

13 Assessing and managing old age psychiatric disorders in community practice

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A shortage of specialised facilities means that general practitioners have a prominent role in community care of the elderly with mental illness

Increasingly, elderly patients with psychiatric illness are being managed in the community by their general practitioners, who have varying access to specialist clinicians with expertise in this area. Although government policies vary across States, it is commonly accepted that general practitioners have a pivotal role in detecting psychiatric illness in their elderly patients and providing ongoing management. Aged psychiatry services, when available, can assist with assessment expertise and treatment strategies, but most such services (especially in rural areas of Australia) are too poorly resourced to provide appropriate ongoing care and interventions.

Trends in ageing and mental health care

The number of people aged over 65 years will increase by 43% between 1991 and 2001; the number aged over 85 will increase by 103%.¹ As a result, there will be more dementia sufferers, people with pre-existing mental disorders who grow old, elderly people who require treatment for "functional" mental disorders, such as depression and anxiety, and more ageing-related physical disorders and disabilities that give rise to social and psychological problems.²

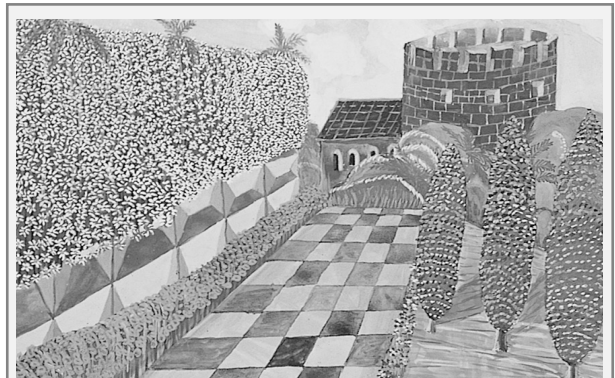
The postwar "baby-boomers" will reach old age within the next two decades and this group will be vocal in their demands for high quality care.

Because of the complexity of managing health problems in the elderly, there is a general trend towards cooperative alliances between aged care services and mental health services. These alliances can make it easier and faster to provide appropriate aged care services, which usually involve multiple disciplines. In some instances, aged care and mental health services are located together and share common management structures and referral mechanisms.³⁻⁵

The elderly with special needs

The elderly in residential care: Although only a minority of elderly people are in residential care, they are a frail and vulnerable group who are over-represented in terms of psychiatric morbidity. Up to 24% of nursing home residents suffer from clinically diagnosable affective disorders requiring treatment.⁶ These patients may not be brought to the attention of their general practitioner because they may not display overt behavioural disturbance or are unable to express their distress.⁶

The elderly from non-English-speaking backgrounds: Language and cultural differences can interfere with access to mental



A painting by an elderly patient, showing obsessionalism and naivety. Reproduced with permission from the Cunningham Dax Collection of Psychiatric Art in the Mental Health Research Institute of Victoria.

Synopsis

- ▶ There is an increasing expectation that elderly patients with psychiatric illness will be managed in the community whenever possible.
- ▶ The common presentations of psychiatric disorder in the elderly are delirium, dementia, depression and anxiety.
- ▶ Comorbid physical illness is common in elderly people with a psychiatric disorder.
- ▶ Access to specialised expertise in psychogeriatric assessment, treatment and residential care varies according to location. It is anticipated that these services will become more available to general practitioners.
- ▶ Assessment in the home can reveal more information about the patient's psychological condition than an office consultation.
- ▶ Monitoring carer stress, judicious use of psychotropic medication and manipulating environmental factors are management strategies that the general practitioner can use to optimise care of their psychiatrically unwell elderly patients.

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health services, particularly for recently arrived elderly migrants. Even long-term migrants who have integrated well may develop a specific psychiatric disturbance associated with premigration experiences. Post-traumatic stress disorder is not uncommon in this group, who may be socio-culturally maladjusted because of wartime experiences. This is particularly so when the older person is confronted by new losses or the development of short term memory impairment.⁷

The elderly from indigenous backgrounds: Assisting Aboriginal communities to develop services that are sensitive to cultural needs but which also incorporate the knowledge and expertise of mainstream psychiatry is a challenge that has yet to be addressed.

The elderly in rural communities: Psychiatrists (probably more so than other medical specialists) tend to practise in urban centres. Expertise in old age psychiatry is difficult for rural general practitioners to access. Telepsychiatry has the potential to lessen this isolation and improve the management of disturbed elderly patients, for whom transfer to a city psychiatric facility is either not feasible or would worsen their symptoms. Currently, general practitioners are not remunerated by Medicare for attending telepsychiatry consultations, although in some States (e.g., South Australia) government funding has allowed patients' non-medical psychiatric case managers to access this service.⁸

How does psychiatric illness present in the elderly?

Depression: Older people may present with the classical depressive symptoms seen in younger patients, but there are some special features in older age groups that may prevent its recognition:

- The elderly are less likely to admit to depressive symptoms spontaneously.
- The elderly depressed patient may present with persistent pain or other physical complaints (see Case history 1)
- Depression in old age may present with behavioural disturbance, especially in association with dementia.
- Apparent cognitive impairment or mental slowing, so-called "pseudodementia", may be an indication of a primary depressive illness.
- In the setting of physical disability or illness, depression may be less easily recognised because of overlapping symptoms.⁹

Dementia: People with dementia (loss of cognitive and intellectual ability caused by cerebral disease) frequently present to their primary care doctors with psychiatric symptoms. Common presentations in the doctor's surgery that may indicate dementia are acute confusion (delirium superimposed on dementia), listlessness, inactivity and loss of interest (superimposed depression), and medical instability or injury (which may indicate poor compliance with treatment regimens). The cognitive impairment of dementia modifies the clinical presentation of other mental disorders so that it can be difficult to tease out specific target symptoms.¹⁰ For example, depression may be masked by cognitive slowing. It

is wise to suspect depression in a patient with vascular dementia who becomes irritable or aggressive.

Forty per cent of people with dementia will develop psychotic symptoms during some phase of their illness (see Case history 2).¹¹

Dementia sufferers are more likely to develop delirium.

Delirium: The elderly, and particularly those with pre-existing dementia, are particularly vulnerable in the setting of acute physical illness and polypharmacy. Suspicions should be raised when there is a sudden onset or increase in confusion or when there is a fluctuation in a person's mental state, especially when there is worsening at night.¹²

Paranoid disorders: Schizophrenia and delusional disorders in old age can be longstanding or of recent onset. An annual incidence of about 17–23 per 100 000 has been reported in community surveys.¹³ Isolated elderly people may be psychotic for some time before they come to the attention

Case history 1: Depression presenting as physical illness

A recently widowed 76-year-old woman presented with her son to her general practitioner complaining of diffuse itchiness all over her body, particularly her arms. She attributed this to having recently spring-cleaned her flat. She thought she may have disturbed some mites, which were biting her. Further questioning of the patient and her son revealed that the patient had become more socially withdrawn over the last four weeks, was having trouble sleeping and was reluctant to invite people to her flat or to meet friends in case she "infested them".

The woman denied lowered mood and said that she was coping well with the loss of her husband. She believed that if her doctor could just get rid of her "rash" and the son could help her fumigate her flat, she would be fine.

On examination there was evidence of recent weight loss but no sign of any rash or bites. She was otherwise physically well and taking no medication. On mental state examination, she was found to have rather flat, slightly irritable affect, no thought disorder and intact cognitive function. She had no insight into the possibility that her itch may have had a psychological basis.

Her general practitioner correctly suspected a depressive disorder with somatic delusions in the setting of unresolved grief. He referred her to a psychogeriatrician, who treated the depression with a selective serotonin reuptake inhibitor. Grief counselling was also an essential component of her management.

Within eight weeks she had made a total recovery, but (quite typically in these circumstances), although she realised that she had been depressed and that the medication and talking had helped, she was unable to accept that the disappearance of both itch and infestation was connected with her emotional state.

of medical services. Initial referral may be via police or other community agencies. A typical presentation may involve an elderly person repeatedly asking police or doctor to intervene because they are being harassed in some way.¹⁴

Anxiety: It is unusual for primary anxiety disorders to develop for the first time in old age. If they develop, general practitioners should be alert to the possibility of underlying depression or occult physical illness such as cardiac or thyroid disease. Like dementia and post-traumatic stress, longstanding but unrecognised anxiety may be revealed by the death of a spouse or the sudden discontinuation of prescribed or non-prescribed medication.¹⁵

Assessment

The value of the home assessment: A quick appraisal of how a person is managing at home will provide a rich source of information about such issues as hygiene, nutrition, neglected injuries, hoarding or misunderstanding of prescribed medication, or alcohol abuse. For example, a previously highly functioning individual may let standards slip during a depressive episode, or a paranoid person may have barricades at windows and doors, important features that will not be evident at a surgery-based consultation.¹⁶

Confusion, aggression and tearfulness: These are common symptomatic presentations in the elderly, for which there may be many possible causes. The major causes of confusion are dementia (onset months–years), depression (onset days–months) and delirium (onset hours–weeks). Other causes are physical illness and side effects of medications. Assessment of aggression and tearfulness is outlined in Boxes 2 and 3.

Collateral history: It is essential to obtain a reliable collateral history of the presenting complaint. A cognitively impaired person will not be able to give essential information, and a deluded or depressed person may not give an accurate account of events. If available, the doctor should seek substantiation of the history from a close relative or friend.

Medical history: A thorough, well substantiated medical history, including recent changes in somatic symptoms and/or treatments, is fundamental when performing psychiatric evaluation of the elderly. For example, a history of thyroid disorder would be important when assessing someone with anxiety; occult carcinoma may present with paranoia and hallucinations. Alterations in medication regimens may account for changes in mental state (e.g., an anticholinergic drug prescribed for urinary incontinence is a prime suspect in the onset of delirium, or the discontinuation of a benzodiazepine may cause withdrawal agitation).¹⁷

Physical examination: Patients with dementia are particularly at risk of undiagnosed physical illness, such as infections or fractures, as they may be unable to identify somatic symptoms accurately. Acute confusion in a patient with dementia may indicate, at one extreme, a minor problem such

Case history 2: The paranoid elderly patient

Mr C was a 79-year-old man living with his wife in a hostel. He had accepted this placement two years previously after a minor stroke left him with weakness in his right arm. His wife had suffered from Alzheimer's disease for several years and he had devoted himself to her care. In the hostel they shared a pleasant double room and Mr C was initially sociable with the other residents, although quite protective of his wife. After a couple of months he began refusing to allow his wife to eat meals with the other residents or join in social activities. He became irritable with the staff and accused them of encouraging his wife to leave their room at night. There was some concern that he was becoming verbally aggressive towards her.

At his own insistence Mr C had not been medically reviewed for some time and had always been reluctant to take any form of prescribed medication. With persuasion he allowed his wife's general practitioner to undertake a brief examination. This revealed mild hypertension and it became more obvious that Mr C was concerned that his wife had developed a liaison with one of the other residents and that the staff were facilitating meetings between his wife and this person at night. In reality, his wife wandered at night and the staff would allow her to watch television, so as not to disturb other residents.

As Mr C refused to consider any medication, he was referred for psychiatric assessment. Further mental state examination revealed delusions of persecution and jealousy, but no perceptual disturbance. Cognitive testing showed widespread deficits, although his short term memory was relatively spared. The general practitioner, having developed some rapport with Mr C, persuaded him to have a CT scan of the head. This suggested a diagnosis of multi-infarct dementia. By this time Mr C's irritability towards his wife was escalating and there was concern that they may need to be separated. Confronted with this possibility, he became more accepting of treatment and began taking haloperidol 1 mg at night.

Over three weeks Mr C's delusional ideas resolved, but he developed a fine resting tremor. The haloperidol was changed to risperidone 1 mg at night and he had no further side effects.

1 Warning signs of psychiatric disturbance in the elderly

- Self-neglect
- Sudden onset or escalation in confusion
- Any self-harming behaviour
- Persistent somatic complaints without organic basis
- Persistent requests for hypnotic medication
- Exhaustion of carers
- Repeated complaints by neighbours or the police

as constipation or, at the other extreme, a major problem such as unrecognised hip fracture. Patients receiving neuroleptic drugs are at risk of postural hypotension and falls.¹⁸

Investigation: Judicious and well targeted tests should be performed according to the physical and mental status findings. Marginally abnormal pathology results may indicate delirium in patients whose cognitive function is already compromised. Major depression occurring for the first time in later life may signal occult disease, such as carcinoma of the lung, and investigations, such as plain x-ray of chest, should be performed to exclude this. Urinary tract infections may be relatively asymptomatic and a simple dip test will indicate the need for further investigation.

Mental state examination: Mental state examination begins from the time the patient walks into the surgery or the doctor walks into the patient's residence. The environment, and the patient's interaction with it, are important pointers to his or her mental health. Specific mental status findings for dementia, depression and delirium are given in Box 4.

Many older people are not used to speaking in psychological terms and may need to be coaxed to explain their feelings. It is sometimes awkward for family physicians to ask questions about memory and orientation when they have known the patient over many years, but it is essential to perform at least a brief cognitive test. This may reveal surprisingly poor cognition once a patient is pressed beyond the social niceties or "well worn tracks".¹⁹ A short test of cognitive state is given in Box 5.

Management

Risk assessment (see decision tree, Box 6): In developing a management plan, the first issue for a general practitioner to address is whether the person is safe in his or her environment or requires a more protective setting. Factors to be considered in risk assessment are:

- The presence of suicidal or homicidal ideation or intent. This needs to be carefully enquired of the patient and corroborated. Chronic physical illness can be associated with suicidal behaviour in the elderly.²¹ Once a suicide attempt has been made, the risk of subsequent successful suicide is high.
- New or increased confusion, which may place an elderly patient at physical risk because of disorganised, impulsive

2 Assessing aggression in the elderly

Aggression in dementia

Usually inexplicable by patient
Unpredictable
Occurs impulsively, particularly when being attended to (e.g., hygiene)
Easily distracted from target of aggression
Cannot remember being aggressive or why

Aggression in delirium

May be in response to delusions or hallucinations
Appears to be random
Unpredictable
Fluctuating aggressive episodes

Aggression in depression

Occurs in setting of irritability (e.g., of wanting to be left alone)
May be angry with him/herself

Aggression in paranoia

Occurs in response to delusional beliefs
Patient may be aggressive as a defence against profound fear
Remembers aggressive outbursts and may have associated guilt
Has clear reasons for aggression, which are associated with paranoid delusions and self-defence

3 Assessing tearfulness in the elderly

Tearfulness after a stroke*

Usually inexplicable by patient
Not associated with sadness
"Emotional incontinence"
Typically associated with "pseudobulbar palsy"
May revert to uncontrollable laughter

Tearfulness in delirium

Emotionally labile
Tears not sustained
Can be distracted from sadness

Tearfulness in depression

Occurs in setting of sustained lowered mood
Associated with reported sadness and misery
Other features of depression are present

Tearfulness in adjustment reaction

Associated with recent upsetting experience
"Understandable sadness" or anger of recent onset

* Remember: patients who have had stroke are also at risk for depression, delirium and adjustment reactions.

- or disinhibited behaviour. Compliance with the administration of prescribed medication needs to be checked.
- Persecutory or depressive psychotic symptoms. It is crucial to ascertain whether the patient feels compelled to act on them (eg, in response to command hallucinations).
- Exhaustion in a carer, which may lead to neglect or even abuse.

When the general practitioner does not feel confident about assessing the level of risk in a mentally disturbed patient, referral to a psychiatric service (either general or old-age specific) is indicated. As well as providing expert opinion, these services are authorised by State Mental Health Acts to provide compulsory hospitalisation when patients at risk cannot be assessed and treated in a less restrictive setting.

Pharmacological treatments

Only a brief overview of psychotropic medication use in the elderly can be provided and readers are referred to more comprehensive texts for further information.²² General issues to note regarding these agents are:

- Their potential overuse in the elderly. For example, more

4 Indicative findings on mental status examination

Examination item	Dementia	Depression	Delirium
General appearance	——— Normal-to-neglected according to amount of care provided and degree of impairment ———		
Behaviour	Variable	Recent self-neglect, psychomotor retardation or agitation	Restlessness, picking at clothes or bedclothes
Affect	Flat, apathetic, occasionally irritable	Depressed, tearful, apathetic, irritable	Fluctuates, labile. May be tearful, giggly, anxious
Thought stream	May be normal, depends on degree of impairment	Normal to slow	Not fluent. Fluctuating
Thought form	May be normal, depends on degree of impairment	Normal. Perhaps some “blocking”	Thought disorder
Thought content	Poverty of thought content, may be perseverative	Themes of hopelessness, helplessness, guilt, poverty, emptiness, unworthiness or paranoia. There may be suicidal ideas or intent. Possible mood-congruent delusions or somatic complaints such as constipation or contamination. Occasionally negativistic and nihilistic thoughts are of delusional intensity.	There may be a variety of florid delusional beliefs of paranoid, grandiose or depressive nature.
Perception	Occasional hallucinatory experiences (usually auditory). May have periods of misidentification	Occasional hallucinatory experiences that are congruent with the depressive thought processes. Usually auditory hallucinations	Frequent florid and bizarre hallucinations. May be visual and in all other senses
Cognition			
Attention and concentration	Usually intact	May be poor but can be engaged	Very poor
Orientation	Poor	Usually unaffected but may be uninterested	Absent
Short term memory	Poor	Usually intact but may not want to be bothered	Absent or fluctuates

than half of nursing home residents receive psychotropic medications, usually for “behavioural disturbance”.²³

- ▶ Administration of more than one psychotropic agent in the elderly can result in additive side effects. Anticholinergic effects are a particular problem.
- ▶ Ageing-related body changes require modified (usually reduced) doses.

Neuroleptic agents are not only prescribed for psychotic symptoms in the elderly, but can be effective for agitation and aggression that accompanies dementia. They are least effective for repetitive, non-aggressive behaviours such as wandering, excessive vocalisations and sexual disinhibition. High-potency, low-dose agents (e.g., haloperidol) are usually preferred to low potency, high-dose agents (e.g., thioridazine or chlorpromazine) because of their lesser propensity to cause confusion and postural hypotension. However, haloperidol can cause extrapyramidal symptoms even at low doses and tardive dyskinesia is a risk with long-term use. The new atypical neuroleptic agents (e.g., risperidone and olanzapine) are postulated to minimise these side effects and are likely to be increasingly used as first-line treatments in the elderly.²⁴

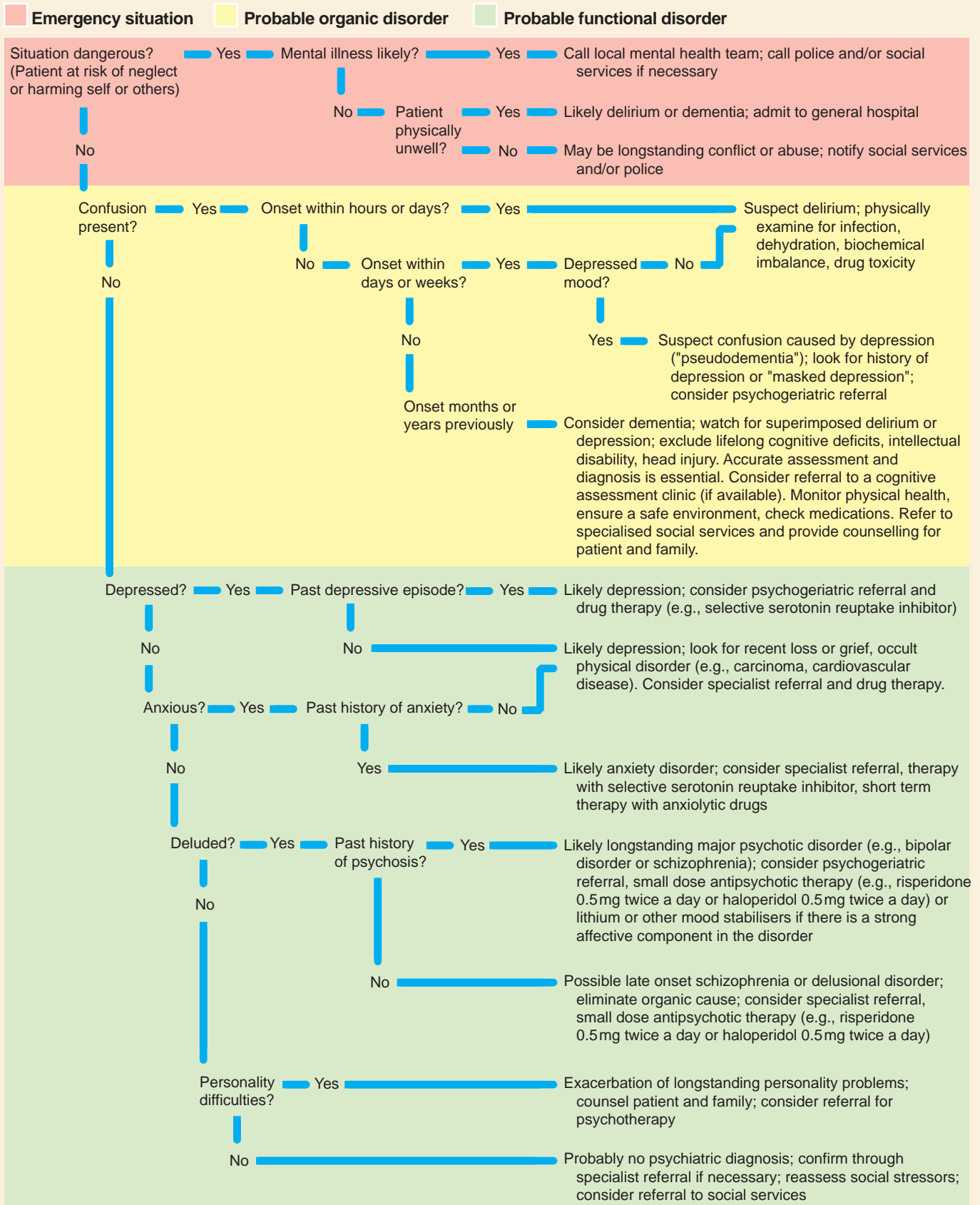
Antidepressants, unlike neuroleptic agents, are usually prescribed in doses similar to those used with younger patients. However, courses of treatment are likely to be significantly longer or given indefinitely if late-life depressive episodes are recurrent or severe. Given the potential anticholinergic and cardiotoxic effects of tricyclic antidepressants, these agents are now prescribed far less frequently. The expanding range of new antidepressants, with their more selective mode of action, higher degree of tolerance and less lethal side effects, has enabled the pharmacological treatment of depression in old age to be undertaken more assertively.²⁵

5 Abbreviated mental test score²⁰

1. Age
2. Time (to nearest hour)
3. Address for recall at end of test: “42 West Street”
This must be repeated by the patient to ensure that it has been heard properly.
4. Year
5. Name of the hospital or present location
6. Recognition of two people (e.g., doctor, nurse)
7. Date of birth
8. Year of First World War
9. Name of the Prime Minister
10. Count backwards from 20 to 1

Allocate 1 point for each correct response. A score of 7 or less in an older person is suggestive of mental impairment

6 Decision tree for assessing a disturbed or distressed elderly person



Anxiolytic agents, particularly benzodiazepines, must be prescribed with caution in the elderly. In this age group central nervous system toxicity (drowsiness, ataxia and confusion) is more likely to occur, especially with longer-acting agents. Short-acting benzodiazepines (e.g., oxazepam, temazepam and lorazepam) are preferable, although rebound symptoms will develop if treatment is prolonged and dosage is not tailored to the half-life of the drug.¹⁵

Psychological/behavioural strategies

The elderly are less likely to be considered for psychological therapy, whether to enhance benefits gained from pharmacotherapy or as an alternative treatment. However, even when cognitive deficits are present, modified psychotherapeutic strategies can be beneficial.²⁶ Psychological treatments for elderly patients include:

- Cognitive-behavioural strategies as adjunctive treatment in depression.
- Supportive/remembrance therapy for bereavement.
- Marital therapy.
- Behavioural strategies and carer support/education for dementia-related problems.

Respite/residential care

Periods of temporary respite care for people with dementia have been shown to lessen carer burden and stress.²⁷ Unfortunately, the more behaviourally disturbed the elderly person is, the more difficult it becomes to find residential facilities with an appropriate safe physical environment and the necessary nursing expertise. Some aged care and aged psychiatric services dedicate a small number of hospital beds to this function, depending on their resources. It must be remembered that, while removing an elderly confused and demanding patient temporarily from their home may provide relief for their carer, it is not always in the best interests of the patient. Changes in environment have been shown to increase confusion and behavioural disturbance in persons with dementia, even when specialised care is provided. "In home" respite programs provide an alternative that still allows the carer to have some relief, but does not remove the elderly patient from their familiar environment. Expense is usually the main factor restricting this form of care, but local government and community agencies are increasingly becoming involved in providing these needed services.

In the past, longer term psychogeriatric residential care was provided in the large psychiatric asylums, which are now closing. Small, specialised facilities such as the CADE (confused and disturbed elderly) units in New South Wales and psychogeriatric nursing homes in Victoria offer an alternative, more home-like environment for the elderly with persistent behavioural disturbance. As this type of care is resource-intensive, stringent gatekeeping is required to maximise the efficiency of these facilities. There is an expectation that most patients will only require this form of care for a limited time and can then be transferred to generic aged hostels or nursing homes.

Conclusion

As part of the continuum of psychiatric services for the mentally ill of all ages, aged psychiatry is continuing to grow as a major healthcare area and a challenge to government health authorities worldwide. The chronically mentally ill, particularly those who have grown old with schizophrenia, must be acknowledged and provided for. As the politically powerful generation of baby-boomers grows old, perhaps we will see, at last, a more adequate level of attention to the conditions under which the elderly mentally ill live.

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