WELCOME
to this Old Age Faculty webinar on the Impact of the COVID-19 Pandemic on Functional mental health of Older Adults
23 November 2020 at 4pm

‘Case presentations of functional mental illness in older adults during COVID-19’

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RCPsych OA Faculty

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SRTT Champion (HEE)

Background

- Dual trained

- 6 PA, 2PA, 1PA

- CMHA
- 16 bedded ward
- Mixed – M&F, organic & functional
- >75

- Home, care homes, liaison
- MHA, Dols

- COVID – March (3-4 months)

Mrs X

81 year old

No previous contact with mental health services

May 2020

S2 MHA

Admitted through liaison psychiatry

Treated for infection, IV fluids.

HOPC:

Short history (<2 weeks) of anxiety and preoccupation of not being able to by food during lockdown

Remote consultation with Gp-started on citalopram.

Not eating & drinking, staying in bed, not communicating, confused

Blood sugars erratic

Mrs X

On admission

‘She appeared very frightened by what may happen when the doors opened. She spoke about having hurt thousands of people, stating "nobody looks at this scruffy dirty old woman and thinks she can be capable of this heartache".

She spoke about being smelly because she could not take off her clothes, as we would be evaporated. ‘

80 year old woman, admitted from x Hospital, with a probable severe depressive episode with psychotic features (?nilhilistic delusions) and reduced oral intake.

Husband

wondered if Mrs x might have been ok if there was no pandemic, and wondered if not being able to go out exacerbated Mrs X's deterioration

Mrs X - progress

Initial improvement on sertraline
Significant decline
Increasingly psychotic, scared and uncommunicative

Challenges
-lack of engagement
- Minimal food and fluid
- Encouragement ++ to take meds
- Unstable BMs
- Repeated UTIs
- Vascular event

Detained on s3

Mrs X - Treatment

- Citalopram – sertraline
- Riperidone – little response, EPSEs
- Olanzapine – severe side effects on 5mg
- Quetiapine

- ECT

- -frontoparietal stroke confirmed on CT,
- unclear if previous CT in May had missed (an emerging picture)

- Aripiprazole
- Mirtazapine

Mrs X – finally…

- No evidence of psychosis
- Brighter, expressionless, lacks motivation, unwilling to engage in certain things
- Limited with communication (hearing)
- Anxious
- Step down from base line

- Neuroradiology review – vascular dementia

- Trial leave with husband – day & nights
- 'exceptionally well’
- 'enjoyed being at home,' 'it felt like a dream.'

Mr Y

77 year old
No previous contact with mental health services
May 2020
S2 MHA

Admitted via liaison psychiatry

HOPC
Planned overdose (Mirtazapine)
Increasingly struggling with tinnitus since Feb
Significant decline in lockdown - increasingly preoccupied with tinnitus
Low, anxious and agitated, not sleeping
Significant weight loss

Mr Y - admission

Preoccupied with tinnitus

Hopeless & resigned

suicidal ideation

Agitated and anxious

Lived in silence for 6 weeks prior to overdose

Lockdown made things unbearable & anxiety, preoccupation much much worse +++

Mr Y - progress

Initial improvement in anxiety
Followed by significant decline

S3 MHA

Increasingly psychotic and delusional about hearing
Agitation +++, anxiety +++
Unusual, odd behaviour, responding to visual hallucinations

Not eating & drinking
Not leaving bed
Not taking medication

Needing restraint and IM aripiprazole

Mr Y treatment

- Mirtazapine – sertraline
- Olanzapine (worsening)& falls - stopped
- Aripiprazole – improvement in psychosis
- Sertraline – venlafaxine

- ECT

- Psychology

Mr Y – Finally…

No evidence of psychosis
No suicidal ideation, plans
No agitation but some anxiety around hearing
Brighter in mood, more communicative
Engaging in psychology
Clearly a step down

Home leave – wife anxious
Fall – NOF
Rehab

Other cases

Mrs R

- 75
- Severe depressive disorder and anxiety, No previous history
- Planned overdose

Mrs B

- 78 year old, No previous history
- Severe depressive disorder with psychotic symptoms, preoccupation with cleanliness
- Numerous med changes

Mrs K

- 76 year old
- Known BPAD
- Compliant with meds in care home
- Significant relapse related to lockdown.

Reflections

- Increase in frequency & severity of functional illness

- Large proportion first presentations with no previous contact with mental health.

Some attempt to see GP

- A proportion have premorbid personality traits such as anxiety but not all

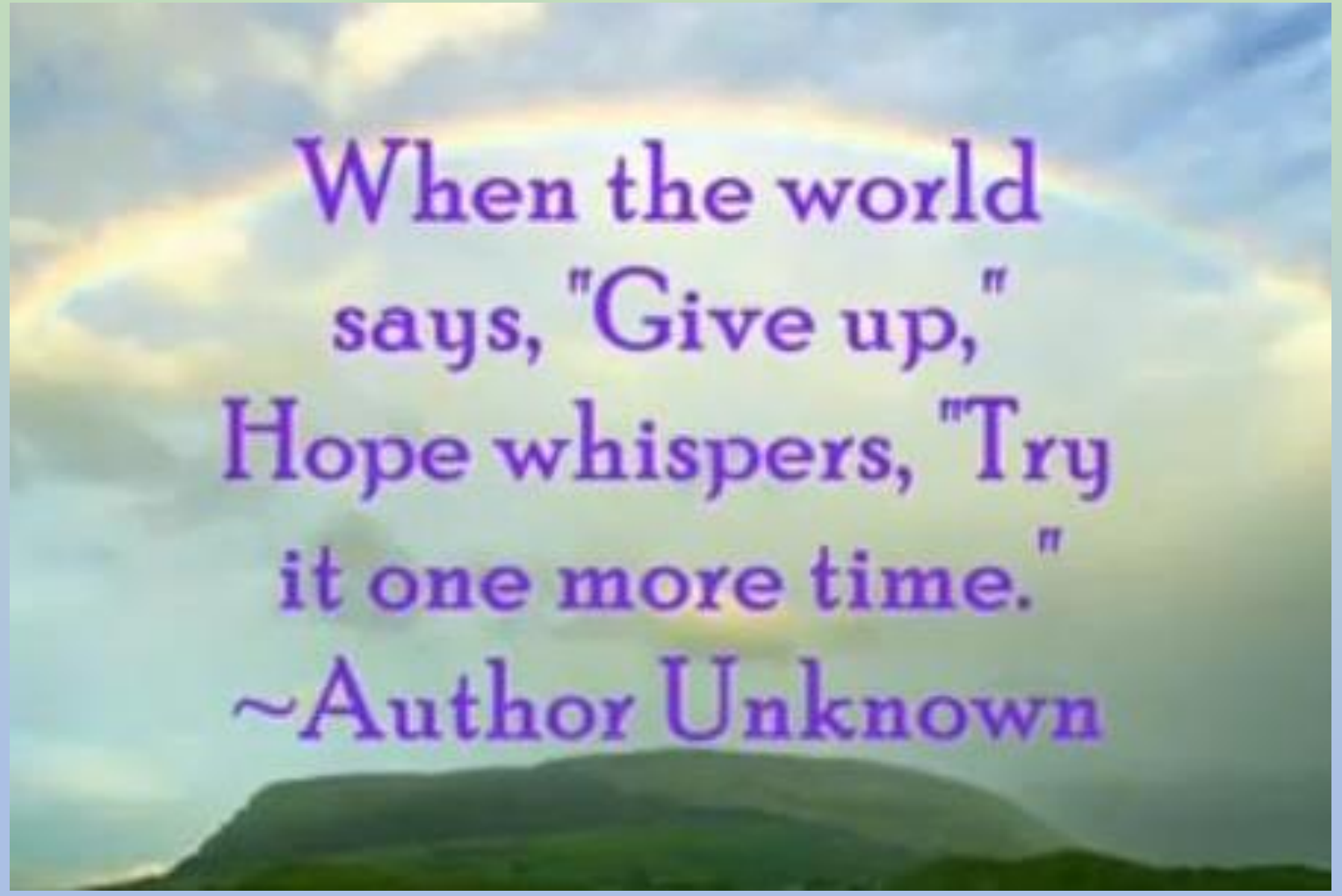
- Difficult to treat (initial improvement) – multiple education changes

- Much longer period of admissions

- On discharge, not back to baseline

- Lockdown inevitably a contributing factor

- First Impressions
- Self doubt, hopeless
- Realistic hope
- Recovery



Thank you

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Summary of recent research findings on the impact of COVID-19 on older people's mental health

Dr K Sachdev

Consultant Old Age Psychiatrist

East London Foundation Trust

Outline

- Reason for looking at this research
- List of papers
- Detailed summary of four papers with key recommendations
- Table of recommendations from literature for maintaining mental health in older people during COVID 19 quarantine
- Suicide in England since the pandemic

Why

In our CMHT there was an increase in the number of referrals we received for older adults

Reasons for referrals included- presentations with anxiety and depression, psychotic symptoms, inability to sleep, paranoia, increase in disturbed behaviour

But it was not clear why there was this increase?

SARS epidemic in 2003 was associated with 30% increase in suicide of those 65 years or older, 50% of patients remained anxious, 29% of health care workers remained anxious

Predictive models

Mental health surge model published by Strategy unit indicates 11% more new referrals to mental health services, each year for the next three years; and

Associated costs amount to an extra £1 billion a year. This is around 8% of annual NHS expenditure on mental health services.

This is in addition to approximately 5,00,000 people that were unable to access services during the national lockdown

Studies published

Looking through the literature early studies indicated that there were some publications from China mainly Wuhan area about the impact of COVID 19 on older adults mental health

- ELSA substudy on COVID 19
- Impact of Social Isolation Due to COVID-19 on Health in Older People: Mental and Physical Effects and Recommendations
- https://www.ageuk.org.uk/globalassets/age-uk/documents/reports-and-publications/reports-and-briefings/health--wellbeing/the-impact-of-covid-19-on-older-people_age-uk.pdf
- Psychological impact of COVID 19 in older adults https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7373678 (Pakistan)
- Multidisciplinary research priorities for COVID 19 pandemic – Lancet paper
- Impact of COVID-19 on loneliness, mental health, and health service utilisation: a prospective cohort study of older adults with multimorbidity in primary care https://doi.org/10.3399/bjgp20X713021 (Wuhan based)

The ELSA COVID substudy (English Longtitudnal study of Ageing findings

- Only 60% of older people instructed to shield were strictly isolating in April and May, staying at home and trying to limit face-to-face contact.
- Severe depression and anxiety symptoms were twice as common among high risk older individuals who were socially isolating compared with average risk participants (32% vs 17%).
- Loneliness was much more common in the shielded group (33% vs 21%).
- Participants in the high risk group were more likely to have been hospitalised with COVID-19 (15% vs 3%) and to be worried about obtaining food and other essentials (12% vs 6%).
- People who were in the shielded group were more likely to be less physically active than usual and to spend more time sitting compared with others (47% vs 33%).

Other relevant findings on people with multimorbidity

- 35% of older people with multimorbidity were instructed by the NHS or GP to shield.
- 94% of people with multimorbidity reported either isolating or staying at home in April 2020, whether they were asked to shield or not.
- 20% of people with multimorbidity did not have access to community health and social care services and support needed (such as dentist, podiatrist, nurse, counselling or personal care).

Impact of Social Isolation Due to COVID-19 on Health in Older People: Mental and Physical Effects and Recommendations

- Published in J Nutr Healthy ageing September 25
- Main outcomes reported were anxiety, depression, poor sleep quality and physical inactivity
- Mental and physical health were negatively impacted in older people
- Multi-component exercise and physical health strategies are highly recommended during the confinement

Mental health impacts of social isolation in older people during COVID pandemic

- Published in Progress in Neurology and Psychiatry Journal 9th November 2020
- Review of literature by Dr Tappenden and Dr Tomar on the mental health consequences of social isolation on mental health of older people especially during epidemics
- Effects of social isolation- decline in cognition, mood and sensitivity to threat, higher rates of depression and anxiety
- Short term effects and long term effects looked at

Age-UK report

- Impact on physical health- decrease in levels of activity, less energy (1/3), less steady (1/5), unable to walk as far as before (1/4)
- Diet and malnutrition- low mood, lack of help for food prep, decreased physical health and activity, increased pain
- New or emerging cognitive decline
- Impact on older people who were asked to shield or had multimorbidity
- Anxiety- 1/3 anxiety worse or have developed anxiety
- Depression- proportion of over 70s who experience depression has doubled since the start of pandemic
- One in three over 60 feel less motivated to do things they used to enjoy
- Effect of bereavement, self neglect

Recommendations from literature for maintaining mental health in older people during COVID 19 quarantine

Author	Aim	Main recommendations
Patient		
Goethals L et al. 2020 (43) Banskota S et al 2020 (45) United Nations 2020 (48) Holmes EA et al. 2020 (47) Cudjoe TKM et al. 2020 (7) Ransing R et al. 2020 (50]) Li Tao et al 2020 (51) Yuan S et al. 2020 (37]) Ransing R et al. 2020 (50) Li Tao et al. 2020 (51) Jiménez-Pavón A et al. 2020 (64)	Prevent loneliness Prevent sleeping disorders Maintain cognitive stimulation Prevent cognitive impairment or decline and improve self-esteem	Keep connected with relatives, strength social connections. Increase use of digital resources, online tools, social media Follow a regular sleep-wake cycle Maintain PA Appropriate nutrition habits Use electronic tools and apps, technology resources. Participate in adequate and tailored daily activities Multicomponent exercise program 5–7 days per week of aerobic and resistance training with moderate intensity
Caregivers		
Li Tao et al 2020 (51) Holmes EA et al. 2020 (47) Etard J-F et al. 2020 (100) Doraiswamy S et al 2020 (101)	Prevent depressive symptoms Prevent anxiety	Help the person be useful, contribute to simple chorehouses or gardening. Prevent overexposure to media and help manage the effect of viewing images with traumatic content. Seek information in official sources.

Recommendations from literature continued..

Health workers		
Banskota S et al. 2020 (45) Sánchez-Rodríguez D et al 2020 (102).	Reduce the exposure to the virus and improve rapid access to health care.	Implement telehealth
DiGiovanni G 2020 (52)	Give care to vulnerable populations Avoid conductual disorders, delirium.	Telemedicine by video. Assessment tools for geriatric population: Telehealth SCO-RARE GA Cognitive and physical stimulation
Huang Y et al 2020 (38)	Avoid anxiety and depressive symptoms	Psychological training and surveillance in risk cases
Brooks SK et al 2020 (23) Wang H et al 2020 (49) Zhang Y et al 2020 (35)	Reduce stress	Reduce boredom and improve the communication: telephone support lines, social media, support groups Reinforce than quarantine is helping to keep others safe (reinforce altruism) Self-help guidance tools such as relaxation or meditation exercise, delivered through electronic media Combination of health education with psychological counseling for vulnerable people
Webb L et al 2020[46]	Increase resilience	Basic CBT approaches, support lines and practical

Wang H et al 2020[49]	Dementia care	provide mental health and psychosocial support: multidisciplinary and collaborative teams support behavioural management through telephone hotlines. online consultation for caregivers at home and in nursing homes. encourage people who have a parent with dementia to have more frequent contact and take some caregiving duties
Health authorities		
Webb Let al. 2020.[46]	Increase resilience Gain compliance with lockdown strategies	Adopting inclusive language when talking about the elderly, valuing older people's contributions and avoiding negative emphasis on risk. Use non-patronising media stories of older people's strengths Promoting citizens' trust in 'experts' (scientists and their data), giving clear factual information, and promoting altruism
Brooks SK et al 2020 [23]	Reduce stress	Keep quarantine as short as possible, give as much information as possible, provide adequate supplies

Suicide in England since the pandemic – early figures from real time survelliance

- Preliminary report published by NCISH from Real time surveillance (RTS) in several parts of England total population of 9 million
- 2020 monthly average- pre-lockdown 84.0
- Post lockdown 85.4. The post-lockdown figure was 7.3% higher than equivalent period in 2019

Conclusions:

- No evidence of national rise in suicide post-lockdown where the RTS was carried out.
- The higher figures in 2020 should be seen in the context of a rising national rate and maturing real-time surveillance systems;
- These are early figures and could change over time and it was too early to examine full long term impact of COVID 19

Studies

ELSA substudy on impact of COVID 19 in older adults

Impact of Social Isolation Due to COVID-19 on Health in Older People: Mental and Physical Effects and Recommendations

https://www.strategyunitwm.nhs.uk/mental-health-surge-model

Suicide in England since the COVID-19 pandemic -early figures from real-time surveillance NCISH

Acknowledgments Dr Amanda Thompsell

Deliberate self-harm in older people during the coronavirus pandemic

Dr Josie Jenkinson
Consultant Psychiatrist for Older People, ASPH Psychiatric Liaison Service

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Mental Health Services

For a better life

Introduction

Surrey and Borders Partnership NHS Foundation Trust

- Background
- Method
- Preliminary results
- Next steps

Background

- SABP anecdotally experiencing fewer liaison referrals - but what felt like greater numbers of older people presenting with **severe** DSH
- Increasing stress on community services and adaptations due to COVID-19 – less face to face reviews
- Stress and loneliness during pandemic worse for OA?
- What is really happening with referrals to OA liaison during COVID? Are presentations of OA with DSH increasing?
- Expansion of liaison services due to investment as part of 5YFV→ good quality data available to explore this

What is already known about this topic?

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- OA considered at a higher risk of physical and mental health problems, with social isolation inducing anxiety or low mood symptomology[1]
- Loneliness and social support to be strong predictors of suicide ideation[2]
- Social isolation in response to a pandemic poses risks of further psychological issues such as fear of the infection to self and loved ones, hospitalisation and death[3]
- OA with depression 15 times more likely to engage in self-harm[4]
- Social isolation and living alone have been found to associate with increased suicidality in older adults[5]
- Loneliness → three-fold risk of suicide attempts and completed suicide, those above 75 most affected [6]

Background

- ONS data – suicide deaths decreasing – but note during pandemic inquests have been delayed[7]
- NCISH data – no increase in suicides since lockdown in context of a rising trend (but early data)[8, 9]
- During the pandemic, older adults were advised to keep isolated and maintain social distancing
- Lockdown → increased isolation →loneliness in older people linked to depression → increased rates of DSH and suicide

First steps

- Started to look at SABP data to see if it was of good enough quality and accessible to explore the issue further
- Discussed with local R+D department and audit department – happy to register no ethical approval needed (routinely collected data)
- Put call out over jiscmail to see if anyone wanted to collaborate to increase data available
- Met virtually to discuss and expand the idea
- Put together a one page methodology and proforma
- Started data collection with support of other OA liaison consultants and junior doctors

Collaborators

- Needed to have well set up liaison services and access to high quality referral data -
- Birmingham and Solihull MH NHS FT
- Nottinghamshire Healthcare NHS FT
- Oxleas NHS FT
- East London NHS FT
- Norfolk and Suffolk NHS FT

THANK YOU!

Method

- Local registration with audit department/R+D
- 3 month time period from start of lockdown
- Same time period in 2019 (seasonality of liaison referrals)
- Reason for referral, age, sex
- Anonymised data shared and pooled for analysis
- Suicide data requested from Trusts (n/a yet)

Preliminary data

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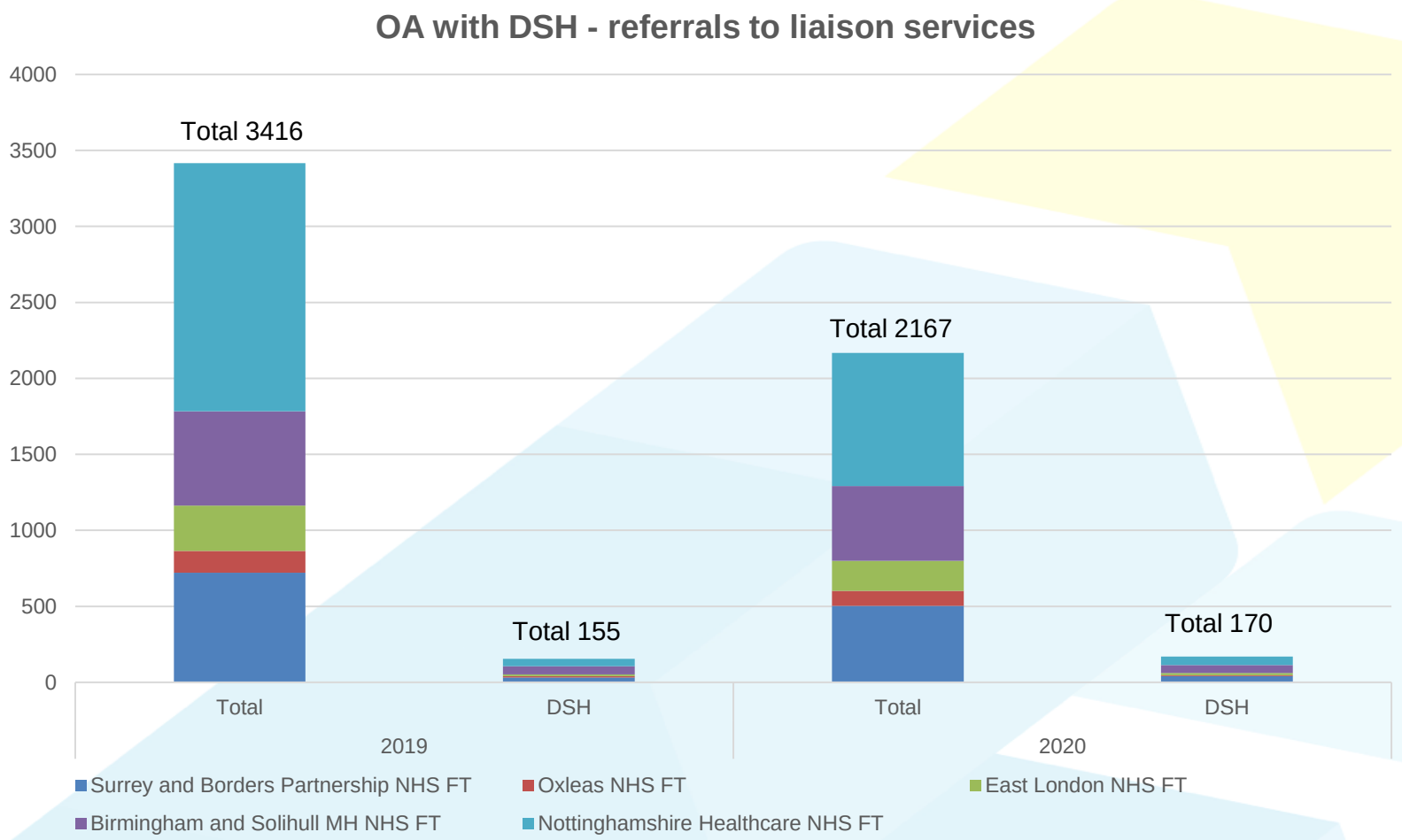
		2019			2020	
Trust	**Total**	**DSH**	**%**	**Total**	**DSH**	**%**
Surrey and Borders Partnership NHS FT	722	32	4.43	504	40	7.93
Oxleas NHS FT	142	9	6.33	98	7	7.14
East London NHS FT	299	12	4.01	197	14	7.11
Birmingham and Solihull MH NHS FT	620	53	8.55	493	53	10.75
Nottinghamshire Healthcare NHS FT	1633	49	3	875	56	6.4
Overall	**3416**	**155**	**4.54**	**2167**	**170**	**7.84**

Preliminary results



Preliminary results

- Numbers of OA DSH referrals do not appear to have increased
- BUT referrals have gone down overall
- A few possible reasons for this (increased discharge times, stricter referral criteria to liaison, people with less serious problems staying away from hospital)
- Haven’t answered question yet as to whether presentations are more severe, or if more completed suicides
- Delayed effect (only looked at 3 months) – anecdotally referrals have increased back to usual levels

Next steps

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- More detailed analysis of data
- Extend data collection period to 12 months
- Expand data set via further collaboration
- Seek ethical approval – to do deep dive into individual records
- Request data on completed suicide for this age group from NCISH and local trust data
- Further exploration of factors contributing to suicidality during the pandemic – patient interviews
- May help identify who is most at risk and guide service development

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8. Suicide in England since the COVID-19 pandemic NCISH

9. Suicide rates continue to rise in England and Wales BMJ 2020; 370

Thank you!

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