Mental Health problems in Older adults

Dr. Conor O’Luanaigh MRCPsych FRANZCP
Consultant Old Age Psychiatrist
The Prince Charles Hospital
Mental Health Problems in Older Adults

- Depression
- Anxiety
- Adjustment disorders
- Psychosis
- Loneliness
- Delirium
- BPSD
Challenges

• ‘Atypical’ presentations
• Medical co-morbidities
  • Frailty
  • Falls
  • Neurodegenerative conditions
  • Pain
• Polypharmacy – interactions, side effects etc
• Ageism
Case 1

• Maria – 76 yo widow
• Presents following collapse and possible overdose
• Poor appetite
• No energy
• Reduced level of functioning
• Denies being depressed but says she is sick – thinks she might have cancer.
• Wants to go home
Case 2

- Hilary 78yo lives with her husband. He has Parkinsons and has become increasingly dependent on her. She has been feeling increasingly carer burdened. Mood deteriorated. Significant anxiety. Feels she can’t go on …..

- Started on sertraline – became confused. Bloods checked – sodium dropped to 128. Sertraline ceased. Started on oxazepam – admits she has been taking more than GP told her to……
Late onset depression

- Not differentiated in diagnostic manuals (DSM)
- However numerous studies indicate the following
  - Hypochondriasis
  - More somatic symptoms
  - Less dysphoria and guilt
  - In severe episodes, catatonic symptoms and nihilistic delusions not uncommon
  - Cognitive symptoms may be more prominent (pseudo-dementia)

- In practice, neurovegetative symptoms such as sleep and appetite are harder to rely on due to other physical factors which may affect these.
- Loss of some kind can play prominent aetiological role
- Apathy – consider vascular aetiology/contribution
- If cognitive symptoms present – will need follow up post resolution of depression as may be harbinger for future dementia
Late onset depression – management

• Beware of myths – i.e too old to do therapy!
• CBT – good evidence base
• Exercise
• Socialisation
• Medications
• ECT
Medications

• Start low – give at least 3 weeks before increasing dose. After increase dose wait another 3-4 weeks before deciding on further increases

• SSRIs – usually first line however…
  • Beware of hyponatraemia – v common with all SSRIs
  • Citalopram / escitalopram – lower maximum recommended dose in older adults due to increased risk of arrhythmias.
  • Fluoxetine / fluvoxamine – interact with numerous drugs thru C450 enzymes -eg. Warfarin; alprazolam..

• Consider mirtazapine as suitable alternative first line – start at 7.5-15mg.
  • Helps with sleep
  • Aids appetite
  • Anxiolytic
  • Less likely to cause hyponatraemia
  • Is more sedating at lower doses due to preferential binding to histamine receptors at low doses.
Medications

• Generally avoid TCAs due to anticholinergic and arrhythmia side effects.
• Venlafaxine – usually 2nd line treatment (or first if clear melancholic depression with prominent anergia.)
  - Monitor blood pressure – can cause raised BP
  - Nausea and headaches common side effects – should resolve 5 days after starting.
• Avoid benzos – medium to long acting benzos such as diazepam and oxazepam accumulate – higher risks of falls and cognitive impairment, while shorter acting ones such as alprazolam have higher addictive quality and higher risk of acute confusion.
• if agitation very prominent, preferable to use very low dose antipsychotic such as quetiapine 25mg or olanzapine 2.5mg.
• Refer to Old Age Psychiatrist if not responding to above…
Case 3

- Noel 78 yo presented initially with agitation and pacing. No reported sadness. But loss of interests very prominent. Reports that he is not right. Has history of hypertension and dyslipidaemia. Treated with antidepressant and low dose antipsychotic. Agitation /pacing resolved. Family report that he no longer does anything – continues to be very apathetic and generally reports non specific anxiety.
Vascular Depression

• Increasingly recognised subset of incident late onset depression
• Associated with microvascular ischaemia (particularly subcortical and in circuits involving frontal lobe and basal ganglia)
• Apathy – prominent feature
• Cognitive impairment (executive dysfunction and reduced processing speed)
• Significant loss of function
• Poor response to conventional treatments /dosing – may require high doses/augmentation strategies
Case 4

- Harry – 78yo recently separated.
- Feels he cannot cope.
- Complains of low mood.
- GP started on venlafaxine and augmented with mirtazapine several weeks later after no response.
- Harry feels he can’t go on and presents to ED complaining of suicidal thoughts
Adjustment Disorder

- The development of emotional or behavioural symptoms in response to an identifiable stressor(s) occurring within 3 months of the onset of the stressor(s).
- These symptoms or behaviours are clinically significant, as evidenced by one or both of the following:
  - Marked distress that is out of proportion to the severity or intensity of the stressor, taking into account the external context and the cultural factors that might influence symptom severity and presentation.
  - Significant impairment in social, occupational, or other important areas of functioning.
- The stress-related disturbance does not meet the criteria for another mental disorder and is not merely an exacerbation of a preexisting mental disorder.
- The symptoms do not represent normal bereavement.
Tips for diagnosis of AD

• Identifiable major stressor and context of presentation
• ++distress
• +loss /reduction in function
• Magic wand test – removal of stressor – resolution of disorder – i.e. absence of significant cognitive distortions
Why is AD important to recognise?

- Poor response to medications
- Responds well to problem solving therapy and CBT
Case 5

• Frank – 90 yo widower x 10yrs. Misses wife greatly. Enjoys cards and piano. Frequently thinks of death. Has chronic pain. Says he prefers his own company. Admitted to hospital after calling ambulance informing them that he had taken overdose.
Loneliness

• 5-16% in British community studies of older adults
• > 50% of nursing home residents reported frequent loneliness
• Not the same as social isolation
• Loss of attachment figure
• Bereavement, reduced physical health, F>M (?), Pain, personality factors.
WHY IS LONELINESS A PROBLEM?

- Loneliness
  - Physical health
  - Mental Health
  - Cognition

Morbidity & Mortality
? Health care costs
Management of loneliness

• Again like adjustment disorders – poor response to medications
• Socialisation – works for some forms of loneliness
• Pet therapy
• CBT – to address underlying cognitive distortions
• Societal factors – breakdown of neighbourhoods, ghettoization of nursing homes - ? Target for public health measures – prevention may be better than cure.
Case 5

Anne – 87yo lives with daughter. Independent for ADLs but daughter helps her with shopping, bills, meal prep etc. Has history of hypertension, osteoarthritis, IHD. Following recent medical admission with chest pain (subsequently cleared) she became increasingly paranoid in persecutory way about her daughter – convinced she was trying to take her home and money from her. Also believed that she was trying poison her. No fluctuations in her mental state and no evidence of acute confusion. Mood otherwise ok when not in daughter’s company!
Case 6

• Edith – 91 yo nursing home resident. Still quite functional. Independent for ADLs. However several month history of bizarre reports – believes the NH management are shooting laser beams through her windows – sees lights. Also has ‘overheard’ other nurses talking about a missing child that one of them has abducted. Increasingly preoccupied and agitated. Medically quite well apart from recurrent UTIs. Has poor hearing and should wear hearing aids.
Late onset psychosis

• Prevalence of around 1%
• Two spikes in terms of age of onset
  • mid 50s (more akin to delusional disorder or paranoid schizophrenia but without the negative symptoms);
  • 70s onwards (very late onset) – more associated with organic changes to brain and sensory changes (reduced hearing/eyesight)
• Low dose antipsychotic medications (eg. risperidone 0.5mg, olanzapine 2.5mg)
• Consider pre-existing physical health/mobility/falls risk in relation to choice of antipsychotic.
• Rule out delirium – should be no significant attentional disruption
Delirium

- Acute confusional episode
- Fluctuations
- Impaired attention
- Often but not necessarily disoriented
- Visual hallucinations
- Perplexed
- Other psychotic symptoms
Delirium

• Usually multifactorial
• Often no clear cause found
• **Normal bloods and urine does not rule delirium**
• Check medications – opiates, benzos, steroids and anticholinergics (many antihistamines, antidepressants, cardiac meds)
• Collateral from staff – look for fluctuations in mental state – usually worse at night
Delirium

- Assess attention
  - Can they follow conversation or are they losing track easily
  - Are they very distractible
  - Months of the year in reverse order

- Can be prolonged
Delirium

• Address reversible/treatable factors
• Reorientation
• Safe environment
• Avoid benzos
• If have to use medications – low dose haloperidol or risperidone is preferable (0.5mg for either of them)
• Evidence for their use is controversial – recent study indicated that worse outcomes seen with use of antipsychotic, however these were in ICU delirium patients.
• No evidence that they ‘treat’ the delirium, and no evidence that the delirium will resolve quicker.
• Rationale for their use is to reduce risk of harm to patient or others.
• Very important to cease antipsychotic as soon as delirium resolved.
Older Persons Mental Health Team

- Metro North consists of RBWH OPMHS; TPCH OPMHS and RedCab OPMHS
- TPCH team consists of 1x FTE Consultant (me!), 2x FTE registrars, 6x FTE clinicians (nurses, social workers, OT and psychologist)
- Community team sees people in their home, NH and in clinics
- Inpatient unit (non aged specific – 8 beds)
- However good relations with geriatric services means that for people with significant frailty, falls risk, mobility issues admissions to medical wards can be facilitated to treat primary mental health disorder.
Referring to OPMHT

- Currently referrals go to central acute care team
- However I would encourage addressing referrals to my name/OPMHT as can be fast-tracked to us.
- Urgent referrals (i.e need to be seen within couple of days) will generally be seen by acute care team initially and then transitioned to OPMHT once assessed and deemed to need further care.
- Less urgent/ non acute referrals will generally be seen within 4 weeks.
- focus is on recovery model and referral back to GP once stable for some months - At any one time we are managing 120+ older adults
Working together

• Keep in contact - please inform us of any changes in medical condition or treatments (medical or psychiatric).

• Happy to always talk on phone – can be contacted directly through switch.