RESEARCH TO PRACTICE BRIEFING 7

Supporting older people who are experiencing mental distress or living with a mental illness

Mental distress or illness is not a normal part of ageing. However, like people of any age, older people can be vulnerable to mental illness. Some older people develop a mental illness as they age, while others grow older with a continuing experience of a mental illness that developed earlier in their lives.

This briefing reviews the research on the symptoms and treatments of mental illness in older people. It focuses on how those in the community aged care sector (including care workers, case managers, team leaders, and managers) can support people who show signs of mental illness.

Research to Practice Briefings

Research to Practice Briefings bring together lessons learned from the literature on a topical issue in community aged care as a resource for those working in this sector. As in most areas of social policy and practice, the research evidence on community care is continually evolving. The Briefings aim to distil key themes and messages from the research and to point to promising and innovative practices.

An advisory group of academics and expert practitioners working in the area of aged care provide advice and peer review.

This briefing has been prepared by the National Ageing Research Institute (NARI) in partnership with The Benevolent Society.

Overview of mental health and older people

Mental health has been defined as the embodiment of social, emotional and spiritual wellbeing (VicHealth, 2005). Mental illnesses include depression, anxiety, psychosis and bipolar disorders.

Mental illness is not a normal part of ageing. However, older adults can be vulnerable to mental distress and/or illness (Watson and Hall, 2001). Some older people develop a mental illness as they age (late onset), while others grow older with a continuing experience of a mental illness that developed earlier in their lives.

Mental health concerns and symptoms in the ageing population

Mental illness can be hard to detect in older people, as symptoms may not be reported or physical conditions may be of greater concern. This section describes some of the mental illnesses most commonly experienced by older people.

Anxiety disorders are the most common mental illnesses at any age and are generally characterised by persistent and excessive worry. There are several types of anxiety disorder, including Post-Traumatic Stress Disorder, Obsessive Compulsive Disorder, Generalised Anxiety Disorder, and phobic disorders.

Psychological symptoms can include apprehension, inability to relax, fear, irritability, difficulty concentrating and thinking, and feeling tense and jumpy.

The psychological distress of anxiety is often accompanied by physiological symptoms such as heart palpitations, hot flushes or chills, shortness of breath, muscle tension, dizziness and nausea, insomnia and diarrhoea.

Anxiety increases older people's risk of mortality, both from suicide and from physical illness such as cardiovascular disease (Bryant, Jackson et al., 2008).

Depression can occur at any stage in a person's life, and depressive symptoms are thought to occur in approximately 10 to 15% of older people living in the community and up to 50% of older people living in residential aged care (Ostling & Skoog, 2002). Risk factors for depression in older people include the loss of relationships, independence and physical function; social isolation; bereavement; changes in living arrangements; chronic pain and other health conditions.

There are many symptoms of depression which may have serious negative effects on physical and mental health, including:

- moodiness or irritability
- loss of interest in daily activities
- withdrawing from family and friends
- loss of energy
- feeling hopeless or helpless
- sleep changes
- unexplained aches or pains
- appetite or weight changes.

In older people, the risk of both anxiety and depression is increased for those who:

- have multiple physical illnesses or limitations
- live in residential aged care or are hospitalised
- are homeless or at risk of homelessness
- have experienced oppression, racism and discrimination, including women, Aboriginal and Torres Strait Islanders, people from a Cultural and Linguistically Diverse (CALD) background (Haralambous, Lin et al., 2009) and people who are lesbian, gay, bisexual, transgender and intersex (Bailey, 1999).

People who have experienced trauma (eg war and holocaust, family violence, childhood neglect and abuse, time spent in foster care or children's homes) may be at risk of developing Post-Traumatic Stress Disorder.

Psychosis is a term used to characterise several symptoms that are associated with a number of conditions.

Psychosis is typically identified by the presence of hallucinations, delusions and confused thinking. Delusions are false beliefs, and older people are more likely to experience delusions of a persecutory nature for example believing others are stealing from

them or that relatives are not who they claim to be. Hallucinations can occur in any sensory modality including auditory or visual for example, older people might report voices that others are unable to hear. The most common causes of psychosis in older people include Alzheimer's disease, Parkinson's disease and Schizophrenia. However, people affected by other conditions including depression, alcohol and drug addiction, delirium and mania can also experience psychotic symptoms.

Bipolar disorder (BPD) is more common in younger people. However, people who develop BPD in their younger years continue to experience the condition as they grow older, and it has been reported that up to 10% of older people in residential care settings or hospitals have BPD. Those who develop late onset BPD tend to present with milder symptoms (Vasudev & Thomas, 2010).

People with BPD can experience euphoria, become over-excited and reckless, or perceive themselves to be more prominent or powerful than they really are. They can also experience extreme lows, feeling helpless and depressed, and have difficulty concentrating or making decisions. These intense mood swings can lead to uncharacteristically irrational or dangerous behaviour, and the suicide risk is quite high (SANE Australia, 2010).

People with neurologic impairment or physical disorder caused by stroke or head trauma and those with a history of major depression, are at increased risk of BPD.

Delirium is a temporary state of acute confusion, where the person affected has a reduced ability to focus, sustain or shift attention. It also involves a change in cognition (such as memory deficit) or the development of a perceptual disturbance. Delirium is typically sudden in onset and the disturbance fluctuates during the course of the day (APA, 2000). Delirium can usually be traced back to an underlying physical cause, for example, dehydration, infection or medication (Insel & Badger, 2002).

Misconceptions about mental illness

There are a number of common misconceptions about mental illness and ageing, including:

- Depression and anxiety are a normal part of ageing.
- Mental illness can't be treated in older people.
- All individuals who are affected by a mental illness are violent or dangerous.
- All mental illnesses are the same.
- Medication is the only treatment for mental illness.
- All people with mental illnesses who are from CALD backgrounds have extensive family support.
- People who live with others are not lonely or socially isolated and are therefore not at risk of becoming depressed.

Stigma or misconception about mental illness can lead to lack of diagnosis or treatment, delayed diagnosis, shame and social isolation.

Suicide risk

Older people have a much higher risk of suicide than the general population (World Health Organization, 2001). In Australia, a higher proportion of males over the age of 85 years commit suicide than in any other age group, and at more than five times the rate of females in the same age group (ABS, 2011). Up to 83% of older people who commit suicide suffered from depression (Baldwin, Chiu et al., 2002; Rodda, Boyce et al., 2008). Additional risk factors for suicide in later life are:

- previous suicide attempts
- other psychiatric conditions
- serious physical illness
- social isolation, poor social support and significant loss including bereavement (Baldwin et al., 2002; Chiu, Tam & Chiu, 2008).

All acts of deliberate self harm, including suicide attempts, should be taken seriously, even those deemed not medically serious (Chiu, Tam et al., 2008).

Importance of detection and treatment

It is important that mental illness is identified and treated, otherwise symptoms can deteriorate rapidly and lead to reduced quality of life or the development of physical illnesses that may lead to hospitalisation.

Some questions that can help community care workers to identify mental distress include:

- Has there been a recent life changing event for this person?
- Do they seem sadder than usual or have there been any noticeable changes in their behaviour (eg, neglecting personal hygiene, not showing interest in their usual activities)?
- Is the person losing weight?

Community care staff are not expected to diagnose or treat an older person with mental illness, but should refer the person to a registered medical practitioner.

Differentiating mental illness from other physical and psychological conditions

Older people may experience mental distress as a result of life events, or show symptoms of mental illness resulting from a physical or neurological disorder.

Reactions to grief and other life changing events

The loss of partner or friends, loss of mobility, retirement, moving from one's usual place of residence, or any other life changing event can affect a person's mental health and wellbeing. Reactions to such life changes manifest differently in each individual, and can include sadness, disbelief, guilt, anger, numbness, anxiety, trouble concentrating and making decisions, loss of energy and changes to sleeping and eating patterns. These symptoms typically lessen over time through adjustment to the change.

Helpful responses to grief include:

- acknowledging how the person is feeling
- acknowledging the different cultural practices the person is observing
- allowing the person space and privacy if that is what they want
- providing support and companionship as required and requested
- providing practical information (e.g. about relevant services, brochures or websites).

Grief may become abnormal if it is chronic, delayed, causes intense reactions (such as nightmares or suicidal thoughts), or occurs without warning (a risk factor for PTSD).

Dementia

Older people with dementia are at greater risk of depression. Diagnosis can be challenging as symptoms can overlap. For example, memory or concentration problems can be symptoms of both depression and dementia. However, these are different conditions; depression is a mood disorder and dementia is a brain disorder.

There are some key differences to be aware of when distinguishing between the two. Decline due to dementia typically happens slowly, whereas decline due to depression can be noticed over a relatively short period of time. Symptoms more common to dementia include difficulty with short term memory, confusion and disorientation, and trouble writing or speaking. People with depression may have difficulty concentrating, have slow but normal language skills, and be correctly oriented to the date and locations. A detailed history from the older person and family members is helpful in distinguishing between the two conditions. It is important for older people to be diagnosed as early as possible as there are different treatments for each of these conditions.

Delirium and depression

Delirium, as described on page 3, can often have an underlying physical cause such as urinary tract infections.

Depression can also be a symptom of some health conditions including:

- brain injuries and diseases (e.g. stroke, heart disease, head injury, epilepsy, Parkinson's Disease)
- urinary tract infections
- low thyroid function

- some forms of cancer
- infectious diseases
- blood vessel disease in the brain due to diabetes and/or hypertension
- anaemia
- chronic pain.
- If the underlying condition is treatable, delirium and depressive symptoms may ease following treatment.

Depression may also be a reaction to some medications, such as tablets or patches used for quitting smoking (beyondblue, 2000), and some steroid and hormonal treatments.

Cultural differences and perceptions

A person's cultural background can influence their perception of health, their response to how they deal with their health and their approach to accessing services. There may be a stigma about mental illness in some cultures. These perceptions can be driven by:

- insufficient knowledge about specific mental illnesses
- specific religious and spiritual practices
- practices of traditional medicine as well as or instead of western medicine as a response to specific health concerns
- a limited understanding of services available, which could lead to limited use of services and supports by people from CALD backgrounds.

It is important to recognise the individual needs of older people as well as their broader community and cultural context. Taking a person-centred approach (discussed below) is a useful way of ensuring individual needs are considered.

Strategies for addressing mental distress

Community care workers may feel that it is not appropriate to mention to a client or patient that they are concerned about their mental wellbeing. However, helping an older person seek assistance and treatment as soon as possible will help them and their carer/family deal with the issues they are facing, and ultimately improve their quality of life.

The following steps can be taken when approaching the subject of an older person's mental distress:

1. Identify informal supports

An understanding of an older person's support network will help clarify how much support they have, and who they prefer as a support, if necessary. Consider:

- Do they have social networks and/or support services?
- Do they have supportive relationships with their family/friends?
- Do they often confide in the staff member?

2. Consider the person's background and life history

For people from CALD backgrounds, there may be unresolved issues of grief as part of their immigration, and experiences of racism and discrimination. However, it is important not to make assumptions that all people from a particular cultural background treat their health in the same way. Some beliefs and practices can vary within and across cultures. Staff may prompt people for more information about their social networks and family supports, and consider referral to external support and specialist services.

- For Aboriginal and Torres Strait Islander people, consider whether they were a member of the Stolen Generations.
- For gay, lesbian, bisexual, transgender and intersex older people, consider factors that may contribute to their mental distress such as discrimination, lack of family or community support or stigma.

3. Initiate a conversation about mental health

Initiating a conversation depends on the relationship staff members have with the person, how long they have known them, and how comfortable staff feel about talking about their concerns. Staff may consider asking the following:

- You seem to be a bit upset today (lately), would you like to talk to me about it?
- Sometimes when we feel upset, it helps to talk to someone about it; would you like me to call [family member, friend, GP, case manager or alternative] and ask them to give you a call?

If the person does not want the community care worker to speak to anyone, the worker can suggest that someone else comes to visit and provide support. If they continue to decline this suggestion, staff should seek advice from a supervisor.

4. Refer to another service

An effective referral will help the older person access the service/s they need. Consider the following:

- Has the person recently been seen by a case manager or had an ACAT assessment?
- Which other services, if any, are they receiving?
- Do they see their general practitioner (GP) regularly and do they have a good relationship with them?
- Has anyone recently spoken to the person's GP or other health professional about their health and wellbeing?
- Would they like a family member to be involved in the referral process?

Services can include a GP, community mental health service, community health centre, case manager, social worker, psychologist or psychiatrist.

Person-centred care practices

Person-centred care involves a "collaborative and respectful partnership" where "the service provider respects the contribution the service user can make to their own health, such as their values, goals, past experience, and knowledge of their own health needs, and the service user respects the contribution the service provider can make, including their professional expertise and knowledge, information about the options available to the service user, and their values and experience" (Dow, Haralambous et al., 2006). Person-centred care involves:

- Getting to know the client. This means getting to know their needs, preferences, life goals, life history, and what or who is important to them.
- Empowering the client by allowing them to make decisions which will affect their life and sharing power and responsibility over these decisions. For example, if staff think they should be referred to another service, involve them in this decision wherever possible.
- Providing accessible and flexible services which respond to clients' changing needs.
- Coordinating and integrating service provision to maximise outcomes, reduce duplication, and improve communication within and between services (Dow, Haralambous et al., 2006).

What older people, family and friends can do

There are many things that older people and their family and/or friends can do. Keeping physically active, eating a healthy diet, getting adequate sleep, maintaining interests and hobbies, reducing stress and staying socially connected are helpful for both mental and physical wellbeing at any age. Family and friends can encourage the older person to stay in touch, go on outings with them, participate in social and physical activities such as walking, gardening, going shopping, going to church or sporting events, depending on their interests. As social isolation is a key risk factor for many types of mental illness, phoning and visiting the person is important for their mental wellbeing.

Contemporary practice in mental health

A range of treatment options are available for older people experiencing mental distress.

Medication prescribed by a qualified medical practitioner can be effective in treating and managing some mental illnesses in older people.

Psychosocial treatments such as cognitive behaviour therapy, relaxation therapy, music therapy and trauma informed care have all been found to be effective in some cases. These approaches should only be implemented by professionals who have had formal training, after a formal assessment by the appropriate professional.

Approaches focused on recovery. Contemporary practices in mental health extend beyond primary symptom management and take a more holistic approach to wellbeing, encompassing physical, social and mental aspects of health. These approaches are referred to as Recovery Oriented Practice or

the Recovery Approach. They recognise that the process is not necessarily about cure, but creating opportunities to live a meaningful life with mental illness (Jacobson & Greenley, 2001).

In using recovery approaches with older people, particularly those with dementia, there is the potential for the term 'recovery' to be misleading. It may give an unrealistic expectation of recovery, and removes the focus from understanding the nature of the progression of the dementing illness (Hill et al., 2010). However, recovery approaches can provide people with a sense of being valued and respected, leading to improved wellbeing and quality of life. This can be enhanced further when used in collaboration with person-centred care practices (Barker, 2001).

Discussion guide

- What are some of the signs of mental distress or illness that you would be looking out for?
- What are some of the physical conditions that your clients may experience that can lead to symptoms of depression and anxiety or delirium?
- If you notice that a client's behaviour has changed, what questions would help you ascertain the underlying reason/s for the change?
- Have you ever been concerned about a client's mental health? What did you do about it, and what other strategies might you now use?
- How might service providers better equip staff to recognise and respond to symptoms of mental illness in their clients?
- Does your organisation have, or will it develop, protocols for working with older people who are experiencing mental distress?
- What do you think are some of the reasons that older people may be reluctant to discuss their mental health? Given those reasons, how would you go about supporting a client?
- Using real practice examples, explore how you might take a person-centred approach to supporting a client with a mental illness.

Practice implications

1. All acts of deliberate self-harm, including suicide attempts, should be taken seriously.
2. Some older people are more at risk of developing a mental illness than others. Community care staff should understand people's backgrounds, living conditions and physical health, and be aware of the possibility of mental illness or distress.
3. It is important to understand the differences and links between mental health, physical health and life events. Symptoms of mental illness may ease when physical health conditions are treated.
4. Community care staff should understand the specific needs of older people experiencing mental distress or illness. For example, some people may be physically capable of undertaking a task, but unable to manage it because of their mental health.
5. An understanding of older people's formal and informal supports will help community care workers to act appropriately on any concerns about people's mental health.
6. There are a number of supports available for community care workers. Staff should seek advice from their supervisor or other professional, and can call information lines such as beyondblue or Lifeline.
7. Community care services should provide staff with ongoing training about the risk factors and symptoms of mental illness, and how to respond. Staff should also receive adequate support and supervision.
8. Community care services should also provide training in cultural competence and in person-centred care.

Helpful resources

National

Alzheimer's Australia, depression and dementia page www.fightdementia.org.au

Australian Department of Health and Ageing, mental health page www.agedcareaustralia.gov.au

Beyondblue info line 1300 22 46 36 or www.beyondblue.org.au

Lifeline Australia 24 hour telephone counselling 13 11 14

Multicultural Mental Health Australia (MMHA) www.mhima.org.au

Sane Australia, factsheets and Helpline 1800 18 SANE (7263) or www.sane.org

QLD

QLD Health Older Persons Mental Health Service www.health.qld.gov.au/pahospital/services/aged_care_mh.asp

QLD Health – Factsheet 6: Caring for older people with mental health issues www.health.qld.gov.au/mhcarer/docs/fs6-olderpersons.pdf

ACT

Mental Health ACT www.health.act.gov.au/health-services/mental-health-act/mental-health-services/older-persons

NSW

NSW Health – Specialist Mental Health Services For Older People (SMHSOP) www.health.nsw.gov.au/mhdao/program_information.asp

VIC

Victorian Transcultural Psychiatry Unit www.vtpu.org.au/

Victorian Government Health Information – Aged persons mental health services www.health.vic.gov.au/mentalhealth/services/aged/index.htm

Health Victoria - Aged Psychiatry Assessment and Treatment Team www.health.vic.gov.au/mentalhealth/services/aged/innernorthwest-g.htm

SA

SA Health – Mental health services for older people www.sahealth.sa.gov.au

WA

WA Department of Health – information on Older Adult Mental Health Services (OAMHS) www.nmahsmh.health.wa.gov.au/services/oamhs.cfm

TAS

Department of Health and Human Services – Older Persons Mental Health Service www.dhhs.tas.gov.au

We welcome feedback on this Briefing.
A full list of references can be accessed on The Benevolent Society's website.

NARI NATIONAL AGEING RESEARCH INSTITUTE

The National Ageing Research Institute (NARI) is an independent not-for-profit research institute that aims to improve older people's health and wellbeing through research.

We are The Benevolent Society

We help people change their lives through support and education, and we speak out for a just society where everyone thrives.

We're Australia's first charity. We're a not-for-profit and non-religious organisation and we've helped people, families and communities achieve positive change for 200 years.

New South Wales
Level 1, 188 Oxford Street
Paddington NSW 2021
PO Box 171
Paddington NSW 2021

T 02 8262 3400
F 02 9360 2319
ABN 95 084 695 045

Queensland
9 Wilson Street
West End QLD 4101
PO Box 5347
West End QLD 4101

T 07 3170 4600
F 02 3255 2953

www.benevolent.org.au or find us on

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