Treatment of Primary Mental Health Disorders in LTC

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This presentation is broadcasted from the traditional territories of the Kwikwetlem, Musqueam, Squamish, Stó:lō and TsleilWaututh First Nations.

Land acknowledgement

Conflict of Interest

- No financial dealings with any pharmaceutical companies
- Remuneration for this activity is from the conference organizer only
- Medications will be discussed in generic names

Objectives

- Understand treatment modalities for primary mental health disorders in older adults.
- Learn about managing primary mental health disorders in older adults in LTC.
- Brief review of challenges with medication side effects.
- Excludes substance use disorders and delirium.

Overview

1. General principles
2. Decision-making pathway
3. Common disorders
4. Brief description of medication AEs
5. Special situation: renal and hepatic

1. General Principles

A good history …

- Clinical assessment
- Review meds
- Identify comorbid medical conditions
- MSE
- Physical examination
- Management

Management

- Biomedical
- Biosocial
- Biopsychosocial

How drugs affect? (Pharmacodynamics)

Increased incidence & severity of adverse effects (AEs)

- Constipation due reduce BM, such as anticholinergics
- Falls due to orthostatic BO such as TCAs
- Increased sensitivity to CNS depressants such as benzodiazepines

Delayed Response

- Longer time to respond to antidepressants

How body reacts? (Pharmacokinetics)

- Absorption: slow causing delayed action
- Distribution: more body fat, less body water, less protein leading to increased volume of distribution, longer duration of action. Higher drug concentration, reduced albumin-bound drug
- Metabolism: affected if hepatic derangement
- Excretion: may require dosage adjustment

Drug Interactions

- Some have a narrow therapeutic index leading to marked toxicity or therapeutic failure, such as Lithium
- Some Induce or inhibit
- Check interactions

How to reduce AEs

- Decide on the necessity of prescribing medications
- Avoid, if possible, drugs
  - Affecting receptors such as anticholinergic, alpha-blockers
  - Marked sedative effects
  - Long half-life
  - Potent inhibitors
  - Treating AEs with another drug
- Start LOW
- Go SLOW

Investigate

- Review comorbidities
- Identify all meds, including OTC
- Order relevant investigations

Psychological

- Psychoeducation
- Supportive psychotherapy
- Individual Therapies: CBT, psychodynamic, skills building, ERP
- Group Therapies
- Trauma-informed practice

Social

- Life story
- Family & friends
- Pre-morbid traits

2. Decision-making pathway

82yrs old female admitted from the hospital following a stroke with functional impairment. She has comorbid HTN, CAD, dyslipidemia & OA. On no psychotropic meds. Eats and sleeps invariably. She was noted to have crying spells, poor interest, avoiding contact, and irritability. The recent lab work is unremarkable.

What are the symptoms?	
Are the symptoms new, or relapsing?	
Is there a formal diagnosis?	
Are there any identifiable triggers?	
Are there any risks?	
Can we manage in LTC?	
Is the person receiving treatment?	
Does the person need treatment adjustment?	
Are other measures available?	
Re-assess	

3. Managing Primary Mental Health Disorders

Depression

- Two weeks' history of depressed mood or loss of interest and associated symptoms
- Common to have symptoms not meeting the full criteria
- Symptoms vary
- Comorbidities common
- High morbidity if untreated
- Baseline anxiety, physical illness and poor executive functioning associated with poor outcome

Management

- No one antidepressant superior to the other
- Avoid TCAs
- SSRIs are generally well tolerated
- SNRIs, Mirtazapine and Vortioxetine are alternatives
- Therapies: exercise, CBT, problem-solving therapy, behavioural therapy, behavioural activation, reminiscence, psychodynamic and IPT

Psychosis

- Schizophrenia
  - 2 or more features of delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behaviour or negative symptoms
- Schizoaffective
  - Mood and psychosis components
- Chronic or late-onset

Community Management

- Responders: 1/3rd improve, 1/3rd relapse, 1/3rd have a chronic course
- Non-responders: Clarify diagnosis, ensure adherence, assess SUD, comorbidities, AEs and drug Interactions
- Treatment-resistant with moderate symptoms, impairment & 2 failed therapeutic antipsychotics trials
- Multidisciplinary input
- Frist choice: SGA. Some may need more than one or on a LAI
- Adjunct: psychoeducation, follow-up, CBT for psychosis, skills building, ACT, family intervention, crisis intervention

LTC Management

Without CI

- Chronic with residual symptoms
- Some cognitive changes
- One or more SGA: do not alter until reviewed
- Multiple comorbidities and AEs

With CI

- Clarify if needing the # and dose of meds as before
- Identify & treat comorbidities/AEs

Clozapine

- Effective for treatment-resistant
- Choose: if ANC ≥1500 cells/microliter, benefits outweigh the risks, adherence, monitoring, & agree
- PTOP: Clozapine initiation protocol in the community
- Average target dose: 300mg daily
- If stopped for 48H or more: start low, then quicker titration
- Monitoring: weekly, then fortnightly & then monthly
- Red, amber & green signals may suggest caution or hold
- AEs: Myocarditis (CMP), Metabolic, GI, QTc prolongation, agranulocytosis, PE, weight gain, seizures, sialorrhea, incontinence, sedation, movement disorders

Delusional Disorder

- One or more delusions.
- Prominent hallucinations and other psychotic or mood modalities are absent
- Examples: grandiose, morbid jealousy, persecution, reference, somatic
- May have predominant paranoid personality traits

Community Management

- Develop a therapeutic relationship
- First choice: SGA
- Difficult to shift beliefs as patients as they do not believe they have a problem, stop meds or default
- Often require MHA use
- Other measures: CBT for psychosis, supportive

LTC Management

Without CI

- Will likely see a chronic illness so decide if treatment required
- First choice: already on or stopped SGA
- Decide on MHA use
- Other measures: supportive

With CI

- Often seen as a prodrome of MNCD & develop beliefs of varying degrees or one fixed delusion

Bipolar Disorder

- Chronic or late-onset
- May have
  - Depressive episode
  - Hypomanic or manic episode
  - Mixed episode

Community Management – 1

- Remission: 1 or 2 minor symptoms & no psychosis
- Response: reduced #, frequency & intensity
- Meds: start low, go slow, monitor SEs, drug-drug interactions, review Medical comorbidities
- Mood stabilizers: monotherapy or adjunct
- Poor responders: review diagnosis, adherence, comorbidities & stressors

Community Management – 2

Bipolar Depression

- First choice: Lithium, Lamotrigine, Lurasidone or Quetiapine
- Second choice: Divalproex, adjunct SSRIs, Bupropion, SGA, ECT

Bipolar Mania/Hypomania

- First choice: Lithium, Divalproex, Quetiapine, Asenapine, Aripiprazole, Paliperidone or Risperidone
- Second choice: Olanzapine, Ziprasidone, Carbamazepine, Haloperidol

LTC Management

- Existing chronic disease either in remission or partial response
- Likely on multiple meds: monitor AEs, drug interactions, review medical comorbidities
- If on AEDs or SGA: adjust based on the episode, monitor AEs
- If on lithium: adjust based on the episode, may need to reduce the dose or other meds if patients has CI, monitor levels & AEs
- Ensure adherence & review stressors

Lithium – 1

- Generally require low dose: 300-900 single or divided doses
- Renally excreted
- Serum levels: 0.4-0.7/8 taken 5-7 days after each inc.
- AEs: ataxia, GI upset, hypothyroidism, hypercalcemia, polyuria, polydipsia, nausea, metallic taste, rash, tremors, confusion, weight gain, cognitive dysfunction, and arthritis
- Toxicity: Look for worsening signs exacerbated by comorbidities such as dehydration
- Drug interactions: ACE-I, NSAIDs & Thiazide diuretics can inc. levels

Lithium – 2

Baseline	eGFR, TSH, calcium, ECG, weight
After starting	Lithium levels 5-7 days after each dose change until the steady state has reached Depressed: 0.4 mmol/l Hypomanic: 0.6-0.8 mmol/l Blood sample should be taken after 12H
Monitor	Lithium levels every month for 3 months, then every 3-6 months eGFR every 3 months after starting, then every 6 months TSH 6 after starting then every 12 months Calcium every 12 months
Discontinuing	Hold if toxic & seek assistance If discontinuing, then reduce slowly over 1-3 months before stopping.

Divalproex

- Start low: 125 mg daily (generally 500-1500 mg daily but may need a higher dose)
- May adjust the dose if needed
- AEs: nausea, vomiting, hair loss, easy bruising, sedation, weight gain, tremors, elevated LFTs, encephalopathy, thrombocytopenia

Baseline	CBC, LFTs & weight
After starting	Loading dose may be given for hypomania. Blood sample should be taken before the next dose 2-5 days after dose change
Monitor	Divalproex levels, CBC & LFTs every 6 months
Discontinuing	Reduce slowly over at least 1 month but faster if needed

Obsessive Compulsive Disorder

- Obsessions: Recurrent, intrusive and distressing thoughts, images, or impulses
- Compulsions: Repetitive mental or behavioural acts compelled to perform to prevent or reduce distress
- Often with comorbid illnesses
- Treatment: 1-2 years or longer

Management

- First choice: SSRIs, CBT or both
- Second choice: switch to another SSRI, Clomipramine or Venlafaxine
- Augmentation: CBT, antipsychotic or Clomipramine

CBT: Exposure & Relapse Prevention (ERP)

Meds: Higher doses to achieve Serotonergic response

Generalized Anxiety Disorder

- Excessive worry and anxiety that are difficult to control.
- Common
- Often with comorbid illnesses

Community Management

- Decide on treatment
- First choice: SSRI/SNRI or CBT or both
- Other choices/augmentation: Buspirone, Gabapentin, Mirtazapine, Vilazodone, Vortioxetine, antipsychotics (SGA)
- Meds: A lower starting dose, review previous trials, response, SEs, and drug-drug interactions.
- If acute: Gabapentin
- A select group of patients: low-dose benzodiazepines (short-term)
- Other: psychoeducation, supportive psychotherapy, CBT, Mindfulness therapy (MT)

LTC Management

Without CI

- Either a chronic subsyndromal state or a relapse
- Identify triggers
- Decide on treatment
- Review existing meds, previous trials, responses, SEs, comorbidities, and drug-drug interactions.

With CI

Generally, part of the DRB

Phobias

- Specific is a fear of a particular object/situation leading to avoidance
- Common
- Most don’t seek help

Community Management

- Psychoeducation
- First choice: CBT with exposure
- Limited role of medications
- If acute: benzodiazepines for a select group

LTC Management

Without CI

- No significant difference
- BUT identify fears/past trauma that may interfere with engagement and socialization

With CI

Identify fears/past trauma that may interfere with engagement, socialization and interventions such as care

Post Traumatic Stress Disorder

- Exposure to a traumatic event involving actual or threatened harm to themselves or others
- Key: intrusive thoughts, nightmares, flashbacks, avoidance of reminders of the trauma, hypervigilance, altered sleep
- Some avoid seeking treatment
- Often have comorbid SUD, TBI, sleep disturbance

Community Management

- Trauma-focussed psychotherapy: CBT, exposure, eye movement desensitization and reprocessing (EMDR)
- SSRIs
- SNRIs
- Prazosin (alpha-adrenergic blocker) for nightmares
- May need an SGA

LTC Management

Without CI

- Meds: SSRIs, SNRIs, Prazosin (alpha-adrenergic blocker) for nightmares and an SGA
- Therapies: Trauma-focussed psychotherapy
- Trauma-informed Practice

With CI

- May pose a challenge in trusting others, isolating, resistive to care
- Trauma-informed Practice

Somatic Symptom Disorder

- One or more somatic symptoms accompanied by excessive thoughts, feelings and/or behaviour related to the somatic symptoms.
- Chronic
- Coexisting medical condition, such as pain makes it difficult

Community Management

- Scheduled visits
- Rapport
- Psychoeducation and therapy (CBT)
- Reduce/stop unnecessary consultations/investigations
- Identify & treat comorbid medical condition
- Identify & treat comorbid psychiatric illness
- Identify the need for medication
- Involve families

LTC Management

- Most cases have a comorbid psychiatric illness and/or AMC
- Scheduled visits
- Rapport
- Psychoeducation for the patient and/or family
- Reduce/stop unnecessary consultations/investigations
- Psychotherapy – relaxation is a Key component

Panic Disorder

- Recurrent and unexpected panic attacks worry about future attacks or consequences or a change in behaviour due to the attack.
- Chronic course
- Can occur with or without other disorders
- Can occur with or without avoidance such as Agoraphobia

Community Management

- Decide on treatment
- First choice: SSRI or CBT or both
- Second choice: SNRI
- Meds: A lower starting dose, review previous trials, response, SEs, and drug-drug interaction. Try for at least a year and review
- If acute: Gabapentin or Pregabalin
- A select group of patients: low-dose clonazepam (short-term)
- If insomnia: Mirtazapine
- Other: psychoeducation, supportive psychotherapy, group psychotherapy

LTC Management

- Chronic or relapse with or without a comorbid cognitive impairment
- Decide on treatment
- Assess comorbidities, including medications contributing
- Identify triggers

Personality Disorder

- Pervasive lifelong patterns of perceiving, relating to, and thinking about others impair functioning and QoL
- Rigidity makes them vulnerable to stress
- Often have comorbidities
- High utilization of community services
- May have cognitive distortions or perceptions (paranoid), impulse control (SIB, conflict, stealing) & affective dysregulation (anger, anxiety, labile mood)

Management – 1

- Clear plan
- Clarify diagnosis & comorbid conditions
- First choice: psychotherapy
- Adjunct: meds based on comorbidity while avoiding meds that may cause harm if OD, psychoeducation
- Minimize hospital admission or changing meds as a crisis intervention

Management – 2

- Cluster A (paranoid, schizotypal, schizoid): psychotherapy and sometimes low-dose SGA
- Cluster B (borderline, narcissistic, histrionic): psychotherapy, meds including antidepressants, mood stabilizers, and sometimes low-dose SGA
- Cluster C (avoidant, dependent, obsessive-compulsive): target comorbid anxiety & mood dysregulation

LTC Management

- Identify, classify, Can interfere with their care and affect teams
- Agreeing on a care plan with realistic goals and acknowledging limitations
- Improving communications at all levels
- Apply behaviour management: a clear & consistent approach, setting boundaries, validating symptoms, minimizing frequent med changes
- May use meds & psychotherapy if available and willing: symptom relief & improving adaptation but unrealistic to expect a significant change
- Staff support
- Seek help

4. Adverse Effects – a brief description

Antidepressants

- Anticholinergics AEs: TCAs, Paroxetine
- Postural hypotension: TCAs, Trazodone
- Falls risks: SSRIs, TCAs
- High blood pressure: SNRI
- Sedation: variable with TCAs, Paroxetine, Fluvoxamine, Mirtazapine, Trazodone
- Weight gain: TCAs, Paroxetine, Citalopram, Mirtazapine
- Weight loss: Duloxetine
- OD: SSRIs & SNRIs are relatively safer
- Bleeding: SSRIs (+NSAIDs +Aspirin)
- Interstitial Lung Disease: SSRIs, SNRIs
- Nausea: More with SNRIs
- Hyponatremia: All antidepressants
- Prolong QTc interval

Antipsychotics

- Metabolic – weight gain, hyperlipidemia, hyperglycemia, and hypertension
- Cardiac – Orthostatic hypotension with Inc HR, prolonged QTc, Myocarditis, Cardiomyopathy
- Sexual – Galactorrhea
- Hematological – Abnormal WCC
- Seizures
- Anticholinergic – Inc HR, dry mouth, urinary retention, constipation, blurred vision and confusion
- Sedation
- Neuroleptic Malignant Syndrome

Extrapyramidal Side Effects (EPSEs)

- Akathisia is a sensation of restlessness, frequent pacing, a compelling urge to move, or an inability to sit still.
- Parkinsonism
- Dystonia is a tonic contraction of a muscle or muscle group.
- Tardive Dyskinesia
  - Sucking, smacking of lips
  - Choreoathetoid movements of the tongue
  - Facial grimacing
  - Lateral jaw movements
  - Choreiform or athetoid movements of the extremities and/or truncal areas

5. Special situation

Hepatic Impairment

- Use fewer meds and lower starting doses
- Avoid extensively hepatically metabolized meds (except Amisulpiride, Gabapentin & Lithium)
- Slow titration leaving longer intervals
- Avoid meds with long half-lives, such as Fluoxetine
- Avoid highly sedative meds or constipating
- Preferred meds
  - AD: Paroxetine, Sertraline, Citalopram or Vortioxetine
  - SGA: Amisulpiride, Sulpiride, Paliperidone
  - Mood stabilizers: Lithium
  - Sedatives: short-acting

Renal Impairment

- Use fewer drugs
- Assumed to have mild renal changes
- Avoid nephrotoxic meds
- Avoid extensively renally excreted
- Start low and go slow
- Avoid long-acting agents
- Monitor SEs – weight gain, toxicity, serotonin syndrome, NMS, anticholinergics
- Preferred meds – no clear preferred
  - AD: Sertraline, Citalopram
  - Antipsychotics: Haloperidol, Olanzapine
  - Mood stabilizers: Avoid lithium. Use Valproate or lamotrigine if needed
  - Sedatives: short-acting

Questions?