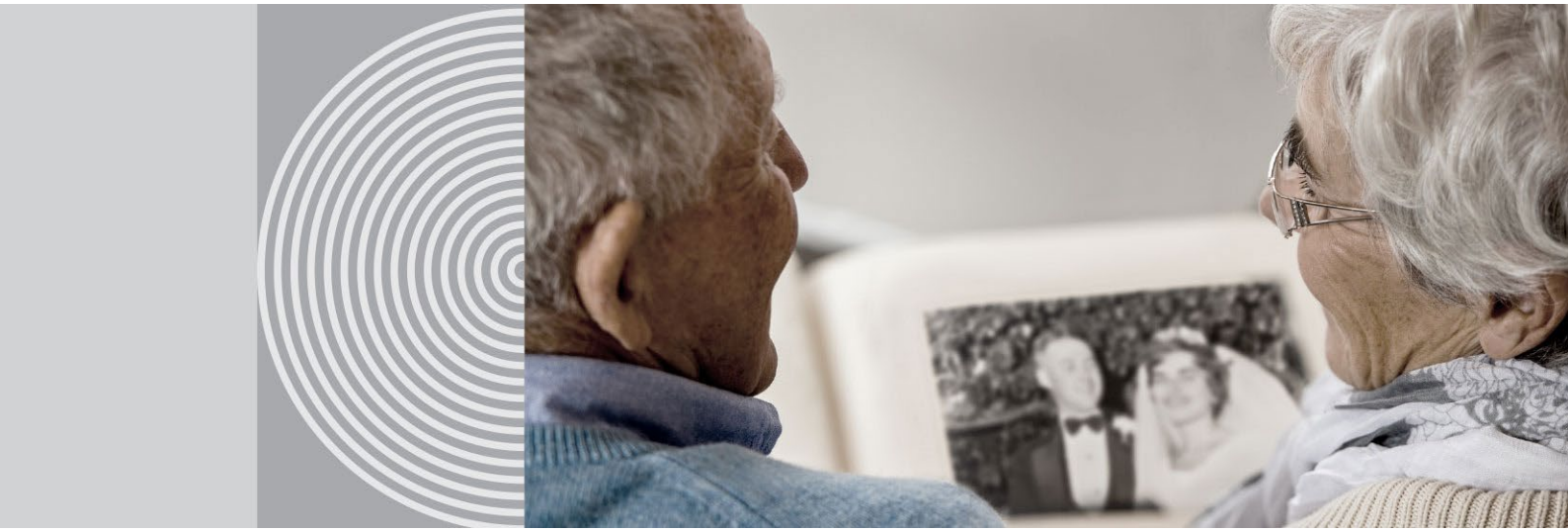
RACGP
Royal Australian College *of* General Practitioners

# *RACGP aged care clinical guide (Silver Book)*

## 5th edition

Part A. Mental health



## *General principles*

- Ageing is a significant time of adjustment and change, where depression and anxiety can be common.
- Restoration of social connectedness is highly beneficial to long-term care and independence.
- Suicidal ideation and attempts have increased frequency in older populations.
- Psychological support (eg counselling, cognitive behavioural therapy) can be beneficial.
- Psychoactive pharmaceuticals need to be used with care in older patients, and need to be regularly reviewed.

## *Practice points*

| Practice points | References | Grade |
|---|---|---|
| Access to clinical and non-clinical services can help support older people with their mental health | 2 | Consensus-based recommendation |
| Tailor activities and programs that aim to address social isolation to individual patients | 3, 4 | Consensus-based recommendation |
| Management of loss and grief may help to prevent older people from developing depression, or worsening their condition | 5 | Consensus-based recommendation |
| Diagnose depression using validated screening and assessment tests | 7, 8 | Consensus-based recommendation |
| Manage depression and anxiety disorders using an individualised approach that is tailored to the patient's needs | 9 | Consensus-based recommendation |
| Establish those at the highest risk of suicide in the immediate future who have the intention to end their life, a specific plan, the means to carry out the plan and a time frame | 27 | Consensus-based recommendation |

| | | |
|---|---|---|
| Consider adjunct psychological treatments for bipolar disorders along with pharmacological treatments | 31 | Consensus-based recommendation |
| Antipsychotic medication is the first-line treatment in schizophrenia; cognitive behavioural therapy has been found to aid in the management of patients with persistent auditory hallucinations | 37, 38 | Consensus-based recommendation |

# *Introduction*

Mental health is a vital component of an individual's overall health and welfare, and has a strong effect on physical health. Statistics show that almost half of all Australians will experience a mental health condition at some stage in their lives.[1] It is important to reassure the patient that help and support are available to them, whether in general practice or through other support programs.

It is important to recognise that some subpopulations of older people, including Aboriginal and Torres Strait Islander peoples, veterans, and culturally and linguistically diverse peoples, experience much higher rates of mental health conditions. The management of mental health in these patients needs to be tailored and individualised.

The purpose of this chapter is not to list all of the potential mental health conditions that older people experience. Rather, it will highlight some of the more prevalent mental health conditions, including depression, anxiety disorder, suicide, bipolar and schizophrenia, and provide information regarding their diagnosis and management.

# *Clinical context*

Good mental health is a significant component of healthy ageing, and comprises psychological, biological and/or social and cultural factors.[2] Appropriate access to effective clinical and non-clinical services can help support older people with their mental health.

## Social isolation and loneliness

Evidence is increasingly illustrating that social isolation is a major contributor of ill health and early mortality.[3] Social isolation needs to be a focus of general practitioner (GP) consultations in order to prevent, minimise and manage patients experiencing social isolation, especially those with a mental health condition.[4]

Social isolation is an issue that can affect individuals of all ages and does not discriminate against older people; however, it significantly affects older people with mental health conditions. This problem is compounded, as older people with mental health conditions may be less likely to participate in community activities and/or have mobility issues or health conditions.

Activities and programs that aim to address the issue of social isolation need to be tailored to each individual patient in their environmental setting, whether in a residential aged care facility (RACF) or the community.

## Loss and grief

Experiencing loss and grief is a major issue that affects people of all ages; however, this is often amplified in the older population group. For older people living with mental health conditions, loss is often related to independence, status, death of family members and friends, and financial stability. The addition of loss and grief on top of pre-existing mental health conditions can complicate the management of the older person.[5]

GPs, RACF staff and nursing staff need to be aware of, and acknowledge, the effects of loss and grief in older people. Appropriate management of loss and grief may help to prevent older people from developing depression, or worsening their condition.

Often there are no signs or symptoms that an older person is experiencing loss and grief, and it can manifest as:[6]

- crying or a reluctance to cry
- changing eating habits
- losing interest in family, friends and hobbies

- difficulty sleeping
- difficulty concentrating
- difficulty making decisions.

# *In practice*

The UK's National Health Service (NHS) encourages health and medical practitioners to recommend the Five steps to mental wellbeing (Box 1) to all patients who may be experiencing a mental health condition.

**Box 1. NHS' Five steps to mental wellbeing**

Encourage all patients to:

- Be active – find an activity you enjoy
- Keep learning – for example, a new skill
- Be giving to others – acts of kindness can improve mental health
- Take notice – be 'mindful' of the present moment
- Stay connected – make an effort to develop relationships with family and friends and colleagues.

## Safety considerations

Consideration must be given to the safety of older people who may be prescribed pharmacological treatments for their mental health (eg antidepressants, antipsychotics). Consider the following:

- Close monitoring of effectiveness and side effects
- Appropriate pathology testing
- Falls risk (refer to Part A. Falls)
- Increased risk of bleeding with selective serotonin reuptake inhibitor (SSRIs) and serotonin and norepinephrine reuptake inhibitors (SNRIs) when combined with other medicines known to increase gastrointestinal bleeding risk
- Syndrome of inappropriate antidiuretic hormone secretion (SIADH)
- Use in people with cardiac disease
  - QT prolongation
- Switching between antidepressants
- Switching between antipsychotics
- Serotonin syndrome
- 'Start low and go slow'
- Use of combinations of antidepressants is not well supported by the literature

## Depression

Depression extends beyond low mood, and is a serious mental health condition that has an effect on every aspect of the older person's life. An estimated 10–15% of older people aged ≥65 years are thought to experience depression,[7] and this figure reaches as high as 50% in those living in an RACF.[8]

Depression is often under-detected and under-diagnosed in older people, as its symptoms (eg sleeping, memory and concentration issues) are often mistakenly attributed to the normal part of ageing.

Older people who are lonely and do not have appropriate social and support networks are at a significant risk of developing mental health conditions such as depression. This is also the case with other physical illnesses, especially as the older person becomes more dependent on others for activities of daily living, leading to a loss of independence and dignity.

## Diagnosis

The diagnosis of depression in older people may include screening and assessment tests, such as the following:

- Geriatric Depression Scale – available and validated in multiple languages and countries. Used to identify depression in older people in hospitals, RACFs and community settings.[9]
- Cornell Scale for Depression in Dementia – designed for the assessment of depression in older people with dementia who can at least communicate basic needs. It has been tested for reliability, sensitivity and validity on patients in hospitals, RACFs and community settings.[9]
- Psychogeriatric Assessment Scales – designed to gather information on the major psychogeriatric disorders: dementia and depression.

## Management

The management of depression in older people needs to be individualised and tailored to the patient's needs. Management may include:[10]

- lifestyle changes (eg diet, physical exercise, social support) to prevent and treat symptoms of depression
- psychological treatments such as cognitive behavioural therapy (CBT), interpersonal therapy (IPT) and reminiscence therapy
- pharmacological treatments (antidepressant medication) along with psychological treatments; however, it is important to consider the duration of treatment and potential side effects. For most older patients, it is important to consider non-pharmacological strategies before considering pharmacological treatments.

# Anxiety disorder

Anxiety disorders are a group of mental health conditions that include:

- generalised anxiety disorder
- phobias (eg social, agoraphobia, claustrophobia)
- panic disorder
- obsessive compulsive disorder
- post-traumatic stress disorder.

An estimated one in four people in the population will have an anxiety disorder that requires treatment at some time in their life, and another 25% will have less severe anxieties (eg fear of spiders, snakes). Anxiety disorders are common among older people; however, the prevalence is less common than for older people in RACFs.[11]

The prevalence rates of anxiety disorders among older people are 1.2–15% in community samples and 1–28% in clinical samples of older adults.[11]

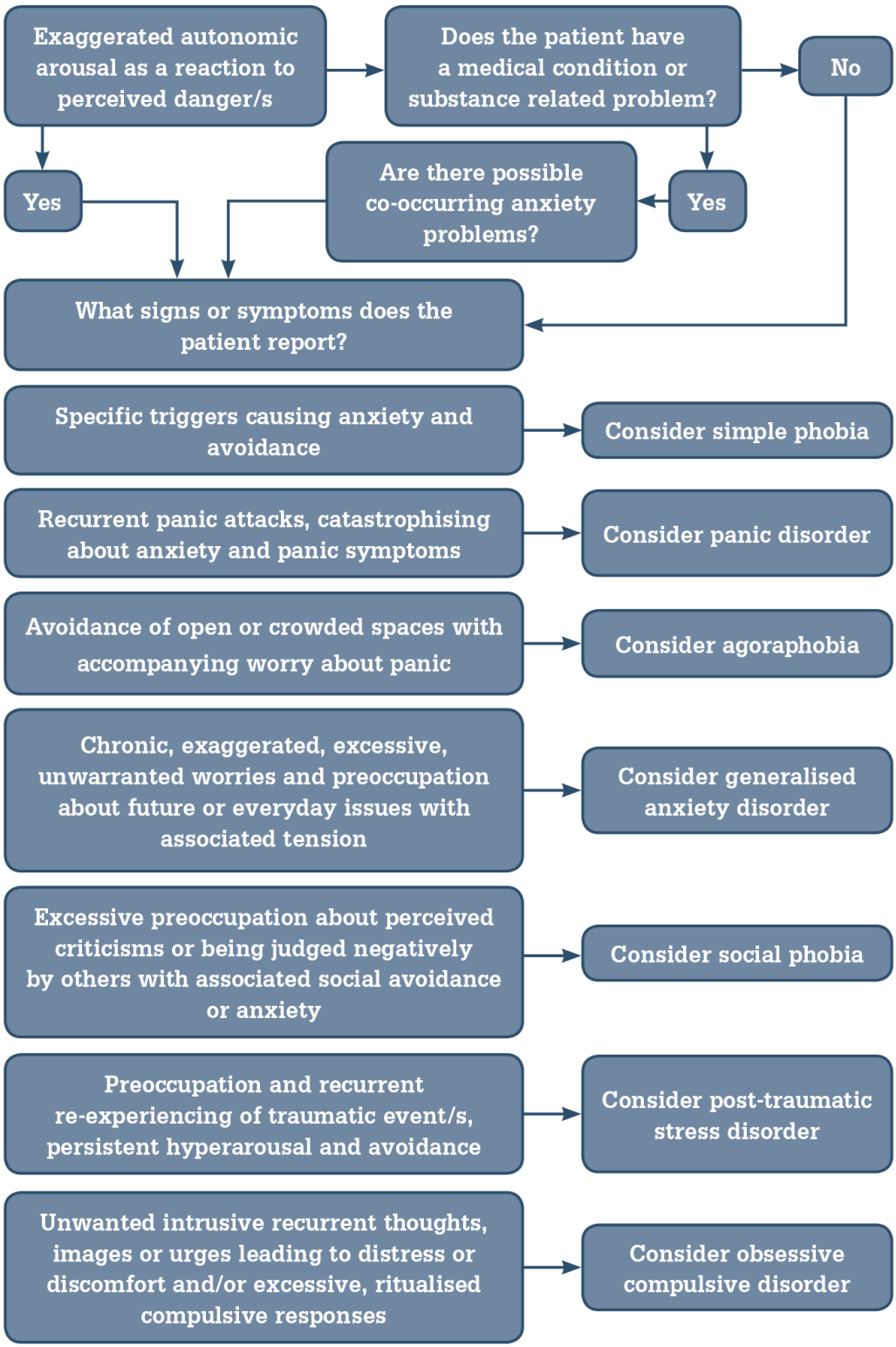
It is important to note that not all experiences of anxiety and fear are considered anxiety disorders. It can become a problem when the patient's experience becomes excessive and irrational, and the anxiety begins to interfere with activities of daily living.

## Diagnosis

Figure 1 is a flowchart that may assist in the diagnosis of anxiety disorders. Anxiety-specific tools and questionnaires may assist with the diagnosis of anxiety disorders, including the following:

- Depression Anxiety Stress Scales-21 (DASS21) – shorter version of the 42-item DASS that was designed to measure three related negative emotional states of depression, anxiety and tension/stress.
- Kessler 10 (K10) questionnaire – a 10-item questionnaire to measure distress based on questions about anxiety and depressive symptoms in the past four weeks.

**Figure 1. Differential diagnosis of anxiety disorders**[12]




Reproduced with permission from Kyrios M, Moulding R, Nedeljkovic M. Anxiety disorders: Assessment and management in general practice. Aust Fam Physician 2011;40(6):370–74.

## Management

The management of anxiety disorders in older people needs to be individualised and tailored to the patient's needs. Management may include:

- psychoeducation (education about the nature of anxiety, its purpose and how it can present is important when dealing with someone with any anxiety disorder)

- psychological treatments (eg CBT has been found to be at least as effective as medication for anxiety disorders)[13,14]
- pharmacological treatments – SSRIs and SNRIs are the first-line pharmacological agents used to treat anxiety disorders.[15] Benzodiazepines should only be used for a short time frame, and only when anxiety is severe and disabling, or causing the patient unacceptable distress; GPs need to be aware of the associated adverse effects (especially falls in older people). The long-term use of benzodiazepines should only be considered when both psychological and pharmacological treatments have failed, and once specialist review have been sought.[16]

Despite the widespread, concurrent use of CBT and pharmacological treatments, there has been no evidence to suggest that concurrent use is superior to either treatment alone in the long term.[17,18]

## Suicide

In 2000–13, an estimated 140 residents in RACFs took their own lives.[19] Studies have found that older men with depression entering RACFs are at the greatest risk of suicide, and the system is not equipped to support these residents. Older people aged ≥65 years, especially men, have one of the highest rates of suicide of all age groups in Australia.[20] The suicide rate of men aged ≥85 years is more than double that of men aged <35 years, and around seven times higher than that in women of all ages.[21]

### Diagnosis

It is important to complete a risk assessment of patients who may be contemplating suicide. Some of the risk factors for suicide to consider include:[22,23,24,28]

- previous suicide attempt/s or deliberate self-harm
- older age
- substance abuse
- low or limited social support
- male gender
- Aboriginal and Torres Strait Islander peoples[25]
- being widowed[26]
- chronic and terminal medical illness
- the 12 months following discharge from a psychiatric hospital
- women experiencing intimate partner violence
- lesbian, gay and bisexual, transgender, intersex, queer identification
- a feeling of hopelessness or absolute despair
- having lost a family member to suicide
- living alone or in prison[27]
- mental disorders, especially mood disorders, and alcohol and drug abuse.

There is currently limited evidence on the efficacy and validity of screening tools for suicide risks.[28] People who are at the highest risk of suicide in the immediate future are those who have:[29]

- the intention to end their life
- a specific plan
- the means to carry out the plan
- a time frame.

Questions to consider during assessment should include:

- Suicidal thinking – if suicidal thinking is present, how frequent and persistent is it?
- Plan – if the person has a plan, how detailed and realistic is it?

- Lethality – what method has the person chosen and how lethal is it?
- Means – does the person have the means to carry out the method?
- Past history – has the person ever planned or attempted suicide?
- Suicide of family member or peer – has someone close to the person attempted or completed suicide?

It is important to note that this is a delicate and sensitive conversation, and care needs to be taken when assessing the risk. If you believe a patient is at high risk of suicide based on your clinical judgement, seek help immediately by calling 000 (police, ambulance).

## Management

Figure 2 lists some of the management options for patients with suicidal risk or behaviour, with additional treatment options for those with comorbid mental health conditions.

**Figure 2. Acute management of patients with suicidal risk or behaviour**[30]

| Behaviour | Treatment | Notes |
|---|---|---|
| Patients with suicidal risk or behaviour | First | Hospitalisation or outpatient monitoring |
| | Adjunct | Psychotherapy |
| | Adjunct | Psychosocial interventions |
| | Adjunct | Treatment of physical injury if suicidal attempt |
| With bipolar | Plus | Mood stabiliser |
| With schizoaffective disorder | Plus | Antipsychotic and/or mood stabiliser |
| With depression | Plus | Selective serotonin reuptake inhibitor (SSRI) |
| With personality disorder | Plus | SSRI |
| With substance abuse | Plus | Detoxification and monitoring |

The General Practice Mental Health Standards Collaboration (GPMHSC) has developed *Suicide prevention and first aid: A resource for GPs* to provide advice to GPs about mental health first aid for suicide prevention. Beyond Blue has also developed resources for patients who have attempted suicide: *Finding your way back*.

# Bipolar

An estimated 1% of the Australian community has bipolar disorder, where the patient is more likely to experience broken relationships and make suicide attempts than even those with unipolar depression.[31] Up to 25% of all patients with bipolar are older people, and the prevalence will increase as the population continues to age.[32]

## Diagnosis

The main characteristic of bipolar disorder is the tendency to swing between the two contrasting ‘poles’ of elevated mood (ie hypomania or mania [Box 2] and depression), with a return to largely normal functioning in between these episodes.[33]

**Box 2. Symptoms of mania and hypomania (symptoms need to be present for at least four days for hypomania and seven days for mania)**

- Abnormally elevated or euphoric mood, frequently associated with an increased tendency to irritability
- Increased energy and activity (more 'wired')
- Reduced need for sleep (as distinct from insomnia)
- An inflated sense of one's own abilities (grandiosity)
- Disinhibited behaviour – increased sexual drive; increased spending or excessive generosity; tendency to make overly frank comments about others
- Increased subjective speed of thoughts ('my thoughts are too quick for my tongue to keep up with'); more talkative; speaking more loudly
- Increased distractibility – reduced ability to focus and complete tasks (despite having many plans or projects)
- Enhanced perceptual experiences – for example, sounds are more harmonious, colours richer than usual

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## Management

There is growing evidence that adjunct psychological treatments with pharmacological treatments can help more than just pharmacological treatments alone.[34] Pharmacological treatments include:[16,33,35,36]

- lithium
- anticonvulsants
- first-generation antipsychotics
- second-generation antipsychotics.

# Schizophrenia

Schizophrenia affects an estimated 30,000 Australians,[37] with a median lifetime risk of 7.2 per 1000 in the population.[38] Symptoms of schizophrenia include delusions, hallucinations, flatness of affect, poverty of speech or incoherence of speech; and may also include mood symptoms, cognitive problems and movement disorders.[39]

## Diagnosis

The management of older people with schizophrenia and depressive symptoms must first include a reassessment of the diagnosis to ensure symptoms are not due to a comorbid condition, metabolic problems or medications.[40]

The *Diagnostic and statistical manual of mental disorders,* fifth edition (DSM-5) notes that a diagnosis of schizophrenia can only be made when two or more of the following has occurred for at least one month:[41]

- Delusions
- Hallucinations
- Disorganised speech
- Grossly disorganised or catatonic behaviour
- Negative symptoms (eg diminished emotional expression)

In addition, at least one of the above must include one of the following:[41]

- Impairment in work, interpersonal relations or self-care for a significant period
- Last for a continuous period of at least six months
- Schizoaffective disorder and bipolar or depressive disorder with psychotic features have been ruled out

## Management

Pharmacological treatment, psychological treatments and lifestyle changes are vital in the management of older patients with schizophrenia and depressive symptoms. Management may include:[40]

- pharmacological treatment – antipsychotic medication is the first-line treatment in schizophrenia by maintaining symptom control and minimising exacerbations of illness.[42] GPs need to be aware of the side effects, and manage these adverse events accordingly.
- psychological treatments – specific treatments can help in the management of patients with schizophrenia; CBT has been found to aid in the management of patients with persistent auditory hallucinations.[43]
- lifestyle changes, including social and vocational rehabilitation for the establishment or return of functional capacity in activities of daily living, exercise[44] and diet.

# *Patient resources*

- Lifeline – 13 11 14
- MensLine Australia (for men of any age) – 1300 789 978
- Suicide Call Back Service – 1300 659 467
- Healthdirect Australia – 1800 022 222
- Beyond Blue – 1300 224 636

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