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Management of Older Adult Mental Health Conditions in sub-Saharan Africa

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Background

The number of older persons living in sub-Saharan Africa (SSA) is projected to increase by 239% between 2015 and 2050.¹ The rising demographics present several challenges for both mental and physical health services provision in the region. For example, while there is an increase in the burden of conditions such as dementia in SSA¹, specific and implementable policies for the health and well-being of older adults are rare in most countries in the region. There were no geriatric assessment units in Nigeria in the year 2002² and little has changed since then, with only one such unit in the University College Hospital, Ibadan. The same is true of most sub-Saharan Africa except, probably, South Africa.³

Inadequacies in mental health provision in Africa can be viewed from two angles: poverty and lack of policy. Per

capita health expenditure is low in many SSA countries; in the year 2014 it was 17 US dollars in Central Africa Republic, Kenya \$78, Ghana \$58, Nigeria \$118 and South Africa \$570. The overall amount for sub-Saharan Africa was \$98.⁴ These figures are inexplicably low compared with Canada \$5292, Switzerland \$9674. The World Alzheimer's Report⁵ clearly pointed out the relationship between mental health provision for older adults and per capita health expenditure. It thus follows that to some extent there is a relationship between good economic status and provision of good health services. Also, only a minority of pensionable persons are able to access their pension. There are no social welfare packages, and access to health care is mostly dictated by personal financial resources.⁶

In this chapter we will provide an overview of the current trends in the management of mental health disorders in the older population, and within the unique social, economic and cultural context of SSA.

Differences in clinical presentation of mental health disorders in younger person may include the presence of physical health co-morbidities. This often leads to a more complicated clinical picture and lead to a more complicated diagnosis and treatment. It is often important to get collateral information from other close relatives, neighbours or friends to get a better understanding of the patient's condition.

Co-occurrence of physical and mental health disorders also serves to complicate the management of mental health disorders in the older person. First, the presence of physical morbidities are also more likely to complicate the management of mental health disorder. Second, the older person is also likely to use multiple medications for their physical health conditions. Third, the older person is also likely to use multiple medications for their mental health conditions. Whereas, age-related changes in metabolism and reductions in renal function may lead to older people more likely to be susceptible to side effects from these medication.⁷

In the particular context of SSA, the management of mental health disorders are still poorly understood. Many of

capita health expenditure is low in many SSA countries; in the year 2014 it was 17 US dollars in Central Africa Republic, Kenya \$78, Ghana \$58, Nigeria \$118 and South Africa \$570. The overall amount for sub-Saharan Africa was \$98.⁴ These figures are inexplicably low compared with Canada \$5292, Switzerland \$9674. The World Alzheimer's Report⁵ clearly pointed out the relationship between mental health provision for older adults and per capita health expenditure. It thus follows that to some extent there is a relationship between good economic status and provision of good health services.

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1. Challenges in managing older people's mental health

Mental health disorders in older adults could present unique challenges in diagnoses and management. As such, clinical practice of old age psychiatry requires skills that bridge the gaps between psychiatry, general medicine/geriatrics, neurology and psychopharmacology.

Differences in clinical presentation between the older and younger person may include the presence of mental and physical health co-morbidities. This overlap may conflate signs and symptoms of one condition with that of another and lead to a more complicated clinical picture. It is thus often important to get collateral information from carers and other close relatives, neighbours or friends.

Co-occurrence of physical and mental health conditions also serves to complicate the management of mental health condition in the older person. First, elderly persons with co-morbidities are also more likely to have greater disability which in turn compounds the management of the mental health disorder. Second, the older person with co-morbidities is also likely to use multiple medications or receive other therapies. Whereas, age-related reductions in hepatic metabolism and reductions in renal drug clearance make older people more likely to be susceptible to the effects of these medication.⁷

In the particular context of SSA, mental health disorders are still poorly understood. Many of the important signs and symptoms of emerging neurobehavioural and emotional disorders are often interpreted in terms of the prevailing socio-cultural beliefs. For example, symptoms such as worsening memory, slowing of function and a lack of spontaneity are perceived as normal and inevitable aspects of

aging: whereas hallucinations and delusions are sometimes interpreted as demonic,⁸ and many patients with these presentations are ultimately accused of witchcraft or demon possession. These explanatory models, coupled with the prevailing intergenerational living arrangements in many African societies, prevent large numbers of patients from presenting for diagnosis and treatment in the earlier stages of disease.

In most situations of emerging mental health conditions, family members simply take over the everyday responsibilities of their wards, and only present them at the hospital when their behaviour becomes too bewildering to cope with at home.

2. Assessment and treatment of cognitive disorders

Dementia is one of the major causes of disability in older people. It is a complex syndrome characterized by an acquired global, mostly irreversible, and progressive decline of intellect, memory, personality, and ability to cope with activities of daily life, occurring without impairment of consciousness. Dementia runs a chronic course, and is associated with severe adverse consequences on social participation, physical activities and quality of life.

In cognitive impairment (no dementia) and mild cognitive impairment, the cognitive deficit is often less severe

than in dementia and normal daily function and independence are generally maintained. Mild cognitive impairment may sometimes precede dementia, and this is observed to be so in up to one third of cases.^{9,10}

The most common type of dementia is Alzheimer's disease, followed by vascular dementia (caused by cerebrovascular/stroke disease); dementia with Lewy body (associated with Parkinson's disease); Parkinson's disease dementia (a separate condition from Lewy body dementia); fronto-temporal dementia (Pick's disease). In sub-Saharan Africa, HIV-related dementia, which is a disease of younger adults not just older people, is of clinical importance.

The flagship of dementia research is the Indianapolis-Ibadan research study^{11,12} which reported low prevalence and incidence of dementia in Nigeria. Similar findings have been reported in other studies in Nigeria.^{13,14} Some studies from Central African Republic and Tanzania have reported higher prevalence rates.^{15,16} The prevalence of dementia generally rises exponentially with age up to the age of 85 years.^{11,12} Many studies in the Western world suggest that regular physical exercise and a healthy diet, control of cardiovascular risk factors, such as high blood pressure, lipid levels, blood sugar, weight, alcohol intake and smoking, can reduce the chances of developing dementia. In a recent report, the

incidence of dementia decreased in Indianapolis while it remained stable in Ibadan over about 10 years.¹⁷

A possible explanation for that is the increased awareness in American society which has allowed both individuals and health-care facilities to take appropriate preventive strategies as indicated above. Prince in a global survey suggested that there is some evidence that the incidence of dementia is decreasing in the industrialized world, while the prevalence rate is increasing in East Asia and that is consistent with a worsening cardiovascular risk factor profile.¹⁸

The most commonly cited risk factors for dementia in the context of SSA include older age and female gender,^{12,13,14} hypertension,¹⁹ poor pre-dementia cognitive function and unskilled lifetime occupational attainment.²⁰

HIV-associated dementia

Neurocognitive disorders in people with HIV may be caused by the virus directly damaging the brain. They may also be the result of a weakened immune system enabling infections to damage the brain. Countries in sub-Saharan Africa are among the highest contributors to the global HIV burden.

HIV-associated dementia affects younger adults but there may be an increase in older HIV/AIDS survivors on highly active anti-retroviral drugs. Older adults may particularly be at risk of HIV-associated dementia. Reports from SSA gave

the prevalence of HIV-associated dementia at between 7% and 38% among HIV clinic attendees.^{21,13}

Clinical features and management of dementia syndromes

There are clinical features common to all the dementia syndromes, irrespective of the primary cause of the disease. These include memory loss, which usually presents gradually over time, but can occasionally be abrupt (for instance as a consequence of an acute stroke) with disturbances in new learning and learning capacity, aphasia (language difficulties), apraxia (difficulties with motor movements), agnosia (inability to recognise people/objects), loss of executive function, difficulties in thinking, orientation, comprehension and judgement.

Consciousness is usually not clouded unlike in delirium. In addition, patients with dementia can present with neuropsychiatric features called behavioural and psychological symptoms of dementia (BPSD), including psychotic symptoms such as delusions and hallucinations, repetitive behaviour, mood disturbance (e.g. depression), agitation, wandering, physical aggression, sleep disturbance and disinhibition.²²

In the studies conducted in Ibadan, Nigeria, depression was the most common behavioural symptom in the context of dementia and mild cognitive impairment.²³ The two most

important stages for the clinician to follow in the diagnostic process are:

- i. To establish a diagnosis of dementia, and
- ii. To establish the cause of the dementia syndrome.

This will help to both guide management strategies and rule out treatable confounding illnesses such as depression and delirium.

Investigations

Table 1. Assessments to be made in dementia

<p>Clinical history: cognitive, behavioural and psychological symptoms (family history as well as input from close informants/careers)</p> <p>Physical examination: causes of cognitive impairment (eg: urinary tract infection, cardiac failure, visual or hearing impairment)</p> <p>Executive functioning: check for impairment of</p> <p>Activities of daily living: (including washing, dressing, eating)</p> <p>Medication review</p> <p>Full blood count (FBC),erythrocyte sedimentation rate (ESR), liver function test (LFT), thyroid function test, Fasting blood sugar, vitamin B₁₂ and folate, calcium, fasting lipids</p> <p>Scans: Computed tomography scan or magnetic resonance imaging</p>

<p>If indicated</p> <p>Chest X-ray, electrocardiogram (ECG), mid-stream urine (MCS), serology for HIV, syphilis electroencephalogram</p>
<p>Special Investigation</p> <p>Neuropsychological assessment: These include Consortium to Establish a Registry for Alzheimer's Disease (CERAD)²⁴</p> <p>Cambridge Cognition Examination (CAMCOG)²⁵</p> <p>Clock Drawing Test²⁶</p> <p>Mini Mental State Examination MMSE²⁷</p> <p>In the context of low literacy as observed in the sub-Saharan region, Sick Design Test²⁸ might be useful.</p>

Treatment for dementia

Treatment for dementia can be divided according to the stage of dementia (early stage, middle stage or late stage), subdivided into pharmacological and non-pharmacological treatment, and further sub-divided into treatments for cognitive symptoms and treatments for non-cognitive symptoms.

People with mild to moderate Alzheimer's disease, dementia with Lewy bodies, and mixed dementia (caused by both Alzheimer's disease and vascular dementia) could benefit from taking a cholinesterase inhibitor. Cholinesterase inhibitors are not a cure, but can treat some symptoms in

some patients. They are not licensed for treating any other form of dementia.

There are three cholinesterase inhibitors licensed to treat Alzheimer's: Donepezil (Aricept), Rivastigmine (Exelon) and Galantamine (Reminyl). All three drugs work in a similar way. So far, no difference in the effectiveness of the three cholinesterase inhibitors has been shown, but some people may seem to respond better to one drug than another or have fewer side effects. Rivastigmine is also available in liquid form or in patches, where the drug is absorbed through the skin. People with mild or moderate Alzheimer's disease may find that their conditions improve by taking a cholinesterase inhibitor. This could be improvement in thinking, memory, communication or day-to-day activities. Others may find that their condition stays the same.

Cholinesterase inhibitors work by blocking the enzyme responsible for the breakdown of acetylcholine in the brain. Acetylcholine is the main neurotransmitter for memory, but this treatment option will not stop the disease from progressing in the brain and symptoms can continue to get worse over time. However, they can help people to function at a slightly higher level than they would do without the drug. The most common side effects of cholinesterase inhibitors are nausea (sickness), vomiting, diarrhoea,

insomnia, muscle cramps, and tiredness. These effects are often mild and usually only temporary.

Memantine is a partial *N-methyl-D-aspartate* (NMDA) receptor antagonist currently recommended for people with severe Alzheimer's disease, and for people with moderate Alzheimer's if cholinesterase inhibitors don't help or are not suitable. Memantine prevents the excitotoxic actions of glutamate by blocking the influx of calcium ions into the neuron, slowing down cell damage. It is normally given as tablets, but it is also available as a liquid.

Managing behavioural and psychological symptoms of dementia

Behavioural and psychological symptoms of dementia (BPSD) affects between 70% and 90% of individuals with dementia and is of significant distress to both the individual and their care givers.^{23,29}

Non-pharmacological management is considered firstline in the management of dementia with or without BPSD and should be employed regardless of whether a decision is taken to commence medication. Routine monitoring and evaluation need to be undertaken on a regular basis by the clinician. These strategies are listed.

Non-pharmacological management strategies

- Provide a 'dementia-safe' and friendly environment
- Maintain a set routine
- Avoid over-stimulation
- Psychoeducation for family/care-givers
- Adequate training for care-givers
- Reminders and repetition of information
- Orientation with clocks, calendars, newspapers
- Regular social interaction and activity
- Regular exercise
- Reminiscence therapy
- Validation therapy
- Resolution therapy
- Pet therapy
- Respite care to relieve care-giver burden
- Supportive counselling for family members

A recent study from Tanzania indicates that cognitive stimulation therapy produces substantial improvements in cognition, anxiety, and behaviour symptoms with smaller improvements in quality of life measures in persons with dementia.³⁰

A number of individuals with dementia may require pharmacotherapy for the treatment of BPSD. Antipsychotics have traditionally been the treatment of choice for the management of behavioural disturbance in dementia but recent warnings of the increased risk of stroke in elderly patients using all classes of antipsychotics and risk of worsening confusion in dementia now make these drugs second line treatments. A useful approach when deciding on an appropriate agent would be to first identify and treat depression and anxiety disorders if present, secondly to consider cognitive enhancers where appropriate, and finally to consider alternative agents, e.g., anticonvulsants, and antipsychotics (see table 2).

Table 2. Pharmacological therapies in elderly patients

Therapy	Medication	Additional notes
Antidepressants	Citalopram 20mg/day: initiate at 10mg Fluoxetine 20 - 40mg/day	Few CYP450 interactions Inhibits CYP450 2D6 & 3A4 Some dopaminergic activity
SSRIs	Serttraline 50-100mg	
SARI (serotonin 2 antagonist/reuptake	Antitriptyline initial dose 25 - 50mg/day, increase gradually to	Cardiotoxic, anticholinergic, antihistaminic side-effects

inhibitor)	100mg/day	Hypotension
TCAs	Trazodone 25mg at night	Antihistaminic side-effects Hypotension
	Donepezil 5 - 10mg at night	
Cholinesterase inhibitors	Galantamine 16-24mg/day Rivastigmine 6 - 12mg in 2 doses	GIT side-effects are common in all three
NMDA receptor antagonist	Memantine 10 mg twice daily	Dizziness and headache may occur
	Sodium valproate 10 - 15mg/kg in divided doses	
Anticonvulsants	Carbamazepine 400mg/day in divided doses	Start with smaller dose and titrate up CYP450 3A4 inducer
	Haloperidol 0.5 - 1mg/day	Watch for EPSs
Anti-psychotics	Risperidone 0.5mg twice daily: may initiate at 0.25mg twice daily	Weight gain, may increase prolactin
Typical	Quetiapine 25 - 50mg at night	Hypotension, sedation, weight gain
Atypical	Olanzapine 2.5 - 10mg/day	Weight gain

Management of depression in older people

Depression is a common disorder in older adults. The prevalence of depression in elderly people has been reported to be between 10 and 20%. Older adults with physical illnesses or living in residential care facilities showed a higher prevalence rate of depression. Generally, physical illnesses are associated with an increased risk of depression and depression is significantly more common in people with chronic illnesses than in people who are in good physical health.³¹ Depression is generally associated with an increased risk of suicide, decline in functioning and quality of life. It also increases the utilisation of health-care services.

The prevalence rates of depression in older adults in sub-Saharan Africa vary depending on location and methodology. Studies where depressive symptoms are measured tend to report higher rates than those in which a categorical diagnosis based on ICD-10 or DSM-IV are used. Some of the studies in Nigeria include that of Uwakwe³² in older adult in-patients; Gureje³³ a community-based study in urban and rural areas; and Sokoya and Baiyewu³⁴ in older adults attending primary care. Others include those of Baiyewu,³⁵ of older adults living in rural areas and Olagunju³⁶ which looks at the burden of depression and social support. A report from South Africa by Tomita³⁷ examined depression and disability in older adults.

Depression is generally associated with an increased risk of suicide, decline in functioning and quality of life. It also increases the utilisation of health-care services. There are no reports of suicide rates in the older adults in sub-Saharan Africa but suicidal ideas, plans and attempts were 4.0%, 0.7% and 0.2% respectively in community dwellers 65 years or older.³⁸

Compared with non-depressed people, those with a 12-month diagnosis had a worse overall quality of life. There is also a high level of unmet needs for treatment of depression in older people. One Nigerian survey found only about 37% of elderly persons with lifetime depression had ever received any form of treatment, either from orthodox or traditional health providers for their depressive illness, with men more likely to have ever done so. Area of residence was related to access to treatment, with those in urban areas three times as likely to have received treatment as those in rural areas.³³

Many developed countries recommend screening for depression in primary care settings. This is because detection of depression in older adults is difficult, as somatic symptoms of depression such as loss of appetite, weight loss, decreased energy and disturbed sleep are similar to the symptoms of other physical illnesses. However, devoting time to screening in a busy clinic in sub-Saharan Africa may be difficult. Despite all of these complex interactions, depressive illnesses

are fairly easy to treat and the cost of treatment is relatively low.

A wide range of pharmaceutical treatments and psychosocial interventions can relieve the symptoms of depression especially if detected and treated early. Early detection and management of the disease can alter the prognosis.

Management options

Screening

Screening for depressive symptoms by use of questionnaires should not be routine, but may be needed in certain clinical situations. Questionnaires that have been proved useful in research situations are ideal. They include the Geriatric Depression Scale (GDS-15 items).³⁹ There are shorter versions GDS-6 and GDS-5. Another questionnaire that is useful for adults and older adults is Patient Health Questionnaire (PHQ-9). It is a 9 item questionnaire.⁴⁰ A shorter form, PHQ-2, is available and can be administered before either PHQ-9 or GDS-15. These questionnaires can easily be filled out by patients, but with the situation of low literacy in the SSA, it might be necessary to have the interviewer administer.

Psychological and talking therapies

There is good evidence for the effectiveness of a number of psycho-social interventions such as cognitive behavioural therapy (CBT), behavioural activation and problem solving treatment. These should be tried before or along with the use of medication (as appropriate) depending on the severity of the depression.

Medication

Antidepressant drugs are equally effective. The principles of prescribing antidepressants are the same as those for prescribing for younger people. Firstline treatment should be with an SSRI (selective serotonin reuptake inhibitor). Choice of antidepressant should be guided by the patient's previous experience of an antidepressant, and by co-morbidities and side effects.

Tricyclic antidepressants (TCAs) and Serotonin and Noradrenaline reuptake inhibitors (SNRIs) should not be initiated in primary care, but are occasionally suggested for secondary care for use in treatment-resistant depression. Amitriptyline is frequently started in primary care for older people with chronic pain, but co-prescribing of both a TCA and an SNRI should be avoided. At least four weeks of one antidepressant should be tried (and concordance ensured)

before changing to another SSRI or an antidepressant of a different class.

The side effects with SSRIs include insomnia, agitation, headache, sexual dysfunction, gastrointestinal disorders (including GI bleeding) so care must be taken if the patient is prescribed aspirin). Antidepressants should be continued for at least six months. Long term treatment for relapse prevention should be considered in people who have had recurrent depression. The use of mood stabilisers and electroconvulsive therapy for severe treatment resistant depression follows the same principles in treating younger adults.

Recognising and treating delirium/acute confusional states

Delirium is characterised by abrupt onset and fluctuating disturbances of cognition (memory, orientation, language skills, mood, thinking), perception, motor behaviour, and the sleep wake cycle.

Delirium is encountered in all health-care settings but probably more so, in non-psychiatric settings. In a study in the United Kingdom, delirium in hospital patients was associated with infections, falls and incontinence. It affected a fifth of acute medical admissions and a third of those aged ≥ 75 years, and was associated with increased mortality,

institutionalisation and dependency over a two year follow-up period.⁴¹

In Africa, a recent Nigerian study found rates of delirium as high as 18%. Delirium was found in 21.4% of referrals from general medical outpatients, 17.7% of referrals from private hospitals, and 31.6% from the accident and emergency department.⁴² Delirium, however, seems to carry an especially grave prognosis in Africa. However in a recent follow up study among post stroke patients in Ibadan, 33 of 99 patients with a mean age of 61 years had delirium. Of those with delirium 65.6% had the hypoactive type, 21.9% hyperactive and 12.1% mixed. At a three-month follow up, 24 had died and 11 others were lost to follow up. Severity of stroke was associated with delirium mortality and dementia.⁴³

Despite its public health importance, delirium can be under diagnosed or misdiagnosed, cases often being construed as non-organic mental illnesses or being given no diagnosis. The core cognitive disturbance is impaired attention. The symptoms of delirium may result in agitation at night and drowsiness during the day. However, the presentation varies, ranging from the floridly agitated, hyper-alert, hyperactive patient to the drowsy, hypo-alert patient sleeping quietly in their bed.

Many patients have a mixture of symptoms including inattention, varying degrees of consciousness, hallucinations and delusions. Hypo-alertness in patients is often mistaken for dementia, resulting in delayed or missed opportunities for therapeutic intervention.

It is thought that multiple aetiologies and mechanisms may converge to alter brain function and produce the characteristic symptoms of delirium. Risk factors for delirium include dementia, older age, multiple co-morbidities, psychoactive medication use, sleep deprivation, dehydration, immobility, pain, sensory impairment and hospitalisation.

Delirium is closely linked to dementia—each is a risk factor for the other—and it is now recognised that delirium can cause irreversible decline in cognitive and physical function, as well as increased mortality and nursing home placement.

Most individuals had delirium due to infections, with gastrointestinal infections being the most common source with reports that 73.1% of those with typhoid fever had delirium. It is therefore imperative that psychiatrists in sub-Saharan Africa are vigilant for infectious diseases in patients presenting with confusion, as well as the importance of training health professionals in these environments to recognise and treat delirium.⁴²

- M metabolic – hyponatraemia, hypoglycaemia, hypoxaemia
- I infective – urinary tract infection, pneumonia
- S structural – subarachnoid haemorrhage, urinary retention
- T toxic – drugs (e.g. digoxin, lithium) or poisons
- E environmental – being in hospital or the emergency department

Box 1. MISTE: a mnemonic for possible causes of delirium.⁴⁴

Management

Screening and diagnosis

The crucial, and unfortunately, often missing step in delirium management is diagnosis. Given the large and increasing number of older patients in hospital, screening for delirium should become part of routine observations, at least for high-risk patients. However, some training of staff is required. It is very useful, when unsure if a patient's poor cognitive status is new or pre-existing, to ask their family or carer whether they are usually like this.

Further management

Once delirium is identified, initial management aims to detect and treat underlying medical and surgical causes. The list of

possible causes is long, and the simple mnemonic MISTE serves as an aide-memoire to categorize potential causes (see box 1 above). A comprehensive assessment including history, examination and appropriate investigations is required when delirium is detected, because many older patients have more than one diagnosis contributing to their delirium.

Appropriate management of the underlying condition(s) and the drugs that the patient is taking, remains the mainstay of delirium treatment. A thorough medication review is important. Anticholinergics, psychoactive medications (including antiepileptic and pain medications), and NSAIDs may also contribute to delirium. Even drugs that are used to treat delirium, particularly if given in excess, can prolong or worsen delirium. It is also important to enquire about over-the-counter and complementary medications, which have marked anticholinergic properties, as these may precipitate delirium.

Hospital Elder Life Program

The Hospital Elder Life Program (HELP) addresses six of the risk factors for delirium, namely cognitive impairment, sleep deprivation, immobility, dehydration and visual and hearing impairment. The program recommends the following:⁴⁴

- reorient and mobilise the patient
- reduce sensory deprivation

- ensure the patient is hydrated
- implement a non-pharmacologic sleep regimen
- limit catheters and restraints

Patients with hyperactive delirium

Managing a patient with hyperactive delirium can be a challenge on any ward. Restraints should be avoided, as they aggravate delirium, as well as increase injuries and falls. Where suitable, asking family to be present as much as possible, even organising a roster of relatives, generally helps to calm agitated patients.

It is important to prevent complications so, for example, agitated patients who keep climbing out of bed may be nursed on low beds or mattresses placed on the floor. It is preferable to allow an agitated patient to pace around a secure delirium ward than to sedate them as this can lead to hypostatic pneumonia or pressure sores.

Use of medication in the management of delirium

Drug therapy is reserved for patients who are at risk of harming themselves or others, for example by pulling out essential medical devices or lines.

Antipsychotics

If drugs are needed, antipsychotics are generally accepted as first-line, except in delirium tremens (caused by alcohol withdrawal). Suggested initial doses are haloperidol 2.5mg, risperidone 0.5mg or olanzapine 2.5mg. Depending on the response, additional doses can be given after 2-4 hours, otherwise daily. However, for more frequent dosing, the patient should be closely monitored for over-sedation.

Treatment of psychotic and other disorders

There are three causes of psychotic illnesses in older people. These are:

- Disorders that have started in adult life and persist into old age, such as schizophrenia, mania and depressive psychosis.
- Psychotic disorders starting after the age of 65 years (such as late onset schizophrenia or paraphrenia)
- Organic psychoses (seen in dementia or delirium)

Treatments for these as well as other common conditions including anxiety and somato form disorders follow the same principles described for younger adults, remembering the

essential aphorism of geriatric pharmacology: start low and go slow.

Conclusions

It is important to pay attention to the mental health of older adults in sub-Saharan Africa in clinical service, research and teaching of health practitioners of all categories. This is because of the need for a multidisciplinary approach that is required in the management in geriatrics and psychogeriatrics. In sub-Saharan Africa in particular there is a dearth of infrastructure and personnel in the subspecialty. This chapter hope to fill some of the learning gaps for those practising in the sub-specialty.

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