Fire and Rain

CASE PRESENTATION
POA/BGS JOINT MEETING 29/1/16
DEARBHAIL LEWIS
CONSULTANT PSYCHIATRIST, BELFAST H&SC TRUST
Attitudes to ECT

• Medical student knowledge and attitudes regarding ECT prior to and after viewing ECT scenes from movies. J ECT. 2002 Mar;18(1):43-6

• 94 students, shown images of ECT from 5 movies
• Watching movies influenced attitudes
• Support reduced by one third
• Proportion who would dissuade family/friend rose from <10% to 25%
“Depression is the most unpleasant thing I have ever experienced. It is that absence of being able to envisage that you will ever be cheerful again. The absence of hope. That very deadened feeling, which is so very different from feeling sad. Sad hurts but it's a healthy feeling. It is a necessary thing to feel. Depression is very different.”

JK ROWLING
Demographics

• 87 year old lady
• Retired housekeeper
• Married
Referral

• 9/7/15
• Admitted generally unwell and recent fall
• Hyponatraemia/AKI
• Ongoing low mood
• Mirtazapine held due to hyponatraemia
HPC

• ‘Poorly’, sore all over
• Feeling worse than when first admitted
• Memory failing
• Something to help me walk

• Collateral
  • Confusion improving
  • Multiple falls
  • Mood low in hospital
Past Psychiatric History

- Known to POA Northern Trust
- Mirtazapine since 2007
- Dose of 30mg on admission
Personal and Social History

• B&B in Fermanagh
• Left school age 14
• Housekeeper for ‘The Colonel’
• Husband’s job in Belfast → moved to Belfast
• 3 children
• Youngest daughter RIP 2010
• Living with husband
• Independent ADLs
Initial MSA

- Little reactivity/spontaneous conversation
- Sleep – poor for years
- Appetite – recent ↓
- ↓↓ energy
- No TLNWL, no TSH,
- Nil psychotic
- MMSE 24/28
Initial Management

• Colleague advised trial of Sertraline

• Re-referral 21/7/15
  • Further ↓ in Sodium following commencement of same
Reassessment 22/7/15

• Daughter present throughout
• Eyes closed for most of assessment
• Little spontaneous
• Subjectively and objectively mood very low
• Appetite poor, sleep also poor, energy levels very low

• No viable option for anti-depressant therapy
Further reassessment 30/7/15

• Sodium 127
• Feeling ‘very poorly, very low’
• Very poor sleep, ↓ energy levels, ↓ interest, anhedonia
• Poor concentration
• MSA
  • Mild PMR
  • Eyes closed
  • Subjectively & objectively depressed, biological markers
  • Restricted affect
  • Negative cognitions, guilty ruminations
  • Nil psychotic
  • Good insight
• Moderate depressive illness
• Limited options for anti-depressant therapy
Deterioration in Mental State 12/8/15

• Reporting anxiety

• Increase in negative cognitions

• MSA
  • Very lethargic
  • Speech ↓ rate, ↓ volume, very limited spontaneity
  • Further deterioration in mood
  • Biological markers all ↑
  • More ruminative
  • Hopelessness, uselessness

• Moderate-severe depressive episode

• Discussed ECT
ECT

• ECG/Echo/CXR/Repeat bloods
• Anaesthetics opinion
• Consent
• Staff in Ward D agreed to facilitate
• First session 18/8/15
• 8 session in total
Progress with ECT

• Improvement evident from session 3
  • Concentration ↑, motivation ↑, brighter, ↑ spontaneity

• Review 9/9/15
  • Mood ‘good enough for an old doll my age’
  • Eating well, motivation ↑, positive re future
  • Good insight

• One further ECT on 10/9/15
Follow-up

• Discharge to Inver House on 11/9/15

• D/W Ward Sister on 21/9/15
  • Mood reasonable
  • Confused – diagnosed with UTI
  • Explained likely diagnosis of delirium; advice given

• Services reconfigured in Northern Trust
  • HTT/RAID/Community POA?
  • Initial follow-up by RAID practitioner
  • Transfer care back to Community POA
Suicide in the Elderly
“Things aren’t going to get worse. You want to kill yourself. That is as low as it gets. There is only upwards from here.”

“Ignore stigma. Every illness had stigma once. Stigma is what happens when ignorance meets realities that need an open mind.”

MATT HAIG

REASONS TO STAY ALIVE
Epidemiology

• Around 75% of suicides in older people are in males
• Violent methods more common in males
• Recent years – rate of suicide in older people ↑
Age-specific rates of suicide 2001-2013 (Office of National Statistics)
Factors in higher rate of completion

• Higher burden of physical illness
• Reduced physical reserves
• Higher rates of living alone
• Access to medications
• Greater planning
Self harm, suicidal ideation and suicide

- Lower rates self harm
- Similar demographics
- Rate of suicide ↑ in year following episode of self harm
- Murphy et al - risk of suicide x67 in those over 60 who self harm
- Violent methods - ↑ higher overall rates in males

- Suicidal ideation ↓ with ↑ age
- Tiredness of life → wishing to die → suicidal ideation
Mental illness and Suicide

• 71-95% completed suicides had diagnosable mental disorder at time of death

• Suicide in older people linked to
  • Bipolar disorder
  • Unipolar depression
  • Anxiety disorders
  • Psychotic disorders
Depression

• Principal psychiatric disorder seen in completed suicides

• Specific symptoms
  • Insomnia
  • Weight loss
  • Guilt feelings
  • Agitation
  • Hypochondriasis

• More hopelessness

• Poorer social networks
Dementia

• Does not appear to lead to an overall increased risk
• Increased risk early in the disease
• Disease progression may be protective
Personality Disorder

• PD/personality trait accentuations important predictors
  • Anankastic
  • Anxious

• Reclusive/hostile/independent

• High neuroticism scores

• Low openness to experience scores
Suicide and terminal illness

- Beeston et al – 25% suicidal/wished for an early death

- Independent association with increased risk
  - CCF
  - Chronic lung disease
  - Seizure disorders

- Chronic pain conditions

- Multiple illnesses
Social factors, life events and alcohol

• Retirement
• Change in living arrangements
• Bereavement
• Decline in functional level

• 1/3 of male, 1/4 female completed suicides
• Harmful/dependent use are important risk factors
Risk Assessment

- Assess act itself
  - Intended outcome
  - Prior planning
  - Attempts to prevent discovery
- Thorough medical history – chronic pain/terminal diagnosis
- Past psychiatric history/ past self harm
- Social stressors/loss of function
- Mental state assessment
  - Depression
  - Cognitive assessment
Prevention

• Reduce availability of lethal methods

• Service provision
  • Primary Care
    • Training and Education
  • Secondary Care
    • Greatest risk in 1/52 after discharge
  • Treatment Adequacy
    • Low antidepressant treatment levels
  • Preventive Strategies
    • Screening policies
    • Development of community POA
    • Education/liaison with general hospital
    • Local/national audit programmes
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