SoaCAG Guidance:

Working With Older People Who Have Mental Health Problems

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1. Introduction

1.1. Scope of this guidance

This document offers guidance on working with older people with mental health problems. The purpose is to highlight key facts and guidance for best practice and to provide references and further reading for service users, carers, clinicians and managers, should they wish to refer to best practice evidence and guidance in more detail. Services for all people should be person-centred and needs-led rather than age-led, however as an approximate guide, 'older people' are considered to be aged 65 and over. It is important to recognise old age as a specialist domain of mental health care as this serves as a proxy for need in the majority of cases. (Banerjee and Child, 2018).

1.2. Mental health presentation in older people

The Department of Health has estimated that 40% of older people in GP clinics have a mental health problem, rising to 50% of older people in general hospitals and 60% of those in care homes (Social Care Institute for Excellence, 2006). Depression is the most common mental health problem in older people with estimates of prevalence ranging from 20 – 28% in the general older population, rising to between 50-60% of older people in care homes and general hospitals. Depression rates are higher in those with long-term physical conditions and the presence of depression is associated with poor physical health outcomes.

Depression tends to be under-diagnosed in older people. Its presentation tends to differ to that in younger people, including a greater focus on somatic symptoms (e.g. sleep disturbance, fatigue, psychomotor retardation) and cognitive symptoms (memory and concentration difficulties). There is often less focus on depressed affect, but a loss of interest in living and a sense of hopelessness (Fiske, 2009). Poor recognition of depression in older people in turn leads to high levels of untreated depression and the associated poor outcomes for health and mortality (Age UK, 2016).

Anxiety disorders are experienced by 20% of the older population, often presenting with depression. Bipolar disorders are present at less than 10% and psychosis is less common still. Where there is first-onset psychosis in an older person, delirium or dementia should also be considered as possible causes.

Older people account for approximately 20% of all suicides; the most common method in older people is overdose and attempts are more often with an intent to die than younger cohorts (Age UK 2016, NHS England 2017, Royal College of Psychiatrists 2018).

Research has found that older people with common mental health conditions are more likely to be on drug therapies and less likely to be in receipt of talking therapies compared to other age groups. Older people themselves may be reluctant to seek

help, with fewer than one in six experiencing depression ever discussing it with their GP (NHS England, 2017).

Precipitating risk factors for declining mental wellbeing in older people include loss of a partner through bereavement, separation or divorce in the last two years, being a carer, social isolation, recent retirement (especially involuntary), low income, recent physical health problems or long-term conditions, giving up driving and age-related disability (NICE, 2016).

1.3. Provision of specialist mental health services for older people

Given the data in relation to mental health recognition and treatment in older people, it is important that services are set up to understand the unique presentations and risk factors of the older population and that referrers are supported and encouraged to make appropriate referrals. This applies across primary mental health care/ IAPT services, secondary mental health care and acute and liaison services.

The Royal College of Psychiatrists (2018) highlights that older people have poorer psychological wellbeing and physical health outcomes as a result of ageism, unconscious discrimination and healthcare inequalities. Services and teams that focus on care for older people are in the best position to maintain and develop clinical knowledge and expertise and to avoid the effects of unconscious discrimination.

Specialist mental health services for older people should be provided by multi-disciplinary teams that are appropriately trained and skilled. This includes having the skills to work with people with dementia and their carers, such that there is not a false divide between assessing and treating “functional” and organic mental health problems (given that these frequently occur together). Specialist Older Adult Mental Health services should be equipped to respond to the differences in presentation of mental health problems in older people and the complexity that comes with the mental and physical health comorbidities that occur in the context of the psychological and social changes and challenges of old age.

Services should be physically accessible to older people, including physically accessible rooms (with sufficient capacity to accommodate families/ carers), disabled and accessible parking, consideration of sensory loss (eg. hearing loops, large print version of standard information available), dementia-friendly signage and environments and some consulting rooms with high- backed chairs that have arms, appointments available in satellites close to home. Home visits should be available for those unable to come into a clinic base.

2. Care Delivery

When delivering mental health care to older people, guidance and menus of intervention with respect to the Sussex Partnership care pathways should be followed as for younger individuals, with added adjustments and considerations as

referenced in the present paper. The Practice Primer published by NHS England (2017) provides a useful starting point for considering special presentations and treatment needs of the older population.

2.1. Daily Life

As part of treating or sign-posting an older person with mental health problems, factors of daily life to take into account include:

- Social context or social isolation. Have there been recent changes in social contacts and ability to connect socially? Is the person socially isolated or at risk of becoming so? As loneliness and social isolation impact on health and mental health, consider interventions that support the person to develop and maintain connection with a social context. Consider the need for interventions that will enable the person to reduce loneliness and social isolation. See SCIE (2012) and also be aware of your local community resources.

- Living situation. Is the person living in their own home or a care setting? Do they receive care and if so, is this from paid carers or from family/ friends? Consider the impact that their living and caring situation may be having on their mental health. Does the person have caring responsibilities for others and are they able to manage these (see Carers Trust, 2015)?

- Activities of Daily Living. Consider any loss of skills (and the reasons for this) and what is needed to support adjustment and maximise independence. Liaison/ joint working with Adult Social Care to consider provision of equipment and assessment for a social care package.

- Finance. Consider needs for sign-posting to benefits advice and support.

- Lifespan development. Consider the life stage the person is at psychologically/ psychosocially to support your formulation

2.2. Family and Carers

For an older person it is important to consider their roles and position within the extended family across the generations - i.e. with a partner/spouse, adult children, grandchildren and sometimes also parents. The person's changing physical/mental health needs may affect family relationships, as well as vice versa. Be aware also of loss and bereavement of close relationships.

When a person is receiving formal or informal care, consider the historical context of care received in the past (e.g. attachment history, history of abuse/ neglect that may make it difficult to receive care or be dependent on others, history of evacuation in the war). Consider the quality of the care being provided and whether this is meeting the person's relational needs.

Wherever possible, aim to include family and carers in assessment, planning and care for the older person (with the person's consent if they have the mental capacity to give it). Consider the need for family interventions, ranging from psychoeducation and support to indirect interventions with carers or systemic couple/family therapies.

Consider also the impact on mental health if the person has a lack of close family relationships.

2.3. Psychological Therapies

Clinicians should assume that evidence-based psychological therapies work for this age group unless there is evidence to the contrary. Awareness and understanding of the interplay between biological, psychological and social factors is essential when working therapeutically with an older person and appropriate adaptations should be made to support the older person in making use of the therapy. These may include:

- Some older people may need a period of time for 'socialisation' to psychological therapy and a collaborative working relationship. More time may also be needed to understand the person's current difficulties in the context of their life history and their current life stage.

- Consideration of cognitive abilities and use of support with information-processing and memory if this is needed.

- Consideration of physical health needs and limitations. Adaptations may include shorter sessions and sessions in the person's home. The therapist will need to take into account how entering a person's home for psychological therapy affects the therapeutic relationship.

2.4. Medication Treatment

Medication should only be prescribed in response to clearly defined clinical need and must be kept under close review, either by or with the GP, or through the Specialist Older Adult Mental Health Service (SOAMHS), as appropriate to need. When medication is being considered or reviewed there should be evidence that the following have been taken into account for people aged 65 and over:

- Potential slower onset of action, impaired kidney and liver function, causing heightened sensitivity longer duration of action and reduced tolerability to all medication as age increases.
- Increased risk of toxicity due to polypharmacy and also due to the use of over-the-counter medicines, for example, purchased NSAIDs taken alongside prescribed lithium.
- Reduced adherence to medication due to complex regimens, for example, multiple daily dosing,. swallowing difficulties, impaired vision and forgetfulness

- Potential for medication originally prescribed for agitation or anxiety, for example, benzodiazepines and antipsychotics, to cause confusion, disorientation and falls.
- Antipsychotics increase the risk of strokes in people living with dementia and should be used only when essential and then for the shortest period possible. It is recommended when used for agitation they are prescribed as a course and not an automatic repeat.
- Potential for slower response to antidepressants with older people. Also there is greater potential for side-effects, such as gastro-intestinal bleeding, sedation, hyponatraemia, postural hypotension and falls. The risks associated with GI bleeds and falls increase with age.
- Potential greater risk of drug-induced psychosis in older people. For example with benzodiazepines, anti-epileptics, antidepressants, anticholinergics and dopamine agonists.
- Consider blood tests and measure the QTc interval prior to commencing psychotropic medication because of the risk of adverse physical reactions.
- Potential for drug toxicity (including that of physical health drugs, such as digoxin, steroids, opiates etc.), to be mis-diagnosed as delirium, acute confusional state or psychosis etc.
- If considering stopping or reducing the dose of multiple medicines, reduce the dose slowly of one medicine before considering reducing and or stopping a second.

Key points from 'Mental Health in Older People A Practice Primer' (2017) are summarised below, and please refer to the guidance for summaries of drug treatments for common mental health problems experienced by older people:

- In older people, physical illness or medication side effects are more likely to result in poor mental health and warrant thorough investigation in every case.
- Every older adult should have a medication review, a targeted physical examination, some basic blood tests and a urine test (if they have urinary symptoms).
- The rule 'start low, go slow' applies for psychotropic medications, and treatment regimens should be kept as simple as possible, trying to avoid augmentation, or treating side effects with additional medications. Older people might take much longer to respond to psychotropic medications.

2.5. Physical Health Care

2.5.1. Long-Term conditions:

Many older people with mental health problems have co-existing physical health problems, often multiple conditions, some of which will be long-term. NICE (2015) describe a long-term condition as one that usually lasts a year or longer and has an

impact on everyday life. The effects of long-term conditions and their symptoms often change over time and may need to be managed with medicines or other therapies. It is common now for older people to be living with more than one long-term condition. Examples are arthritis, breathing disorders, cancer, dementia, diabetes and high blood pressure.

2.5.2. NICE (2015) guidance:

The NICE (2015) guidance states that health and social care practitioners should be able to recognise, consider the impact of, and respond to:

- Common conditions, such as dementia, hearing and sight loss.
- Common care needs, such as nutrition, hydration, chronic pain, falls and skin integrity.
- Common support needs, such as dealing with bereavement and end of life.
- Deterioration in someone's health or circumstances.
- Good practice for assessing for Physical Health needs:
- Assessments with older people will need to evidence that physical health needs have been considered and facilitated in the following ways:
- Enquiry as to whether the person has had an annual physical health check at assessment and at each review.
- Facilitation of the physical health check with the GP if appropriate.
- Evidence of communication and liaison with physical health care providers, including neurologists and geriatricians if complex physical health problems are present in an older person.
- SPFT's physical health CQUIN (Commissioning for Quality and Innovation) policy should be followed

2.5.3. Frailty

Physical health complexities resulting from ageing and multiple long-term conditions may result in frailty. The British Geriatrics Society (2014) cited by the Royal College of Psychiatry (2018) define frailty as 'a distinctive health state related to the ageing process in which multiple body systems gradually lose their in-built reserves'. Around 10% of people aged 65 and over currently live with frailty, rising to between 35% and 50% of those aged over 85 (Age UK, 2017).

2.5.4. Interaction between depression and physical health

The presence of physical illness increases both frailty and the risk of depression. However, outcomes among depressed older people with physical illness are equal to those who are physically relatively healthy. The Royal College of Psychiatry's paper on 'Suffering in Silence, Age Inequality in Older People's Mental Health Care, 2018, cite research by Ryan et al. (2008) finding that depression also doubles, and sometimes trebles, natural death rates, and research by Alexopoulos (2006),

Wanless et al. (2006), and Licht-Strunk et al. (2009) that depression impairs the ability to function independently, increases the likelihood of admission to long-term care and worsens the outcome of other medical conditions.

2.5.5. Somaticizing mental health difficulties

Mental health difficulties in older people are far less likely to be volunteered, detected or treated. Specifically, older people are less likely to complain about losses, such as relationships or abilities, as these may be considered to be normal. The presentation of mental illness is much more likely to be with physical rather than emotional symptoms, though health anxieties are more commonly expressed (NHS England, 2017). It is important to look beyond the presentation of physical health concerns and enquire directly about psychological and emotional problems. Older people are also much more likely to be treated with medication when mental health problems are recognised than younger adults (Royal College, 2018), yet benefit significantly from non-pharmacological interventions just as much as younger adults.

It is really important to exclude any physical causes that may be underlying or contributing to the person's current mental health difficulties. If this is a new presentation, then any underlying medical cause, including side-effects of medication, must be ruled out. For example, common causes of anxiety disorders include heart conditions, thyroid disorders and vitamin deficiencies. Anxiety can also be a presenting feature of dementia, depression and physical illness.

2.5.6. Delirium

Remember, especially in older people, hidden infections are very common and infection should be considered for any new mental health problem in a frail older person. Even simple constipation may present as either confusion or low mood. Key points about delirium noted by NHS England and NHS Improvement, Mental Health in Older People A Practice Primer, 2017, are:

- Delirium is an acute illness onset, starting and often (but not always) finishing abruptly.
- Delirium is a medical emergency.
- Delirium is always due to a physical cause even if you cannot find it.
- The clinical syndrome of delirium can last weeks and sometimes months after the physical insult has resolved. The clinical syndrome can persist sometime after the white blood cell count has returned to normal.

2.6. Social Care

Identifying and assessing social care needs will be important to consider when working with older people presenting with mental health problems. Referring to the local authority for a needs assessment should be considered when social care and support needs are identified in older people, or discussions held with the Specialist

Older Adult Mental Health Team, where these are integrated with Social Services, for those people who are experiencing complex mental health needs and require the expertise of older adult specialists to manage these.

It is important to recognise that many carers of older people with social care needs and multiple long term conditions will also need support. If the person's carer has specific social care needs of their own, a referral to the local authority for a needs assessment in their own right will need to be considered.

The recommendations below have been informed by the NICE (2015) guidelines on working with people experiencing long-term conditions

- Older people should always be included in discussions about their care and what support they need to live well.
- The principles of Triangle of Care (Carers' Trust, 2017) should be followed and older people should be consulted to find out how they would like their carers/family members to be involved in decisions about their care.
- Consideration should be given to having an advocate present, as enshrined in the Care Act 2014 if it would help to have an independent person present to support the person in putting their views across.
- For older people with significant health conditions which limit mobility or for whom travelling to community sites would cause undue stress, then meetings within the home should always be considered for assessment and intervention.
- Always take into account the person's strengths, needs and preferences.
- Involve the relevant practitioners to address all of the person's needs, including their medical, psychological, emotional, social, personal, sexual, spiritual and cultural needs; sight, hearing and communication needs; and accommodation and environmental care needs.
- Ensure that if a person and their carer cannot attend an assessment meeting, they have the opportunity to be involved in another way, for example in a separate meeting or through an advocate.
- Provide people with information about the services available to them, their cost and how they can be paid for.

2.7. Communication

- Older people's communication needs need to be considered as part of routine care, including the person's level of understanding and sensory needs (hearing and sight loss).
- Reasonable adaptions must be made to support older people with difficulties with communication to express their needs. This can be aided by providing face to face contact, reducing background noise, allowing more time for people to express themselves, liaising with Speech and Language Therapists

when advised, using larger print text for people with s ight difficulties, having rooms with hearing loops available.
- Communication advice should be provided to family and carers.
- Where mental capacity concerns are present and it is not clear whether someone is able to express their views and make decisions about their care and treatment, then a Mental Capacity Assessment should be considered.

2.8. Safety Planning and Risk Management

2.8.1. Suicide

About one fifth of all suicides happen in older people. The most common method is overdose. Suicide attempts should be taken seriously and a higher proportion compared to younger people are genuine attempts to die (NHS England, 2017). Older people who self-harm are less likely to be referred to specialist mental health services than younger adults, despite a higher risk of suicide in this group (Morgan et al, 2018). In all cases, people aged 65 plus who are presenting with a recent suicide attempt should be seen for a face to face assessment within secondary care mental health services within 1 week.

The following are known risk factors for people aged 65 plus and if present should be thoroughly reviewed and a decision made about providing an assessment:

- Depression (past or present) and especially if accompanied by anxiety, agitation, guilt and social isolation. Depression in later life is the major risk factor for suicide – 80% of people over the age of 74 who die by suicide have depression (Conwell et al, 1998; Hawton & Harriss, 2006 cited in The Royal College of Psychiatry (2018) Suffering in Silence Age inequality in Older People's Mental Health Care).
- Recent losses or major life changes, for example, bereavement, home, independence, autonomy, change in circumstances etc.
- Signs that the person is not eating or drinking well.
- Previous suicide attempt.
- Experiencing chronic pain.
- Recent diagnosis of chronic or serious illness, especially in men.
- Frequent GP visits with vague non specific symptoms i.e. tiredness, memory loss, anxiety, poor sleep, chronic painful symptoms such as backache, joint pain, headaches and back and face pain etc.
- Ex-service men or women.

NHS England and NHS Improvement, Mental Health in Older People A Practice Primer, 2017, also note risk factors as being male, being widowed, increasing age, social isolation, physical illness (present in up to 80% of cases), pain, alcohol misuse and depressive illness (past or present).

2.8.2. Neglect

Self-neglect is a significant risk concern and following the introduction of the 2014 Care Act, should be considered as a reason to think about making a safeguarding referral. Self-neglect can present itself with poor nutrition, hydration, poor personal care, social isolation, hoarding and a deterioration in 'usual' standards of hygiene and cleanliness within the home for the person. These risks may require a multi-agency approach including Mental Health, Social Services, GP and Environmental Health Services etc.

2.8.3. Abuse/exploitation

Abuse of older people must also be considered and can be due to acts of commission (physical, sexual, verbal or emotional abuse; financial exploitation) or omission (neglect, such as withholding food or ignoring cries for help). In older people the risk is similar across gender, age and socioeconomic status. Risk factors for being the victim of abuse are social isolation, absence of a suitable guardian, and high dependency. Carers with mental health, substance use or financial problems are more likely to be committers of the abuse (NHS England, 2017).

Key points from 'Mental Health in Older People: A Practice Primer' (2017) are:

- Domestic abuse in older people is underreported.
- The most common forms are verbal abuse and financial exploitation by family members, as well as physical abuse by spouses.
- The most important prevention strategy is reducing social isolation.
- We all have a role to be alert to signs of abuse and discuss suspicions with the local safeguarding team.

3. Assessment and Outcome Measures

ReQol is the Patient Reported Outcome Measure that is used across Adult services and this is also suitable for use with older people. Measures for depression and anxiety that are recommended for use with older people are below, as well as cognitive screening tests.

Depression:
• Hospital Anxiety and Depression Scale (HADS)
• Geriatric Depression Scale (GDS)

Anxiety:
• Hospital Anxiety and Depression Scale (HADS)
• Geriatric anxiety Scale (GAS)

Cognitive screening:

- Mini Mental State Examination (MMSE)

- Addenbrookes Cognitive Examination III (ACE-III)
- Montreal Cognitive Assessment (MOCA)

4. References

Age UK (2016) Hidden in Plain Sight: The Unmet Mental Health Needs of Older People. Age UK www.ageuk.org.uk/brandpartnerglobal/wiganboroughvpp/hidden_in_plain_sight_older_peoples_mental_health.pd

Age UK (2017) Later Life in the United Kingdom Factsheet. Available at: https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/later_life_uk_factsheet.pdf

Alexopoulos G.S. (2006) Depression in the elderly. Lancet, 365: 1961–70.

Banerjee, S. and Child, J (2018) Strategic Review of Sussex Partnerships NHS Foundation Trust's Older People's Mental Health and Dementia Services. Sussex Partnership NHS Foundation Trust

British Geriatrics Society (2014) Fit for Frailty. British Geriatrics Society.

Carers Trust (2015) Caring About Older Carers; Providing Support for People Caring Later in Life. https://professionals.carers.org/sites/default/files/caring_about_older_carers.pdf

Carers Trust (2017) The Triangle of Care. Carers Included: A Guide to Best Practice in Mental Health Care in England; Second Edition http://staff.sussexpartnership.nhs.uk/document-library/newsletters-1/4097-triangle-of-care-2016-latest-version-0/file

Conwell Y, Duberstein P, Cox C, Herrmann J, Forbes N, Caine ED (1998) Age differences in behaviours leading to completed suicide. American Journal of Geriatric Psychiatry, 6: 112–26.

Fiske, A., Wetherell, J. L., & Gatz, M. (2009) Depression in older adults. Annual review of clinical psychology, 5, 363-89.

Hawton K, Harriss L (2006) Deliberate self-harm in people aged 60 years and over: characteristics and outcome of a 20 year cohort study. International Journal of Geriatric Psychiatry, 21: 572–81.

Health & Social Care Act (2014) The Stationary Office Limited.

HM Government (2011) No Health without Mental Health: A cross-Government Mental Health Outcomes Strategy for People of All Ages. Department of Health.

Jackson T, MacLullich A, Gladman J, Lord J, Sheehan B (2016) Undiagnosed long-term cognitive impairment in acutely hospitalised older medical patients with delirium: a prospective cohort study. Age & Ageing, 45: 493–9.

Licht-Strunk E, Van Marwijk H, Twisk J, De Haan M (2009) Outcome of depression in later life in primary care: longitudinal cohort study with three years follow up. BMJ, 3079: 338.

Morgan C, Webb R, Carr M, Kontopantelis E, Chew-Graham C, Kapur N, et al (2018) Self-harm in a primary care cohort of older people: incidence, clinical management, and risk of suicide and other causes of death. Lancet Psychiatry, 16: 53.

NHS England (2017) Mental Health in Older People: A Practice Primer. NHS England and NHS Improvement https://www.england.nhs.uk/wp-content/uploads/2017/09/practice-primer.pdf

NICE (2015) Older people with social care needs and multiple long-term conditions. National Institute for Health and Care Excellence. Available at: http//www.nice.org/guidance.

NICE (2016) Mental wellbeing and independence for older people. Quality standard [QS137]. National Institute for Health and Care Excellence. Available at: http//www.nice.org/guidance.

Royal College of Psychiatrists (2018) Suffering in silence: age inequality in older people's mental health care. https://www.rcpsych.ac.uk/docs/default-source/improving-care/better-mh-policy/college-reports/college-report-cr221.pdf?sfvrsn=bef8f65d_2

Ryan J, Carriere I, Ritchie K, Stewart R, Toulemonde G, Dartigues JF, et al (2008) Late life depression and mortality: influence of gender and antidepressants. British Journal of Psychiatry, 192: 12–8.

SCIE (2012) Preventing Loneliness and Social isolation among Older People https://www.scie.org.uk/publications/ataglance/ataglance60.pdf

Social Care Institute for Excellence (2006) Assessing the Mental Health Needs of Older People (SCIE Guide 3). SCIE.

Wanless D, Forder J, Fernandez JL (2006) Securing Good Care for Older People. King's Fund.