Medicine in Old Age

Dementia in the Elderly: Management

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Most demented people are at home. Dementia greatly increases the likelihood that an old person will eventually need institutional care, but it is not in itself grounds for removal from home; except where short-term hospital admission for investigation or treatment is necessary, the issue turns on the resources and tolerance available outside the hospital as much as on the disease itself. Thus in most cases the doctor's job is to see that all available medical and social sources of help are deployed, and to co-ordinate and monitor their provision.

Can the Patient be Managed at Home?

The old person who lives alone poses the biggest problem. The available services are rarely able to offer anything approaching continuing around-the-clock care, yet such old people often have to be admitted not because they need heavy care, but simply because they need someone to "be around" to keep an eye on them most of the time—to reassure or gently to restrain if they start to wander out of the house. If they cannot have this care at home, then it is residential, not hospital care that they need. But old people who are being looked after by relatives or friends may pose equally taxing problems. Sometimes the burden of disability or behaviour disorder is such that the doctor may feel it his duty to try to persuade a devoted family to accept that their parent is beyond their reasonable capacity to cope, and to help them with their guilt at accepting institutional care. The cost of caring for an aged relative in terms of stress, and even of lasting damage to such families may be clearer to the doctor than to the family, who may find it hard to confess it to themselves or to each other.

More often the old person can well continue to be looked after at home; and relatives and friends will often want to continue to do so. Often it is not the immediate burden that makes families despair, but the prospect of carrying on indefinitely without relief, or without even the expectation of a holiday—or for that matter, without some recognition by others of the size of the burden which they are carrying. Often the whole burden of caring for an aged parent seems to be carried by only one among many brothers and sisters, commonly for reasons which are obscure or derive from long-standing family feuds. In these cases the child who is doing the caring may voice so much resentment towards the brothers and sisters who "don't want to know," that the doctor thinks that the resentment is harder for them to bear than the burden itself. The family's attitude to an old person seems often to derive more from her past personality and behaviour towards them, than from the objective burden of her dementia: in a word, whether they like her.

Many families who do not want to give up the care of the old person need reassurance that their difficulties are appreciated, and not taken for granted, and "therapeutic listening" will go a long way. But often families are unaware that welfare services exist at all, or, for example, that the old person can have guaranteed periods of relief-admission to hospital or old people's home and that their holiday arrangements can be underwritten by booking a temporary admission. Often too the behaviour problems can be greatly mitigated by medical measures, which will be discussed later.

If the decision is for hospital admission the family must be clear why the patient is being admitted—whether it is for care and not for "treatment", or whether it is for short-term investigation only. Sometimes, however, the family's hopes prove stronger even than careful attempts to explain. In a good unit, however demented the patient, she is likely when first admitted to go to an assessment ward, and only very rarely will a commitment to permanent hospital care be made at the time of admission.

Is Day Care Likely to Help?

Day care may help families and may give an opportunity further to assess or treat the patient. But demented old people generally take poorly to being moved from place to place and easily become confused and this may limit the feasibility of day care for some patients, just as it often restricts the appropriateness of "rotating" admission, which is such a source of help to many families looking after physically sick old people.

There are often transport difficulties; it may be impossible to pick up a patient, even if she can be got up and ready, before the family leave for work; and at the other end of the day relatives still have the old person arriving home at about the same time as they themselves get back weary from work. It may be possible to let the family have some respite in the evenings by offering to keep the day-patient until after they had had their supper, and giving her hers in hospital. This generally depends on the family being able to make their own arrangements for collecting her, since transport is rarely available at this time. Many of these problems are solved when the day hospital has its own minibus and driver. Another scheme which at least one enterprising local authority is trying out is a "granny-sitting" service in the evenings at residential homes; by arrangement with the matron, families wishing to go out in the evening may leave an aged relative watching the television with other old people—but, again, confused old people may become still more confused by such temporary changes of surroundings.

Can the Patient Manage her Financial Affairs?

An important practical aspect of the care of demented old people, often forgotten, is the legal one. A demented person is most unlikely to be able to appreciate the nature of her affairs,

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still less to look after them, and if there are any substantial assets the family should be advised to contact the Court of Protection. In these circumstances a Power of Attorney is inappropriate because the old person is unlikely to be capable of understanding its significance. The approach to the Court of Protection may be made through a solicitor, or to the Personal Applications Branch*. Occasionally it may be the doctor's duty to contact the Court, if he has reason to believe that a demented person is being financially exploited.

Informal or Compulsory Admission?

About 15% of our own admitted patients with organic psychosyndromes come into hospital under compulsion, almost all of them under Section 25 of the Mental Health Act. It is impossible to give hard-and-fast advice on when the use of these powers is justified and the decision can be a taxing one; paradoxically perhaps, I have, very rarely, used an Order to bring in for a temporary relief admission a demented old person being cared for by her family, yet refused to do so in respect of a demented old person who lives alone and constitutes some danger to herself.

This is the result of using the following general criterion: if the old person's unwillingness to enter hospital is, in the light of at least a reasonable awareness of the consequences for herself and for others, due to a clear wish to remain at home, it is rarely justifiable to remove her compulsorily. But if her refusal is the result of lack of insight or delusional attitudes to her predicament—that is, if her refusal is itself the result of her mental disorder—removal is probably justified if she cannot reasonably be cared for at home. By this criterion an old lady living on her own who has perhaps had several falls or even wandered out into the road on occasion, but who has a reasonable grasp of her situation and often indicates her wishes forcibly by some such phrase as "I want to die in my own home" should be left at home, though attempts to persuade her that she needs more care should continue.

If a psychiatrist, balancing the risks in relation to the patient's welfare and civil rights, decides against compulsory admission, it is reasonable for the general practitioner to expect him to make his reasons clear in writing and to share the responsibility, for such a lady may well come to harm at home, or she may wander out in front of a passing car. (and the predicament of the potential passing motorist who may have her death on his conscience must be considered too).

By contrast a perhaps less demented old person who is nevertheless wholly dependent on others for her personal functioning, who rarely moves from her room, yet who insists that she is entirely independent, that she does her own shopping, etc., may justify compulsory admission. But such cases are difficult and always sad.

In deciding on compulsory admission because of the hazards at home, one has to weigh also the hazards of an enforced change of surroundings, which is often followed by greater confusion and mysterious decline and death. Clear thinking on these matters demands that the interests of the patient, and the interests of other people be distinguished, though each has a right to be considered; errors of both logic and humanity can occur when the one is confused with the other.

No patient (old or young) should ever be denied admission to a medical (or surgical) bed when that is what they need, merely because they come under compulsion; this was the clear intention of the Mental Health Act of 1959. Special nursing provision may have to be made for such patients in a general ward, but more commonly they pose few problems. The belief that a confused old person admitted under compulsory powers is likely to be more disturbed than one who has come informally is understandable but false, and it is rarely these patients that upset medical wards.

What Supportive Services are Needed?

An account of the supportive services would make an article in itself, and the unevenness of their availability in different areas is notorious. I list only the main ones; fuller advice should always be available from the area office of the social services department.

(1) Support and surveillance may be sought from social workers, health visitors, district nurses, and occasionally specially appointed "geriatric visitors".

(2) Home helps and home meals are obtained through the social services department or sometimes on direct application to the organizers of the particular service.

(3) Modifications to the home, appliances such as walking-aids or commodes, and disposable incontinence pads or sheets (and in some areas a laundry service) may be arranged through the social worker or in some cases direct with the health department, or with the aid of the health visitor.

(4) Chiropody services are in relatively short supply, as are home physiotherapy and home occupational therapy; in some areas these are unobtainable.

(5) Local authorities may run day centres, often with transport, but these are not always suitable for, or willing to receive, confused old people; only in a minority of areas are there special day centres for the elderly confused. Many local authorities will accept old people for the day care at old people's homes.

(6) In most areas there is an Old People's Welfare Association, which organizes activities such as visiting, clubs, competitions, etc., using lay volunteers.

(7) The local authority may sometimes be able to organize holidays even for quite demented old people.

(8) Some demented old people may be so dependent as to qualify for either the full, or the partial Attendance Allowance.

Residential Accommodation

Residential accommodation is the responsibility of the social services department under Part III of the National Assistance Act and the extent and type of provision are extremely variable up and down the country. Some local authorities have special homes for the "elderly mentally confused", and, though these have recently been criticized, I believe that well-designed and well-run ones are the most appropriate way of meeting the needs of some demented old people. But most demented old people living in residential care are in ordinary old people's homes, and dementia itself (as opposed to severe behaviour disorder or severe nursing dependency) should not disqualify an old person for a place in such a home. Doctors who are in the habit of visiting old people's homes will not need telling that anything from a third to over a half of residents there are appreciably demented. The Government has urged local authorities to expand residential provision, but it is certain to remain in short supply almost everywhere. Lists of private residential homes should be available from social services departments; some are excellent, others frightful.

Warden-supervised "sheltered" accommodation comes under the housing department, and control of sheltered housing and residential accommodation are thus unfortunately separated administratively. In fact, sheltered accommodation is almost never appropriate for a demented old person, unless he or she is to live with a well-preserved spouse.

Medication

Depression, intercurrent illnesses, and contributory ailments and disabilities must of course all be treated in their own right. There are no specific drugs for dementia; drugs for which it is claimed that they improve cerebral blood supply or oxygen utilization have not yet been proved to be of practical value and I do not use them, though this may change in the light of new drugs or convincing evaluations.

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TRANQUILLIZERS

The staple drugs in the management of behaviour disturbance in demented old people are the tranquillizers, and there is little evidence that any one is much better than any other.

It is best to become accustomed to one or two drugs, and I prefer promazine because it is not as potent weight for weight as the other phenothazines, and its dosage can thus be more exactly adjusted; when heavier dosage is required I use thioridazine or chlorpromazine, though with the latter jaundice is not a negligible risk. Some units make more extensive use than we do of the butyrophenone haloperidol.

The tranquillizing value of the dry chlormethiazole has not yet been established. Often old people prefer "medicine" to tablets, and syrup is thus sometimes acceptable when tablets are not; and liquid is harder to hide in the mouth and subsequently spit out than are tablets, and cannot be hoarded in pockets or under pillows.

The important thing about tranquillizing regimens is that they should be planned and titrated against the patient's needs. So used they can be an important part of the management, not only of confusion but of paranoid phenomena and of the repetitive questioning and overactivity which can drive relatives to distraction. There is no place for shutting the stable door after the horse has bolted—for large doses to be given only when the grossly disturbed behaviour has already occurred. In such circumstances one is likely merely to make the patient unconscious, or even to make her more confused. One must try to forestall the disturbance, without making the patient dozy. This means taking a careful history of the pattern and circumstances in which the disturbed behaviour most often occurs.

The commonest problem is nocturnal restlessness, and an increased dose of the tranquillizing drug at bedtime together with a hypnotic such as nitrazepam will often give a night's sleep to both the patient and her relatives. It is traditional not to use barbiturates as hypnotics for confused old people, since they are said readily to produce either increased confusion or excitement.

DEPOT FLUPHENAZINES

There is a very limited place for the depot preparations of fluphenazine either in the decanoate or enanthate form.

The trouble with these drugs, which need to be given only once every three or four weeks (and which in old people should generally be given in about half the dose of younger people and if necessary more frequently), is that they have a high incidence of dystonic and depressant side effects. Once the injection is given the effect cannot be wholly reversed until the drug has been metabolized. Old people with extrapyramidal disease, or very decrepit old people, are thus unlikely to tolerate these drugs, but we find that a few relatively robust demented patients may be much helped by them. When phenothiazine medication is associated with Parkinsonian side effects, an antiparkinsonian drug such as orphenadrine, 50 mg thrice daily, is given concurrently—though antiparkinsonian drugs, notably benzhexol, are themselves prone to cause confusion in old people. When it cannot be controlled by general measures or oral drugs acute confusion or excitement almost always responds to intramuscular injection of 50 or 100 mg of thioridazine or chlorpromazine.

Too heavy tranquillizing (or antidepressant) medication may make a confused patient more confused: drug regimens must be reviewed often, and reduction of medication may be more effective than additions.

Vitamins have no proved value in dementia unless there is evidence of a deficiency state; but it makes sense to give them to old people who have been living alone and not eating well.

Other Practical Measures

There are no easy answers to problems such as wandering or incontinence. Often drug control of night-time restlessness can fortify the family by ensuring a night's sleep for everyone. But simple practical measures may go a long way: thus, fitting a lock on a door may stop aimless wandering on to the street, and so enable the family temporarily to leave an otherwise contented old person alone; a change from more dangerous gas or oil to safer electric appliances can diminish obvious dangers; an approach by the doctor or social worker to a friend or local teenager, whom the family may be shy to ask, may give regular periods of help to enable relatives to do shopping, or to have an evening out. Incontinence of urine is dealt with in a later article, but of faecal incontinence it should be remembered that it is most often due to a remediable cause, such as diarrhoea or impaction, and periodic enemas may solve the problem.

Conclusion

Old people with failing brains have three main needs: for security, because their capacity to function far outstrips their capacity to adapt to change; for stimulation, because dementia, especially when restricted mobility and sensory privation in the form of deafness or blindness are added to it, makes the world a frightening and lonely place, in which withdrawal and apathy may be the way of least resistance; and for patience, because old people are slow, but time and again will astonish one by their capacity to "get there in the end"—indeed, they are often "there" from the start, and it is their attendants who are too hurried to get there with them.

These needs are not of course confined to the demented elderly, but are among the basic needs of all of us, but the disabilities of the demented may make their needs more urgent, and their lack of inhibition may make more direct the efforts to satisfy them. The "attention-seeking" behaviour of old people, their wandering, and their incontinence, may in part at least become intelligible, and so perhaps more manageable, if seen against the background of these needs.

But no amount of understanding can make the care of demented old people easy, and the doctor and social worker must beware of attempting to "interpret away" the heavy realities of caring for these severely disabled old people. I hope that this review will be of some practical help, but I should not disagree with the view that not all human problems have their solutions.

Further Reading

Sources for statements other than personal opinions will be found in the following, which also provide a way into the now growing literature of dementia.

The British Journal of Hospital Medicine of March 1969 contains five review articles on various aspects of dementia.

Recent Developments in Psychogeriatrics, ed. by D. W. K. Kay and A. Walk. London, Royal Medico-Psychological Association, 1971, is a valuable symposium.

Sir Martin Roth's review of "The Psychogeriatric Problem" in *Approaches to Action*, ed. by G. McLachlan. London, Oxford University Press for Nuffield Provincial Hospitals Trust, 1972. Another chapter in the same volume gives an account of our own psychiatric service for old people at Goodmayes Hospital.

Felix Post's *The Clinical Psychiatry of Late Life*. Oxford, Pergamon, 1965, and the chapter on *Mental Disorders in the Aged* (effectively a short text book in itself) in Mayer-Gross, Slater, and Roth's *Clinical Psychiatry*, 3rd edn. London, Baillière, Tindall and Cassell, 1969, are authoritative accounts of geriatric psychiatry.