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Short Communication

# Age-Related Anxiety Disorders: Psychiatry

**Batista Ferreira***

*Department of Geriatrics, University of Leicester, Leicester, United Kingdom*

## DESCRIPTION

Evaulating the results of acute care delivery in geriatric psychiatry was the study's main goal. The Medline, PsycINFO, and Cochrane Collaboration databases of English language papers published up to 1998 on the evaluation of service delivery in "old age psychiatry," "psychogeriatrics," and "geriatric psychiatry" were used as data sources, and a manual search of references from pertinent literature was also conducted. The outcomes of service delivery in old age psychiatry from acute hospitals and community settings were included in all controlled trials, audits, and surveys. Included in the scope of care were medical, adult psychiatric, and consultation/liaison services. Long-term institutional care was eliminated, although outreach programmes to nursing homes were included. The paper extracted all of the data. Using an evidence hierarchy allowed for the evaluation of data quality. A qualitative review of evaluation methods was conducted. Controlled studies, audits, and surveys have all been found to be valuable sources of information for assessing service performance. Compared to other treatment kinds, old age psychiatric services have higher quality data supporting their usefulness. The majority of research show that elderly psychiatric services, especially when used for depression, have successful acute treatment outcomes, which care methods are linked to better results cannot be determined without more data.

The five core clinical areas of mood, behaviour, functioning, cognition, quality of life, and career burden are pertinent to the elderly psychiatrist. Each one can be evaluated independently using a particular scale or alternatively as a component of a multi-dimensional instrument.

The time available and the individual performing the rating are important considerations when choosing a scale. A scale must be succinct and simple to use in order to be utilized in everyday clinical practise. While many instruments need specialised instruction, scales may typically be performed by any qualified clinician. Unless the scale is being used to a population that is different from that in the original description, there is rarely a need for an independent assessment of interrater and test–retest reliability.

For a diversity of reasons, geriatric psychiatric investigations tend to ignore the elderly. They are firstly less accessible for study outside of institutional contexts. When opposed to adults 65 to 74 years old, people 85 and older have far more difficulty enrolling in ambulatory-based clinical trials, and the participants in these studies are not generally representative of the oldest old. Moreover, transfers from one environment to another and busy ward schedules frequently interfere with recruitment from institutional settings. Second, it is frequently impossible to investigate a disease's pure forms when it coexists with other conditions, both physical and mental. Who is the typical geriatric psychiatric patient, according to one response. Consider oldest, sickest, most difficult-to-treat patient—not the one who is often a part of geriatric mental research, particularly clinical trials. Eventually, at the oldest ages, the lines between psychiatry and medicine are inexorably blurred.

Alzheimer's disease, including Behavioural and Psychological Symptoms of Dementia (BPSD), is frequently diagnosed and treated in old age psychiatry, which accounts for up to 25% of all memory clinics, at least in the Netherlands. Here, patients with a wide range of potential Cognitive Impairment (CI) aetiologies, such as major depressive, schizophrenia, and bipolar illnesses, are presented. Due to demographics and increased public knowledge of CI (Alzheimer's disease International), combined with the tendency of earlier assessment with milder symptoms, it should be expected that there would be an increase in referrals to memory clinics and old age psychiatry.

**Correspondence to:** Batista Ferreira, Department of Geriatrics, University of Leicester, Leicester, United Kingdom, E-mail: Ferreira@gmail.com

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