

key points

SELECTED BY

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Psychosis is a relatively common condition in older adults with a prevalence of 5-15% in elderly inpatients and 10-62% in nursing home patients. In older adults, delusional beliefs frequently incorporate themes of paranoia, persecution, personal injury and partition. Hallucinations are most likely to be visual or somatic, and these should alert clinicians to the possibility of an underlying organic condition such as delirium. Agitation and aggression are also associated with late life psychosis and may often be the first presentation in primary care. Negative symptoms may include social withdrawal, poor motivation and difficulty carrying out daily activities.

Late life psychosis may be caused by organic conditions including: delirium, dementia, drug intoxication or withdrawal, or a general medical condition. In these situations there should be evidence of a temporal relationship between the psychosis and the underlying condition. Approximately 60% of older adults presenting with new onset psychosis have an identifiable underlying organic cause.

If an underlying medical condition can be excluded, and there is no evidence to support a diagnosis of delirium or dementia, then the cause of psychosis may be functional. This is more likely if there is a family or personal history of mental illness. Functional psychosis includes a primary delusional disorder, schizophrenia spectrum disorder or mood disorder. Both depression and mania can be associated with psychosis. Psychosis presenting in the context of mania, may arise from a known bipolar disorder. However, mania can present for the first time in the elderly. A first presentation of mania may suggest undiagnosed bipolar disorder, but a full exploration of organic causes of mania including cerebrovascular disease, neurodegenerative conditions or brain tumours should be carried out.

The history and mental state examination must include the nature of psychotic symptoms as well as onset, duration and the patient's degree of insight. Collateral history may be invaluable and it is important to distinguish between features that point towards a medical or psychiatric cause. The initial assessment should include a review of the impact on functioning and a risk assessment. The history should explore the temporal relationship between any medication changes or substance misuse, and the onset of symptoms. A physical examination should also be carried out and as a minimum should exclude evidence of infection.

Patients presenting with persistent psychotic symptoms without an identified reversible cause should be referred to the Older People's Mental Health Services. More urgent referral may be needed if there is: a history of significant psychiatric illness; presence of delusional, persecutory or paranoid beliefs; current or previous ideas of self-harm or harm to others; recent stressors; increasing withdrawal; or evidence of self-neglect. If there are multiple risk factors and acute concerns about risk to self or others referral to local Crisis Resolution and Home Treatment services or assessment under the Mental Health Act should be considered.