




# COVID-19 and older adults with bipolar disorder: Problems and solutions

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The implementation of public health measures designed to limit the spread of coronavirus disease 2019 (COVID-19) has been applied particularly stringently to people at high risk of complications, such as individuals older than 70 years and people with concurrent health morbidities like chronic respiratory or cardiovascular diseases. Older adults suffering from mental disorders are an especially high-risk group not only because of their age but also because the prevalence of chronic somatic conditions is disproportionately high in this group. Data on hospital admissions for people with mental disorders during the COVID-19 pandemic are yet to be published, although preliminary evidence suggests that adults with BD have been reporting increasing psychological distress and symptoms of anxiety and depression. Further emerging evidence suggests that the pandemic has been associated with a marked drop in hospital admissions for all causes other than COVID-19 related,<sup>1</sup> raising concerns about how this might affect the management of people with chronic health conditions and their access to services, including people with BD. At this point in time, it is unclear how the pandemic will affect older adults with BD (OABD), although withholding action until more evidence becomes available is unlikely to be helpful. A high proportion of OABD have concurrent chronic somatic morbidities and cognitive deficits<sup>2</sup> and therefore deserve particular attention as the medical and psychiatric community responds to the pandemic. We anticipate that the impact of the

COVID-19 pandemic on this group will unfold along four overlapping stages (Table 1). Here, we will describe the expected complications of the pandemic and suggest mitigating measures for each stage.

The first, direct impact, may result in a high number of OABD developing severe somatic complications as a result of the viral infection, leading to a large number of deaths among a group of people who already have decreased life expectancy. For example, about 35% of people infected with COVID-19 develop neurological symptoms during the course of their illness, including confusion, dizziness, headache, anosmia, encephalitis and stroke.<sup>3</sup> Potentially lingering executive dysfunction after recovery has also been reported, but it is unclear whether these deficits are likely to persist in the long term. These findings raise concerns that infection with COVID-19 could worsen the cognitive deficits that are already present among people with OABD. Future research should clarify this issue and determine whether the direct and indirect effects of the COVID-19 pandemic have affected the course of OABD.

Next, the worldwide introduction of measures designed to increase the capacity of health services to manage the acute medical complications of COVID-19 together with the various public health measures introduced to contain the spread of the virus in the community will most likely decrease access to specialized mental health services (resource restriction – stage 2).<sup>4</sup> Access to acute treatment

TABLE 1 COVID-19 among older adults with bipolar disorder.

Stages	Possible Complications	Mitigating Measures
1. Direct impact	<ul style="list-style-type: none"> <li>Severe complications of acute illness (due to prevalent comorbidities)</li> <li>Increased mortality</li> </ul>	<ul style="list-style-type: none"> <li>Education (e.g. hygiene, social distancing)</li> <li>Access to personal preventive equipment</li> <li>Consider need for isolation</li> </ul>
2. Resource restriction	<ul style="list-style-type: none"> <li>Decreased access to general medical services (including ECT)</li> <li>Medication toxicity</li> <li>Increased risk of inappropriate use of medications and interactions</li> <li>Discontinuation of treatment</li> <li>Worsening of affective symptoms</li> </ul>	<ul style="list-style-type: none"> <li>Provide access to web-based technology or telehealth</li> <li>Active mental health surveillance</li> <li>Use of web-based technology for assessments/support (or telephone, mobile applications)</li> <li>Home delivery of medications</li> <li>Home collection of samples</li> <li>Regular medication checks</li> </ul>
3. Interrupted care	<ul style="list-style-type: none"> <li>Functional decline</li> <li>Relapse/Recurrence of symptoms</li> <li>Unplanned hospital admissions</li> <li>Increased cost of care</li> <li>Strained social networks</li> </ul>	<ul style="list-style-type: none"> <li>Active mental health surveillance using web-based technology, telephone, or mobile applications</li> <li>Active liaison with general practitioner / family physician</li> <li>Promote regular contact with family and friends</li> <li>Monitor risk</li> <li>Use of web-based cognitive-behavioural interventions, as required</li> </ul>
4. Delayed consequences	<ul style="list-style-type: none"> <li>Loss of employment/income</li> <li>Financial strain</li> <li>Decrease/Collapse of supportive networks</li> <li>Substance use/abuse</li> <li>Anxiety</li> <li>Helplessness and hopelessness</li> <li>Self-harm risk</li> <li>Loss of independence</li> </ul>	<ul style="list-style-type: none"> <li>Early involvement of social services</li> <li>Active mental health surveillance using web-based technology, telephone or mobile applications</li> <li>Use of web-based cognitive-behavioural interventions, as required</li> <li>Monitor risk</li> <li>Support social and functional re-engagement</li> <li>Promote clinical re-engagement</li> </ul>

(such as ECT) may be hampered, and the regular monitoring of symptoms and of the possible adverse effects of medications, which are often magnified in late life, may be compromised. This, in turn, could increase the risk of medicine-related toxicity, sub-therapeutic use or discontinuation of treatment.

The prolonged disruption of care (stage 3) may increase the risk of relapse or recurrence of affective symptoms, leading to functional decline and, potentially, health complications, increased general hospital admissions and increased cost of care. This, together with the widespread public health measures for social distancing and isolation, may strain social networks of support which, often, are already fragile. These factors could result in the collapse of social networks, loss of income and financial strain, increased use of substances (such as alcohol) and feelings of helplessness and hopelessness. An increase in the incidence of suicide attempts would not be unexpected (stage 4). However, this potentially bleak progression of events for OABD is not inevitable.

The timely introduction of risk-mitigating strategies could circumvent most of the complications that OABD might experience in association with the COVID-19 pandemic (Table 1). Education and access to relevant resources is critical to maintaining engagement with management plans and social support. For example, active mental health surveillance and treatment are accessible via telehealth or web-based interventions and should be considered, even though supportive evidence of the efficacy of these approaches is currently limited. In addition, activity scheduling and the embracing

of innovative approaches to encourage social interactions (e.g. web-based book club, choir or exercise group) would allow for enhancement of social engagement in the face of physical distancing and maintenance of a healthy lifestyle and sense of control. When access to such programs is not feasible, health services must consider alternative approaches to remain in active contact with OABD and safeguard the continuity of their care – some of these community-based approaches have already proven clinically useful.<sup>5</sup>

#### AUTHOR CONTRIBUTION

Oswaldo P. Almeida and Esther Jimenez, drafted the first version after the idea and outline for the manuscript was discussed by OA, EJ, SR, LE, MS and AD. All authors approved of the final version.

#### DATA AVAILABILITY STATEMENT

This commentary does not contain original data.

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