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Review

The health care situation of the mentally ill elderly in Germany ☆

H. Gutzmann *

Krankenhaus Hedwigshöhe, 12526 Berlin, Höhensteig 1, Germany

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ABSTRACT

The majority of geropsychiatric patients live in the community and are supported by their families or by professional care providers. The multidimensional nature of the problems and the complexity of the professional care system require psychogeriatric-specific planning and regulation of health care services. In the majority of cases, medical care is provided by general practitioners. The belief that the supply of general psychiatric services alone can satisfy the demand for geropsychiatric care is not realistic. As an example, the situation of dementia patients highlights the problems of medical care in the geriatric psychiatry sector. It must be assumed that the patients will only meet demographic and epidemiological expectations where there is a functioning specific psychogeriatric health care. In the long term – due to the installation of efficient care networks – the significance of the inpatient sector will decline. In the meantime, there is a need for psychogeriatric centers and for competent inpatient care as an obligatory part of the regional mandatory care system. In order to keep up with international developments, the adequate and competent medical care of mentally ill elderly people in Germany urgently demands for the establishment of a psychogeriatric focus in the framework of psychiatric professional qualification.

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1. Demographic change and history of health care efforts

The medical care of mentally ill elderly people has become a societal issue. The main reason for this lies in the achievements of modern medicine. Since 1840, life expectancy has risen by 2.5 years every decade. In the second half of the 19th century, 62% of increased life expectancy was due to reduced mortality in children aged 14 years and younger. Between 1990 and 2007, 79% of increased life expectancy could be attributed to people over the age of 65 (Christensen et al., 2009). Today, on average, a 60 year old woman will live another 23.8 years. A man of the same age will live another 19.7 years. In 2005 there were 3.7 million people in Germany aged 80 and over. In 2020 there will be almost 6 million, in 2050 10 million. Mental health disorders in the broadest sense occur in 25% of people over the age of 65. About 40% of these disorders display severity to an extent that requires treatment. Until the second half of the last century, the care provided to the chronically mentally ill in state hospitals, in the outpatient sector and in nursing homes was equally bad. This mobilized public opinion led to the parliamentary decision to

* Tel.: +49 30 6741 3000; fax: +49 30 6741 3002.
E-mail address: h.gutzmann@alexius.de

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commission an inquiry into the mental health system that also took the elderly into account ('Psychiatrie-Enquete') (Psychiatrie-Enquête, 1975). The final report included an "outline of a regional network system for psychogeriatric care". Clinics, day care units and "small inpatient assessment units" were seen to be necessary parts of "psychogeriatric centers" with emphases in the provision of medical care, training and research. Regarding care, particular emphasis was placed on the improvement of specialised care for nursing home residents. It was also proposed to test psychogeriatric care networks in a number of catchment areas involving all providers of care. All elements of a comprehensive psychogeriatric care system were addressed and for the most part also illustrated in detail. Inpatient, day-care and outpatient sectors were called for. The subject of networking within the care system was also already discussed in 1975 (Remlein and Gutzmann, 2009). In 1980, a model program for the reform of the psychiatric care system was adopted by the federal government. It aimed to test coordinated overall care networks for mentally ill and disabled people in several regions. Based on the results of these projects, an expert panel was to formulate recommendations for psychiatric and psychotherapeutic/psychosomatic care. In the "Mentally ill elderly people" chapter of these recommendations (Expertenkommission, 1988). the following observations were made: on the one hand geriatric psychiatry had established itself internationally as a research area and care practice. On the other hand, the care situation for mentally ill elderly people in Germany had barely been affected by the initiated reform measures. In the competition for diagnostic and therapeutic opportunities, the elderly were found to still be at a distinct disadvantage compared to younger people. The expert panel recommended that psychogeriatric care should focus on the extramural sector. The 'assessment units' recommended in the 1975 report were rejected, due to the independent geropsychiatric departments which had since been founded. In general, the 'psychogeriatric center' was embedded in the extramural sector und resembled the core of the recommendations of the expert panel on psychogeriatric care (Kanowski, 1999). Ten years after the publication of the expert panel's recommendations, a number of psychogeriatric centers had been founded. However, they were limited to a few regions only (Remlein and Gutzmann, 2009). In several care sectors, i.e. the area of nursing homes, the development of problems had accelerated.

In the process of the psychiatry reform, statements on the number of necessary care services were subject to some changes. For standard catchment areas, the "Psychiatrie-Enquête" had recommended 55 inpatient beds and 25 day care treatment places per 250,000 inhabitants. Furthermore, for the same clientele, 60 specialised permanent accommodation places were seen as necessary. Twenty years later, the "psychogeriatric commission" of the Regional Council of Westphalia called for 30–50 places in assisted housing for mentally ill elderly people – as an alternative to nursing homes – per 100,000 inhabitants as well as 50 day care places. In 1997, the Federal Association of psychiatric hospital providers presented an "action plan for psychogeriatric care". In this, the association demanded a psychogeriatric center for each catchment area with 150,000–200,000 inhabitants. For areas of this size, 30–50 clinical treatment places – of which 20–25% should be day care places – were seen to be appropriate. Despite minor differences regarding the necessary quantity of care (newer reports tend to suggest lower figures), social policy experts have unanimously established the need for the provision of specific psychogeriatric medical care (Gutzmann and Klein, 2012). A report commisioned by the Federal Ministry of Health on the state of geriatric psychiatry (Hirsch et al., 2000) stated that the appropriate care of the mentally ill elderly had so far not been a central concern in the implementation of measures of the mental health reform. Only few of those responsible for the provision of care had perceived shortcomings in geriatric psychiatry to be insufficienct in need of regulation. In addition, state laws were not found to take the special needs of the mentally ill elderly into account. Neither were they considered in the development of community mental health care structures. Rather, it was assumed that geropsychiatric care could be provided by geriatric medicine and nursing. Programmes for social integration, sustaining independence and day-structuring measures had only rarely been implemented. According to the report, in many regions in Germany, psychogeriatric specialist care is underrepresented or nonexistent.

2. A look at the diagnostic spectrum

The most common mental disorders in old age are depression and dementia, the latter being subject to a significant age effect. Their prevalence increases sharply with age: from just over 1% between the ages of 65 and 69 up to more than 30% beyond the age of 90. Until the age of 90, the rule of thumb is a doubling of risk for every 5 year interval. After this time, the curve seems to flatten out, possibly even plateauing after the age of 95. Thus, a long life need not necessarily lead to dementia. The genders are differently affected by the risk of dementia. The greater risk of dementia for women is largely due to their longer life expectancy. Also, women who actually suffer from dementia appear to live longer. In Germany there are more than 290,000 new cases each year and currently about 1.5 million people with dementia over the age of 65 years (Deutsche Alzheimer, 2012).

Review articles show a high dispersion for depressive disorders in the elderly, with higher prevalence rates consistently reported in studies which also include disorders which are subdiagnostic, although still pathological. In most studies, the prevalence of severe (major) depression is found to be 2–4%. Minor depression has a prevalence of around 10%. Depressive disorders are about twice as common in women than in men. As opposed to dementia, the risk for depression does not increase with age. Elderly people cared for in institutions are at especially high risk for developing depression (Weyerer and Bickel, 2007).

Addictions are easily underestimated in epidemiological studies, as they are often the subject of trivialization and denial strategies. Studies suggest alcohol abuse in 10–20%, and alcohol addiction in 2–3% of elderly men. While women are much less likely to show alcohol problems, the regular consumption of tranquillizers is more common than amongst men. In general, substance addictions are far more common in nursing homes (Weyerer, 2010). For a long time, the importance of anxiety disorders was underestimated with a prevalence of more than 10% being plausible (Weyerer and Bickel, 2007).

While a lot of attention in recent years has been devoted to unipolar depressive disorders in the elderly, bipolar disorders in older age groups have been largely neglected. Taking representative epidemiological data into account, this appears to be understandable, as their prevalence in all adults lies under 1%. However, in elderly risk populations, bipolar disorders are of a specific significance. Elderly patients with bipolar disorders utilize psychiatric services about four times more often than geriatric patients with unipolar depression (Gutzmann and Gutzmann, 2006). The situation is similar for psychiatric consultation patients of this age group.

The risk for schizophrenia appears to be 3–4 times higher before the age of 40 than between the ages of 40 and 60. Over the age of 60, the risk of illness is extremely low. However, paranoid symptoms occur in about 5% of this age group.

The prevalence figures for deliria vary between 10% and 50%—depending on the chosen inclusion criteria, risk constellation of the clientele and on the type of institution. A particular