



Mental Health in Older People

A Practice Primer

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1. Foreword by Tom Wright CBE, Age UK



It is now widely accepted that the mental health needs of older people have historically been under-recognised and under-treated. Although the proportion of those affected is broadly in line with other age groups, older people have not been able to access the same level of support.

Research has also 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 older people with depression ever discussing it with their GP.

Later life is a time when getting the right support is extremely important for wellbeing due to the complex challenges older people often face. As our population ages, it is crucial to ensure that older people's mental health not only attains parity with physical health diagnostics and care, but parity with other age groups too.

At Age UK we are committed to addressing the mental health needs of older people so that they can live fulfilling later lives. Over the past few years we have worked with NHS England on a campaign to improve older people's access to talking therapies with the aim of fighting stigma and misconceptions. We are also running a number of pilots and services across the country, including in partnership with Mind, to enhance psychological coping strategies, wellbeing and social connections among older people.

Age UK warmly welcomes the initiatives NHS England is taking to concentrate on mental health in older people, to which this Practice Primer is a valuable contribution. Improving the identification and management of older people's mental health conditions in primary care is a priority and the Primer shows that the majority of mental health conditions are highly treatable, whether through medical or non-medical approaches, including talking therapies and social prescribing.

This publication represents a hugely significant step in the right direction and we hope that clinicians will find it an essential touchstone for their practice.

Tom Wright CBE
Group CEO, Age UK

2. Introduction

Mental health problems are as common in older adults as they are in younger adults and are associated with considerable individual suffering, suicide, higher use of health and social care services and poorer outcomes for physical illness. However, mental health symptoms in older people are far less likely to be volunteered, detected or treated. Specifically, older people are less likely to complain about losses (of 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.

This brief summary of those mental health problems in older people, which are not directly related to physical illness or brain disease, is aimed primarily at colleagues in the primary care team, particularly GPs. Professionals risk attributing symptoms to 'old age' or considering the patients' situation as futile. Ninety percent of older people consult their GP at least once each year, underlining the pivotal role of primary care.

We use the shorthand and traditional definition of 65 years of age as the start of old age, recognising that this chronological definition (introduced by Bismarck in 1880's as the age that pensions started) is much less relevant today and successive cohorts of people are living longer and healthier (one in five women born today can expect to live until they are 100).

We are not considering dementia in this document because it has been dealt with elsewhere¹, however delirium is covered briefly. When evaluating an older person with a mental health problem, it can be helpful to bear in mind whether it is a longstanding condition in a person who is growing old. If it is arising in old age as a new condition, the diagnostic approach and treatment could well be slightly different.

We see this as work in progress and any comments and suggestions would be appreciated to Alistair.Burns@nhs.net

After reading and reflecting on this resource pack you should be able to:

- **Describe** distinctive features of common mental health problems in older adults
- **Be confident** to diagnose and treat common mental health problems in older adults
- Use and monitor **psychotropic medications** safely
- **Be aware** of the interaction between physical and mental health in older people
- **Distinguish** functional mental illness from dementia, and identify patients who merit referral to specialist care
- **Develop** a strategy for yourself and your practice to improve the detection and management of mental illnesses in older adults

¹ <https://www.england.nhs.uk/wp-content/uploads/2014/09/dementia-revealed-toolkit.pdf>

3. What's different about mental health in older people?

Depression is both the most common and most treatable / reversible mental illness in old age, affecting one in five older people in the community. This figure doubles in the presence of physical illness and trebles in hospitals and care homes. Anxiety disorders are present in one in twenty people and very frequently along with depression. Less than one in ten people present with bipolar disorder in older age, and even less common are older people presenting with psychotic symptoms (one in twenty). Older people more frequently have symptoms of depression or dementia than late-onset schizophrenia. Hysteria (conversion disorder) in old age is very rare, and any older person presenting with physical symptoms or loss of function has a physical illness until proven otherwise.

Taking a History

There is nothing particularly special about taking a history from an older person with a suspected mental health problem, just listen. A symptom or complaint that started in old age, compared to one which is life-long, is more likely to be due to an underlying mischief. Always listen to the family about the attribution of particular symptoms, but be wary. Many clinicians recognise life-long and enduring awkward 'personality traits' are dramatically improved with antidepressants.

When and how did something start? When families cannot remember exactly, it is probably Alzheimer's disease. Bitter complaints of loss of memory over months are likely to be due to depression and a sudden onset is most often vascular in origin. Enquire about drugs with particular reference to the temporal relation between starting or stopping a medication and the onset of symptoms.

Mental state examination

You know your patient better than anyone and are best placed to judge changes in appearance or behaviour, whether it is the withdrawn disinterested syndrome of depression, the irritability of mania or the mistrusting attitude underlying psychosis. Hearing loss can predispose, specifically, to paranoid ideas.

Formal thought disorder is rare in older people and should raise the suspicion of an underlying organic condition. Pressure of speech or knight's move thinking (flitting from one subject to another with tenuous links) is uncommon. Delusional ideas will usually be volunteered, however, they can be missed if you are too rushed in your interview. General questions such as "what's troubling you at the moment?" and "what's on your mind?" can bear fruit if you allow people to talk after asking the question. Delusions by definition are held with firm intensity, lesser forms are called overvalued ideas and people can be convinced otherwise (best described as having a 'bee in your bonnet'). Press people as to whether they really believe something and you can detect hesitation indicative of an overvalued idea. A good question to screen for psychotic ideas is "does your imagination ever play tricks on you?".

In psychotic depression, delusions are usually ‘mood congruent’ (e.g. the depressed older person who feels that persecution is justified. It is always worth asking in these circumstances if people feel they deserve it. If the answer is yes then the delusion is likely to be secondary to depression). Be alert for ‘gallows humour’ masking severe depression. Remember, people who are significantly depressed do not necessarily cry. Crying is a state of emotion rather than an affect.

Test cognition in the same way as you would when assessing someone with suspected dementia (e.g. using a GP Cog) and remember that difficulties in memory, concentration and attention are not diagnostic of dementia.

It is always important to assess someone's insight and it is universally helpful to ask what a person thinks the cause of their difficulties are as it can sometimes uncover something in their history, hitherto missed. It can also help assess insight, and might uncover the guilt-ridden response of someone who is depressed.

Use your own response to your patient. For generations, clinicians have described patients as ‘pleasant’; remember that this merely reflects what the examiner is made to feel and not any phenomenological state. Negative reactions should be recognised as they might be helpful. A person who consistently annoys you could well be depressed or have a personality disorder, and a person who perplexes you might be psychotic.

Physical examination

Physical illness, whether above or below the neck, and medication side effects are particularly common in older people ([Appendix 1](#) has an exhaustive list of these). It is important to exclude these factors as underlying or contributing to the presentation of the patient. Every new onset of apparent mental illness needs to be investigated, but this needs to be proportionate for everyone's sake.

Remember, especially in older people, hidden infections are very common and any new mental health problem in a frail older person should be considered an infection until proven otherwise. Most psychiatrists have seen cases of psychotic depression miraculously cured by a course of antibiotics. Even simple constipation may present as either confusion or low mood.

As a minimum, undertake a sensible, targeted physical examination. For example, if someone is breathless, listen to their heart and chest; if someone coughs, listen to their chest; if someone looks to be in pain, examine their joints; if there is unexplained weight loss, examine the abdomen; if someone looks parkinsonian, look at their gait, examine their wrists for cogwheel rigidity and do a glabellar tap. A patient's breath smelling of wet leaves may indicate tuberculosis.

Thinking about it another way, what would something look like if it went wrong and was publicised in the media? How would it look, for example, if a chest x-ray was not ordered in an ex-smoker with a chronic cough, or a family's concern over a lump was ignored? Common things can look common, however caution would be wise; bear in mind a phaeochromocytoma might not be the first thing a GP thinks of when faced

with a patient suffering from a headache, people who become paranoid for the first time might have had a silent myocardial infarction (MI) and severe depression can be the presenting symptom of pancreatic cancer for some reason.

Investigations

Complete blood tests similar to those for a dementia screen i.e. glucose (or HbA1c), U&Es, eGFR, FBC, TFTs and LFTs. If an infection seems likely further investigation should be guided by likely diagnosis and may include a urine test or a chest x-ray.

Indications for referral to specialist and older adult mental health services

- Psychotic symptoms.
- Loss of appetite; if severe and rapid, get the person checked out by a geriatrician first.
- Suspicion of underlying cognitive impairment (and one antidepressant not effective).
- Depression where:
 - two antidepressants (ideally of two different classes) have not been effective or tolerated;
 - there is a history of hyponatraemia;
 - there is prominent suicidal ideation.
- If you are not sure or if you are worried, if the family are worried and cannot be reassured.
- If there is diagnostic difficulty.
- If you think they need an urgent assessment under the [Mental Health Act \(1983\)](#)².
- Safeguarding concerns.
- Capacity issues are tricky, and referring for a MCA assessment might be worthwhile. However, remember that a capacity assessment can be done by any professional, not just a specialist. The critical thing is to ensure that it is specific to each occasion and each decision, rather than a generic judgement i.e. any capacity assessment is decision, date and time specific.

Prescribing

The general rule ‘start low, go slow’ applies to the prescription of psychotropic medications in older people. 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.

In general, do your best to avoid:

² <http://www.legislation.gov.uk/ukpga/1983/20/contents>

- Alpha-adrenoceptor blockers, drugs with anticholinergic side effects (possible increased risk of dementia and increased risk of delirium).
- Antipsychotics in people with dementia (increased mortality).
- Very sedative medications (unless some sedation would be advantageous).
- Drugs with a long half-life, and potent liver enzyme inhibitors such as erythromycin, allopurinol or omeprazole.

If a drug is poorly tolerated or not working, consider switching.

Key points:

- 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.

4. Depression

Depression is the most common mental disorder in older people. However, symptoms can be distinctly different to depression in young adults, and it is often missed. The risk factors for depression include physical health problems, female gender, loneliness, life events (particularly bereavement) and loss of independence.

Symptoms of depression

Older adults can present with the same symptoms as younger adults: Core symptoms (low mood, reduced enjoyment, lack of energy), psychological symptoms (low self-esteem, hopelessness/guilt, suicidal thoughts), and biological symptoms (reduced appetite, weight loss, feeling lower in morning, early wakening, reduced sleep, poor concentration, agitation or slowness).

Certain symptoms are more common in older adults and might be the only presenting features:

- Reporting physical rather than emotional symptoms (somatisation). Typical symptoms are: faintness or dizziness, pain, weakness all over, heavy limbs, lump in throat, constipation.
- Health anxieties (hypochondriasis), especially if unusual for the person.
- Prominent anxiety.
- Unusual behaviour. Hysteria does not exist in older people.
- Slowing-down of emotional reactions or agitation.

- Psychotic features (delusions of guilt, poverty or physical illness, or having no clothes which fit. Auditory hallucinations with derogatory or obscene content, provoking guilt and paranoia).

A sensitive indicator for the diagnosis of depression includes lacking interest in something previously enjoyed. A measure of the severity of that depression is to ask if people enjoy visits from their grandchildren. People who don't, tend to be very depressed.

Mood congruent delusions are present in psychotic depression. These are delusions reflecting the person's low mood- such as ideas of poverty, having no clothes which fit, of impending death, or Cotard's syndrome (where a person feels that their insides are dead). Ask if people deserve the content of their delusions. If they say yes, they might well be depressed. Sometimes the presentation of depression can be atypical, many people will be familiar with what we used to call amitriptyline deficiency syndrome (sertraline deficiency syndrome would be the obvious modern equivalent).

Distinguishing Depression and Dementia

Difficulties in concentration and memory are common features of depression in older people, making it difficult at times to rule out dementia. Pointers towards it being depression include: having mood symptoms, sudden onset, saying 'don't know' in cognitive testing, difficulties with effortful cognitive tasks (months of the year backwards, counting back from 20 to 1), remembering items with cues and asking for help. Speech and word-finding difficulties are suggestive of dementia rather than depression. If in doubt, trial an antidepressant for 6 weeks and investigate for dementia if cognitive problems persist.

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. Risk factors include: 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).

Bereavement

Normal bereavement reactions encompass many distressing symptoms including emotional numbness, intense pangs of grief, guilt, hallucinations of the deceased person and a feeling of inner restlessness. Usually these symptoms fade over six months; if they continue in an intense form after this time, the bereaved might need counselling or support from IAPT or CRUSE. The distinction between normal grief and depression can be difficult. In general, people who cannot experience pleasure, who have more generalised guilt (i.e. not just related to their care of the deceased person), or who have suicidal thoughts, probably need treatment for depression. Benzodiazepines are best avoided apart from for very short-term treatment of acute

distress after bereavement. Guidance on sleep hygiene, healthy eating and exercise is useful for all those who are bereaved.

Drug treatment

Selective Serotonin Re-Uptake Inhibitors (SSRIs) or mirtazapine are preferred first line agents. Sertraline and mirtazapine are safer in cardiovascular disease and are therefore often used in older people ([Table 1](#)). Mirtazapine can be helpful to aid sleep as it is sedative and it can increase appetite if weight loss is a particular issue.

In general, start at a low dose and increase gradually (steps of one or two weeks). In older people antidepressants should be trialled for longer (two to three months) with a longer period of maintenance treatment after recovery (at least two years, or life-long if the depression has been very severe). If there are difficulties in swallowing, alternative formulations may be helpful – trazodone liquid is very expensive, mirtazapine oro-dispersible less so. If one antidepressant is neither tolerated nor effective and a switch is necessary, cross-taper cautiously while introducing the new agent at a low dose (this applies only to agents listed in this publication). An example of cross tapering is given below.

		Week 1	Week 2	Week 3	Week 4
Withdrawing citalopram	20mg od	10mg OD	5mg OD	Nil	Nil
Introducing mirtazapine	Nil	15mg OD	30mg OD	30mg OD	45mg OD (if required)

Main side effects are hyponatraemia, nausea, insomnia and an increased risk of gastric bleeding (particularly for people over 80 years old, consider gastricprotection with a ppi such as omeprazole in patients who are also taking aspirin). Non-steroidal anti-inflammatory drugs should only be used with caution and for short courses in older people.

Table 1: Drugs for depression and anxiety

Drug	Drug class	Starting dose	Maintenance dose	Maximum dose
Citalopram	Selective serotonin re-uptake inhibitor (SSRI)	10mg OM	10-20mg OM	20mg OM
Sertraline	Selective Serotonin Re-Uptake Inhibitor (SSRI)	25-50mg OM (25mg can be increased to 50mg after 1 week)	50-100mg OM	100mg (occasionally up 150mg OM)
Mirtazapine	Noradrenergic and specific serotonergic antidepressant (NaSSA)	(7.5mg) 15mg ON	15-30mg ON	45mg ON
Trazodone	Serotonin antagonist and reuptake inhibitor (SARI)	50mg BD	100mg OD – 100mg BD	300mg daily
Venlafaxine	Serotonin-norepinephrine reuptake inhibitor (SNRI) (monitor BP on initiation)	37.5mg OD	37.5mg BD – 75mg BD	112.5mg BD

Venlafaxine causes possible QTc prolongation in overdose, but this is very rare (in contrast to Citalopram, where there is a dose related increase in QTc). It has not been evaluated post-MI or in significant coronary disease, and the general recommendation is to avoid using it for these patients, as it is more likely to be arrhythmogenic. In short, there are no concerns about Venlafaxine in a generally healthy heart, but with prominent heart disease Sertraline and Mirtazapine are drugs of choice. If that doesn't work, refer to secondary care.

If first line treatment has not worked, switch to an antidepressant from another class e.g. try venlafaxine or mirtazapine if an SSRI has not worked.

Hyponatraemia deserves special mention as it is common and is easy to test for. Risk factors include being over 80 years old, being female, previous history of hyponatraemia, reduced renal function and low body weight. Other drugs associated with hyponatraemia include diuretics, NSAIDs, ACE inhibitors, carbamazepine, calcium antagonists and co-morbidities such as diabetes, COPD, hypertension, heart failure and cancer are also linked with this condition. Patients at high risk of

hyponatraemia should be monitored for clinical signs (confusion, nausea, cramps, muscle weakness, oedema, seizures), with regular blood tests (at baseline, after 2 weeks, after 4 weeks, then 3-monthly). If a patient has a history of hyponatraemia, prescribe a different class of antidepressant than the agent that caused the hyponatraemia. If previously untried, prescribe mirtazapine. If mirtazapine is not tolerated or is ineffective, refer for a specialist opinion.

Alternatives to drugs

Social interventions are effective such as day centre attendance, befriending, help to attend religious ceremonies and healthy living or independent living programmes. Exercise is excellent and reducing alcohol (but not to nil) can also help.

Psychological therapies are underused in older people. The perception that older people do less well in psychological therapies is simply not true. Their efficacy in old age, both in group and individual settings, is now well established. They include cognitive behavioural therapy (for depression and anxiety disorders) supportive therapies such as counselling (for bereavement and adjustment to other life problems), problem solving (for mild depression and adjustment disorders), and psychodynamic approaches for longer term problems related to personality. Improving Access to Psychological Therapies (IAPT) treats fewer older people than would be expected. In the following circumstances, consider referring to IAPT if:

- the person has depression and anxiety;
- bereavement difficulties;
- family and relationship / interpersonal difficulties;
- difficulty adjusting to health problems;
- medically unexplained symptoms.

It is always worth asking if the person would like to see a therapist to help with their issues. IAPT services will always triage referrals and check that the person is suitable for their service.

Electroconvulsive Therapy (ECT)

Electroconvulsive Therapy (ECT) is a treatment used in a small number of people with depression, which involves passing a small electrical current through the brain under a general anaesthetic, to induce an epileptic seizure. Although a serious treatment, and one which is rarely needed, ECT can be well tolerated and sometimes life saving for older people. People with psychotic depression, those who have severe agitation or slowing up ("psychomotor retardation") respond better to ECT. It is primarily used in either severe life-threatening depression (e.g. where a patient has stopped eating and drinking) or in treatment-resistant depression. Patients will be under the care of secondary mental health services, and will have been reviewed by an anaesthetist to assess their fitness for an anaesthetic.

ECT is usually given as a course of up to 12 treatments, treatments being given twice

a week, and can be given as a day patient although often patients needing ECT will be too unwell to be treated in the community

Management of depression in frail older people

Physical illness increases both frailty and the risk of depression. Management of physical health needs to be careful, but outcomes among depressed older people with physical illness are equal to those who are physically relatively healthy. Polypharmacy, which is common in this group, leads to difficulties with adherence and a higher risk of interactions and side effects. Underlying pain should be addressed and hydration and nutrition should be optimised. Adequate doses of antidepressants should be used (if tolerated and acceptable biochemistry), and can be administered in orodispersible or liquid form if there are swallowing difficulties.

Key points:

- Depression is the most common mental illness in old age.
- Symptoms can be distinctly different from younger adults, and it is often missed.
- People who say they “don’t know” to questions are likely to be depressed.
- Reporting physical rather than emotional symptoms, along with anxieties (especially health anxieties) are common features.
- Both pharmacological and non-pharmacological measures are highly effective in older people.
- When using antidepressants, one needs to be aware of possible adverse effects as there is risk of gastric bleeding or electrolyte disturbances e.g. hyponatraemia.
- Suicide attempts are usually genuine attempts to die in older people.

Case 1:

A 77-year-old relatively healthy woman attends the GP surgery more frequently than in the past. She reports stomach aches, feeling faint and worries that she might have cancer. This has impaired her sleep and appetite, and she seems preoccupied with these thoughts. When the GP takes a history it emerges that her only daughter moved to Australia recently.

Comment: In older people depression often presents atypically. A focus on physical symptoms (somatication), health and other anxieties can be the main features. Initially it is useful to carry out a thorough examination, to exclude any physical illnesses, but also to establish credibility and trust. The underlying depression needs to be treated, with medication, social measures and psychological therapies.

Case 2:

An 80-year-old nun attends the surgery with a 3-month history of increasing forgetfulness, poor sleep and appetite, lack of confidence and prominent anxiety in social situations. She used to welcome visitors at the convent and answer the phone, but has stopped doing so as she afraid of making a fool of herself. She performs poorly on a primary care cognitive screening tool, whereby she most often answers ‘I

don't know'. She is able to answer the question correctly if given a cue. The accompanying sister asks if this is the beginning of dementia. She further reports that she has a history of depression, and spent some time in the acute hospital about 20 years ago after the antidepressant had 'done something' to her electrolytes.

The GP carries out a set of comprehensive blood tests. After this test comes back normal, without a sign of hyponatraemia, she starts the patient on mirtazapine 15mg nocte, which is titrated up 30mg nocte after 2 weeks. The GP monitors the patient's electrolytes after 2 weeks, 4 weeks, and then 3-monthly. The patient responds slowly to the antidepressant, and when her memory still seems impaired after 6 weeks, the GP considers a referral to the memory service. However, her symptoms improve back to her baseline after 12 weeks, and both the nun and sister consider the referral no longer necessary.

Comment: Distinguishing dementia and depression can be very difficult in older people. Pointers towards depression include other mood symptoms, rather sudden onset, difficulties with effortful cognitive tasks saying 'don't know' rather than confabulating an answer in formal cognitive testing, remembering items with cues, and asking for help. A pragmatic approach would be carrying out a dementia blood screen and a 6-week trial of antidepressants. If this is unsuccessful, a referral to a specialist service would be indicated. This case is complicated by a history of hyponatraemia. Mirtazapine is considered relatively safe in these cases, and can be attempted under careful monitoring of electrolytes. If a trial of Mirtazapine fails, the patient should be referred to specialist services for expert advice.

Case 3:

A 78-year-old woman has a several week history of low mood following the death of her dog. She has further been complaining about a stench in the block of flats and has lost a lot of weight. Her daughter has temporarily moved in with her and requested an urgent home visit from the GP as her mother had stopped talking and eating for 3 days and drinks the bare minimum. The patient refuses all assessment and support. After urgent referral to the community old age mental health team, a Mental Health Act assessment is arranged. She is admitted to a mental health unit, given ECT treatment and is discharged on antidepressant medication.

Comment: Severe depression in older people presents more frequently with psychotic symptoms (delusions guilt, feeling already dead), retardation, agitation and poor food and fluid intake. Often a favourable response to ECT is seen.

5. Anxiety disorders

In primary care, anxiety disorders are very common in older people (most often coupled with a life-long history of anxiety which the factors associated with ageing may not have helped, or, in consort with depression). However, it is much less common to see a disorder as a new presentation with anxiety as the primary diagnosis. Anxiety can be a presenting feature of dementia, depression, and physical illness, and should always prompt investigations to exclude any underlying medical

cause (especially new onset anxiety and panic disorder). Common causes are myocardial infarction, arrhythmia, thyroid disorders and vitamin deficiencies ([Appendix 1](#)). On the other hand, symptoms of anxiety can also be mistaken as signs of physical illness (see [Appendix 1](#)).

Treatment

Psychological treatments are the mainstay of therapy in anxiety disorders, and cognitive and behavioural approaches are the ones most commonly used. They are effective in older people, although less so if the anxiety disorder is long-term (anxious personality or generalised anxiety disorder) despite possible difficulties with sensory impairment, mobility, memory or physical ill health.

Often the addition of medication, especially in the initial stages, is necessary. First line treatments are usually SSRIS (see [Table 1](#)). Venlafaxine or mirtazapine can be used as second line treatments. These can be supported by short-term hypnotics, especially if sleep is disturbed, but be very careful, especially if the person has a life-long anxiety/personality disorder or there is any history of substance misuse (e.g. long-term use of nitrazepam in middle age). For hypnotics (see [Table 3](#)) the risk, benefits and pharmacokinetics need to be considered. Longer acting Benzodiazepines (e.g. Diazepam) have a tendency to accumulate in older people and lead to toxicity (sedation, cognitive problems, gait disturbances, falls, delirium), while shorter acting Benzodiazepines (e.g. Lorazepam) carry a higher risk of dependency.

Pregabalin has the advantage of being renally excreted which is beneficial in older people with polypharmacy. Cases of abuse have been described in the literature and when stopping, gradual withdrawal is recommended. It probably has a better side effect profile regarding cognition than benzodiazepines.

The amitriptyline issue is trickier. Despite its wide-spread use, there is no research on this (doxepin had a few studies, showing good tolerability, efficacy and lack of adverse events). At lower doses (10-25 mg) amitriptyline is probably acting mostly as a histamine H1 receptor antagonist, although a degree of 5HT2 and cholinergic muscarinic antagonism might also contribute. The British Association for Psychopharmacology recommends: "[Use drugs according to a knowledge of pharmacology. Consider antidepressants when there is coexistent mood disorder but then use at therapeutic doses. Beware toxicity of tricyclic antidepressants in overdose even when low unit doses prescribed.](#)"³ While no-one would argue with that, sometimes clinical judgement can be helpful and there is no doubt that when carefully and judiciously used, amitriptyline may be useful, although it is associated with falls and cardiovascular side effects.

Patients with anxiety disorders, whose condition does not respond to primary care psychological support or two antidepressants, should be referred to specialist services. The same applies if there is a suspicion of an underlying dementia.

³ http://www.nwcscnseate.nhs.uk/files/1614/5632/9499/Insomnia_literature_review - Jan_2012.pdf - p.34

Insomnia

Lack of sleep is a common complaint amongst older people. It can be idiopathic, but an underlying mental (typically depression, anxiety) or physical illness (typically pain, urinary problems) needs to be ruled out. Older people generally need less sleep than younger adults (in 60s/70s about 6 hours, in 80s/90s about 5 hours).

Prescription of hypnotics should only be initiated after a trial of improved sleep hygiene, and should not last more than four weeks. Sleep hygiene measures can be important. NHS Choices has an excellent guide.

Table 2: Hypnotics and anti-anxiety medications

Drug	Indication	Starting Dose	Maintenance dose	Maximum dose in elderly
Diazepam	Agitation / short-term use for anxiety (up to 4 weeks)	1mg TDS		6mg/day
Lorazepam	Anxiety – only use prn / short-term (up to 4 weeks)	0.5mg OD	0.5-2mg OD	2mg OD
Melatonin	Insomnia – short-term use (up to 13 weeks)	2mg (modified release) OD (1-2 hours before bedtime)		
Pregabalin	Generalised anxiety disorder	25mg BD (increase by 25mg BD weekly, up to 75mg BD, if healthy and normal renal function)	150mg daily	150-300mg daily (if healthy and normal renal function)
Propranolol	Autonomic symptoms of anxiety (e.g. palpitations)	10mg BD		Up to 20mg TDS
Zopiclone	Insomnia (short-term use only – up to 4 weeks)	3.75mg ON	3.75-7.5mg ON	7.5mg ON

Key points:

- Anxiety disorders are uncommon arising de novo in older people and can frequently be features of depression or early dementia.
- Underlying physical causes are common; and symptoms of anxiety can be mistaken as physical illness.
- Psychological therapies are the mainstay of therapy.
- A prescription of antidepressants is often necessary.

Case 4:

An 85-year-old retired archaeology professor attends the surgery with his wife. He has a history of cardiac bypass surgery, heart failure and arthritis. Over the course of the last year he has started to worry about several things, including finances and his health. This is also affecting his sleep and appetite and has led to him shying away from social functions and receiving visitors. His wife further complains about his lack of initiative and motivation. On cognitive testing he doesn't lose any points on a brief screening tool, nor on the longer Mini Mental State Examination. After a comprehensive blood test and check of his cardiac parameters, the GP starts him on Sertraline 50mg mane, which is increased to 75mg after 2 weeks and 100mg after 4 weeks. The patient's symptoms, mainly his sleep and appetite, improve under antidepressant therapy, but he remains very anxious and preoccupied with his worries. The GP cross-titrates him on Mirtazapine up 45mg nocte and arranges psychological therapy via IAPT. Things seem to settle, but after several months his wife attends complaining about residual anxiety and lack of engagement. The therapy report from IAPT indicates that the patient often lacked concentration to complete the therapy tasks. The GP refers the patient to the community mental health team. After an in-depth neuropsychological assessment and an MRI scan, he is diagnosed with dementia in Alzheimer's disease.

Comment: In old age, anxiety disorders are uncommon as a primary diagnosis. However, anxiety symptoms are frequently due to underlying depression or can be the harbinger of dementia. Further, anxiety can be caused by worsening physical health (e.g. arrhythmias). Mainstays of therapy are psychological treatments, but co-prescription of antidepressants might be necessary in older people, to tackle depressive symptoms and enable engagement. Any common mental disorder that is resistant to treatment raises the suspicion of an underlying dementia.

6. Bipolar affective disorder

New onset bipolar affective disorder or mania is far less common in older age. If older people present with symptoms of mania (elevated mood, over-activity, sleeplessness, irritability, excessive spending, confusion) there should always be a strong suspicion of an underlying physical cause for the symptoms (see [Appendix 1](#)), especially if there is no history of mood disorder. Manic episodes are often directly followed by depressive episodes, highlighting the importance of continued adherence to mood stabilising medication.

If patients present to primary care with symptoms of mania or hypomania, short-term prescription of hypnotics (see [Table 3](#)) can be initiated, followed by a referral to specialist care. The two roles of primary care are ruling out underlying organic causes (and referral to specialist care) and monitoring mood stabilising medication (especially Lithium).

Lithium Monitoring

Lithium has a narrow therapeutic window. Therefore, lithium levels need to be monitored to detect toxicity (diarrhoea, vomiting, coarse tremor, confusion, convulsion which can lead to death). Lithium toxicity warrants discontinuation and urgent investigation

The main factors influencing lithium levels are dehydration and polypharmacy. Unpredictable Lithium dose increases (up to 4 fold) are reported with:

- ACE inhibitors / A2 blockers (develops over weeks).
- Thiazides (develops over days) – loop diuretics are safer.
- NSAIDs (develops over days to months) - these have a very unpredictable and sometimes dramatic effect on lithium levels and are best avoided with lithium unless absolutely necessary.

These medications can still be prescribed, but at stable doses (not prn) and under close lithium level monitoring. Seek specialist psychiatric or pharmacist advice if prescribing these drugs with lithium.

At normal levels, long-term lithium use can cause hypothyroidism and reduce renal function. If either of these occur, contact the Community Mental Health Team for advice.

To detect toxicity and adverse effects (on thyroid and kidney), regular monitoring is necessary (see [Table 3](#)).

Table 3: Lithium monitoring

Test	Frequency	Notes
Plasma Lithium level	Every 3 months	Bloods to be taken 12 hours after last dose (0.4 mmol/L might be effective in unipolar depression; 0.6-0.8 mmol/L in bipolar illness in elderly). If stopping; reduce slowly over at least 1 month; avoid incremental plasma level reductions of >0.2 mmol/L.
U&Es (e-GFR), TFTs, Calcium, FBC	Every 3 months	

Key points:

- New onset bipolar affective disorder/mania is uncommon in old age. Investigating for an underlying physical cause is of utmost importance.
- In the case of mania in a patient with a history of bipolar affective disorder, or recurrent depression, start a hypnotic and refer them to specialist services.
- Patients on lithium need 3-monthly blood tests (to detect toxicity and adverse effects on thyroid or kidney function).

Case 5:

An 82-year-old woman with a history of several depressive episodes has recently changed. She is now very irritable, incontinent, and has hardly slept for 2 weeks. Her husband is exhausted. When wandering around the block about two nights ago, she fell, injuring her hip and head. Although chair-bound now, she declines any assistance. The GP carries out a home visit, but she only allows a superficial examination. The GP gets the impression that her hip might be fractured and she might be developing pneumonia. As she is not amenable to any lifesaving intervention, the GP contacts the community old age mental health team to enquire about the possibility of using the Mental Health Act (1983) in this case. The team advises that the use of the Mental Capacity Act (2005) is most appropriate, to convey the patient to hospital in their best interest. After some discussion the ambulance crew takes the patient to the acute hospital where both her fracture and pneumonia are treated. High dose oral steroids for her rheumatoid arthritis are stopped. The mental health liaison team get involved, make a diagnosis of bipolar affective disorder and start the patient on Olanzapine and Lithium. On discharge Olanzapine is stopped, but the patient remains on Lithium with the GP carrying out 3-monthly checks of her thyroid and renal function, as well as her Lithium level (which varies between 0.4-0.7 mmol/L). Following the death of her husband, the patient moves into a care home. The patient is then discharged from the community mental health team, but the GP continues the Lithium monitoring. When her kidney function starts to decline, the GP seeks advice from specialist mental health service regarding Lithium discontinuation and further need for mood stabilisation.

Comment: New onset bipolar affective disorder is relatively rare in old age, and usually presents in patients with a history of recurrent depression. In mania, physical causes and medication side effects need to be ruled out. If a patient presents with a life-threatening condition, declines transport to hospital, and lacks capacity, a best interest decision should be made under the [Mental Capacity Act \(2005\)](#)⁴. GPs have a crucial role in monitoring patients on Lithium for acute and chronic toxicity.

⁴ www.legislation.gov.uk/ukpga/2005/9/pdfs/ukpga_20050009_en.pdf

7. Psychotic disorders

Patients presenting with psychosis can be suffering from a long-standing psychotic illness (chronic schizophrenia, schizoaffective disorder, delusional disorder), a mood disorder (commonly psychotic depression; bipolar affective disorder), early dementia, or a primary psychotic illness in the form of a late-onset schizophrenia (also called paraphrenia or very-late onset schizophrenia-like psychosis). As in all psychiatric disorders, physical causes (especially delirium) and medication side effects need to be ruled out in older adults presenting with psychotic symptoms (see [Appendix 1](#)).

Late-onset schizophrenia

The risk factors for developing late-onset schizophrenia are: female gender, social isolation and sensory impairments (sight, hearing). Many patients have a history of poor adjustment and an unusual personality (paranoia, no interest in social relationships, secretiveness, restricted expression of emotions). Late-onset schizophrenia does usually not progress to dementia and patients perform normally in cognitive testing. Cognitive problems (such as not being able to recall three items) point toward dementia. About a fifth of patients with schizophrenia present with a single, but persistent delusion, which might have been present most of their life.

Symptoms

The most common symptoms are persecutory delusions and auditory hallucinations, whose themes are often intertwined. They frequently involve neighbours (e.g. spying, causing annoyance, infestation or using black magic and wanting them out of their property), and are at times accompanied by so-called partition delusions (i.e. a person or object passes through an impermeable barrier such as a walls). A good general question to inquire for psychosis is “Does your imagination ever play tricks on you?” (Also refer to the earlier section on [Mental State Examination](#)).

About a fifth of older adults with late onset psychosis suffer from visual, tactile or olfactory hallucinations, much more commonly than in younger adults. However, it is rare to have thought disorder, negative symptoms (i.e. deficits in emotional response and motivation) or catatonia. If these are present, there should be a strong suspicion of dementia or other underlying brain damage (e.g. stroke or neoplasm).

If a patient presents with visual hallucinations, the following should be considered:

- Delirium (especially if the hallucinations are frightening);
- Lewy body dementia;
- Anti-Parkinson drugs (used in treating Parkinson's disease);
- [Charles Bonnet syndrome](#) (see below).

Treatment

Although risks are often not high enough to warrant use of the Mental Health Act (1983), the patients suffering is undeniable. A therapeutic alliance is crucial; however it is frequently left unestablished by specialist mental health services, due to the refusal of the patient to accept treatment. In this situation the GP often has a pivotal role as mediator and facilitator. It is important to exclude organic causes (physical illness, medication side effects, dementia), to correct any sensory deficits (hearing aid, ear wax removal, glasses if required) and to address social isolation (day centre, care package can be helpful). Psychological approaches (cognitive behavioural therapy, counselling) can alleviate distress, but are often declined.

Treatment with low dose antipsychotics (see [Table 4](#)) is often necessary, but older people are very sensitive to adverse effects and often the patient declines to take them. It would be rare for a GP to initiate anything other than short-term treatment with antipsychotics.

Table 4: Antipsychotics for psychosis in later life

Drug	Starting dose	Maintenance dose	Maximum dose in elderly
Amisulpride	25-50mg daily	50-100mg daily	200mg daily (caution > 100mg daily)
Risperidone	0.5mg daily	1mg daily	2mg daily
Aripiprazole	5mg OM (takes 2 weeks to reach therapeutic blood level)	5-15mg daily	20mg OM

Physical health monitoring

All patients prescribed antipsychotics should have the following tests at baseline, after 3 months and annually:

- blood pressure, pulse, weight;
- blood tests - fasting glucose (or HbA1c), U&Es including eGFR, FBC and LFTs;
- ECG; and
- Monitoring for motor side effects (tremor, rigidity, restlessness, tongue and mouth movements).

Indications for referral

Older people with persistent psychotic symptoms should be assessed by specialist mental health services. However, this is often declined with patients preferring the established relationships with their GPs. A joint visit or joint assessment in the GP surgery with the specialist mental health team, most helpfully a CPN, can be beneficial. If possible, following an investigation, a low-dose prescription of an antipsychotic and non-pharmacological measures (to correct sensory deficit refer to a day centre, or for social input refer for counselling) can be attempted.

GPs play a pivotal role in the monitoring for adverse effects of antipsychotics in those taking the medication and should ensure that the above physical health checks are carried out annually. If the person in question has a long history of mental illness and is on antipsychotics it would be worth referring them to the specialist team. If they are experiencing increased psychotic symptoms or significant side effects from the medication there might be more recent, suitable treatments available.

If you want to stop a patient's antipsychotic (which they have been on for a long time) it is important to do a thorough risk–benefit analysis first, and ask for advice from a specialist. In particular, you should seek advice if they are on depot medication as the dose needs to be decreased very slowly. If the antipsychotic is stopped and the person relapses it can often be more difficult to find the right dose again for them, so it is important to regularly review the person's mental state to pick up any early signs of relapse.

Key points:

- Psychotic symptoms in older people are often in the context of physical illness (delirium), depression, in patients with long-standing schizophrenia or harbingers of dementia.
- Late-onset schizophrenia is uncommon, but often specialist mental health services are not able to engage the patients until a crisis is reached.
- Prescription of low dose antipsychotics can be helpful and probably more readily accepted if instigated by a well regarded GP with specialist advice.
- All patients prescribed antipsychotics need an annual physical health check.

Case 6:

A 76-year-old woman is relatively healthy and only suffers from impaired hearing and arthritis. She attends the surgery because of 'problems with her joints'. During the consultation the lady mentions that those deformities have been caused by her neighbours, and starts a long monologue about the antisocial behaviours she is experiencing. It further emerges that she had moved to her current address after difficulties with her neighbours in a previous residence. The patient was never married, and her main social contact is her niece who visits once per week. The patient does not want a referral to mental health services, but agrees to counselling to vent her frustrations. After four sessions the therapist feeds back that the patient's beliefs are too fixed to be amenable to psychological treatment at this stage, and recommends referral to specialist care. While the patient engages with repeated assessments, venting frustrations and demanding help with finding alternative

accommodation, she doesn't allow treatment or follow-up. The patient presents with delusions and auditory hallucinations around her neighbours, as well as olfactory hallucinations, but no cognitive impairment. The community mental health team concludes that she suffers from late-onset schizophrenia. Although there is clear distress and suffering, no risks to herself, others or her health can be identified. Following discussion with specialist care the GP initiates a prescription of Amisulpride 50mg nocte (in this case titration is decided against due to risk of worsening compliance if drug doses are changed) to help the patient tackle the 'stress caused by the experience'. Over the coming weeks the patient's distress and preoccupation lessen substantially. Although she remains concerned about her neighbours, this doesn't seem to affect her functioning. She further agrees to get a new hearing aid and to attend a day centre twice per week.

Comment: Female gender, social isolation and sensory impairment are typical risk factors for late-onset schizophrenia. Symptomatology usually involves commonplace themes, most frequently neighbours. The paranoia is often very fixed, and specialist mental health services struggle to engage these patients. Culturally patients trust their GPs, and they might be in the best position to negotiate the prescription of low dose antipsychotics. All patients prescribed antipsychotic medication need an annual physical health screen and ECG (if possible).

Case 7:

A 69-year-old man with a history of schizophrenia since his late teens resides in a nursing home. About 4 years ago he was admitted to a psychiatric ward due to severe self-neglect and then was discharged to the nursing home. He settled in well and keeps to himself. When pressed he reports that an epic battle is going on in which he has a crucial role, but rarely expresses any distress. He needs prompting with his self-care, smokes heavily, but is compliant with all oral medications. The community mental health team has therefore changed his depot medication to Risperidone 2mg BD and discharged him back to primary care. The GP carries out a comprehensive annual physical health check and monitors his cognition. The GP also monitors for side effects from the Risperidone.

Comment: In patients with life-long schizophrenia, negative symptoms (social withdrawal, lack of motivation, poverty of thought and speed) tend to dominate the clinical picture when they grow older. This often necessitates admission to residential care. In these settings patients can often be treated with oral medication and there is no longer a need for involvement of specialist mental health services. While antipsychotic medication often remains unchanged over years, regular assessment of physical health, motor or cognitive status is necessary. If these patients develop dementia, there is often a higher benefit in continuing antipsychotic medication, despite higher risks of stroke and death in dementia populations.

Case 8

An 82-year-old lady has become paranoid over the last few weeks and her son has come to see you. He is very concerned about his mother's behaviour saying something must be done. Her son says that she has not eaten now for four days

because of fear that people are trying to harm her .She looks dehydrated and refuses any medical help.

In the notes, there is a mention that the year before she had a transient psychotic episode when she felt her neighbours were trying to poison her. She was assessed by the mental health team but by the time they saw her things had settled. There had been no record of any problems over the last year.

She had had her annual review three months previously and all her blood tests were normal and there was nothing to suggest that she was developing a dementia. When seen, she was very appropriate in her manner and behaviour and there was nothing to suggest any self-neglect.

Comment: This lady needs to be assessed as a matter of urgency and an urgent home visit by one of the primary care team is indicated. Assuming that there is no obvious cause for her paranoia and that she is psychotic, there should be an assessment to see if detention under the Mental Health Act (1983) is needed. An urgent referral to the local community mental health team is the most appropriate course of action.

8. Delirium

GPs will be readily familiar with episodes of delirium in their older patients. Some keys points about delirium are:

- Delirium is an acute illness onset, starting and often (but not always) finishing abruptly. Dementia is chronic brain failure, delirium is acute brain failure.
- Delirium is a medical emergency.
- Delirium is always due to a physical cause even if you cannot find it. Consider, if it's not below the neck it's above the neck. Also, check the temporal relationship with medication prescriptions.
- 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.
- Dementia is a common accompaniment to delirium. People with dementia are 30 times more likely to become delirious than those without dementia.
- Successive episodes of delirium characteristically lead to deterioration in cognition. Family members often say that people recover but never quite back to how they were before.

- Management of delirium consists of treatment of the underlying medical condition with, if necessary, medication to help alleviate symptoms of agitation or hallucinations (NICE suggest low dose haloperidol, start at 0.5mg, up to 2mg a day or olanzapine 2.5mg to 5mg). Use with caution in Parkinson's disease.
- Be aware of hypo-alert delirium (characterised by withdrawal and apathy), which can be easily missed compared to the usual florid positive symptoms displayed.

9. Charles Bonnet syndrome

Complex visual hallucinations can occur due to visual impairment (especially macular degeneration; more likely if both eyes are affected). Hallucinations often appear unannounced and can last from seconds to days. They can be simple unformed shapes, and range to seeing faces, animals or people. Response to hallucinations differs from patient to patient; they can be frightening or enjoyable. Insight is usually preserved and patients' main worry is that they are suffering from dementia or another mental illness. Offering explanations for the phenomena can provide relief. Simple techniques to make hallucinations disappear are: increasing the lighting, distracting oneself, shutting one's eyes or looking away from the image or repeatedly looking back and forth between two imagined points on a wall. If distress continues, SSRIs have offered some benefit in case reports.

Patients need to be monitored closely, as visual hallucinations can be the harbinger of dementia, particularly dementia with Lewy bodies.

There is an auditory equivalent of Charles Bonnet syndrome where people with deafness experience musical or other auditory hallucinations. Again, distraction such as increasing activity is the treatment of choice.

Key points:

- Sensory deprivation can cause hallucinations. Correction of the impairment usually lessens the experience. If this is not possible, explanation of the phenomena can offer relief.
- Visual hallucinations can be a first sign of dementia (esp. Lewy body pathology).

10. Alcohol

In old age, tolerance for alcohol decreases, leading to greater risk of intoxication. Physical ill health and polypharmacy are common and increase the risk of adverse effects.

Although some older people tend to reduce their alcohol intake and abstinence is frequent, the new generation of baby boomers in their 60s brings a more tolerant attitude to alcohol and more alcohol-related problems. Drinking may increase in old age, often precipitated by psychosocial factors (including bereavement, retirement, boredom, and loneliness), physical or mental illness or memory difficulties. Late-onset substance misuse is more likely to be mild and responsive to brief efforts encouraging reduction or abstinence.

Alcohol misuse is much harder to detect in older people, as it is obscured by non-specific illnesses and conditions such as gastrointestinal problems and insomnia, or misdiagnosed as dementia or depression. Clinicians should be aware of patients with inconsistencies and contradictions in history and presentation, with unexplained ups and downs and those repeatedly doing well in hospital and badly at home.

Management strategies

Addressing the practical problems, which caused the alcohol dependence, can have a large impact in this patient population. This means active management of physical health problems (e.g. pain, mobility) is needed in addition to encouragement to engage in non-drinking social activities, such as day centre attendance or a move to higher supported accommodation. The counselling of older people needs to be based on assessment and each person's needs should be matched to the range of treatment and services available.

Key points:

- Alcohol abuse is less common in older people, but increasing.
- It can be missed if not considered.
- It is very important to address underlying practical physical and mental health problems.
- Older people are more likely to be motivated to abstain when compared with younger adults.

Case 9:

The practice nurse draws the GPs attention to a 72-year-old man who has been a regular attender at the surgery with COPD. His wife passed away about nine months ago and he hasn't attended since then. The GP arranges a home visit and finds the patient's flat in an untidy, but not squalid condition. He reports that his daughter, who lives 100 miles away, visits about once per month to help with cleaning and shopping. The GP notes a large amount of empty wine bottles in the patient's garden. The patient smells of alcohol and appears breathless. He states that he has become very socially isolated following the death of his wife and started drinking increasing amounts of cheap wine. He reports that he ran out of his inhalers several weeks ago. Although his mobility is poor, he can still attend the corner shop to buy a newspaper, sandwich and a bottle of wine every day. The GP contacts social services. A care package is arranged, including assistance with cleaning and shopping and making sure that the patient has enough supply of medication. He is

offered counselling from the local drug and alcohol service. Once his breathlessness is addressed, the patient feels better and agrees to a referral to a day centre. He later decides to move into sheltered accommodation.

Comment: Alcohol problems are relatively uncommon in older people, but often missed. Prognosis is better if practical physical and mental health problems are addressed.

11. Personality problems

With advancing age some personality traits can become more pronounced, (especially rigidity, introversion, cautiousness and obsessions) while others such as psychopathy and emotionally unstable ('borderline') personality disorders can ameliorate. Life events, especially the loss of a supportive partner, can re-ignite unhelpful coping strategies such as excessive help-seeking, self-harm, and requests for sedatives. Regular reviews with (where possible) a single practitioner in primary care and clear boundaries, especially about the prescription of inappropriate drugs, are important.

Personality changes of a relatively sudden onset coupled with increased self-centredness and rigidity need to be investigated for underlying organic causes such as frontal lobe dementia.

12. Hoarding disorder and Diogenes syndrome

Named after the philosopher Diogenes (who lived in a barrel), this relatively rare syndrome describes an aggravation of eccentric and aloof / reclusive personalities, leading to isolation, severe self-neglect, extreme hoarding and squalid living condition. The preferred term (coded in DSM-V) for people who hoard objects is 'hoarding disorder'. Hoarding and squalor can be due to dementia, frontal lobe damage from a stroke, depression, OCD and chronic schizophrenia. Many however do not have an additional psychiatric disorder and there is often a resistance to accept help. Research has shown that a cognitive behavioural treatment can be helpful for people who hoard, although this isn't available everywhere.

In this patient group it is worth seeking a specialist opinion as to whether there is an underlying treatable disorder, to ascertain whether the person might be amenable to CBT or more practical measures (e.g. accepting a clean-up done by a care agency or council). In cases of high risk (e.g. fire or infestation) use of the Mental Health Act (1983) might be necessary to resolve the situation.

Key points:

- Relatively sudden personality changes need to be investigated for dementia and other organic illnesses.
- If older people self-neglect and/or live in squalid conditions a mental illness might not be immediately apparent.
- Following the introduction of the [2014 Care Act](#)⁵, self-neglect should be considered as a reason to think about making a safeguarding referral.
-

Case 10:

A 71 year-old retired librarian is brought to the attention of a GP by social services. He has never married and has lived in his council flat for almost 40 years, initially with his mother until she passed away 10 years ago. No known family exists.

Following complaints about a smell from his neighbours, the housing officer inspected his flat, finding hoarded newspapers, rotting food, dead rodents and excrements. The patient presents with signs of self-neglect, having uncut hair and nails, and he expressed surprise at the state he had got himself into. He is reluctant to accept any help or leave his flat. He is eventually admitted to a mental health unit under Section 2 of the Mental Health Act (1983) for assessment. Although he is started on an antidepressant, no clear psychiatric diagnosis can be established and he is discharged to sheltered accommodation.

Comment: The so-called Diogenes syndrome can be seen as an exaggeration of unusual reclusive personality traits in old age. This leads to extreme self-neglect and living in domestic squalor, with limited insight into their situation. Although there might not be an immediately apparent mental illness, using the powers of the Mental Health Act (1983) might be necessary to resolve the situation. Respectful, timely engagement, interventions delivered as part of an ongoing relationship and support relevant to the individual are the factors judged by patients to be the most important factors in a successful intervention. In less severe cases CBT might be effective.

⁵ <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

13. Elder abuse

Abuse can be due to acts of commission (physical, sexual, verbal or emotional abuse; financial exploitation) or omission (e.g. neglect such as withholding food or ignoring cries for help). In older people the risk is similar across gender, age and socioeconomic status. Domestic abuse is known to be underreported. The most common forms are verbal abuse and financial exploitation by family members, as well as physical abuse by spouses.

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. Reducing social isolation is the most important prevention strategy.

Key points:

- 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.
- A GP's role in safeguarding is to be alert to signs of abuse and discuss suspicions with the local safeguarding team, generally via the social services duty desk.

Appendices

Appendix 1: Psychiatric presentations resulting from physical illnesses and medications

Condition	Physical conditions	Medications
Depression	Brain damage (stroke, neoplasm), Cushing's disease, Huntington's disease, Multiple sclerosis, Hypothyroidism, Vitamin (B,D) deficiency, Parkinson's disease, Angina & Myocardial infarction, Anaemia, Diabetes mellitus, Pain, Malignancy (esp. pancreas, lung), Electrolyte disturbance	Steroids, Anticholinergics, Alcohol
Mania	Brain damage (stroke, neoplasm), Cushing's disease, Huntington's disease, Hyperthyroidism, Multiple sclerosis, Temporal lobe epilepsy, Vitamin (B,D) deficiency, Parkinson's disease	Antiparkinson medication (Dopamine agonists), Steroids, Antidepressants, Alcohol, Caffeine
Anxiety	Brain damage (stroke, neoplasm), Phaeochromocytoma, Huntington's disease, Hyperthyroidism, Parkinson's disease, Heart disease (angina, myocardial infarction, heart failure, arrhythmias), Hypoglycaemia, Lung disease (COPD, pneumonia, pulmonary embolism)	Steroids, Antidepressants, Thyroxine, Anticholinergics, Sympathomimetics, Alcohol, Caffeine
Psychosis	Brain damage (stroke, neoplasm), Cushing's disease, Huntington's disease, Temporal lobe epilepsy, Parkinson's disease, Angina & Myocardial infarction	Antiparkinson medication (Dopamine agonists), Steroids, Alcohol

Geriatric Depression Scale

4-Item Geriatric Depression Scale (GDS-4)

- Are you basically satisfied with your life? Yes / NO
- Do you feel that your life is empty? YES / No
- Are you afraid that something bad is going to happen to you? YES / No
- Do you feel happy most of the time? Yes / NO

(Score 1 for answers in block capitals: 2-4=Depressed, 1=uncertain, 0=Not depressed)

15-Item Geriatric Depression Scale (GDS-15)

- Are you basically satisfied with your life? Yes/NO
- Have you dropped many of your activities and interests? YES/No
- Do you feel that your life is empty? YES/No
- Do you often get bored? YES/No
- Are you in good spirits most of the time? Yes/NO
- Are you afraid that something bad is going to happen to you? YES/No
- Do you feel happy most of the time? Yes/NO
- Do you often feel helpless? YES/No
- Do you prefer to stay at home, rather than go out and do new things? YES/No
- Do you feel you have more problems with memory than most? YES/No
- Do you think it is wonderful to be alive? Yes/NO
- Do you feel pretty worthless the way you are now? YES/No
- Do you feel full of energy? Yes/NO
- Do you feel that your situation is hopeless? YES/No
- Do you think that most people are better off than you are? YES/No

15-Item GDS score

(Score 1 for answers in block capitals: 0-4 normal, 5-9 Mild depression, 10-15 More severe depression)

Screening for depression

The two item questionnaire works in older people.

In the past month, have you:

- Been troubled by feeling down depressed or hopeless?
- Experienced little interest or pleasure in doing things?

“What a GP needs to know about...”

The Mental Health Act (1983)⁶ (MHA)

The MHA is designed to provide a framework to look after people with mental illness (not physical illness) who are refusing treatment.

⁶ www.legislation.gov.uk/ukpga/1983/20/contents

GPs who are not Section 12 approved do not need to know about the MHA in detail. If participating in a MHA assessment you will be supported through the process by an Approved Mental Health Professional (an AMHP, often a social worker) If you are asked by an AMHP to take part in a MHA assessment it is incredibly important to do so if you can. A Section is a major restriction of liberty, and the GPs view can be essential in making a decision based on all the available facts and opinions.

A few commonly used MHA Sections include:

- Section 2 – an assessment order: used to admit someone, where diagnosis and treatment are unclear (e.g. a new presentation), to hospital for up to 28 days.
- Section 3 – a treatment order: usually used for patients well known to services who have been detained before, can be used to detain someone for up to six months, and can be renewed.
- Section 135 – is applied after being approved by court, in order to remove someone from their place of residence to a place of safety (usually a psychiatric hospital), for a full MHA assessment. An example of this might be someone in a state of self-neglect who is refusing entry from agencies to their place of residence.
- Section 136 – the removal of someone from a public place (e.g. a street, or shopping centre) who appears to be suffering from mental illness by the police, to be taken to a place of safety for a full MHA assessment.

How to assess mental capacity

Any capacity assessment is decision and time specific. So if someone asks you to assess a person's mental capacity, your first question should be "what for?"

There are four stages:

- Can the person take in the information required?
- Can they retain it long enough to weigh it up to come to a decision?
- Assuming they can, are they able to weigh it up?
- Can they express it?

The five principles of the Act (ABCDE) can be summarised as:

- A. Assume that capacity is present – the onus is to prove that the person lacks capacity.
- B. Best interests – keep this in mind all the time.
- C. Choose least restrictive method of treatment.
- D. Decisions that are unwise are allowed.

- E. Ensure all steps taken to help maximize a person's ability to take part in a capacity test e.g. quiet room, hearing aids working.

The Care Act⁷

- Introduced in 2014, it placed a duty on local authorities to help individuals with care needs, provide information for them and ensure a range of providers is available.
- Following the act, adult safeguarding has moved up the agenda, particularly elder abuse.
- Health professionals have a duty to be alert to safeguarding concerns, and raise them with the relevant social services team.
- "Abuse" covers physical, sexual, verbal or emotional abuse, and financial exploitation. Sadly, abuse may occasionally be carried out by those who appear to be carers.
- Self-neglect, e.g. Diogenes syndrome, is also covered by the Care Act.

The Deprivation of Liberty Safeguards (DoLS)⁸

- A part of the 2005 Mental Capacity Act which applies when the person lacks capacity.
- In primary care, it is normally applied for in care homes (but it can apply in other settings) and it is where the person is under continuous supervision and control AND is NOT free to leave. The persons' lack of compliance or objection is not taken into account.
- If you think a person is being deprived of their liberty you should tell the managing authority (e.g. a care home) to apply to the supervisory board (a local authority) for a DoLS authorisation.
- In practice, it also means (at the time of writing) that any patient subject to a DoLS who dies should be reported to a coroner. The GP should not issue a death certificate (it is the responsibility of the home, not the GP, to initiate a DoLS).
- Case law has changed the implementation of DoLS, and is subject to review.: Check latest examples on <http://www.ageuk.org.uk/publications/age-uk-information-guides-and-factsheets/>

Power of Attorney

- (Ordinary) power of attorney is when a person with capacity to make such a decision chooses to give someone else authority to act on the persons behalf. It is only valid whilst the person has capacity.
- Lasting Power of Attorney (LPA) covers 2 two areas:
 1. Property and financial affairs (buying/selling properties or paying bills)
 2. Health and welfare (might include medical decisions, social activities)

⁷ <http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted>

⁸ http://www.ageuk.org.uk/Documents/EN-GB/Factsheets/FS62_Deprivation_of_Liberty_Safeguards_fcs.pdf

- LPAs are made when the person has capacity and needs to be registered with the Court of Protection. It comes into effect when the person has lost capacity to manage their affairs.
- LPA replaces the old system of enduring power of attorney.
- LPAs for health and welfare need to be consulted if the person lacks capacity to decide about their medical care.

Brief Summary of NICE guidelines

Depression in adults: recognition and management (NICE Clinical Guideline 90)

- Consider asking people who may have depression two questions:
 - During the last month, have you often been bothered by feeling down, depressed or hopeless?
 - During the last month, have you often been bothered by having little interest or pleasure in doing things?
- Antidepressants should not be offered in new onset mild depression, rather individual guided self-help, (computerized) cognitive behavioural therapy, exercise or a structured group physical activity programme.
- Antidepressants, initially an SSRI, are recommended for moderate to severe depression and dysthymia.
- Antidepressants are not associated with addiction, but patients should be informed about discontinuation (withdrawal) effects.
- Continue medication for at least 6 months after remission of an episode of depression (2 years if at increased risk of relapse).

Psychosis and schizophrenia in adults: prevention and management (NICE Clinical guideline 178)

- For newly diagnosed schizophrenia, offer oral antipsychotic medication. The choice should be made by the patient and health care professional together.
- Offer ECG if specified in product characteristics of antipsychotic, physical exam has identified a cardiovascular risk (e.g. hypertension) or history of cardiovascular disease.
- Do not initiate regular combined antipsychotic medication, except for short periods (for example, when changing medication).
- In the first year after diagnosis, physical health monitoring should be coordinated by the secondary care team.
- GPs and other primary healthcare professionals should monitor the physical health of people with psychosis or schizophrenia when responsibility for monitoring is transferred from secondary care, and then at least annually.

Checks include:

- weight (plotted on a chart);
- waist circumference (done lying down);
- pulse and blood pressure;
- fasting blood glucose, glycosylated haemoglobin (HbA1c), blood lipid profile and prolactin levels;

- assessment of any movement disorders;
- assessment of nutritional status, diet and level of physical activity; and
- smoking cessation and dietary advice might be helpful.

Generalised anxiety disorder and panic disorder in adults: management (NICE Clinical guideline 113)

- Recommends a 'stepped care' approach and treatment of the primary disorder (e.g. depression, substance use) first.
- Psychological therapy should be used as first line therapy whenever possible as it is considered more effective than pharmacotherapy.
- In pharmacotherapy, there is most evidence for SSRIs and sertraline is recommended as first line treatment.
- Panic disorder: encourage CBT-based self-help; don't use benzodiazepines; if SSRI not tolerated or ineffective, imipramine or clomipramine can be used.
- Generalised anxiety disorder: encourage CBT-based self-helper, high – intensity psychological interventions if ineffective; don't use benzodiazepines for more than 2-4 weeks; if SSRI not tolerated or ineffective, SNRI or pregabalin can be used.

Delirium prevention and management (NICE Clinical Guideline 103)

- If symptoms or signs suggest delirium, carry out a clinical assessment such as the short Confusion Assessment Method (short CAM) to confirm the diagnosis.
- In people diagnosed with delirium, identify and manage the possible underlying cause or combination of causes.
- Ensure effective communication and reorientation (for example, explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium.
- Consider involving family, friends and carers to help.
- Provide a suitable care environment.
- If the person is considered a risk to themselves or others and verbal and non-verbal de-escalation techniques are ineffective or inappropriate, consider giving short-term (usually for 1 week or less) haloperidol or olanzapine. Start at the lowest clinically appropriate dose and titrate cautiously according to symptoms.
- Consider delirium.
- Be aware that people in hospital or long-term care might be at risk of delirium.

Local summary of services and phone numbers (*to self-complete*)

Service	Contact details
Mild anxiety/depression <i>IAPT details for referral/self-referral</i>	
Other non-urgent MH issues	
Community Older Adults MH Service	
Primary Care Liaison Service	
Urgent MH Issues <i>i.e. MHA assessment etc.</i>	In hours Out of hours
Social services duty desk <i>i.e. for care packages, Nursing Home assessment etc.</i>	In hours Out of hours
Others, self-complete to act as an <i>aide-memoir</i>	

National services available

Organisation	Contact Details
The Silver Line 24-hour help for older people	Tel: 0800 470 80 90
Mind Advice	Tel: 0300 123 3393 (Infoline: 9am-6pm) Web: http://www.mind.org.uk/information-support/helplines/
NHS Choices <i>Information for patients</i>	Web: http://www.nhs.uk/
Mental Health Foundation <i>Information for patients</i>	Web: https://www.mentalhealth.org.uk/a-to-z/m/mental-health-later-life
Age UK helpline	Tel: 0800 169 2081 Web: http://www.ageuk.org.uk/

Further reading

- Integrated management of depression in the elderly. Edited by Carolyn Chew-Graham, Robert Baldwin and Alistair Burns. Cambridge University Press 2008.
- Mental Health in Older People in Practice. By Alistair Burns, Nitin Purandare and Sarah Craig. Royal Society Press Limited 2002.
- Practical Old Age Psychopharmacology. By Stephen Curran and Roger Bullock. Radcliffe Publishing 2005.
- Geriatric Medicine for Old Age Psychiatrists. By Alistair Burns, Michael Horan, John Clague and Gillian McLean. Taylor and Francis 2006.
- Oxford Handbook of Old Age Psychiatry. Bart Sheehan, Salman Karim and Alistair Burns. Oxford University Press 2011.

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NHS England's mission is to provide health and high quality care for all, now and for future generations. Our role is the commissioning of health services. We empower and support clinical leaders at every level of the NHS, to make genuinely informed decisions and provide high quality services.

NHS Improvement is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority, Patient Safety, the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.
Please contact 0300 311 22 33 or email england.contactus@nhs.net