Sheffield Health and Social Care NHS
NHS Foundation Trust

NHS Sheffield Clinical Commissioning Group

***Older Adults Mental Health (OAMH) Protocol (such as; depression, anxiety, mood disorders or psychosis, excluding dementia).** Primary care and acute trust guidelines to support the assessment and referral to older adult secondary care mental health services of older people (excluding dementia – see link).

Assessment /diagnosis by GP or Hospital Consultant or Liaison service

Common symptoms of OAMH vary due to the range of conditions this term covers, but examples of symptoms to look out for are;

- feeling down, depressed or hopeless
- little interest or pleasure in doing things
- excessive worry, nervousness, restless and / or irritable
- delusional, having hallucinations and disturbed or illogical thinking
- lack of self-care.
- Fatigue/ loss of energy / poor sleep

Assessment should include:

- Description of onset, length of history and progression
- Physical examination
- Routine bloods (may include: FBC, B12 & folate, U&Es, glucose, HbA1c, LFTs, TFTs, calcium plus any test that a clinical assessment suggests should also be performed)
- Previous psychiatric history & risk
- Past & current medical history
- Social situation
- Cognitive impairment see link to dementia protocol
- If applicable, results from screening tool useful but not essential. For example, GAD7 (anxiety), PHQ9 (depression) or the geriatric depression scale/
- Assess for suicide risk, risk to others, self-neglect
- Alcohol or substance misuse (opiate or non-opiate)

OAMH Diagnosed

All patients should receive active support, psycho-education (explanation about the diagnosis and treatments), and active monitoring.

Factors that may lower the threshold for stepping up treatment

- Persistent/longstanding symptoms
- Personal/family history
- Relapse
- Concurrent physical illness
- Multiple adverse events/loss
- Cognitive impairment
- Low social support / social isolation – consider if referral needed to social services / consider social prescribing

Mild/Moderate OAMH

- Consider referral to IAPT http://www.sheffieldiapt.shsc.nhs.uk
- Consider referral to one of the IAPT long term condition courses - where applicable
- Signpost to Silverline http://www.thesilverline.org.uk
- Age Better Sheffield http://www.agebettersheff.co.uk/
- Medication guidance - see link
- Medication review
- Social prescribing
- Encourage activities – see the Sheffield directory for local service
- The Sheffield Mental Health Guide

If **genuinely** housebound consider referral to OA CMHT

Moderate/Severe OAMH

- Manage as mild to moderate

plus

- Consider referral to OA CMHT

Severe & Complex OAMH

- Bipolar or psychotic symptoms
- Significant psychiatric co-morbidity, including cognitive impairment
- Risk of self harm, risk to others or severe self-neglect

Refer to Older Adult CMHT

(Note – NOT SPA)

Urgent referral to Community Mental Health Team Older Adults – Phone Sheffield Care Trust's 24 hour switchboard on (0114) 2716310

Less urgent referral – Referrer to send referral information via email to sct-ctr.olderadultcmht@nhs.net or phone to appropriate CMHT:

- **North Community Mental Health Team** - (0114) 305 0600
- **West Community Mental Health Team** – (0114) 226 3600
- **Southeast Community Mental Health Team** – (0114) 226 3965
- **Southwest Community Mental Health Team** – (0114) 226 3131

Suicide Risk

Suicidal Risk Assessment

- Do you feel life is not worth living?
- Have you thought of the possibility that you might make away with yourself/take your own life?
- Do you find yourself wishing you were dead and away from it all?
- Does the idea of taking your own life keep coming into your mind?
- Have you thought how you would try to end your life?

Risk factors present:

- Previous attempt (consider as moderate risk unless clinical reasons not to)
- Psychological features of depression
- Biological features of depression
- Past psychiatric history
- Social isolation
- Male over 75
- Physical health problems including stroke
- Access to drugs/alcohol
- Recent loss (e.g. bereavement / recent diagnosis of dementia)
- Loss of protective factors
- Recent changes in medication

Suicide risk: Based on your clinical assessment and judgement

Information for carers

Often those caring for older adults with functional mental health need support. The Sheffield Mental Health Guide can be used to signpost patients / carers to providers that can offer support.

Further reading

Mental Health in Older People - A Practice Primer produced by NHSE and NHS improvement is a useful resource to support health care professionals manage functional mental health in older adults.

*Older adults = over 65 years.

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Considerations of prescribing psychiatric medications in older adults/physically unwell patient:

Depression (also see local guidance):

- In mild to moderate depression - Psychological intervention is generally first line unless; past history of moderate or severe depression or initial presentation of subthreshold depressive symptoms that have been present for a long period (typically at least 2 years) or subthreshold depressive symptoms or mild depression that persist(s) after other interventions. In these cases antidepressant medication should be considered after excluding treatable causes.
- As per NICE guidelines, 1st line treatment is with an SSRI and then 2nd line is with either an alternative SSRI or an antidepressant from a different class. Consider tolerability of side effects and interactions with other co-existing physical health problems / medication. Also see NICE CG91
- If no response to an adequate trial of two antidepressants then consider referral to Older Adult CMHTs. Consider earlier referral if concerns about risk.
- Antidepressants generally take longer to work in older adults, so it is important to explain to patients that it may take as long as 6-8 weeks before the full benefit is felt in order to ensure an adequate trial is undertaken.
- If dual antidepressants may be appropriate then refer to Older Adult CMHTs.

Anxiety:

- For people with GAD and a comorbid depressive or other anxiety disorder, treat the primary disorder first, that is the one that is more severe and in which it is more likely that treatment will improve overall functioning.
- Benzodiazepines can be considered for short term treatment of severe anxiety and should ideally not be used for more than 2 weeks at a time. Caution – increased risk of falls due to sedation.
- Follow the stepped-care model, offering the least intrusive, most effective intervention first. Medication is generally not considered until step 3, unless severe/marked functional impairment.
- Treatment with medication is ideally paired with appropriate psychological intervention including CBT, group work (either via IAPT or psychology services).

Psychosis:

- A full physical work-up should be done to exclude an organic cause for symptoms e.g. delirium or delirium tremens.
- If psychosis is suspected and physical health concerns have been ruled out, an urgent referral should be sent to OA CMHT. Risks should be clearly documented.
- Initiation of antipsychotics is normally done by a specialist. Before starting antipsychotic medication, undertake and record the following baseline investigations: weight, waist circumference, 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. Do an electrocardiogram (ECG) if; specified in the summary of product characteristics (SPC), a physical examination has identified specific cardiovascular risk (such as diagnosis of high blood pressure), there is a personal history of cardiovascular disease or patient is being co-prescribed other medicines that prolong the QT interval.

General considerations for prescribing in the older patient - https://bnf.nice.org.uk/guidance/prescribing-in-the-elderly.html or http://patient.info/doctor/Prescribing-for-the-Older-Patient

- Pharmacokinetics and pharmacodynamics may be altered by normal ageing or disease, further heightening the risk of Adverse Drug Reactions (ADRs). Lower doses may be needed. Refer to individual the Summaries Product Characteristics. (eMC)