therapies that are available that involve prevention at the secondary and tertiary levels, that is to shorten episodes of disturbance and to reduce the severity of and the disability associated with the dementia. These have been outlined in Chapter Nine but briefly include:

- the treatment of concurrent physical illness
- the treatment of associated depressive disorder
- the treatment of symptoms such as hallucinations
- the management of behavioural problems with medication and psychological interventions
- the counselling and support of families.

12.5.3 Paranoid symptoms

It has been shown that there is an association between specific sensory deficits, particularly the impairment of hearing, and the development of paranoid ideas and auditory hallucinations. The early detection and treatment of hearing or visual impairment would seem likely to have potential for reducing the incidence of paranoid states. At the secondary and tertiary levels once identified, paranoid disorders can be effectively treated with neuroleptic medication. Admission to a psychiatric hospital is not always necessary to manage these conditions and the establishment of a supportive relationship between mental health professionals and the carers in the community can ensure that affected individuals can remain in their own home.

12.5.4 Suicide prevention

Chapter Eight has shown the extent of suicide in those over 65, particularly among men. Suicide and parasuicide in all ages have many causes, both clinical and social. Clinical causes are perhaps the most amenable to some direct measures which might help to reduce suicide. It has been shown that the majority of individuals who

commit suicide have a psychiatric disorder at the time of death, with depression being the most common specific disorder (47-70 per cent), followed by alcohol dependence (15-27 per cent) and schizophrenia (2-12 per cent), (Robins *et al.* 1959, Dorpat and Riley 1960, Barraclough *et al.* 1974, Walsh 1965, Sainsbury and Barraclough 1968, Frierson 1991, Merrill and Owens 1990). Cattell and Jolley (1995) in a more recent study of 100 consecutive coroners' inquests on people aged over 65 occurring between 1980 and 1991, in which the verdict was suicide, found similar trends. Relating the suicide cases to health service notes, they found that at least 60 per cent were clinically depressed.

Some studies have shown that many people who commit suicide had been in recent contact with doctors, particularly their general practitioner, but many also with psychiatrists. In a Dublin based study on suicide, Walsh (1965) found evidence of a pre-existing disturbance of personality or of mental health to a degree sufficient to have necessitated previous psychiatric treatment in 50 per cent of the cases examined. Cattell and Jolley (1995) found that 65 per cent of suicide cases studied had been physically ill, of which 23 per cent had been hospitalised in the previous year. Forty-three per cent had seen their general practitioner in the previous month but only 14 per cent were in contact with psychiatric services. A total of 31 per cent had a history of previous suicide attempts.

Thus, the most important clinical measure to prevent suicide for any age group, is to detect and treat psychiatric disorders as early as possible in their course. As outlined in Chapter Nine the under-diagnosis of depression in older people raises particular concerns, especially in relation to suicide. Early diagnosis is vital given that there are a variety of treatments available for mental disorders in the elderly that are effective, particularly for disorders such as depression (see Chapters Two and Nine).

Other symptoms which can be prevalent in older people were found to be associated with suicide, namely insomnia, self-neglect and impaired memory (BarracloUGH and Pallis 1975), and strategies that address these symptoms may impact on suicide. Physical illnesses, particularly those of a chronic nature, are common among suicides (Hawton 1994). This has been noted as being especially important for males over 65 who commit suicide, and in these cases, the illness often appears to have contributed to the suicide (Dorpat and Riley 1960). Frierson (1991) found that the most common precipitant of suicide in his study was ill health. In particular, such diseases as obstructive lung conditions, congestive heart failure and chronic pain syndromes, which often necessitated significant lifestyle changes, were most frequently mentioned. The importance of co-existent physical illness is well recognised as a risk factor, along with pain symptoms (BarracloUGH 1971, BarracloUGH and Hughes 1987, Cattell and Jolley 1995). Good pain control and the effective control and management of the symptoms of physical disease may go some way to preventing suicide among older people affected in this way. Consideration should also be given to the implementation of suicide prevention programmes in long-stay care institutions.

There is a growing literature which suggests that by limiting access to various methods, suicide rates can be reduced. According to Kelleher *et al.* (1996a), this is unlikely to reduce suicide among Irish elderly, since most elderly Irish men hang or drown themselves and over half of the women do so. Of the elderly Irish suicides, 30 per cent of females and 11 per cent of males chose to end their lives by deliberate self-poisoning. Other countries report higher rates of self-poisoning among the elderly. A study on attempted suicides who were admitted to the West Midlands Poison Unit (UK) over a two-year period revealed that anti-depressants accounted for nearly one-quarter of the substances ingested by the elderly patients compared to 10 per cent taken by the young and middle-aged. Psychotropic drugs accounted

for 28 per cent, 50 per cent and 69 per cent of all substances taken by the young, middle-aged and elderly patients respectively (Merrill and Owens 1990). Thus, there is scope for prevention of suicide regarding the availability of drugs. Older anti-depressants are cardio-toxic in overdose and should never be prescribed without first assessing suicide risk. Nor should they be given by repeat or large prescription (Kelleher *et al.* 1996a). New anti-depressant drugs such as the selective serotonin re-uptake inhibitors (SSRIs) are safer in overdose and these drugs may be safer to prescribe to depressed patients who are actively suicidal or who have a history of suicide attempts.

12.6 Mental health promotion with older people

One of the major initiatives in this area is education, for example, education of the general public about mental health issues. The Mental Health Association of Ireland plays a major role in this in Ireland and its national public speaking project encourages the wide involvement of secondary school going children to discuss and be aware of mental health issues.

The Mental Health Association's report *Good Practices in Mental Health Projects* (1995) provides information on general practitioners, health centres, local organisations and include comprehensive library book listings of self-help and information books on all aspects of mental health and mental illness. Along with the Alzheimer Society of Ireland, the Mental Health Association of Ireland provide information and advice to individuals, while also organising public lectures on general mental health issues.

In *Shaping a Healthier Future* (Department of Health 1994), responsibility for health promotion is conferred on the Mental Health Association in co-operation with voluntary agencies, "Steps have been taken to promote mental health, principally through support for

the work of the Mental Health Association of Ireland, GROW, AWARE, the Schizophrenia Association of Ireland and other groups active in this field" (p. 69). While these organisations provide invaluable support, advice and information to individuals, there is no national strategy for the promotion of physical or mental health in older people. In fact there are very few health promotion policies and activities directed specifically towards mental health of the elderly, within the voluntary or statutory sector. Health promotion tends to be targeted more generally at the population as a whole and its focus tends to be on physical rather than mental health. *The Years Ahead* (1988) for example, makes very general reference to the promotion of health among the elderly, with little reference to mental health, "Of particular importance in promoting and protecting the health of the elderly are policies affecting housing, security, social cohesion, air quality, road safety, retirement and income" (p. 55).

More specifically the need for targeted education of mental health professionals regarding the special mental health problems encountered by those over 65, has been noted. Education of those approaching the '65 threshold' is increasingly being recognised as important and pre-retirement courses are a means of targeting this population and facilitating a discussion of a broad range of issues.

Retired people often find it difficult to make the adjustment from a life in which work dominates their time to one in which they must organise their own activities. On retirement, a person may lose his or her sense of purpose as a contributing member of the community. *The Years Ahead* report (1988) suggested that employers and trade unions have an obligation to ensure that their employees and members are well prepared for retirement. It recommended that the Federated Union of Employers and the Irish Congress of Trade Unions advise their members to give greater priority to the development of a comprehensive pre-retirement service. The

Retirement Planning Council are actively engaged in such programmes.

One example of the active implementation of this recommendation is in the Midland Health Board, where one of their health promotion strategies is to establish a comprehensive pre-retirement service in each of its sector headquarters. They identify the need for an education service for the elderly staff in respect of the following:

- preparation for retirement
- nutrition and diet services
- securing their home
- safety in the home
- hypothermia

By 1997 the board hopes to have set up a comprehensive pre-retirement service. The service will be for the board's own staff. In addition local private companies will be encouraged to set up pre-retirement courses. The board will periodically open its own courses to pre-retirement workers employed in small companies.

In order to improve and co-ordinate monitoring of older people, 'at-risk' registers for the elderly have been established. Area Care Teams have been set up in each of the community care areas in the Eastern Health Board. One of their aims is to, "develop and implement appropriate preventative health education and health promotion programmes for the elderly", by setting up a register of elderly in each area, to highlight those at-risk. It is not possible to assess the effectiveness of this register, as there is little information available and no known evaluation or research has been carried out to date.

12.7 Summary

The prevention of disability arising from mental illness in old age requires a range of joint activities by the health and social services and voluntary agencies, including lay people and professionals. *Planning for the Future* (1984) recommended that, "The primary care services should play an important part in the prevention of psychiatric illness in old age" and "A preventative programme to ensure that elderly persons remain active for as long as possible in their own homes should be implemented" (p. 89).

Important components of such a preventive programme which would prepare people for old age and help them to retain their independence include:

- suitable housing, including sheltered housing
- support from voluntary organisations
- home nursing
- home helps
- meals-on-wheels
- dietary advice
- neighbourly support

To date there has been only a limited effort devoted to mental health promotion in the elderly, with physical health in general, and other age groups specifically, being given greater priority. Measures should be taken to redress the balance towards specific mental health promotion programmes for older people.

CHAPTER THIRTEEN

Conclusions

Most people over 65 enjoy good mental health and have a positive experience of late life. In fact, the general definition of good mental health would suggest that it is a state acquired over time and that older people possess many of the characteristics we would associate with positive mental health. While it is widely accepted that old age can bring some problems with physical health, there is a general reluctance to accept that problems with mental health can also occur. While these are not severe for most, mental health problems can seriously effect a considerable number and can increase their dependence on others. Even mild symptoms should not be disregarded as these can impact significantly on an individual's quality of life. When the effect on families and friends are considered the occurrence of mental disorder in one individual can be multiplied. Most mental health disorders can be treated very successfully so it is vital that symptoms are recognised and detected at an early stage.

13.1 The numbers requiring care

Estimates of the incidence and prevalence of various psychiatric disorders have been documented in this report according to diagnostic category. As heavy reliance on service use statistics was made in order to obtain some estimate of the level of disorders, it is necessary to make some qualifying and clarifying points. Service use statistics reflect just that, the level of use of particular services in particular areas, and as such they reflect a host of factors, one of which is the level of illness in the community. For example, the type of services available, their accessibility, and policy decisions concerning services, can all be reflected in service use figures. A discrepancy between the rates of new cases recorded in the two case registers and those reported by specialist psychiatry of old age

services was noted in some chapters. The estimates obtained from the case registers reflect those cases currently seen in typical adult psychiatric services. However, when a specialist service is established and available to treat older people with psychiatric disorder, many referrals are made to this service which might not have been made to the generic psychiatric services. Thus psychiatry of old age services have to treat those people in their catchment area who may not have been recognised or 'picked up' by the generic psychiatric service and those additional referrals which a specialist service attracts from other services within the catchment area. These are some of the reasons why it is important to have some estimate of the actual level of morbidity in a community. Table 13.1 shows a summary of the current Irish and international data concerning psychiatric morbidity in those aged over 65 at the community level.

Table 13.1: Prevalence of psychiatric disorder in the community population aged over 65. Estimates from Irish and international studies. Rates per 10,000 population.

Diagnosis	Irish data	International data
Dementia	550-790	520-1,000
<i>Affective disorders:</i>		
Depression	1,310-2,280	910-2,200
Mania	0	0-20
Schizophrenia	0-40	10-30
Alcohol dependence	no data	20
Drug dependence	no data	no data
Neuroses	110-1,480	60-1,790
Personality disorder	no data	0-10
Mental handicap*	20	14-22

* Estimates for over-55s.

These estimates have been derived from a limited number of studies using a particular methodology and should not be taken as definitive. However, these estimates can give us preliminary guidelines as to the level of mental disorder we might expect in older people in the

community. Estimates from Ireland lie within the range of most of the international estimates. The overall level of all mental disorders in those over 65 is approximately 20 to 25 per cent.

In contrast, Table 13.2 shows the rates of dementia and chronic mental illness in older people in long-stay residential care (both psychiatric and non-psychiatric). These are the two broad categories provided in the Department of Health's survey of long-stay units (1994).

Table 13.2: Estimated prevalence of all mental disorders in long-stay care among those aged over 65. Numbers and rates per 10,000 population.

Category of unit	Chronic mental illness		Dementia	
	Number	Rate	Number	Rate
HB geriatric home/hospital	356+	8.8+	950+	23.6+
HB welfare home	100+	2.5+	133+	3.3+
HB district/community hospital	100+	2.5+	224+	5.6+
Voluntary geriatric home/hospital	97-880+	2.4-21.8+	478-1,800	11.9-44.7
Private nursing home	415-1,860+	10.3-46.2+	1,470-3,700	36.5-91.8
Psychiatric hospitals and units	2,000-2,549	49.6-63.3	500-573	12.4-14.2

Source: Department of Health Survey of Long-Stay Units 1994 and Census of Psychiatric Hospitals and Units 1991.

The level of disorder is reflected in the level of medical care and support available in the various institutions, with the rates for dementia being highest in private nursing homes and lowest in welfare homes.

13.2 Mental disorders in late life

Unfortunately mental illness in older people is often not detected, not detected early enough, or not treated appropriately when it is

detected. This is partly due to the lack of knowledge about mental illness and stigma associated with it which hinders many sufferers and their families from discussing a problem and seeking help. However, it is also due, at least in part, to ageist attitudes and beliefs on the part of some general medical and mental health professionals which render mental illnesses in old age 'understandable' or 'difficult to treat'. There is ample evidence that mental illness in late life is not inevitable and that it is amenable to the range of treatments used for disorders in younger age groups. We would therefore advocate that programmes and measures that have already been undertaken by the Mental Health Association of Ireland and others to increase knowledge about and lessen the stigma surrounding mental illness should continue. Similar educational initiatives should be targeted at both mental health professionals and the general public to counter ageist attitudes and beliefs. One of the stated terms of reference of the National Council for the Elderly is to advise the Minister for Health on ways of encouraging positive attitudes to life after 65 years and the process of ageing, and this has been promoted in the many publications produced by the Council.

13.3 Training

Perhaps the first step in ensuring the detection and treatment of late-life mental disorder is to ensure that the health professionals who might encounter it are sufficiently well trained to recognise the disorder and initiate appropriate treatments. Different levels of specialist education and training are required for the different health professionals in contact with older people with a psychiatric disorder. The care and treatment of older people with mental disorders requires a particular set of skills and a specialist knowledge. Training in the care of the elderly and the care of people with mental disorders will equip individuals with many of the skills required, but it is the specific mix or 'crossover' of skills and knowledge between these two fields which is essential to health professionals working with older people

with mental disorders. It is important that this is recognised by the appropriate bodies, for example An Bord Altranais, the university medical schools, and university faculties involved in the education of physicians, nurses, psychologists, social workers and occupational therapists, and that suitable in-service training and postgraduate education is provided.

13.4 Information

This report has gathered together the available Irish data and research in order to describe the incidence and prevalence of mental illness in older Irish people and the treatments available to them. A striking finding from this exercise was the complete lack of data and information concerning illness in the population (morbidity) and some aspects of the health services, and the relative wealth of information from other areas. There are several separate issues surrounding data and information which should be addressed.

Firstly we should recognise our strengths and enumerate those areas for which good data do exist. Ireland is unique among many countries in maintaining a national database on the activities of psychiatric hospitals and units (the National Psychiatric In-Patient Reporting System, NPIRS) and this has proved an invaluable source of information concerning the use of psychiatric in-patient services by older people. We also have two psychiatric case registers, one urban and one rural, which provide a picture of the use of all psychiatric services (in-patient, out-patient, day services etc.) in specific catchment areas. Another valuable national database is the Hospital In-Patient Enquiry (HIPE) system. While all these sources provide important data they are limited in the information they can provide and thus only give us part of the picture.

Chapter One described how most mental illness exists in the general population and attenders at primary care (general practitioner)

services, with only a small proportion reaching the psychiatric services. In spite of this there is very little data concerning psychiatric morbidity in the general community or in general practice attenders. Where studies on these populations have been carried out, here or elsewhere, there is often an age selection bias in those included, with many studies including only those aged 18-64. Data on the incidence and prevalence of disorders in a community population is generally collected by special study, and only one such study on an elderly population has been undertaken in Ireland (Lawlor *et al.* 1994).

When other national data relating to health services is collected, it is often in simple aggregate form with no breakdown by age, diagnosis or any other variable. There is also no national data concerning the use of community psychiatric facilities by older people or the diagnostic mix involved. A lack of coherent descriptions and definitions can also create difficulties in collecting data, for example on residential care facilities in the different health boards.

In order to effectively plan the number and range of services that are required for older people with mental disorders, in an equitable and efficient manner, we need information on the number of people affected with different disorders and the needs they might have. Some of the more important gaps in our current knowledge include:

- the prevalence of mental disorders in general practitioner attenders
- the prevalence of mental disorders in the general community
- national data on the activities of community psychiatric services
- the need for nationally agreed definitions of community and residential facilities
- the need for appropriate outcome measures for evaluation.

The Department of Health strategy document *Shaping a Healthier Future* (1994) recognised the need for and the importance of

information in planning and evaluating service. But it should be noted that information is not cheap. Paper forms and ledgers can no longer provide the information required to evaluate and plan comprehensive, inter-related services, but few health boards have the technology, and more importantly the information systems and expertise to obtain and exploit the information which is necessary to effectively and systematically plan and evaluate services.

13.5 Research

Research studies can provide alternatives to and can complement routinely collected data. It is important that studies are well-designed and that they build successively on previous knowledge rather than repeating work that has already been carried out. For example, future studies on the prevalence of mental disorders in older people could focus on how sub-groups are differentially affected, such as those who are have low incomes, are physically ill or high risk groups that have been identified in previous research.

In examining the Irish and international literature on the epidemiology of mental disorders in the total population (i.e., including older people), and related bio-medical research on specific disorders, what could be termed an 'age-selection bias' becomes apparent. This consists of a few lines in the methods section of most papers noting that 'people aged 15-64 were included in the study'. This is often unavoidable, as when a specific service for this age group is under study for example. Similarly, studies on dementia will usually only include people over 65. However, it is more often the case that people over 65 are routinely excluded because appropriate measures do not exist for this age group, or special training would be required by interviewers or special sampling techniques would be required. Unfortunately much research in Ireland is carried out with very limited finances (and often with none at all) and the extra demands involved in including older people can make it more

difficult. Perhaps the additional resources required could be built-in to a grant proposal so that all adults could be included in research studies. Another area where further work is required is in developing measures which can be used with older people with mental disorders.

An important issue concerning research with older people, particularly those who may have cognitive impairments, is that of consent. A European BIOMED research programme concerned with *Ethical Issues in Bio-Medical Research with Cognitively Impaired Elderly Subjects* (de Wachter and ter Meulen 1996) recommended four procedural safeguards for studies on this group:

- that the project including such elderly subjects be part of a promising scientific programme
- that the research be conducted in specialised institutions
- that the review procedure be both local and central
- that proxy informed consent be complemented by the utmost attention to all verbal and non-verbal signals expressed by patients and which may or should be seen as symptoms of distress.

13.6 Care of older people with a mental disorder

It is generally recognised that dementia provides the biggest challenge to the provision of care for older people. In Chapters One and Nine an outline was given of the type of services required for dementia sufferers and their carers. Previous work by the Council and communication with the range of people providing services for this group would suggest that priority should be given to the development of particular services, including:

- specialised day centres for people with severe dementia and transport to the centres
- day hospitals
- respite care/ day sitting services

- diagnostic and assessment services at community level
- earlier intervention
- 24 hour a day, seven days a week community services for people with severe dementia.

The key to services for people with dementia, or indeed older people with any mental disorder is that flexibility within and between services is paramount and that close links and communication between the various agencies and services is continually facilitated.

The establishment of a Dementia Services and Information and Development Centre in Ireland would act as a focus for information, training, research and evaluation which would be a valuable resource to all those involved in the care of people with dementia, both lay and professional.

Most older people with a psychiatric disorder are cared for in their own homes by their family and other relatives. Previous Council reports have documented the enormous amount of work undertaken by these carers and the support that they require. Detailed recommendations concerning carers, support services required and means of recompense were made by the Council in 1988 (O'Connor and Ruddle 1988). While some of these recommendations have been implemented, others as yet have not. It is to be hoped that efforts will continue on ensuring all the recommendations are addressed.

The primary care services treat the bulk of mental illness in older people. The importance of the general practitioner and the primary care team (including public health nurses and community care) in providing care and support for these individuals cannot be underestimated. The general practitioner is the first point of contact for most individuals who might require treatment for a mental disorder. While most psychological problems are treated at the

primary care level, the general practitioner is also the source of most referrals to the psychiatric services. Given the importance of general practitioners in the detection of mental disorders, it might be appropriate for general practitioners to include screening measures in their assessment of older people. However, there are some practical difficulties in implementing this. Firstly and most simply, there are few screening measures that are quick, easy to administer and appropriate to older people living at home. Secondly, the time involved in conducting such assessments would be considerable and this would have to be considered in both the work structure and means of recompensing general practitioners.

13.7 Treatment

13.7.1 Services

The need for specialist psychiatry of old age services to provide optimum assessment and treatment for older people with mental illness has been described throughout this report. There are currently four such services operating in the country serving approximately 15 per cent of the over 65 population. This situation represents a serious inequity in access to services as only those individuals who live in a catchment area served by a psychiatry of old age service can avail of it. In 1984 the report *Planning for the Future* recommended that psychiatrists with expertise in the psychiatry of old age be appointed. More than a decade later only four such psychiatrists have been appointed. *The Years Ahead* (1988) recommended service norms for the psychiatric services for older people with mental disorders including:

- acute psychiatric assessment beds to elderly population 1.5: 1,000
- beds for elderly severely mentally infirm to elderly population 3: 1,000
- day hospital places to elderly population 2: 1,000

There are difficulties in counting the number of assessment beds and beds for severe dementia because of different definitions and descriptions used around the country. However, only a fraction of the day hospital places recommended have been provided. The joint report of the Royal College of Physicians and Royal College of Psychiatrists (UK) on *Care of Elderly People with Mental Illness* (1989) noted the key resources for a psychiatry of old age service to a catchment area comprising 20,000 people over 65 to be:

• beds for functional illness	12
• beds for organic illness (short-stay assessment and relief)	20
• beds for long-stay	40-60
• day places for functional illness	10-15
• day places for dementia	40-50
• consultant staffing	1 wte*

(*one whole time equivalent consultant per 10,000)

As noted in Chapter Ten, no evaluation of these norms has been carried out in Ireland. It would be worthwhile to carry out some assessment of the level of services, beds and staff currently involved in the care of older people with mental disorders in the context of the needs of this population in order to plan future service provision.

13.7.2 Treatment options

In the discussion of treatment options in Chapter Nine it was noted that the range of treatments available for mental disorders are generally effective in people of all ages. However, older people do not seem to have the same access to non-medical treatments as younger people. This may be due in part to beliefs among health professionals as to the efficacy of psychological treatments in older people and these beliefs should be addressed and tackled as suggested in 13.2 and 13.3 above. However, there is also a lack of suitably trained personnel in psychiatry, particularly in the psychiatry

of old age. While it is recommended that multidisciplinary teams should be in place in each district, in practice these teams usually consist of doctors and nurses with limited input from psychiatric social workers, occupational therapists and psychologists because there are so few in the services. This restricts the range of treatment options available to patients. Also the different range of skills available from psychologists, occupational therapists and social workers are not available to care teams. The inclusion of these professionals in psychiatric care teams would go some way in providing the widest possible range of treatments to older people with mental disorders.

There is a large number of people with mental illness who have grown old in long-stay psychiatric facilities. Their needs both in terms of treatment and care are generally different to older patients with acute illness and younger patients with chronic illness. In general, a range of services is required for older long-stay mentally ill people, to either support them outside of the hospital environment or to take account of their special needs within hospital care.

13.8 Long-stay care

13.8.1 Information

Estimating the number of older people with mental disorders in long-stay care is extremely difficult. This is due firstly to the large number of different institution types which cater to patients with similar medical and social profiles. It is also caused by the poor quality of information arising from the Department of Health's survey of long-stay units. This survey does not allow for an exact estimation of the number of older people with particular disorders in long-stay care. The figures that are available are likely to be a considerable underestimate. Future surveys should therefore provide more detailed information on the medical, psychological and social status of residents to remedy this situation.

13.8.2 Appropriate settings

While reductions in the numbers of older people resident in psychiatric institutions are to be welcomed, the appropriateness of the current residential settings available should be questioned. Most of these settings do not offer access to specialist ongoing assessment and treatment services. In many settings the only treatment option available is pharmacological, with no access to other treatments such as behaviour therapy, counselling or reminiscence therapy. Thus many older people with treatable problems in long-stay care are not receiving the best care possible.

It is clear from the report that the supply of designated community residential beds for older people is very low. In a context where patients are being resettled from psychiatric hospitals to the community or not admitted in the first place there is an urgent need to:

- Increase the supply of housing and hostel accommodation for patients suitable for discharge to the community
- Ensure that older people who are left behind in psychiatric facilities are not left in buildings with falling standards of care as younger patients are discharged. If older patients are to remain, these buildings must be adapted to their needs.

13.8.3 Entry criteria

The criteria for entry to various facilities are often unclear and vary significantly from health board to health board. The North Eastern Health Board region for example has almost twice the number of patients with a mental disorder in long-stay units compared to the South Eastern Health Board. This is in part due to historical variations in the type of facilities available, but is also linked to different admission policies across the health board regions. For the sake of equity, national guidelines for the placement of older patients

with mental disorders in long-stay care should be established. These guidelines would take into account the level of behaviour disturbance present in the patient, their physical health and their differing life circumstances. At local level, these criteria would then be translated into clear policies for admission to various facilities. This process would also highlight where shortages in the provision of accommodation exist.

13.9 Health promotion

A striking finding throughout this report is the common factors which are associated with many disorders which are not necessarily amenable to 'clinical treatment', but which, if they are addressed, could bring about significant reductions in the symptom levels and even the clinical occurrence of many disorders. For example, physical illness can complicate the presentation of mental disorders and can make many worse, notably, depression, dementia, anxiety and alcohol dependence. Physical illness and chronic pain are also significant risk factors for suicide. Thus, timely and effective treatment and monitoring of physical illness in the elderly may resolve the physical problem and may also help to reduce the risk of psychological problems developing, or ameliorate these symptoms if a mental disorder is already present.

Another notable factor associated with some disorders is loneliness or social isolation. This is implicated in depression, anxiety, alcohol dependence and again is a risk factor for suicide. Social intervention measures, such as befriending, day centre attendance and contact with the range of community services can play an important role in lessening a sense of isolation, and may be the link needed to prevent the development of these symptoms or may lessen them if a disorder is present.

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Appendix: Diagnosis Summaries

The diagnostic groups used in this report are a grouping of the individual International Classification of Diseases (ICD 9) categories and codes as follows:

1. Organic Psychoses: 290, 293, 294, 310, 314
2. Schizophrenia: 295, 297, 298.3, 298.4
3. Other Psychoses: 298.1, 298.2, 298.8, 298.9, 299
4. Depressive Disorders: 296.1, 296.3, 298.0, 300.4, 309.0, 309.1, 311
5. Mania: 296.0, 296.2, 296.4, 296.5, 296.6, 296.8, 296.9
6. Neuroses: 300.0, 300.1, 300.2, 300.3, 300.5, 300.6, 300.7, 300.8, 300.9, 306, 307, 308, 309.2, 309.3, 309.4, 309.8, 309.9, 313, 315, 316
7. Personality Disorders: 301, 302, 312
8. Alcoholic Disorders: 291, 303, 305.0
9. Drug Dependence: 292, 304, 305.1, 305.2, 305.3, 305.4, 305.5, 305.6, 305.7, 305.8, 305.9,
10. Mental Handicap: 317, 318, 319.
11. Unspecified: 793, 000.0.

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44. *Elderly Return Migration from Britain to Ireland: A Preliminary Study*, May 1996
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