1

The Assessment of Patients in Old Age Psychiatry

Introduction 1
Setting 2
The psychiatric history in older patients 5
The Mental State Examination (MSE) 10
Assessing cognition with limited time 17
Assessment of everyday functioning 18
Physical examination 18
Investigations 18
Neuropsychiatric testing and the memory clinic 20
Assessment of carers 21
Summary 21
Further reading 22

Introduction

Assessment of patients in old age psychiatry follows similar principles to that in general psychiatry, the main differences being in the practicalities and emphasis. Multidisciplinary working is central to the process; in many cases the assessment involves a number of professionals and occurs over a period of time.
CH 1 THE ASSESSMENT OF PATIENTS IN OLD AGE PSYCHIATRY

Referrals

In general, referrals are made to the appropriate Community Mental Health Team (CMHT, see page 222) and the most appropriate action is discussed in a multidisciplinary meeting. Depending on the nature of the referral, the initial assessment may be completed by one or more members of the team, with involvement of other professionals as necessary.

Beginning the assessment

There are a number of things that it is important to establish at the beginning of the assessment which may seem obvious but make things go a lot more smoothly:

- Introduce yourself and make your role clear – some patients may not realise that they have been referred to a psychiatrist.

- Try your best to put the patient at ease (see above).

- Establish what the patient would like to be called (it’s usually best to use Mr/Mrs/Miss if unsure).

- Make sure you know the names of people accompanying the patient and their relationship/roles.

- Ask if the patient would like some time alone without relatives/carers listening (it may be easier to ask at the end, or give the patient the opportunity during the physical examination).

Setting

Assessments usually take place in the patient’s home or in the outpatient clinic, although sometimes it is necessary to assess a patient on a hospital ward.

Domiciliary visits

The patient’s own home is the ideal environment for an assessment, and allows for a more accurate insight into their social situation and level of functioning, for example:

- Is the house clean, well organised?

- Is there fresh food in the fridge?
SETTING

- Can they make a cup of tea?
- Can they recognise people in photos around their home?
- Is the accommodation safe/appropriate? (For example heating, hot water, stairs, bathrooms, hazards.)
- Are there empty bottles of alcohol?
- Are there boxes of unused medication?
- How much support is available from people living nearby?

Another advantage of a home visit is that friends and family involved in the patient’s care are more likely to be able to attend and give valuable collateral history. This is balanced against the disadvantages of the time necessary for travel, difficulties in performing a physical examination and safety implications for staff. Although the patient may not pose a risk, their environment or other people in the home might. Box 1.1 summarises some important safety and practical procedures.

Box 1.1 Important safety and practical procedures for domiciliary visits

Let the patient and their family/carers know when to expect you.

Plan your route in advance and carry a map.

Familiarise yourself with any history of risk that is available.

Make sure someone knows details of the visit and when to expect your return.

 Carry a mobile phone.

If you feel threatened, leave immediately.

Outpatient clinics

The outpatient clinic is the most convenient setting for assessment from the point of view of medical staff, although there are a number of disadvantages:

- It can be disorientating for the patient to travel, which may lead to a less accurate picture of their mental state and cognitive function.
Friends and relatives are less likely to be able to attend.

Patients often do not have transport.

Psychiatric wards

It may be necessary for a patient to be admitted to a psychiatric ward for assessment because:

- The patient is at risk of self-harm, self-neglect or harm to others.
- A longer period of assessment is needed than a brief interview at home or in the clinic.
- Family/carers are not able to manage/cope with the patient.

The disadvantage is that the patient is out of their home environment and so the assessment may still not reflect the true level of functioning. In addition, patients might lose some of their skills and confidence.

General hospital wards

Medical and surgical inpatients with acute mental health problems may be referred for liaison assessments on the ward. Before the assessment, read the referral thoroughly and if necessary call the referrer for further information, including any test results pending. It is always worth checking whether or not the patient is already known to psychiatric services, and tracking down the notes if they are.

There are a number of things that you can do to make the liaison assessment go more smoothly:

- Get as much information as you can from the ward nurses.
- Try and arrange for a relative or carer to be present.
- Wards are noisy – find a quiet room where you won’t be interrupted.
- Be prepared to do your own physical examination if you feel it is necessary.
- Ask the patient’s permission to phone relatives for further collateral information if you need it.
- Be prepared to make more than one visit.
In the case of a liaison assessment the psychiatrist is only advising the team looking after the patient of the most appropriate management from a psychiatric point of view. Ultimately, decisions regarding management remain the responsibility of the team looking after the patient.

The psychiatric history in older patients

The psychiatric history follows the same scheme as that used in general psychiatry. There needs to be a greater focus on particular aspects, for example social history and assessment of cognition. In addition, much of the history is often obtained from a relative or carer (see page 10). Box 1.2 gives an outline.

**Box 1.2 Overview of the psychiatric history**

- Source and details of referral
- Presenting complaints
- History of presenting complaint
  - nature, onset, duration, precipitating factors, impact, risks
- Personal history
  - birth and milestones, childhood, education, employment, relationships
- Family history
- Past psychiatric history
- Social history
  - accommodation, finances, activities of daily living, level of support
- Past medical history
- Medication and allergies
  - note potential interactions and side effects
- Alcohol and drugs
- Forensic history
- Premorbid personality
- Collateral history
History of presenting complaint

As with any psychiatric interview, it’s good to start with an open question (“can you tell me a bit about what’s been happening lately?”).

More focused questions can be used to direct the history and to establish:

- Nature of the problem
- Speed of onset
- Duration
- Possible precipitating factors (e.g. life events, physical illness, medication changes)
- Impact on the patient’s life (e.g. no longer leaves the house)
- The patient’s perception of the problem
- Whether others think there is a problem
- Risks (Table 1.1).

To establish a timeline it can be helpful to relate the onset and changes of symptoms to events like birthdays, Christmas or holidays.

Whilst the patient needs to be able to tell their own story, there are some features that should be screened for, with more detailed questioning where necessary. The nature and range of symptoms experienced by older patients may be different from their younger counterparts.

| Table 1.1 Areas of risk to explore in the psychiatric history |
|---------------------------------|---------------------------------|
| **Risk to self**                | **Risk to others**              |
| Wandering                       | Aggression                      |
| Poor judgement                  | Disinhibited behaviour          |
| Gas/water taps left on          | Poor driving                    |
| Poor driving                    | Gas left on                     |
| Self-neglect                    |                                |
| Vulnerability to abuse/exploitation |                        |
| Self-harm/suicidal ideation     |                                |
THE PSYCHIATRIC HISTORY IN OLDER PATIENTS

**Personal history**

- Birth and milestones

- Upbringing and significant childhood experiences

- School, higher education and occupational achievements
  - contributes to overall picture
  - gives an idea regarding the patient’s previous level of functioning.

- Relationships, marriage and children

- Life events

- Social network.

Many of the current older generation were affected by the Second World War and may have experienced significant adversity. Separation from carers, interruption of education, loss of parents or a spouse and serving in combat with resulting injuries and psychological traumas are all issues that may affect the presentation of psychiatric illness.

It is always important to put life events in to context, for example being a single mother is generally socially accepted in the UK today, but in the past often had devastating consequences.

**Family history**

Patients with cognitive impairment might seem muddled about the exact names and relationships of family members, and this in itself is informative. Whether from the patient or a carer, it is helpful to obtain accurate information regarding any family history of medical and psychiatric problems.

**Past psychiatric history**

Patients often use terms like “nervous breakdown” to describe episodes of mental illness in the past. They might also describe diagnoses such as “schizophrenia” which seem questionable. It is often best to ask a few questions about the exact nature of the illness and its treatment to get a clearer picture.
Social history

Interventions aimed at optimising the social situation are often extremely effective and well received by the patient and their family. The main areas to cover in the social history are:

Accommodation

- Type (independent/warden controlled/residential home/nursing home)
- House or flat?
- Rented or owned? (If rented, private or local authority/housing cooperative?)
- Stairs – are the bedrooms/bathrooms upstairs or down?
- Heating (open fires, gas heaters).

Finances

- Are there financial worries or concerns about exploitation?
- Do they receive any state benefits, for example, in the UK, Attendance Allowance (AA), or Disability Living Allowance (DLA)?
- Do they have insight into their financial situation?
- Who controls the finances and is this a formalised arrangement (e.g. power of attorney)?

Activities of daily living

- Is assistance required and how much?
- Personal hygiene
- Dressing
THE PSYCHIATRIC HISTORY IN OLDER PATIENTS

- Cooking
- Eating/drinking
- Shopping
- Use of transport
- Hobbies and interests (past and present).

Current level of support

- Input may be from family, friends, neighbours or paid carers (social services or private). How often do they visit and for how long? What do they do?
- Meals on wheels
- Day centres
- Respite.

Past medical history

Ask about any past illness or surgery, as well as current or chronic conditions and cardiovascular risk factors. These may help with diagnosis or may be exacerbating factors.

Medication

- If the patient doesn’t bring a list, call the GP surgery.
- The elderly are particularly susceptible to side effects (see Chapter 10).
- Confusion, anxiety, affective disturbance, psychotic symptoms and falls can all be caused or exacerbated by drugs.

Ask about compliance, and whether or not the patient has a dosette box or prompting/help from a carer to take medication. This is also a good time to ask about allergies.
10  

**CH 1 THE ASSESSMENT OF PATIENTS IN OLD AGE PSYCHIATRY**

**Drugs and alcohol**

Ask about past and present alcohol consumption and smoking. Recent changes may reflect the underlying mental state. Drug abuse may not be thought of as a major problem in elderly patients, but is worth asking about.

**Forensic history**

Ask about any experience the patient has had of the criminal justice system. Recent arrests, convictions and cautions may be important evidence of new-onset psychiatric illness, or a relapse of manic or schizophrenic illness.

**Premorbid personality**

Premorbid personality is often neglected but can be especially important, for example in the case of disinhibition in frontotemporal dementia.

**Collateral History**

The law allows us to take information regarding a patient from anyone who wishes to offer it but it is always best to ask the patient for his or her permission. Explicit permission from the patient is essential if you are going to give details of their illness to their relatives. If the patient lacks capacity to give their consent then information can be given to relatives/careers if it is in the patient's best interests. If you are at all unsure, it is best to discuss the issue with a senior colleague.

Ideally, you will be able to take the collateral history in the presence of the patient, allowing the process to be completely transparent. However, it can often be useful to see the patient's relative alone. For example, the relative may wish to discuss behaviour that is upsetting or embarrassing for the patient.

**The Mental State Examination (MSE)**

The psychiatric history records the symptoms since the onset of illness, whereas the MSE is a snapshot of these symptoms and signs at the time of the interview. In practice, there is considerable overlap between the two. Box 1.3 gives a skeleton plan of the MSE and a more detailed summary is given below.
Box 1.3 Mental State Examination

Appearance and behaviour

Speech

Mood

Thought

Perception

Cognition

Insight

Appearance and behaviour

Awareness

- A reduced level of awareness might reflect effects of physical illness or drugs.
- Rapid fluctuations suggest an acute confusional state.
- Variations in the level of consciousness can also occur in dementia with Lewy bodies.
- The level of awareness will affect performance on cognitive testing.

Appearance

- Personal hygiene: an unkempt appearance and poor personal hygiene suggests personal neglect, although a person might appear well kempt because they are well looked after by a carer.
- Clothing: the state of dress might suggest mania, disinhibition or dressing dyspraxia.
- Environment: on a domiciliary visit the state of the patient’s environment also gives clues (cleanliness, tidiness, empty bottles etc.).
**Behaviour**

- Eye contact
- Facial expression
- Ability to establish rapport
- Anxiety/agitation/aggression
- General slowing/psychomotor retardation/posture
  - can be suggestive of depression, can also occur in dementia
- Overfamiliarity and disinhibition
  - may be suggestive of mania or frontal lobe problems
- Apparent responses to hallucinations
- Tics, mannerisms and stereotypies, for example:
  - as a feature of schizophrenia
  - hyperorality and repetitive behaviours may occur in frontotemporal and other types of dementia.

**Speech**

- Rate and quantity, for example:
  - ↓ in depression; can be to the point of appearing to have dysphasia
  - ↑ in mania, although this is not always the case in the elderly
  - ↓ may be due to dysphasia (see below)
  - pressure of speech and poverty of speech may reflect mania or depression respectively.
- Tone: may be normal or monotonous (e.g. depression, Parkinson’s disease).
- Volume, for example:
– ↑ in deafness, disinhibition and mania
– ↓ in anxiety, depression.

• Word finding difficulties:
  – dysphasia (impairment of language, note: this is different from impairment of articulation of speech which is called dysarthria and is due to poor muscle coordination)
  – language deficits are common in many dementias (e.g. semantic dementia)
  – nominal dysphasia (word finding difficulties) occurs early in Alzheimer’s disease.

Mood

Depression

The current generation of older people may find it difficult to describe their mood. Biological features and somatisation may therefore be more apparent than the psychological features of depression. The assessment of mood also draws from the assessment of behaviour and both subjective (the patient’s) and objective (the clinician’s) accounts are recorded. Table 1.2 gives a list of depressive features to screen for. The 15-item Geriatric Depression Scale (GDS, Appendix 1) is a brief assessment scale that can be completed in the clinic.

Differentiating depression from dementia or bereavement can be difficult; for further information see the later chapters on dementia and mood disorders.

If there is any suggestion of depressed mood, enquiry about suicidal ideation is essential. Older men are one of the highest risk populations for completed suicide.

Table 1.2 Features of depression to screen for in the MSE

<table>
<thead>
<tr>
<th>Psychological features</th>
<th>Biological features</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low mood</td>
<td>Disturbed sleep</td>
</tr>
<tr>
<td>Reduced concentration</td>
<td>Disturbed appetite (weight loss)</td>
</tr>
<tr>
<td>Anhedonia</td>
<td>Reduced energy</td>
</tr>
<tr>
<td>Helplessness and hopelessness</td>
<td>Reduced libido</td>
</tr>
<tr>
<td>Bleak view of the future</td>
<td>Complaints of physical illness</td>
</tr>
<tr>
<td>Guilty feelings</td>
<td>Diurnal mood variation</td>
</tr>
<tr>
<td>Suicidal ideation</td>
<td></td>
</tr>
<tr>
<td>Irritability</td>
<td></td>
</tr>
<tr>
<td>Agitation</td>
<td></td>
</tr>
</tbody>
</table>
14

CH 1 THE ASSESSMENT OF PATIENTS IN OLD AGE PSYCHIATRY

Mania

Mania in older people may present with elation in mood, although often the picture is of mixed affect, agitation, irritability and/or aggression.

Anxiety

- Features of anxiety can occur independently or as a feature of most mental illnesses.
- Anxiety is not uncommon in dementia, especially in the early stages.
- Ask about:
  - background anxiety
  - panic attacks
  - exacerbating factors and coping strategies.

Thought

Thought form

Perseveration  A response appropriate to the first stimulus is given, inappropriately, for further stimuli. For example
  “What is your name?”
  “Peter.”
  “How old are you?”
  “Peter.”
  etc.

- Almost pathognomonic of organic brain disease.
- A feature of frontal lobe damage.

Circumstantiality

- Gets to the point eventually but via a circuitous route
- Common in dementia.
Flight of ideas

- Skipping from one subject to another unrelated subject with only a superficial connection.
- A characteristic feature of mania.
- In older people it might not be associated with rapid speech and can be missed.

Loosening of associations

- Occurs in psychosis and other conditions, for example mania.
- The links between topics seem illogical, and can vary from tangential to “word salad”.

Thought content

Obsessions

- Obsessions are recurrent and persistent thoughts, images or impulses that the patient tries to but is unable to resist.
- May occur in the context of an obsessive disorder.
- Can also be a feature of psychosis, depression or dementia.

Delusions

- Fixed beliefs based on unsound evidence out of keeping with the patient’s social and cultural background.
- Delusions can take many forms and may be associated with a psychotic or mood disorder.
- In the early stages of dementia delusions (especially of theft) may be secondary to forgetting.
- Some types of dementia (e.g. dementia with Lewy bodies) are associated with systematised delusions.
Overvalued ideas

- A belief that may not be unreasonable but is pursued to an unreasonable degree by the patient.
- Often associated with personality disorders.

Perception

Hallucinations in any modality can occur in the context of psychosis, dementia or delirium. Of particular relevance in older people is sensory impairment (i.e. visual impairment or deafness):

- Can lead to hallucinations in the absence of psychosis (e.g. Charles Bonnet syndrome)
- Is an important maintaining factor for hallucinations in the presence of psychosis.

Visual hallucinations are common in dementia with Lewy bodies.

Cognition

Information about cognition is obtained simply by observation throughout the interview, for example:

- General level of orientation
- Ability to follow the conversation
- Ability to remember facts and names during the history
- Asking the same questions/repeating statements
- Presence of confabulation.

More objective testing is mandatory, and in the limited time available in the initial assessment (see below) it is realistic to aim to complete:

- The Mini Mental State Examination (MMSE)
- The clock drawing task
- Bedside tests for more specific cognitive functions, where relevant (Appendix 2).
Insight

Insight may be complete, partial or absent. There may be insight into the presence of a mental illness or dementia but not into the need for intervention.

Assessing cognition with limited time

The MMSE

The Mini Mental State Examination (MMSE, Appendix 3) is a basic 30-point test of cognition over a broad range of areas and provides a quick overview of cognitive function. It is a good idea to make sure that well-meaning relatives know not to prompt answers from the patient, who might become distressed if they are finding the questions difficult.

The score on the MMSE (Table 1.3) must be considered in the context of the overall clinical picture. A low score does not in itself indicate a diagnosis of dementia. Similarly, patients with dementia confirmed by more in-depth neuropsychological testing may score relatively highly on the MMSE, even 30/30.

The MMSE does not contain any items that test frontal lobe function. If there is any suspicion of a frontal lobe deficit then a brief test like category fluency or letter fluency can be performed (see Appendix 1).

Drawing a clock face

Drawing a clock face, writing in the numbers correctly and marking on the hands to show ten past eleven, tests a broad range of cognitive skills and has a relatively high sensitivity and specificity for dementia. It is worth asking the patient to complete this task routinely at the end of the MMSE.

<table>
<thead>
<tr>
<th>Table 1.3</th>
<th>Level of cognitive impairment associated with the MMSE score (those for dementia are the figures used by NICE for Alzheimer’s disease). The score must be interpreted in the context of the clinical picture</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMSE Score</td>
<td>Level of cognitive impairment</td>
</tr>
<tr>
<td>27–30</td>
<td>Normal range*</td>
</tr>
<tr>
<td>27–30</td>
<td>Mild cognitive impairment*</td>
</tr>
<tr>
<td>21–26</td>
<td>Mild dementia</td>
</tr>
<tr>
<td>10–20</td>
<td>Moderate dementia</td>
</tr>
<tr>
<td>Less than 10</td>
<td>Severe dementia</td>
</tr>
</tbody>
</table>

*Performance depends on age, education and premorbid ability
Testing the function of specific lobes

Where it is relevant, the assessment can be refined by brief “bedside” testing of the functions of one or more specific lobes. This is informative but not a substitute for formal neuropsychological testing. Details of these tests are given in Appendix 1.

Assessment of everyday functioning

This can be divided into activities of self-care (Activities of Daily Living, ADL) and more complex activities of everyday life (Instrumental Activity of Daily Living, IADL). An example of a simple scale is the Bristol Activities of Daily Living Scale. A scale can be given to the carer to complete whilst you carry out the physical assessment of the patient.

Physical examination

Ideally, a physical examination is performed for all new patients. This can be difficult in some circumstances and arrangements may need to be made for it to be completed at a later date. The purpose of the physical examination is to identify:

- Reversible causes of psychiatric illness
- Differential diagnoses
- Exacerbating factors
- Factors that may affect prescribing
- Physical impairments that will affect suitability of accommodation
- Unreported physical illness requiring attention.

Investigations

Investigations are aimed at ruling out reversible causes and facilitating diagnosis and are summarised in Tables 1.4 and 1.5.
Table 1.4  Routine investigations in the old age psychiatry assessment

<table>
<thead>
<tr>
<th>Blood tests</th>
<th>Full blood count</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urea and electrolytes</td>
</tr>
<tr>
<td></td>
<td>Liver function tests</td>
</tr>
<tr>
<td></td>
<td>ESR</td>
</tr>
<tr>
<td></td>
<td>CRP</td>
</tr>
<tr>
<td></td>
<td>Thyroid function tests</td>
</tr>
<tr>
<td></td>
<td>Vitamin B12</td>
</tr>
<tr>
<td></td>
<td>Folate</td>
</tr>
<tr>
<td></td>
<td>Fasting glucose</td>
</tr>
<tr>
<td></td>
<td>Cholesterol*</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Microbiology</th>
<th>VDRL (to exclude neurosyphilis)*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urine microscopy, culture and sensitivity</td>
</tr>
</tbody>
</table>

| Neuroimaging         | CT/MRI brain now routine in dementia in most old age psychiatry services* |

*Not included in Royal College of Psychiatrists guidance for routine investigations in dementia

Table 1.5  Investigations guided by the clinical picture

<table>
<thead>
<tr>
<th>ECG</th>
<th>For example if there is suspicion of vascular dementia/cardiovascular disease or if planning to use cholinesterase inhibitors.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest X-ray</td>
<td>For example, on suspicion of chest infection, heart failure or malignancy.</td>
</tr>
<tr>
<td>EEG</td>
<td>Some types of dementia have specific EEG changes. Investigation of epilepsy.</td>
</tr>
<tr>
<td>PET</td>
<td>Positron emission tomography. Only available in a few specialised centres. Uses radiotracers to produce images of brain activity. Includes measurements of glucose metabolism, receptors, neurotransmitters, abnormal proteins.</td>
</tr>
<tr>
<td>SPECT</td>
<td>Single photon emission computed tomography. Similar to PET, lower resolution but cheaper and more accessible. Used increasingly and may become more common in the future. Measures cerebral blood flow, receptors.</td>
</tr>
<tr>
<td>Genetic testing</td>
<td>For example, in early onset AD or if there is a strong family history of dementia.</td>
</tr>
<tr>
<td>Lumbar puncture</td>
<td>If suspicion of acute/chronic infection, malignancy.</td>
</tr>
<tr>
<td>HIV status</td>
<td>If suggested by clinical picture/risk profile.</td>
</tr>
<tr>
<td>Brain biopsy</td>
<td>In exceptional cases.</td>
</tr>
</tbody>
</table>
Table 1.6 Example of a standard memory clinic battery of psychometric tests

<table>
<thead>
<tr>
<th>Test</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mini Mental State Examination (MMSE)</td>
<td>Screening tool covering broad range of cognitive domains</td>
</tr>
<tr>
<td>National Adult Reading Test (NART)</td>
<td>Measure of premorbid intellectual functioning</td>
</tr>
<tr>
<td>Cambridge Cognitive Examination–R (CAMCOG)</td>
<td>Tests a wide range of cognitive functions, takes 35–45 minutes</td>
</tr>
<tr>
<td>Logical Memory Test, Wechsler Memory Scale III (COWAT)</td>
<td>Very sensitive for verbal episodic memory</td>
</tr>
<tr>
<td>Halstead Trail Making Test (TMT)</td>
<td>Detects changes in word association fluency</td>
</tr>
<tr>
<td>British Picture Vocabulary Scale (BPVS)</td>
<td>Evaluates processing speed, visual scanning ability, letter and number recognition and sequencing</td>
</tr>
<tr>
<td>Coloured Progressive Matrices</td>
<td>Measure of vocabulary, does not require any reading, speaking or writing skills</td>
</tr>
<tr>
<td></td>
<td>Measures non-verbal intelligence</td>
</tr>
</tbody>
</table>

Neuropsychiatric testing and the memory clinic

Some patients will require a more in-depth neuropsychiatric assessment. This can be carried out by a psychologist or in the memory clinic. The memory clinic assessment provides a more comprehensive assessment of functioning in all cognitive domains. Since the 1980s the number of such clinics in the UK has been increasing. They provide a way of identifying and monitoring patients with cognitive impairment, and their response to treatment. They are also central to a great deal of dementia research.

The assessment generally takes 1 1/2 hours and may be repeated six-monthly or yearly, depending on local protocol and clinical need. Patients who are likely to benefit most are those with mild cognitive impairment (see page 55), mild dementia or those who present a diagnostic challenge. There are a great number of psychometric batteries that can be used; an example is given in Table 1.6.

Table 1.6 gives details of a psychometric battery that could make up a standard memory clinic assessment.

Non-cognitive assessment scales in dementia

Table 1.7 gives examples of some of the major scales used to measure non-cognitive features of dementia. There are quite literally hundreds of assessment scales related to
SUMMARY

Table 1.7 Non-cognitive assessment scales in dementia

<table>
<thead>
<tr>
<th>Parameters measured</th>
<th>Scale</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Global severity</td>
<td>Clinical Dementia Rating scale (CDR)</td>
<td>Structured interview, six domains on a five-point scale</td>
</tr>
<tr>
<td>Global change</td>
<td>Clinician’s Global Impression of Change (CGIC)</td>
<td>Very few guidelines, clinicians assessment of change on a seven-point scale</td>
</tr>
<tr>
<td>Activities of daily living</td>
<td>Progressive Deterioration Scale (PDS)</td>
<td>29 items, scores from 0–100. Carer rated</td>
</tr>
<tr>
<td>Behavioural and psychological features</td>
<td>Neuropsychiatric inventory</td>
<td>Structured interview with carer, 13 domains, scores from 0–120. Takes 10–15 min</td>
</tr>
<tr>
<td>Depression</td>
<td>Cornell scale for depression in dementia</td>
<td>Validated for use in dementia</td>
</tr>
<tr>
<td>Quality of life</td>
<td>The Cornell-Brown Scale for quality of life in dementia (CBS)</td>
<td>Semi-structured interview based on previous month</td>
</tr>
<tr>
<td>Carer burden</td>
<td>Screen for caregiver burden</td>
<td>25-item self-report questionnaire</td>
</tr>
</tbody>
</table>

dementia and old age psychiatry and it is not possible to provide a comprehensive list here. Further reading is suggested at the end of the chapter.

Assessment of carers

The responsibility of caring for an older person with mental illness often falls to the spouse who is elderly themselves, or to their children who must try to balance their own life against caring for an elderly parent. Assessment of the carers’ needs forms part of the overall assessment of the patient. Carers looking after patients with mental illness have a high risk of developing depression.

Summary

The assessment in old age psychiatry is rarely complete after one interview. The higher frequency of organic disease and co-morbid illness leads to a greater emphasis being placed on physical examination and investigations. The wider psychosocial needs of the patients and their carers must be investigated and a cohesive multidisciplinary approach is
essential. The use of both cognitive and non-cognitive assessment scales allows objective assessment of severity and monitoring of progress and response to treatment. Box 1.4 gives an overall picture of the initial assessment in old age psychiatry.

### Box 1.4 Overview of the initial assessment in old age psychiatry

- **Psychiatric history**
- **Mental state examination**
- **Physical examination**
- **Assessment scales, e.g.:**
  - GDS
  - MMSE
- **Arrange further assessment as necessary:**
  - psychometric testing/memory clinic
  - assessment by other professionals
  - investigations
- **Arrange follow up**
- **Explanation of what is happening to patient and carers**

### Further reading