Geriatric Mental Health
SFDPH Quarterly PCP Meeting

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July 26, 2016
Objectives

• Depression
  – Background, Risk factors
    • Loneliness
  – Complications
  – Screening/Diagnosis
    • Anxiety
    • Suicidality
  – Management
• Late onset psychosis
• Resources
Reflection and Evaluation

• Throughout this talk and workshop, think about how this may impact your work with older adults.

• At the end of this, commit to one change you will make in your practice.

• Fill out our evaluation so we can keep teaching!
Ms. S

71yo African Am F with insomnia, low energy. Mood is “happy”, nml appetite. Memory is “sometimes fuzzy”. Abruptly stopped going to church last year, now rarely leaves home. “I keep thinking about death.”

PMH
- Hx CVA
- Hx SAH after a fall
- DM
- HTN
- Hypothyroid
- Remote hx SA -- no hx
- inpatient psych
- 2010 Neuropsych: mild vascular dementia

SH
- 2yrs college
- Lives alone. DPOA is only friend
- Independent IADL/ADLs
- Was church deaconess/secretary
- No tobacco, EtOH, rec substances

Meds
- Amlodipine
- Atenolol
- Benazepril
- ASA
- Levothyroxine
- MM,
- Vit D
- Diphenhydramine
- TUMS
What’s going on with Ms. S? Is she depressed?
Background

• Depression is not a normal result of aging
• ↑ with institutionalization, chronic illness
  • 1-3% healthy community-dwelling elders
  • 11-45% hospitalized, LTCF, hx CVA, MI, cancer, Parkinson’s, dementia
Complications/Impact

- ↓ Ambulation
- ↑ Falls
- ↓ Function
- Malnutrition
- Higher medical costs
- EtOH/substance abuse
- ↑ Mortality
  - 4x higher post-MI, 3x higher post-CVA
- Suicidality
  - Older adults: higher rate completed suicides
What puts Ms. S at high risk for depression/suicidality?
Ms. S

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Risk Factors

- Loneliness/social isolation
- Female
- Low SES
- LGBT (1.5x)
- Comorbid medical illness
  - CHF, DM, Parkinson’s
  - Vascular dz, CVA, CAD
- Hearing/vision loss
- Psych, substance hx
- Functional impairment
- Cognitive Impairment
- Medications
- Insomnia
- Pain
A Note On Loneliness

• Distinct but tied to social isolation

• High prevalence in SF
  • 29% SF seniors (highest in CA)
  • 60% SF LGBT seniors

• Independent predictor
  • ↓Cognition/function,
    ↑morbidity, ↑mortality
Definitions (DSM-5)

• Unipolar Major Depression (MDD/MDE)
• Persistent depressive disorder (Dysthymia)
• Other Specified Depressive Disorder (Minor/Subsyndromal Depression)
  – Depressed mood + 2-3 sx of MDD
  – More prevalent in older adults
  – ↑ risk of MDD
  – ↑ healthcare use, ↑ disability, ↑ mortality
Geriatric Depression

- Most dx’d older adults don’t meet MDE criteria
- Atypical presentation
  - Anhedonia > sad
  - Anorexia
  - Social withdrawal
  - Cognitive impairment
- Psychotic depression
  - More common in elderly
  - Somatic delusions

Differential Dx

• General medical condition
• Bereavement
• Adjustment disorder
• **Dementia vs “Pseudodementia”**
  – Late-onset depression = prodrome +/- risk factor for dementia
• Delirium
• Primary or secondary psychosis
Screening: Depression

• USPSTF 2016: Grade B
  – Screen adults (including >65) for depression when staff-assisted depression care support in place

• Diagnosis = DSM criteria
Screening: Depression

**PHQ-2** (97% sens, 67% spec)

Positive (≥ 3)

**PHQ-9** (88% sens/spec)

**GDS-5** (94% sens, 81% spec)

Positive (≥ 2)

**GDS-15** (81% sens, 78% spec)
Screening: Depression

• Geriatric Depression Scale (GDS-5)  
  Positive ≥2

1. Are you basically satisfied with your life? (YES/NO)
2. Do you often get bored?
3. Do you often feel helpless?
4. Do you prefer to stay at home rather than going out and doing new things?
5. Do you feel pretty worthless the way you are now?
GDS-15

Over the past week:
1. Are you basically satisfied with your life? (YES / NO)
2. Have you dropped many of your activities and interests?
3. Do you feel that your life is empty?
4. Do you often get bored?
5. Are you in good spirits most of the time?
6. Are you afraid that something bad is going to happen to you?
7. Do you feel happy most of the time?
8. Do you often feel helpless?
9. Do you prefer to stay at home rather than going out and doing new things?
10. Do you feel you have more problems with memory than most?
11. Do you think it is wonderful to be alive now?
12. Do you feel pretty worthless the way you are now?
13. Do you feel full of energy?
14. Do you feel that your situation is hopeless?
15. Do you think that most people are better off than you are?
Screening: Depression

Appendix A
CORNELL SCALE FOR DEPRESSION IN DEMENTIA

Name ____________________________ Age ___________ Sex _______ Date ____________
Address ___________________________ Telephone __________

Inpatient Nursing Home Resident Outpatient

Scoring System

1 = mild or intermittent
0 = absent
2 = severe

Ratings should be based on symptoms and signs occurring during the week prior to interview. No score should be given if symptoms result from physical disability or illness.

A. Mood-Related Signs

1. Anxiety
   anxious expression, ruminations, worrying
   a 0 1 2
Screening: Suicidality

- GDS-SI subscale
  
  3. Do you feel that your life is empty?
  7. Do you feel happy most of the time?
  11. Do you think it is wonderful to be alive?
  12. Do you feel pretty worthless the way you are now?
  14. Do you feel that your situation is hopeless?

- Screen for active SI
  
  “P4”: Past attempt, Plan, Probability, Preventive factors

- Note specific populations
  
  - Veterans: ↑PTSD, firearms
  - LGBT: 39% lifetime prevalence SI
  - Socially isolated/lonely
Screening: Anxiety

• Usually chronic
• If new late-onset, look for secondary cause
• GAD-7  (67-70% sens, 57-90% spec)
  – Validated(ish) in older adults

• Geriatric Anxiety Index (GAI-SF)  (75% sens, 87% spec)
  Positive ≥3

Generally…
– I worry a lot of the time.  (Agree/Disagree)
– Little things bother me a lot.
– I often feel nervous.
– My own thoughts often make me nervous.
Non-Pharmacologic

- CBT, psychotherapy
- Minor depression, Grief, Anxiety
- Tai Chi
- Aerobic exercise
- Light therapy
- Music therapy
- Increased socialization
- Sleep
  - Bidirectional
- Treat impairments
  - Hearing aids/cochlear implants
- ECT (psychotic depression)
Pharmacologic

1st-line

SSRI:
- Citalopram (max 20mg)
- Sertraline
- Escitalopram (max 10mg)
  - Watch QTc, SIADH, UGIB

SNRI:
- Duloxetine
- Venlafaxine XR
- Desvenlafaxine
  - chronic/neuropathic pain, apathy
  - SIADH, GI sx

2nd-line

Mirtazapine
- Sleep, appetite
- Watch SIADH, QTc, anti-Ach

Bupropion (alone/adjunct)
- Parkinson’s, apathy/vascular
- Might ↑ anxiety

Buspirone (anxiety adjunct)
- Trazodone
  - Sleep, SSRI adjunct
  - Watch anti-Ach

Severe, tx-resistant
→ Refer to Psychiatry / Co-mgmt
Pharmacologic - Avoid

- Benzodiazepines
- Hydroxyzine
- TCAs
- MAOI
- Paroxetine, Fluoxetine
- High-dose Gabapentin

*refer to AGS 2015 Beers Criteria for more*
Ms. S, Part Deux

Several SSRI/SNRI trials prove ineffective. You refer Ms. S to an ADHC for socialization, but she never goes.

Subsequent visits:
- Sleeping on couch
- Sounds coming from bedroom, thinks apt manager is entering apt. She calls him an “evil spirit” who tells her, “Little girl, I can do things you can’t even imagine.”
- Reports maintenance man entered her home and ejaculated on her bed.

Denies feeling afraid or unsafe. Denies AVH. Mood is “good”
How do you approach this?
Do you need to call APS?
Ms. S, Part Deux

Home visit: Small pieces of white tape covering every apartment wall “to cover up imperfections” and block noise. Otherwise reassuring, landlord seems reasonable.

You call the DPOA.
- Similar statements for years.
- Left church due to volatility, “inappropriate flirting”
- Hx several antidepressants, antipsychotics
Late-Onset Psychosis – 6 D’s

- Delirium
- Disease
- Drugs
- Dementia
- Depression/affective disorders
- Delusions/Schizophrenia-spectrum
Late-Onset Psychosis

- **Late-Onset Schizophrenia**
  - Hallucinations: Visual, olfactory, tactile
  - Delusions: Persecutory, partition
  - Less formal thought d/o, negative sx
  - ↓ Cognition, ?dementia
  - ↑ Comorbid dz, ↓ life expectancy 20yrs

- **Bipolar Disorder**
  - 2 peaks in life (20-50s, >65yrs)
  - Mania mistaken for BPSD
  - Hypomania often unrecognized
SF Geriatric Mental Health Resources

- **SFHSA Geriatric Resource Guide 2015**
  - Felton Institute
  - Little Brothers - Friends of the Elderly SF

- **SFDPH CBHS Provider Manual 2015-2016**

- Suicide Prevention
  - IOA Suicide Prevention/Grief Services: 415-750-4111
  - 24 Hour Suicide Hotline: 415-781-0500
  - Spanish Crisis Hotline: 800-303-7432
  - LGBT Crisis Line: 415-781-0500

- Mobile Crisis Services
  - Geriatric Mobile Crisis Team: 415-337-4722
  - Mobile Crisis Treatment Team: 415-970-4000 (Psych emergencies)
Takeaway Points

• Geriatric mental conditions often present atypically
• Use a validated tool: PHQ9/GDS, GAD7/GAI
• Screen for suicidality
• Optimize nonpharmacologic tx
• Caution with pharmacologic
Reflection and Evaluation

• What change you will make in your practice?

• Fill out our evaluation!
Optimizing Aging Collaborative

For more information contact: GWEP@ucsf.edu
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• Zahodne et al. Depressive Symptoms Precede Memory Decline, but Not Vice Versa, in Non-Demented Older Adults. JAGS 2014. 62(1):130-134.

• Geriatrics At Your Fingertips

• Geriatrics Review Syllabus, 8th edition

• Cornell Scale Depression in Dementia; http://www.amda.com/resources/2005_updates_ltc_teaching_kits/dementia.pdf

Depression Associated Meds

• Anticholinergics
• BP meds: BBs, clonidine, hydralazine, digoxin
• Antipsychotics: Haldol
• Anticonvulsants: Phenytoin, carbamazepine, phenobarbital
• Anti-Parkinson’s: Levodopa
• Sedatives: BDZ, EtOH
• Glucocorticoids
## R-UCLA Loneliness Scale

<table>
<thead>
<tr>
<th>Question</th>
<th>Hardly Ever</th>
<th>Some of the Time</th>
<th>Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>First, how often do you feel that you lack companionship: Hardly ever, some of the time, or often?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>How often do you feel left out: Hardly ever, some of the time, or often?</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>How often do you feel isolated from others? (Is it hardly ever, some of the time, or often?)</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Late-Onset Psychosis - Management

- Scant research in elders
- Late Onset Schizophrenia, Delusional Disorder:
  - Some evidence for Risperidone, Olanzapine
    - Watch for motor SE, metabolic sx
    - Lowest effective dose: always start at 25%
- Non-pharmacologic
  - Community Integration
  - CBT
  - Cognitive remediation therapy
  - Social skills therapy
  - Family interventional therapy