



# Behavioral Health Issues in the Older Adult

Presented by Linda Shumaker, R.N., B-C., M.A.



The screenshot shows the Adobe Connect interface for a training session. The top bar includes the Adobe logo, 'Meeting', a volume icon, a callout icon (circled in red), and a 'Full Screen' button (also circled in red). A dropdown menu is open from the callout icon, listing various communication actions: Raise Hand, Agree, Disagree, Step Away, Speak Louder, Speak Softer, Speed Up, Slow Down, Laughter, Applause, and Clear Status. The main content area displays a slide titled 'Training Programs' with the Magellan Health Services logo and tagline 'Getting Better All the Time'. On the left, there is a 'Share' panel (empty), a 'Q & A' panel with an input field (circled in red) and a callout icon, and a 'Handouts' panel. The Windows taskbar at the bottom shows the Start button, several open applications, and the system clock at 3:25 PM.

Icons used to communicate with the host.

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# Training Programs



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- Linda Shumaker has no relevant financial relationship commercial interest that could be reasonably construed as a conflict of interest.

# About the Presenter: Linda Shumaker

- Linda Shumaker, R.N., B-C, M.A. is a registered nurse who is currently serving as Outreach Coordinator of the Pennsylvania Behavioral Health and Aging Coalition. She has previously been employed as the Executive Director of the Coalition where she advocated for funding and received over \$325,000 to outreach and educate older adults regarding behavioral health issues. She also has worked at the Central Pennsylvania Psychiatric Institute, Penn State College of Medicine in Hershey, PA. Ms. Shumaker has extensive clinical experience working in community mental health, geriatric assessment teams and in long-term care. In addition, she has been an instructor of psychiatry at the Pennsylvania State University, College of Medicine, co-chair and founding member of the Pennsylvania Mental Health and Aging Coalition. She has served as a member of the Older Adult Committee of Pennsylvania Office of Mental Health and Substance Abuse Planning Council and a member of the Long Term Care Subcommittee of the Medical Assistance Advisory Committee. She has served on the Board of Directors for the Pennsylvania State Alzheimer's Association and the Advisory Board for the Central Pennsylvania Chapter of the Alzheimer's Association. Ms. Shumaker's "special interests" include ethical and social policy issues in relation to the care of the elderly with behavioral health problems.

# Learning Objectives

Upon completion of this course, participants will be able to:

1. Identify the behavioral health needs of the older population.
2. Explain the multidisciplinary needs of seniors with behavioral health issues.
3. Discuss the barriers in regards to service provision for older adults.
4. Identify evidenced based practices for outreaching older adults with behavioral health issues.
5. Develop a multidisciplinary system approach to outreach to older adults with behavioral health issues

# Behavioral Health Problems of Older Adults

- Are not a normal part of aging
- Are treatable
- Behavioral Health issues are debilitating and effect overall health and quality of life in older adults (Geriatric Mental Health Foundation)
- 10 –28 % of older adults have mental health problems serious enough to need professional care
- More than 80% of all seniors in need of mental health services do not get the treatment they need

# Aging Pennsylvania

- Third highest aging population in the country
- One of the highest population of rural aged
- More racially diverse population
- The fastest growing population is over 85 years of age
  - Implications with Alzheimer's Disease
  - Implications for “care giving”
  - Implications with “care facilities”
  - Issues of stigma
  - Multidisciplinary issues – “silos” of care
  - Implications in public policy

# Behavioral Health Needs of Older Adults

- 20% of Americans over 55 years of age experience specific “mental disorders” that are not part of normal aging
- Less than 3% of older adults report seeing mental health professionals for treatment
- 80% + of older individuals in long term care facilities have a “mental disorder”
- 20% of Pennsylvania’s population is over 60 years of age, however they account for less than 4% of County Mental Health Programs

# Behavioral Health Needs of Older Adults

- Mental disorders among the elderly go unrecognized or are often masked by somatic complaints
- Clinical presentation of mental disorders in the elderly may be different, making diagnosis of treatable illnesses more difficult
- Detection may also be complicated by co-existing medical disorders

# The Dilemma

Mr. Johnson is a 81 year old widowed gentleman who resides in a senior apartment building. On Friday afternoon at 4:30 he wandered into the manager's office, confused and distraught over not being able to find his wife. When the manager reminded him of his wife's death 10 years ago, he became agitated, combative and threatened suicide.

# The Dilemma

The apartment manager contacted Mr. Johnson's daughter regarding her father's confusion and suicidal comment. Her concern was that her father collects guns and had numerous weapons in his apartment. Due to the daughter residing out of state, the manager also contacted the Office on Aging for assistance. She was told to call Crisis Intervention due to the mental health concerns. On doing so the manager was told that he had dementia and could not be psychiatrically hospitalized.

# The Dilemma

- **Who has responsibility to provide services for this gentlemen?**
- **What would you do as a “care provider”?**

# Depression

# Depression in Older Adults

- Causes may be physical, social, or psychological in origin, including:
  - Specific events in a person's life, such as the death of a spouse, a change in circumstances, or a health problem that limits activities and mobility
  - Medical conditions - Parkinson's disease, hormonal disorders, heart disease, or thyroid problems
  - Chronic pain
  - Nutritional deficiencies
  - Genetic predisposition to the condition
  - Chemical imbalance in the brain

# Depression and the Older Adult

- Affects approximately 15 out of every 100 older adults age 65 and older – higher percentage in hospitals and nursing homes
- Affects more older adults in medical settings, up to 37% older patients in primary care – approximately 30% of these patients have major depression the remainder have a variety of depressive syndromes that could also benefit from medical attention (Alexopoulos, Koenig )

# Depression and the Older Adult

- Individuals who get depressed for the first time in later life have a depression that is related to medical illness
- Untreated depression can lead to disability , worsening of other illnesses, institutionalization, premature death and suicide (GMHF)
- Community surveys have found that depressive disorders and symptoms account for more disability than medical illness
- With proper diagnosis and treated more than 80% of individuals with depression recover and return to normal lives (GMHF)

# Older Adults at Risk for Depression

- Those with co-morbid disorders
- Frail elderly
- Older adults residing in care facilities
- Caregivers of older adults
- Isolated older adults

# Depression and the Older Adult

- Symptoms: sleep, appetite, energy, mood, anxiety, “confusion”
  - May not complain of feeling depressed
  - Somatic equivalents
  - Loss of motivation, withdrawal and irritability
  - May become suicidal
  - Brain chemical changes

# Depression

- Major Depressive Episode
  - Depressed mood
  - Loss of interest or pleasure
  - Appetite disturbance
  - Insomnia or hypersomnia
  - Psychomotor agitation or retardation

# Depression

## ■ Major Depressive Episode

- Fatigue or loss of energy
- Feelings of worthlessness or guilt
- Decreased concentration indecisiveness
- Thoughts of death or suicide
- Impaired level of functioning

# Late Onset Depression

- Depression occurring for the first time in late life – onset later than age 60
- Usually brought on by another “medical illness”
- When someone is already physically ill, depression is both difficult to recognize and treat
- Greater apathy/ anhedonia
- Less lifetime personality dysfunction
- Cognitive deficits more pronounced
- In some individuals may be a precursor to dementia

# Depression and the Older Adult

With proper diagnosis and treatment more than 80% of older adults with depression recover and return to normal lives

(Geriatric Mental Health Foundation)

# Suicide in Older Adults

- NIMH - Although they comprise only 12 percent of the U.S. population, individuals age 65 and older accounted for 16 percent of suicide deaths in 2004.
- American Association of Suicidology – the elderly population makes up 12.5% of the population in 2007 but they accounted for 15.7% suicides in 2007.

# Suicide in Older Adults

- American Association of Suicidology - Suicide rates for elderly males are the highest risk at a rate of 31.1 per 100,000 (2007).
- White men over 85 (the old-old) were at the greatest risk of all age-gender-race groups. In 2007, the rates for these men was 45.42 per 100,000 - 2.5 time the current rate for men of all ages (18.3 per 100,000).

# Risk factors for Suicide Among the Elderly

- Differ from those for younger persons
- Higher prevalence of depression
- Greater use of highly lethal methods
- More social isolation
- Fewer attempts per completed suicide
- Higher male-to-female ratio
- Often visits a health-care provider before attempts
- More physical illnesses

**Source: Aging and Mental Health and CDC**

# Assessing Suicide Risk (SAD PERSONS)

<b>S</b> ex	(Male)
<b>A</b> ge	(Elderly or adolescent)
<b>D</b> epression	
<b>P</b> revious	Suicide
<b>E</b> thanol	Abuse
<b>R</b> ational	Thinking loss (psychosis)
<b>S</b> ocial	Support lacking
<b>O</b> rganized	Plan commit suicide
<b>N</b> o Spouse	(Divorce>widowed>single)
<b>S</b> ickness	Physical illness

# Suicide Prevention Strategies

- Effective and appropriate clinical care for mental, physical and substance abuse disorders
- Easy access to a variety of clinical interventions and support for help seeking
- Restricted access to highly lethal methods of suicide
- Family and community support

# Suicide Prevention Strategies

- Support from ongoing medical and mental health care relationships
- Learned skills in problem solving, conflict resolution and nonviolent handling of disputes
- Cultural and religious beliefs that discourage suicide and support self preservation instincts

**Older Adults who take their own  
lives are more likely to have  
suffered from a depressive illness  
than individuals who kill  
themselves at younger ages**

# Incidence and Prevalence of Depression among Caregivers

- Family Caregiver Alliance 1997 – 58% of caregivers showed clinically significant depressive symptoms

# Incidence and Prevalence of Depression among Caregivers

- 1/3 family caregivers of individuals with dementia have symptoms of depression

(Alzheimer's Association, 2008; Yaffe and Newcomer, 2002)

# Incidence and Prevalence of Depression among Caregivers

- Care recipients behavior is an overwhelming predictor of caregiver depression

(Shultz and Colleagues 1995)

# Depression and Dementia

Depressive symptoms of various intensity occur in approximately 50% of demented patients

Symptoms can include:

- Abrupt loss of interest, increased irritability, refusal to eat, crying, and sudden deterioration in skills (Rovner)

# Depression and the “Nursing Home”

- Occurrence 10 times higher than those elderly residing in the community (Rovner)
- NIMH – April 2002 – up to 50% of nursing home residents are affected by significant depressive symptoms
- Associated with distress, disability and poor adjustment to the facility (Rovner)
- Most common cause of weight loss in long term care (Katz)

# Depression and the “Nursing Home”

- **Behavioral Symptoms include:**
  - Low mood /hopelessness
  - Preoccupations with pain and somatic functions
  - Poor sleep
  - Lack of energy/low motivation

# Depression and the “Nursing Home”

- **Behavioral Symptoms include:**
  - Loss of appetite and subsequent weight loss
  - Withdrawal and isolation
  - Uncooperativeness/refusal of care
  - Screaming

# Depression Scales

- Mini-Mental Status Examination MMSE-(Folstein) – Copyrighted
- Geriatric Depression Scale - (Yesavage)
- Patient Health Questionnaire PHQ-9 for Depression
- Center for Epidemiologic Studies Depression Scale
- Beck Depression Protocol
- Hamilton Depression Rating Scale
- Cornell Scale for Depression in Dementia

# Assessment of Depression

- Previous treatment history
- Family History
- History of response
- Alcohol use

# Treatment Interventions for Depression

- Behavioral Interventions
- Therapy
- Medications
- ECT

# Behavioral Interventions for Depression

- Structured activities
- Maintain social contacts
- Exercise
- Sleep hygiene
- Relaxation techniques
- Consistent staff
- Issues of autonomy and choice

# Therapy and the Older Adult

- Life review/ reminiscing
- Psychotherapy
  - Cognitive Behavioral Therapy
  - Problem Solving Therapy
  - Insight Oriented Therapy
  - Family therapy
  - Psycho-educational approaches
- Religious/ Spiritual needs
- Support groups

# Therapy and the Older Adult

- For older adults, especially those who are in good physical health, combining psychotherapy with antidepressant medication appears to provide the most benefit.
- One study showed that about 80 percent of older adults with depression recovered with this kind of combined treatment and had lower recurrence rates than with psychotherapy or medication alone.

(Reynolds, C ,Frank E, Perel JM, et al, 1999)

# Antidepressant Medications

- Common Uses
  - Major Depression
  - Obsessive Compulsive Disorder
  - Panic Disorder
  - BPSD (Behavioral and Psychological Symptoms of Dementia)
    - Emotionality and Irritability
    - Agitation and Aggression
    - Depressive Syndromes
    - Sleep-Wake Cycle Disturbance

**In the aged, anxiety  
rarely occurs in the  
absence of depression**

**Anxiety**

# Anxiety

- Universal human experience
- Catastrophic reaction?
- Emotionally based physical symptoms
- Question the cause of anxiety
  - Environmental issues
  - Developmental / Psychosocial issues
  - Organic Anxiety Disorders
  - Anxiety Disorders

# Anxiety in Older Adults

- Affects as many as 10 – 20% older adults, though it is often under diagnosed
- Most common behavioral health problem for women, second most common behavioral health problem for men after substance abuse
- Causes of Anxiety Disorders:
  - Stress or trauma, complicated grief, caffeine, medications, medical or psychiatric illness, a family history of anxiety disorders, a neurodegenerative disorder

# Anxiety and Older Adults

- High level of co-morbidity of anxiety and depression
  - 50% of clinically depressed older adults suffer from co-morbid anxiety
  - 25% of those with anxiety suffer from major depression

Beekman et al, 2000

# Anxiety

## ■ Symptoms

- **Cognitive** – nervousness, worry, apprehension, fearfulness, irritability
- **Behavioral** – hyperkineses, pressured speech, exaggerated startle response
- **Physical** – muscle tension, chest tightness, palpitations, hyperventilation, parasthesias, sweating, urinary frequency

# “Organic Anxiety”

- Anxiety associated with illness or medications
  - Common presentation
  - Maybe co-morbid as psychiatric illness with common medical illness
    - Cardiac
    - Respiratory
    - Endocrine disorders
    - Neurological disorders

# Anxiety

- Common Medical Disorders that can produce anxiety symptoms –
  - Endocrine disorders – hyper- and hypothyroidism, hypoglycemia, menopause
  - Cardiovascular disorders – Congestive Heart Failure (CHF) Pulmonary Embolism, Angina, Arrhythmias
  - Pulmonary conditions – Chronic Obstructive Pulmonary Disease (COPD), Pneumonia
  - Neurological disorders – Parkinson's disease

# Anxiety

- Common medications/ substances that can produce anxiety symptoms –
  - Stimulants – caffeine, Theophylline, ephedrine or pseudoephedrine
  - Steroids
  - Thyroid preparation
  - Anticholinergic medications
  - Antidepressants (first 1 -3 weeks of treatment)
  - Alcohol

# Anxiety Association with Dementia

- Anxiety occurs commonly with Dementia
  - Depression and anxiety early to middle stages
  - Anxiety/ agitation in moderate to late stages
    - Frequently with motor restlessness and inappropriate behavior
- Need to identify “triggers”
  - Environmental stimuli
  - Medications
  - Inability to communicate

# Generalized Anxiety Disorder

- Constant /Pervasive worry
- Focuses on situations where anxiety is unwarrantated
  - Health issues, finances, family problems or disasters
- Symptoms include:
  - Fatigue, chest pains, headaches, muscle tension, nausea, irritability, frequent urination, twitching, lightheadedness, hot flashes

# Panic Disorders

- Unpredictable acute anxiety attacks – terror!
- Complicating anticipatory anxiety
- Usually lasts 10 minutes, but may last much longer
- Symptoms include:
  - Pounding heart, chest pain, sweatiness, weakness, dizziness, nausea
- Not common among older adults

# Phobic Anxiety

- Intense irrational fear to a specific object or situation which poses little or no threat
  - Social phobia (Social Anxiety Disorder) – feelings of overwhelming anxiety and self-consciousness in every day situations
  - Agoraphobia -- fear of going where escape is difficult, leaving ones home or being alone
- Symptoms include:
  - Blushing, heavy sweating, trembling, nausea and difficulty communicating

# Obsessive-Compulsive Disorders

- Not common among older adults
- Irrational , intrusive thoughts (contamination / doubt / symmetry) control by Repetitive behaviors (hand washing / checking / arranging objects)
- Hoarding – once considered subtype OCD, now believed it is a separate disorder

# Hoarding

- Hoarding is defined as the acquisition of and inability to discard items, even though they appear (to others) to have no value
- Hoarding behavior has been observed in other neuropsychiatric disorders, including:
  - Generalized Anxiety Disorders, Social Phobias, Schizophrenia, Dementia, Eating disorders, Autism and Mental Retardation

# Hoarding

Compulsive hoarding is most commonly driven by obsessional fears of losing important items that the individual believes will be needed later, distorted beliefs about the importance of possessions, excessive acquisition, and exaggerated emotional attachments to possessions

# Hoarding Statistics

- Estimates are that hoarding behaviors effects 2 million Americans
- Hoarding usually begins in adolescence and worsens with age
- It effects more women than men
- “Surfaces” in late life
- Substantial familial component

# Post Traumatic Stress Disorder

- Develops after a traumatic event that involved danger, threat of danger or physical harm or muggings, rape, or disasters
- Symptoms may appear months or even years later
- Symptoms include:
  - Intrusive memories, flashbacks, numbing of emotions, autonomic hyper-arousal, irritability, aggression, difficulty feeling emotion, lack of interest

# Therapy for Anxiety Disorders

- A study by Stanley and Novy demonstrated after 14 weeks of treatment for anxiety that 50% of individuals receiving Cognitive Behavioral Group therapy and 77% of individuals receiving Supportive Psychotherapy showed significant improvements and maintained those improvements for 6 months.
- Cognitive-Behavioral Interventions consisted of Cognitive Interventions and Relaxation techniques

(Stanley , M and Novy, D., 2000)

# Antianxiety Medication

- Common Uses
  - Situational Anxiety
  - Panic Disorder
  - Insomnia
  - BPSD
    - Anxiety
    - Acute Agitation
    - Sleep Disturbance

# Antianxiety Medication

## Benzodiazepines

### SE Profile:

- Drowsiness
- Ataxia
- Confusion
- Slurred speech
- Anterograde amnesia
- Physical dependence

# The Dilemma

Ms. Moore, **73**, was admitted to the geriatric-psychiatry unit from a local personal care home for withdrawal, decline in personal hygiene, poor appetite and disorientation. Upon admission it was determined that her symptomatology was due to pneumonia. She quickly responded to treatment, however fell and fractured her hip.

# The Dilemma

Ms. Moore, who suffers from schizophrenia, retired from state government at 69 and resided at home with her mother until her death 3 years ago. After her mother's death she was hospitalized, re-stabilized on medication and discharged to a small, local, personal care home. Ms. Moore functioned well until her recent medical illness and subsequent hip fracture. Discharge planning for rehabilitation became difficult as long term care facilities were hesitant to take a patient with a psychiatric diagnosis.

# The Dilemma

- **Who has responsibility to provide services for this woman?**
- **What would you do as a “care provider”?**

# Other Psychiatric Disorders

- Mood Disorders with Psychosis
- Bipolar disorder
- Schizophrenia / Late-Onset Schizophrenia
- Personality Disorders
- Adjustment Disorders
- Grief/ Bereavement Disorders

# The Dilemma

Mr. Barns is a 78 year old widowed gentleman who has been residing in a park for the past two weeks. Crisis Intervention responded to a call regarding his disruptive “behaviors”. When assessed they found a disheveled, suspicious, slightly confused man who refused to go to the shelter. Protective Services from the local office on Aging was contacted regarding potential self neglect. They found he was eating and taking care of his hygiene, though was drinking alcohol daily. He refused all follow-up including medical care.

## The Dilemma

- Information revealed Mr. Barns was recently discharged from a nursing home after being institutionalized for over one year for a fractured hip. He wanted to leave, and with support from a waiver program he was discharged to his own apartment. Shortly after discharge he began drinking, not paying his rent and being disruptive.” He was then evicted.

# The Dilemma

- **Who has responsibility to provide services for this gentlemen?**
- **What would you do as a “care provider”?**

# **Alcohol and Substance Abuse in Older Adults**

# Substance Abuse and Older Adults

Alcohol and substance abuse is less likely to be recognized in the older adult:

- Lack of adequate history
- Alcohol related problems may be mistaken for medical or psychiatric problems
- Older individuals live alone
- No job related difficulties
- Usually no legal problems

# Substance and Medication Abuse/Misuse

- It is estimated that the number of older adults in need of substance abuse treatment will increase from 1.7 million in 2001 to 4.4 million in 2020.
- This is due to a 50 percent increase in the number of older adults and a 70 percent increase in the rate of treatment need among older adults.

“Substance abuse treatment need among older adults in 2020: the impact of the aging baby-boom cohort” - **Joseph Gfroerer, Michael Penne, Michael Pemberton and Ralph Folsom**

# Substance and Medication Abuse/Misuse

- Currently the over 50 group makes up 10% of those in substance abuse treatment (1.8 million) - predominately for alcohol abuse.

“Substance abuse treatment need among older adults in 2020: the impact of the aging baby-boom cohort” - **Joseph Gfroerer, Michael Penne, Michael Pemberton and Ralph Folsom**

# Substance and Medication Abuse/Misuse

- Of those in treatment over 65 (2005) – alcohol is predominately the drug of choice, but ages 50-64 more extensive substance abuse treatment histories – foretelling ...
- The majority of problems in current older adults appear related to - prescription medications alone, alcohol in combination with prescription medications/OTC, or alcohol only.

<sup>1</sup> 2007 National Survey on Drug Use & Health: National Findings  
SAMHSA

# Substance and Medication Abuse/Misuse

- Older adults in increasing numbers are also addicted to illicit drugs – currently as high as 4.1% of the general population.<sup>1</sup>

<sup>1</sup> 2007 National Survey on Drug Use & Health: National Findings  
SAMHSA

# Older Adults and Illicit Drug Use

- Current illicit drug use in older adults is the lowest of all age groups
- Approximately half of baby boomers have tried illicit drugs
- Birth cohorts that experience high rates of illicit drug use in earlier ages have shown higher rates of use as they age as compared to other cohorts

Source: The NHSDA Report, Substance Use Among Older Adults; November 2001

# Medication Abuse and Misuse

Adults 65 and older consume more prescribed and over-the-counter medications than any other age group (13% of population but 25-30% of medications)- one of fastest growing health concerns.



# Medication Abuse and Misuse (cont.)

- Adults 65 and older consume:
  - 25- 30% of all medications.
  - 70% of all over-the-counter medications.
- Average adult over 65 uses 11 different prescriptions over one year.
- One out of four prescription medications taken by older adults is psychoactive.

# Medication Abuse and Misuse (cont.)

- 50% of prescribed medications are not taken according to directions.
- Older adults experience two to three times as many adverse drug reactions as do younger adults.
- Over ½ of individuals who are hospitalized for adverse drug reactions are over age 65.
- Special concern - prescription medications and alcohol!

# Medication Abuse and Misuse (cont.)

- Age-related changes affect how we process medications and alcohol:
  - Lean body mass decreases
  - Fat increases
  - Total body water decreases
  - Decrease in the stomach's ability to metabolize alcohol
  - Renal changes
  - Decreases in liver function
  - Neurotransmitter/brain-related changes

# Older Adults and Medications

- 20% suffer from problems with medications or alcohol and may not know it.<sup>1</sup>
- Likely to be prescribed more long-term prescriptions, as well as multiple prescriptions.
- Large percentage also use over-the-counter (OTC) medications, herbs and dietary supplements along with prescription medications .
- Also at risk for prescription drug abuse – intentionally take medications that are not medically necessary: “accidental addicts”.

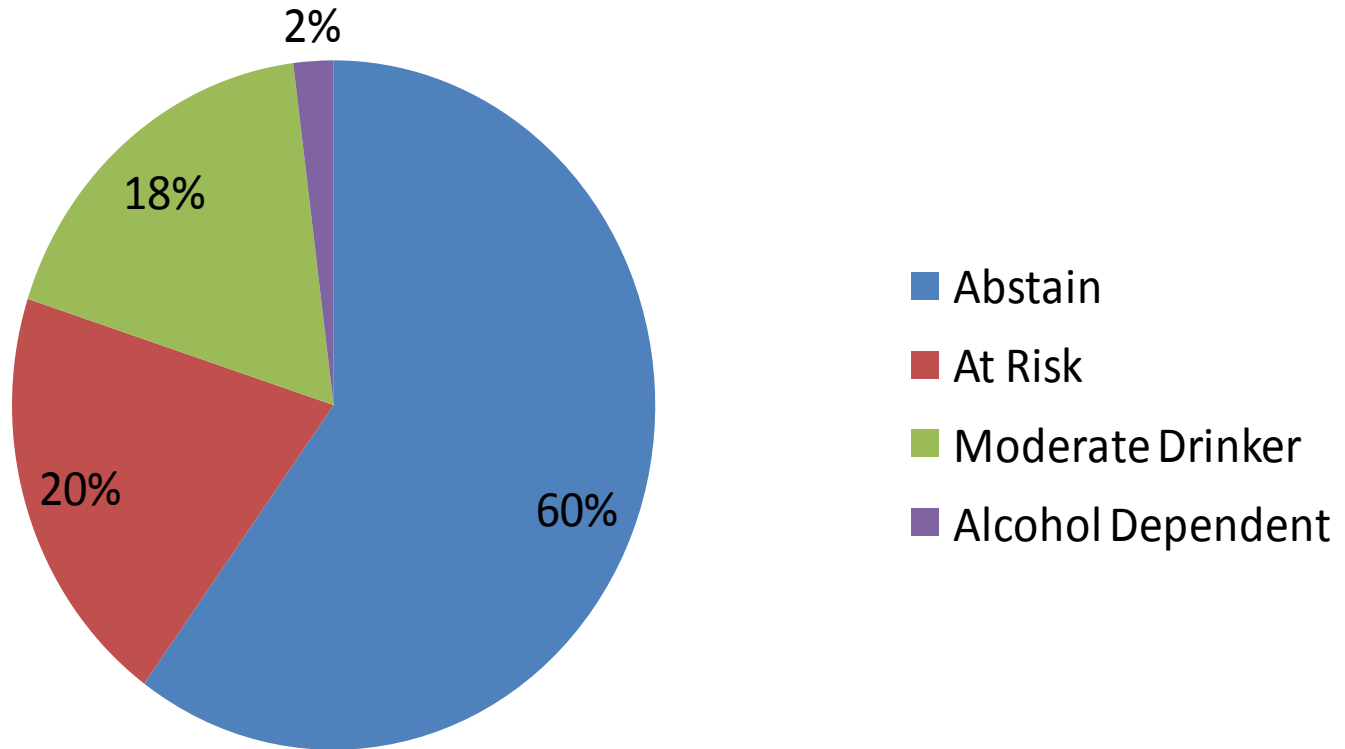
<sup>1</sup> SAMSHA—Get Connected! Linking Older Americans With Medication, Alcohol, and Mental Health Resources. DHHS Pub. No. (SMA) 03-3824. Rockville, MD: Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, 2003

# Ways to Avoid Medication Misuse: Health Literacy

- Improve doctor-patient communication.
- Encourage health care professionals to explain carefully how and when to take medications and what must be avoided, e.g. alcohol, OTC, etc.
- Encourage consumers to let doctors know all medications they are taking, e.g. OTC, herbs, supplements.
- Improve medication adherence by consumers.
- Address communication barriers, e.g. hearing loss, language.
- Provide consumers aids, e.g. medication tracking devices.
- Implement policy changes, e.g. geriatric-relevant labeling.

# Older Adults and Alcohol

**Spectrum of Older Adult Drinking**



# Older Adults and Alcohol Abuse

## Types:

At Risk - a pattern of use with potential for adverse consequences

- Individuals whose quantity/ frequency have not changed, but experience problems due to age-related changes in alcohol metabolism, combining alcohol with medications
- Early Onset (Chronic) – alcohol abusers in adult years who have grown older without treatment
  - Higher incidence of psychiatric co-morbidity
  - Intermittent (Periodic)
    - Same as Early Onset
    - Periods (sometimes lengthy) of abstinence from substances

# Older Adults and Alcohol Abuse

## Types: (cont.)

- Late Onset – increased consumption of alcohol due to losses or stresses associated with age
  - Represents 1/3 of older adults with alcohol problems (Oslin and Liberto, 1995)
  - Sensitivity/tolerance to alcohol changes in older years
  - More rapid progression of addiction: < 1 year
  - Significant problem for older women

# **Risk Factors for Alcohol Problems**

## **– Late Onset**

- Death of a spouse, friends and other family members
- Loss of job – and related income, social status and sometimes, self-esteem – as a result of retirement
- Loss of mobility – trouble using public transportation, inability to drive, etc.
- Impaired vision and hearing, insomnia and memory problems
- Declining health because of chronic illness
- Separation from children and loss of home as a result of relocation
- Loss of social support and interesting activities

# Protective Factors

- Access to resources, such as housing and health care
- Availability of support networks and social bonds
- Involvement in community activities
- Supportive family relationships
- Education (e.g. wise use of medications) and skills
- Sense of purpose and identity
- Ability to live independently

# Drinking Guidelines for Older Adults

The Consensus Panel<sup>1</sup> recommends the following usage guidelines for Older Adults:

## Guidelines for Men

- No more than one drink per day (1)
- A maximum of two drinks on any drinking occasion (e.g., New Year's Eve, weddings).

## Guidelines for Women

- Somewhat lower than for men

<sup>1</sup> TIP 26: Substance Abuse Among Older Adults, Frederick C. Blow – Consensus Panel Chair, SAMHSA, 1998.

# Screening Process

Screening needs to be holistic as the older adult is more likely to have a co-occurring physical, behavioral or cognitive impairment.

# Screenings

## When to Screen?

- At routine medical exams (SBIRT).
- If never before - recommended at age 60.
- During major life transitions, e.g. menopause, recent empty nest, approaching retirement, caretaker for sick relatives or young child.
- After life events, e.g. minor traffic accidents, loss of housing, decrease in ADL or driving abilities, inability to complete chores and paperwork without mistakes.

# SBIRT Intervention and Treatment

- SBIRT – Screening, Brief Intervention, and Referral to Treatment – [www.ireta.org](http://www.ireta.org)
- Health and wellness focus
- Formal and brief process
- Used for prevention, risky behavior as well as to screen for serious problems
- Primary care centers,  
natural settings
- “Normalizes” message

# Alcohol Screening Instruments

- AUDIT - Alcohol Use Identification Test
- CAGE - Cut down, Annoyed, Guilty, Eye Opener
- MAST-G - Michigan Alcoholism Screening Test – Geriatric Version
- ARPS/shARPS/CARPS – Computerized Alcohol-Related Problems Survey

# Specialized Treatment for Older Adults

- Need extended detoxification and medical stabilization
- Need slower transitions between levels of care
- May have cognitive issues to consider
- Hearing, speech and vision impairments
- Need for longer rest, relaxation and recreation periods
- Nutrition issues
- Chronic pain may be a problem
- Grief and loss issues
- Social support/ loneliness issues

# Summary...

- Substance use disorders are a serious problem for older adults and are:
  - **Under-estimated**
  - **Under-identified**
  - **Under-diagnosed**
  - **Under-treated**
- Often have co-morbidity – more at risk for physical and other behavioral health problems.
- Prescribed medications and OTC are a major factor in most cases of misuse, abuse and dependency.
- Alcohol is the primary drug of choice.

# The Dilemma

Mrs. Johnson is an 84 year old married women residing in an assisted living facility dementia unit. She has a history of agitation and anxiety and is having increasingly unprovoked outbursts. She is under the care of a geriatric psychiatrist. Mrs. Johnson has been tried on a number of different psychotropic medications without effect. The next recommendation would be a trial of Depakote, which should be instituted on an inpatient basis due to her medical history.

# The Dilemma

On a Wednesday afternoon at 4:30 Mrs. Johnson became increasingly anxious, and began throwing things in the unit dining room, including pulling the “glass covers” off of the dining room tables. She threw a walker at another resident. The staff were unable to redirect her. She was taken to the Emergency Room by her family. She was given an anti-anxiety medication at the ER. Crisis was called. During their assessment, she was calm and the commitment was denied. She was discharged back to the assisted living facility.

# The Dilemma

The following week the Mrs. Johnson displayed similar behavior and hurt a staff member during her outburst. The 302 Commitment was denied. The staff was instructed to petition for a 304 Court Ordered Commitment emphasizing her failure at outpatient psychiatric treatment, suspiciousness, unprovoked aggression, and harmful behavior toward herself, other residents and staff. The Petition was approved and the resident was given 20 days on an Inpatient Psychiatric Unit. The assisted living facility agreed to take the resident back upon discharge. Follow-up was scheduled with her current outpatient clinic. After 10 days of attempts to find a psychiatric bed, the patient was hospitalized.

# The Dilemma

Mrs. Johnson remained in the hospital for 2 weeks. She was discharged on Haldol. Upon arrival at the assisted living facility she was lethargic and unresponsive. The facility called for an outpatient appointment to assist in titrating the patient's medications to ensure her functionality. Nursing home placement was planned as Mrs. Johnson's level of care became high. Due to her medication regime with Haldol and her "psychiatric hospitalization" nursing facilities were unwilling to accept her.

# The Dilemma

- **Who has responsibility to provide services for this women?**
- **What would you do as a “care provider”?**

# Dementia

# Dementia

- Irreversible chronic brain failure
- Loss of mental abilities
- Involves memory, reasoning, learning and judgment
- All patients with dementia have deficits, but how they are experienced depends on their personality, style of coping and their reaction to the environment

# Dementia

- Impairment of the short and long-term memory
- One of the following:
  - Impaired abstract reasoning
  - Impaired judgment
  - Aphasia (language disturbance)
  - Apraxia (action disturbance)
  - Agnosia (recognition disturbance)
  - Personality change

# Dementia

- Disturbance of work and /or social functioning
- Not occurring only during a delirium
- Evidence for or presumption of organic etiologic factor

# Causes of Dementia

- Alzheimer's Disease
- Lewy Body Disease
- Multi-Infarct or Vascular Dementia - strokes, mini-strokes, TIA's
- Pick's Disease
- Jacob-Creutzfeldt Disease
- Parkinson's Disease
- Substance abuse

# Alzheimer's Disease

- 50% of all Dementias
- Diagnosis of inclusion
- Age related, though not consequential to the aging process
- Heredity issues
- Behavioral manifestations

# Behavioral and Psychological Symptoms of Dementia

- Symptoms of Disturbed Perception, Thought Content, Mood or Behavior that Frequently Occur in Persons with Dementia
- BPSD are Treatable
- BPSD can result in:
  - Suffering
  - Premature Institutionalization
  - Increased Costs of Care
  - Loss of Quality of Life for the person and caregivers

# Behavioral and Psychological Symptoms of Dementia

- Hallucinations (Usually Visual)
- Delusions
  - People are stealing things
  - Abandonment
  - This is not my house
  - You are not my spouse
  - Infidelity

# Behavioral and Psychological Symptoms of Dementia

## ■ Misidentifications

- People are in the house
- Talk to self in the mirror as if another person
- People are not who they are
- Events on television

# Behavioral and Psychological Symptoms of Dementia

- Depressed Mood
- Anxiety
- Apathy
  - Decreased Social Interaction
  - Decreased Facial Expression
  - Decreased Initiative
  - Decreased Emotional Responsiveness

# Behavioral and Psychological Symptoms of Dementia

- Wandering
  - Checking
  - Attempts to Leave
  - Aimless Walking
  - Night-time Walking
  - Trailing
  - Excessive Activity

# Behavioral and Psychological Symptoms of Dementia

- Verbal Agitation
  - Negativism
  - Constant Requests for Attention
  - Verbal Bossiness
  - Complaining
  - Relevant Interruptions
  - Irrelevant Interruptions
  - Repetitive Sentences

# Behavioral and Psychological Symptoms of Dementia

- Verbal Aggression
  - Screaming
  - Cursing
  - Temper Outbursts

# Behavioral and Psychological Symptoms of Dementia

- Physical Agitation
  - General restlessness
  - Repetitive mannerisms
  - Pacing
  - Trying to get to a different place
  - Handling things inappropriately
  - Hiding things
  - Inappropriate dressing or undressing

# Behavioral and Psychological Symptoms of Dementia

- Physical Aggression
  - Hitting
  - Pushing
  - Scratching
  - Grabbing Things
  - Grabbing People
  - Kicking and Biting

# Behavioral and Psychological Symptoms of Dementia

## ■ Disinhibition

- Poor Insight and Judgment
- Emotionally Labile
- Euphoria
- Impulsive
- Intrusiveness
- Sexual Disinhibition

# **Dementia Assaults the Person's Identity and Self-Esteem**

# Medication Interventions for Dementia

- Antidepressant Medication
- Antianxiety Medication
- Antipsychotic Medication
- Mood Stabilizers
- Cholinesterase Inhibitors
- NMDA Receptor Antagonist

# Delirium

- Delirium is a sudden, severe confusional state with rapid changes in brain function that occur with physical or mental illness
- Fluctuating level of consciousness
- Reversible/ treatable

# Delirium

- Symptoms:
  - Changes in alertness
  - Changes in feeling (sensation) and perception
  - Changes in level of consciousness or awareness
  - Changes in movement
  - Changes in sleep patterns, drowsiness
  - Confusion (disorientation)

# Delirium

- Symptoms:
  - Decrease in short-term memory and recall
  - Disrupted or wandering attention
  - Disorganized thinking
  - Emotional or personality changes
  - Incontinence
  - Psychomotor restlessness

# Delirium

## ■ Causes:

- Medications
- Infections
- Metabolic/ endocrine
- Vitamin Deficiency
- Anesthesia
- Trauma
- Alcohol or sedative drug withdrawal

# Assessment Scales

- Mini-Mental Status Examination MMSE- (Folstein) – Copyrighted
- Clock Drawing
- Short Portable Mental Status Exam
- Blessed Dementia Scale
- BEHAVE-AD: Behavioral Pathology in Alzheimer's Rating Scale
- Dementia Behavior Scale
- Cornell Scale for Depression in Dementia
- Hachinski Ischemic Scale (Vascular Dementia)

# Multidisciplinary Approach

- History and Physical
- Laboratory tests - CBC with Differential, Thyroid studies, B12, Folate, Chemistry Profile, RPR, UA, Sedimentation Rate
- Psychiatric Assessment
- Psychological testing
- Evaluation of functional abilities
- Social factors

# Barriers to Care!

# Patient and Family Barriers

- Isolation
- Ageism – belief that depression, confusion are normal conditions of aging
- Preference of primary care
- Focus on somatic complaints
- Stigma
- Reluctance to discuss psychological symptoms
- Lack of /misinformation

# Provider Barriers

- Ageism – “normal aging”
- Training barriers
- Focus on “medical issues”
- Lack of awareness of “geriatric-specific” clinical symptoms
- Complexity of treatment issues
- Reluctance to inform patients of diagnosis
- Lack of access to psychiatric care
- Lack of /misinformation

- Fragmentation
- Intersystem boundaries – including exclusion of dementia from many community mental health programs
- Time constraints
- Lack of access to geriatric specific services/treatment
- Reimbursement issues – including a mismatch between covered services and a changing system of long-term and community based care
- Cultural diversity needs

# EVIDENCE BASED PRACTICES FOR OLDER ADULTS WITH BEHAVIORAL HEALTH ISSUES

- Psychosocial and pharmacological treatment for depression and dementia
- Integrated mental health services in primary care
- Mental health outreach services
- Brief alcohol interventions for at-risk use
- Family/ caregiver support interventions

Draper, 2000; Unutzer, et al., 2001; Schulberg, et al., 2001;  
Sorenson, et al., 2002; Bartels, et al., 2002, 2003

# PENNSYLVANIA'S APPROACH

## **Pennsylvania's Cross System Approach**

**2006** - Mental Health Bulletin was released from the Deputy Secretary of Mental Health on the rights of older adults, even those with dementia, to receive mental health treatment (Bulletin issued, February 2006.)

## **Pennsylvania's Cross System Approach**

**2006** – Cross System development with the Pennsylvania Department of Aging and Office of Mental Health and Substance Abuse Services, of a Suicide Prevention Strategy for Pennsylvania that specifically addresses the needs of older adults.

# **PDA & OMHSAS Memorandum of Understanding (MOU)**

The 2006 Program Directive MOU required PDA Office of Community Services and Advocacy and the OMHSAS to collaborate and to develop MOUs between each county's MH/MR program and the county's Area Agency on Aging.

## **Pennsylvania's Approach to Collaboration**

- Memorandums of Understanding (**MOU**) between the Office of Mental Health and Substance Abuse Services (**OMHSAS**) and the Pennsylvania Department of Aging (**PDA**) – State and County agreements

## **Pennsylvania's Cross System Approach**

- Cross systems collaboration is necessary to serve the older adult population.
- MOUs between behavioral health and aging provide an agreed-upon roadmap to establish and build collaboration.

# Pennsylvania's Cross System Approach

- Many Counties have built effective cross-systems Aging and Mental Health programs to meet the needs of their citizens as a result of the MOU intent.
- All cross system initiatives should include all systems of care that interface with older adults – truly Multidisciplinary!

# **Mental Health Needs of Older Adults**

- **Older adults with mental illness are at increased risk, compared with younger adults, for receiving inadequate and inappropriate care**

# Mental Health Needs of Older Adults

- Multidisciplinary approach
- Consumer input
- Stakeholder-generated principles – CSP/CASSP
- Culturally competent
- All levels of interagency collaboration
- Toward the aim of dispelling stigma
- Integrated at the community level
- Continuum of care from prevention to treatment

SAMHSA Strategic plan Substance Abuse and Mental Health  
Issues facing Older Adults 2001 - 2006

# Resources

- **Alzheimer's Association** – [www.alz.org](http://www.alz.org)
- **ADEAR (NIA)** – [adear@alzheimers.org](mailto:adear@alzheimers.org)
- **Family Caregiver Alliance** – [www.caregiver.org](http://www.caregiver.org)
- **Geriatric Mental Health Foundation** – [www.gmhfonline.org](http://www.gmhfonline.org)
- **Positive Aging Resource Center** – [positiveaging.org](http://positiveaging.org)
- **Medline Plus (NIH)** – [medlineplus.gov](http://medlineplus.gov)
- **Suicide Prevention Network USA** – [www.spanusa.org](http://www.spanusa.org)
- **Pennsylvania Behavioral Health and Aging Coalition** - [www.olderpa.org](http://www.olderpa.org)

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# Questions and Answers

- Use the Q&A pod to type your questions or press \*1 to ask your question using operator assistance. We will attempt to get to as many questions as possible.
- Post webinar course evaluation and post test link –
- For those seeking CE credits – post-test and course evaluation needs to be completed no later than 9:00 pm, Eastern, today.

# Upcoming Webinars

- December 15<sup>th</sup> – Veterans Issues and Recovery presented by Eric E. Hill, MSW, LCSW, Program Manager, Reaching Rural Veterans Initiative, Geisinger Health System