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Older Adult Mental Health 101

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SAMHSA Substance Abuse and Mental Health Services Administration

Grant#: 6H79FG000600-01M001
SAMHSA's mission is to reduce the impact of substance misuse and mental illness on America's communities.
1-877-SAMHSA-7 (1-877-726-4727) • 1-800-487-4889 (TDD) • www.samhsa.gov

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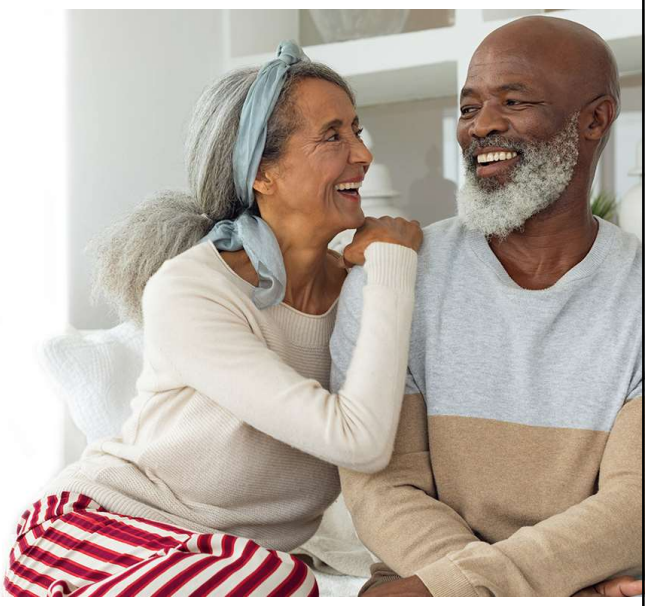
Mission

Engage, **Empower**, and **Educate** health care providers and community-based organizations for **Equity** in behavioral health for older adults and their families across the US.



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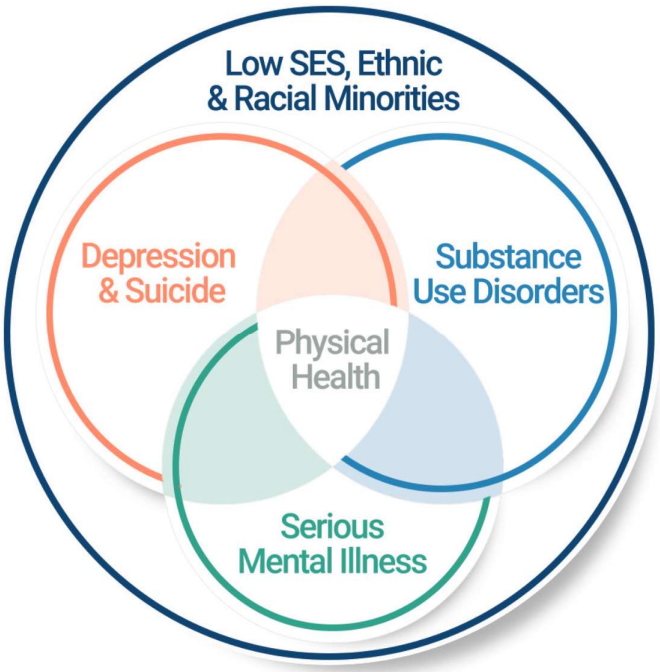

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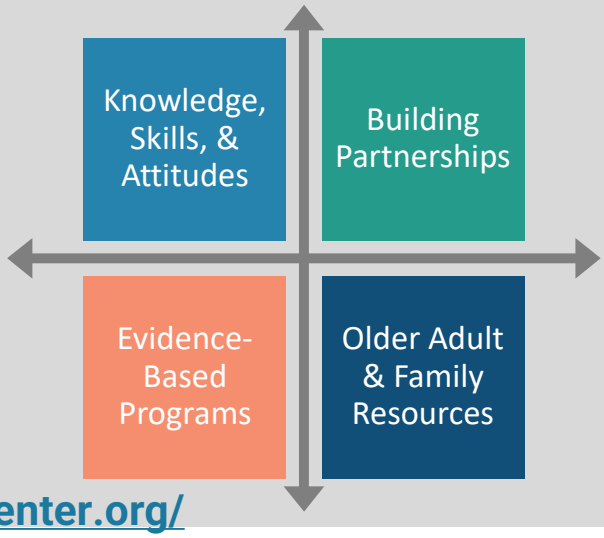
E4 Center: Engage, Educate & Empower for Equity



https://e4center.org/

Email: e4center@rush.edu

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Disclosures

CATCH-ON
A HRSA GERIATRIC WORKFORCE ENHANCEMENT PROGRAM

HRSA
Health Resources & Services Administration

CENTER
Center of Excellence for Behavioral Health Disparities in Aging
AT RUSH UNIVERSITY MEDICAL CENTER

SAMHSA
Substance Abuse and Mental Health Services Administration

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Learning Objectives

- Conceptualize later life as part of a developmental process, with unique challenges that may impact mental health
- Identify and challenge systemic and personal stereotypes and promote positive attitudes toward aging
- Recognize risk factors for mental health problems in older adults and identify barriers to diagnosis and treatment
- Characterize unique presentations of mental health disorders in older adults and employ evidence-based assessments and treatments
- Distinguish normal cognitive aging from abnormal cognitive aging and differentiate Alzheimer's disease presentation from other causes of cognitive decline

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Grab a pencil

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COMING SOON!
Foundational Competencies in Older Adult Mental Health
Online Certificate Program

- Attitudes about older adults and aging
- Adult development
- Depression
- Suicide
- Anxiety
- Trauma and PTSD
- Substance use
- Psychopharmacology
- Cognition
- Common life issues
- End of life and grief
- Practice Issues
- [coming soon: Serious Mental Illness]

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Elderly

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Older Adults

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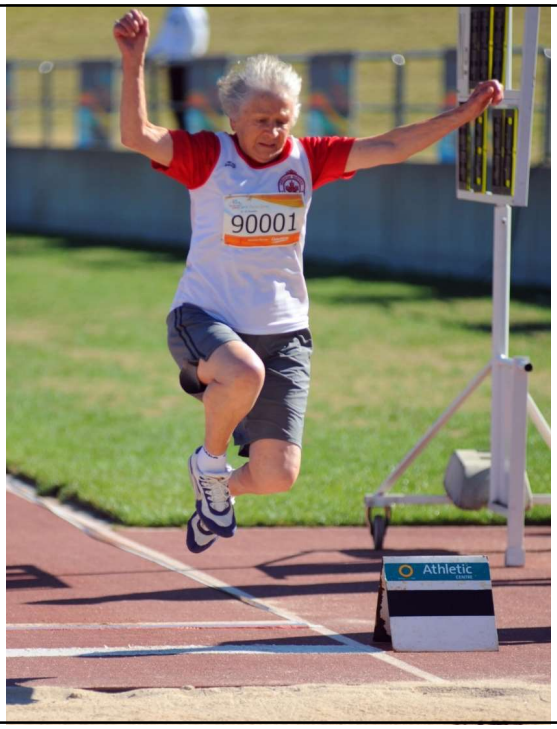

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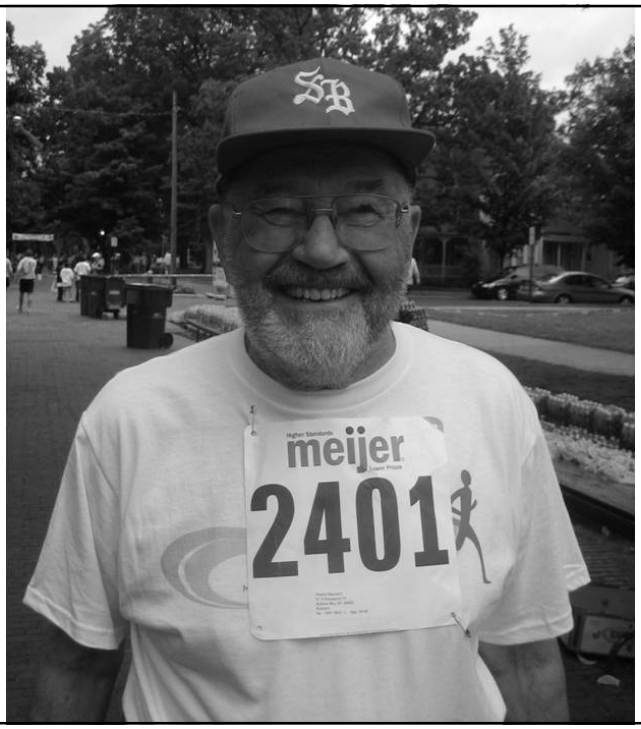

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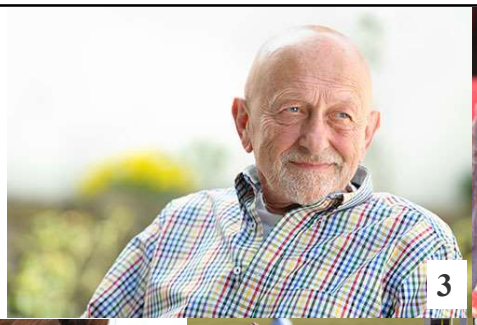
Noticing

Elderly (1)

Older Adults (2)



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Elderspeak

- Singsong voice, exaggerating words
- Simplifying sentences
- Speaking slowly.
- Using limited vocabulary
- Using terms like "honey" or "dear"
- Using statements that sound like questions.

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Effects of ElderSpeak

- Does not improve comprehension[1,2]
- Threatens older adult self-concept, personhood[3,4]
- May increase aggression in people with dementia[5-6]
- Increased resistive behaviors in dementia linked to increased morbidity & mortality[7]
- Removing ElderSpeak can decrease resistive behaviors in older adults with dementia by HALF[8]

[1]Kemper & Harden, 1999; [2]Leland, 2008; [3]Kitwood, 1997; [4]Kitwood & Bredin, 1992; [5]Herman & Williams, 2009; [6]McCallion, Toseland, Lacey & Banks, 1999; [7]Hermann et al, 2006; [8]Williams et al, 2016

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Attitudes about Aging

Myth

- Pretty much all alike
- Alone and lonely
- Sick, frail, dependent
- Cognitively impaired
- Depressed
- Old age brings rigidity
- Problems in coping with late life

Reality

- Very diverse
- Most maintain close contact with friends & family
- Most live independently
- Most are cognitively intact
- Lower rates of depression than younger adults
- Personality fairly consistent throughout life
- Most successfully adapt

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Attitudes about Aging

- "Ageism: negative or positive stereotypes, prejudice and/or discrimination against (or to the advantage of) elderly people on the basis of their chronological age or on the basis of perception of them as being 'old' or 'elderly'."
- Social stereotyping is common and often invisible
- https://implicit.harvard.edu/implicit/selectatest.html

Iversen, et al, 2009

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Negative Self-Perceptions of Aging

- Greater disease burden, lower life satisfaction and greater loneliness than racism, sexism, and heterosexism/ homophobia; effects grow over time[1]
- Increased functional impairment[2]
- Increased depression, anxiety, suicidal ideation[3]
- Increased mortality risk[4]
- *Positive* SPA is *protective*[5]

[1]Sutin et al, 2015; [2]Levy et al, 2009; [3] Levy et al, 2014; [4]Sargent-Cox et al, 2012; [5]Ng et al, 2016

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Impact of Ageism

7.5

Years added to your life with positive perceptions of aging

Levy, 2022

Reframing Aging

https://www.reframingaging.org/

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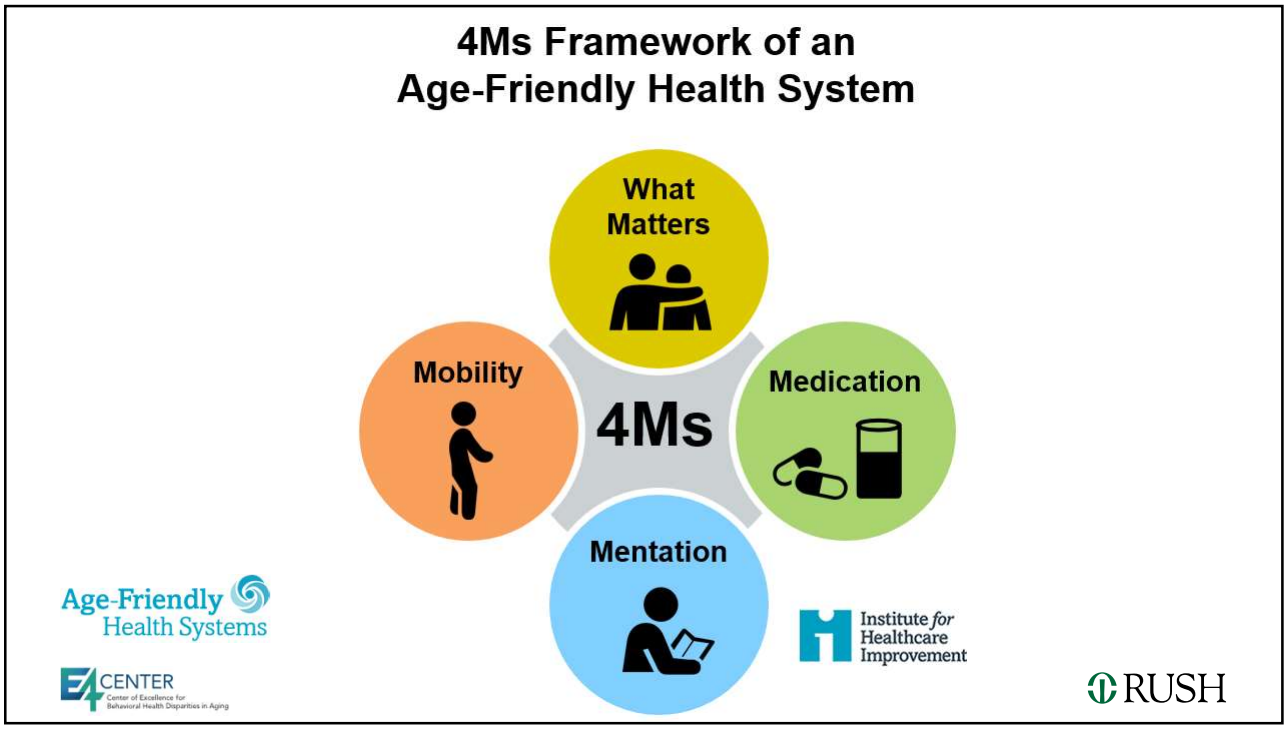
4Ms Framework of an
Age-Friendly Health System
What Matters
Mobility
4Ms
Medication
Mentation
Age-Friendly Health Systems
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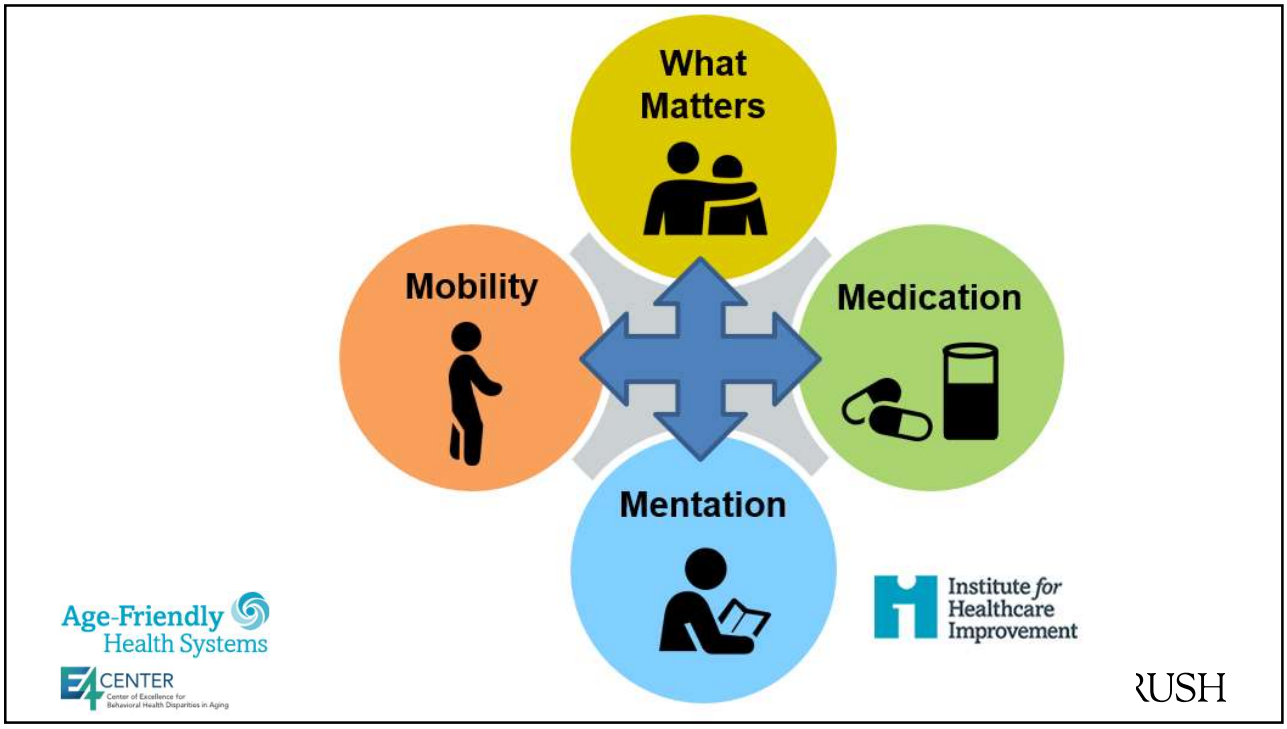
What Matters
Mobility
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Barbara's* story

- 74yo African American woman with depression
- COVID, race protests, insurrection
  - **What Matters**
  - Mobility
  - Medication
  - Mentation

- **pseudonym, not her actual photo*

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Age-Friendly Health Systems

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Adult Development

The body and mind change with age. We adapt.

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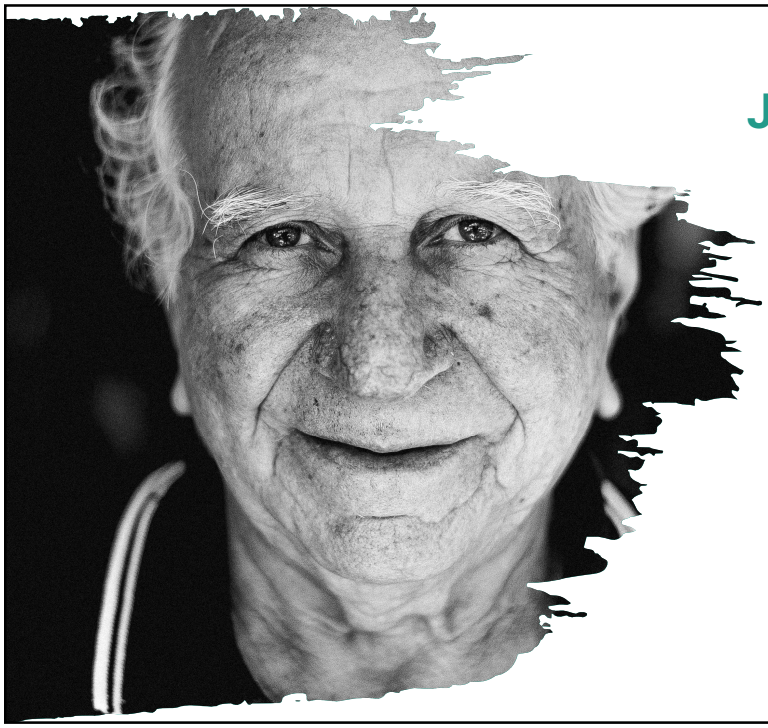

Jack*

- 74yo white male
- Diabetes, Hypertension
- Weight gain
- Mobility difficulty
- Depression
- Walks with a cane

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Developmental Experiences

- Life expectancy
- Retirement
- Social Security
- Personality

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Changes in Physiology with Age

- Metabolism and Elimination
- Absorption and Distribution of Medication
- Pulmonary Function
- Mobility and Strength
- Senses (hearing, sight)
- Sleep
- Mental Health

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Developmental Theories

- Erikson's stages
- Selective Optimization with Compensation
  - Selection: Choosing goals
  - Optimization: focusing resources, refining skills
  - Compensation: selecting alternative means to achieve goals

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Common Life Issues

Transitions can be both challenging and joyful.

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Life Transitions

- Employment
- Volunteer
- Leisure
- Finances
- Living environment
- Resources
  - Establish new routines
  - Get involved in new activities
  - Lifelong learning university
  - Area Agency on Aging
  - Senior/Community Center
  - Financial planning
  - Care management

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Caregiving

- Caring for spouses, adult children
- Can be taxing and rewarding
- Higher rates of depression for dementia caregivers
- Resources
  - Support groups
  - Community services
  - Medicare respite
  - Family Caregiver Alliance

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Relationships

- Most older adults very connected
- Fewer, deeper relationships
- Integrating generations
- Loneliness
  - Increased risk for depression, dementia, multiple health issues
- Resources
  - Senior/community centers
  - Support groups
  - Congregate living
  - Friendly caller programs

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Health Conditions

- >80% older adults with 1+ chronic conditions
- Health behaviors matter, and so do social determinants of health
- Functional impairment
  - In-home assistance available
  - Workforce issues

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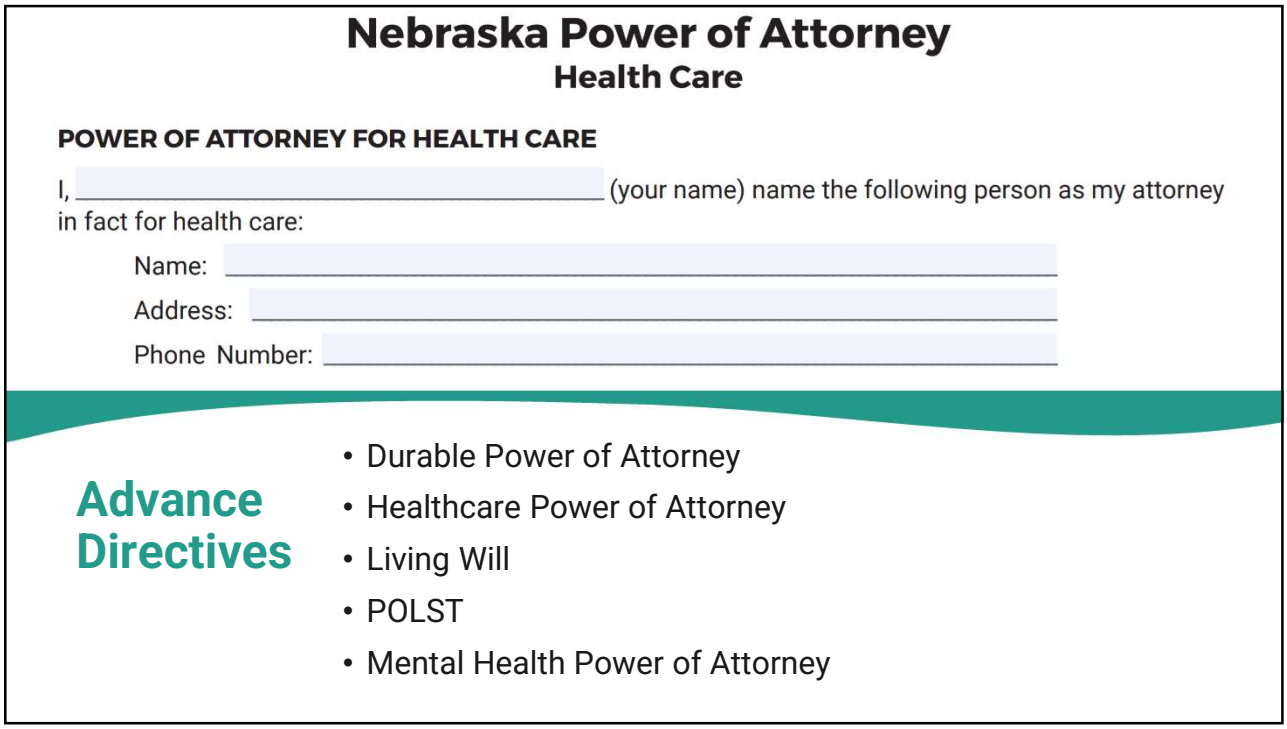

Advance Directives

- Durable Power of Attorney
- Healthcare Power of Attorney
- Living Will
- POLST
- Mental Health Power of Attorney

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Practical Issues

The environment of care and team connections matter.

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Environment of Care

- Physical space
  - Parking, ramps, elevators
  - Wheelchair accessible counters and rest
  - Chairs with arms, not wheels
  - Written materials in large font
  - Signs with high contrast, minimal glare, way-finding
- Sensory issues
  - Hearing, vision, speech
  - Cognition
- Telehealth
- Long-term care

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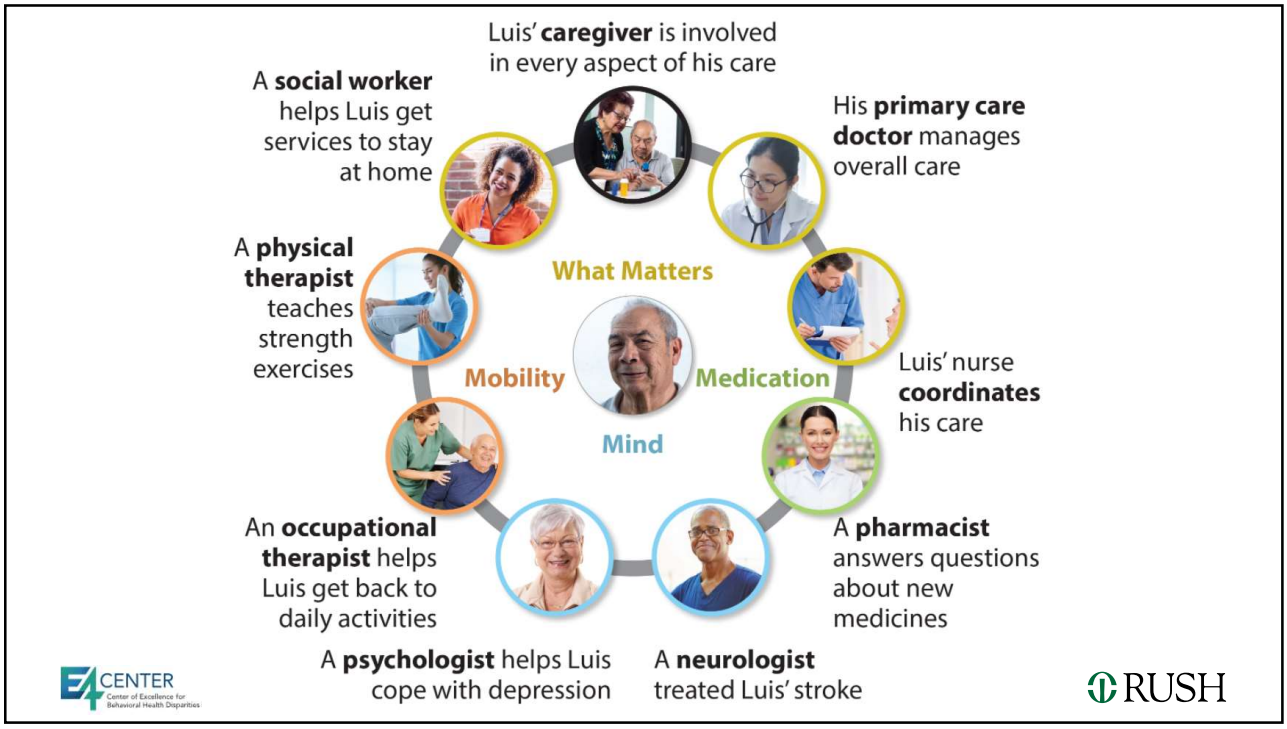

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Community Based Organizations (CBOs)

- Get to know the Aging Network!
- In home services
  - Housekeeping
  - Activities of Daily Living
- Social engagement
  - Friendly visitor
  - Congregate meals
- Caregiver support
- Health promotion
- Adult Protective Services

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Involving others in care

- Family caregivers
- Decision-making capacity
- Guardians
- Elder abuse and neglect

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Stand up, Stretch, Walk Around!

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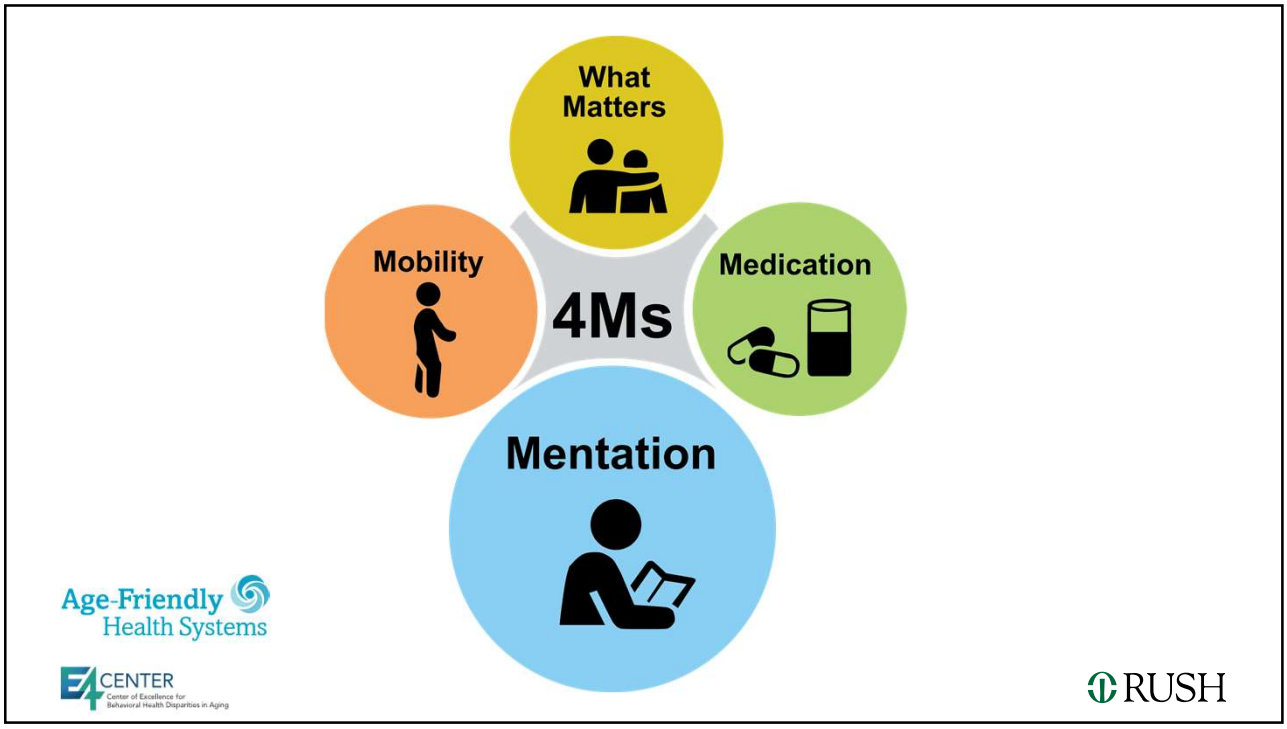

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Older adults with mental health issues are *more* likely than younger adults to have:

- Functional impairment[1],
- Poor mobility[2],
- Symptom burden[3]
- Longer hospital stays[4]
- Health issues that put them at risk for loneliness[5]

[1]Haigh et al, 2018; [2]Lampinen et al, 2003; [3]Abdel-Kader 2009; [4]Myers et al, 2012; [5]Ilgen et al, 2010

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Older adults are *less* likely than younger adults to:

- Pursue or engage in mental health[1] or SUD[5] treatment
- Survive a suicide attempt[4]
- Receive adequate services[2] especially if Black or Latino[3]

[1]Wang et al 2000; [2]Bartels et al 1997; [3]Jimenez et al 2013; [4]SAMHSA, 2015; [5]Huang et al, 2013

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Depression

NOT a normal part of aging.

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Depression

- Unique presentation in later life
  - Less likely to report depressed mood
  - More likely: Anhedonia, sleep, fatigue, being slowed down, hopelessness, overall body aches and pains, and memory problems[1]
  - More likely to be successful if attempt suicide
- "Minor" or subsyndromal depression
  - ~15% in the community[2]
  - Associated with decreased function in later life[3]

[1]Fiske, Wetherell, & Gatz, 2009; [2]Blazer, 2003; [3]Alexopoulos, 2005

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Depression and Health Behavior

- Depression can cause poor self-care
- Non-adherence with medication regimens
- Decreased levels of physical activity
- Poor dietary habits
- Exacerbates existing medical conditions
- Causes medical conditions

Iovino et al, 2020; Roshanaei-Moghaddam et al, 2009; Vogelzangs et al, 2008; Walsh et al, 2013

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Depression Assessment

- Clinical interview
- Self-report measures
- Interviewer administered measures
- Family or caregiver report, as appropriate
- Consider reciprocal relationships of depression, physical illness, cognitive impairment

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Validated Depression Screening Tools

- GDS: Geriatric Depression Scale (Yesavage, 1988)
- PHQ-9: Patient Health Questionnaire – 9 Item (Kroenke, Spitzer, & Williams, 2001)

GERIATRIC DEPRESSION SCALE (GDS-SV)

Issues:
The GDS is a screening tool and not a diagnosis. Where a score of more than five is indicated, a more thorough clinical investigation should be undertaken. Feher et al.37 have concluded that the GDS is a generally valid measure of the mild-to moderate depressive symptoms in Alzheimer patients with mild-to moderate dementia. *The client should be interviewed to collect the following information.*

1. Are you basically satisfied with your life?	Yes	No
2. Have you dropped many of your activities or interests?	Yes	No
3. Do you feel that your life is empty?	Yes	No
4. Do you often get bore		
5. Are you in good spirit		
6. Are you afraid that so		
7. Do you feel happy mo		
8. Do you feel helpless?		
9. Do you prefer to stay		
10. Do you feel that you most?		
11. Do you think it is wo		
12. Do you feel pretty w		
13. Do you feel full of e		
14. Do you feel that you		
15. Do you think that m		

When a score of more than fi undertaken.
Score: _____/15

One point for No to question
One point for Yes to other q
Normal ± 2
Mildly Depressed 7± 3

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use "✔" to indicate your answer)	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

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Evidence-Based Treatment for Depression

- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Problem-solving Therapy
- Anti-depressant medication

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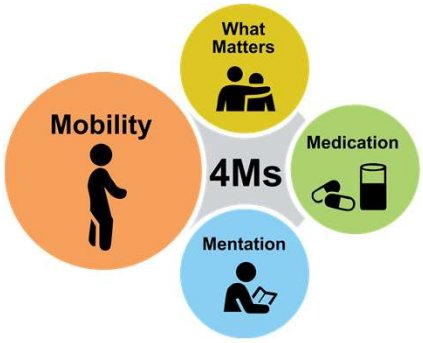
Regular Research Article

The Mental Health Benefits of Physical Activity in Older Adults Survive the COVID-19 Pandemic

Daniel D. Callow, Naomi A. Arnold-Nedimala, Leslie S. Jordan, M.S., Gabriel S. Pena, M.S., Junyeon Won, M.A., John L. Woodard, Ph.D., J. Carson Smith, Ph.D.



International Journal of *Environmental Research and Public Health*

MDPI

Article

Sleep Quality and Physical Activity as Predictors of Mental Wellbeing Variance in Older Adults during COVID-19 Lockdown: ECLB COVID-19 International Online Survey

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Mobility and Social Connectedness

- Group activities can increase motivation for physical activity, maintain mental health[1]
- Group activities can decrease loneliness[2]

[1]Lindsay-Smith et al, 2019; [2]Franke et al, 2021

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Suicide

Take suicidal thoughts very seriously.

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Suicide among older adults

- White males age 85+
- 85-90% older adults who die by suicide had major mental illness
- 1 of every 4 older adults who attempts suicide dies, compared to 1 in 25 for younger adults
- Risk factors: change in health status, grief, lack of purpose or meaning, dementia, social isolation and loneliness

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Suicide Assessment

- Within a month before their suicide, ~45% of have seen primary care; 20% have seen mental health professional
- Asking about suicide risk does not encourage an attempt
- Ideation, intent, plan
  - Distinguish between wishes for death and plans to die
- Consider the means
- **Columbia-Suicide Severity Rating Scale (C-SSRS)**

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Suicide

Internal Protective Factors

- Coping skills
- Adaptive skills
- Sense of humor
- Engagement in social interests
- Ability to recognize success

External Protective Factors

- Strong family and community network
- Engagement with religious groups
- Supportive and engaged health care team

Beautrais, 2002; Dombrovski, & Szanto, 2005; Holkup, et al 2003; Mitty & Flores, 2008

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Substance Use

Always screen for substance use with older adults!

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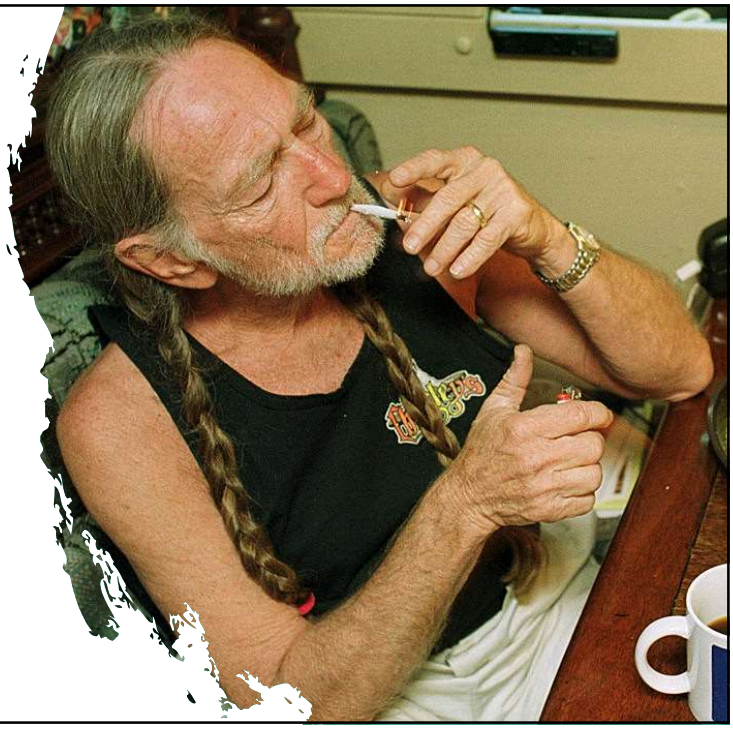
Substance Use

- Don't assume anything about older adult substance use
- Because of physiological changes with normal aging, the same amount is increasingly potent in later life
- Interactions with medications
- Cognitive impairment
- Mental health
- Fall risk



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Substance Use

- 2.3% of US older adults reported having a substance use disorder in 2019
- The most commonly used substances among older adults:
  - World: alcohol, cannabis, opioids
  - US: Alcohol

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Older Adult Risk Factors for Substance Use

- Male
- White
- Low socioeconomic status
- Undergoing life transitions
  - Retirement or death of a spouse
  - Identifying as part of the LGBTQ community
  - Being socially isolated
  - Experiencing health problems
- History of substance use and mental health problems

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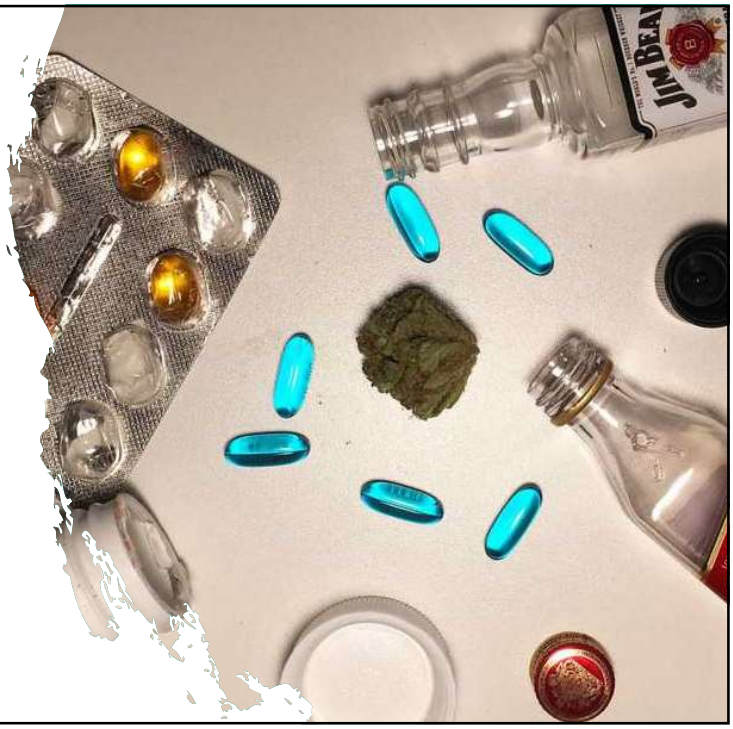
Substance Use Issues

- Alcohol
  - <2 for men; <1 for women
- Cannabis on the rise
- Prescription medication misuse vs. mismanagement
- Opioids
  - 3.6% in adults aged 50-64 and 1.2% in adults over 65
  - 1999-2019 1,886% increase in opioid deaths age 55+



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Screening Tools for Substance Use Validated with Older Adults

AUDIT / AUDIT-C	MAST-G, SMAST	SAMI	CUDIT-R
Alcohol Use Disorders Identification Test	Michigan Alcohol Screening Test	Senior Alcohol Misuse Indicator	The Cannabis Use Disorder Test
10 or 3 items	24 or 10 items	5 items	8 items
Frequency rating	Yes/No	Checklist	Likert

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Substance Use Interventions for Older Adults

- SBIRT: Screening, Brief Intervention and Referral to Treatment
- Cognitive Behavioral Therapy
- Motivational Enhancement Therapy
- 23% of treatment centers designed to accommodate older adults
- Seniors in Sobriety

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Anxiety

The overlap of anxiety and medical conditions is significant.

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Anxiety Disorders in Older Adults

- More likely to say “concern” rather than “anxiety”
- Focused on loved ones, general health concerns, sexual minority status, and the state of the world
- Less likely to describe feeling anxious or depressed and more commonly emphasize physical health or other bodily concerns.

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Anxiety & Medical Conditions

- Overlap with medical symptoms – assess carefully
- Medication side effects may explain some anxiety symptoms
- New onset anxiety in late life may be a symptom of cognitive impairment

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Screening Tools for Anxiety Validated with Older Adults

GAD-7	GAI	GAS	PSWQ / PSWQ-A
Generalized Anxiety Disorder	Geriatric Anxiety Inventory	Geriatric Anxiety Scale	Penn State Worry Questionnaire
7 items	20 items	30 or 10 items	16 or 8 items
4-point Likert	Agree / Disagree	4-point Likert Subscales: somatic, cognitive, affective	5-point Likert

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Evidence-Based Treatment for Anxiety

- Cognitive Behavioral Therapy
- Acceptance & Commitment Therapy
- SSRI/SNRI

**NOT benzodiazepines*

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Trauma & PTSD

Symptoms may emerge later life, but likely were always there.

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Trauma and Older Adults

- 70% of adults experience potentially traumatic event in lifetime
- 20-40% of those develop PTSD
- Lifetime prevalence of PTSD in older adults 4.5%; higher among veterans and marginalized groups

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Post-Traumatic Stress Disorder (PTSD)

- Delayed onset rare; more likely increase from sub-threshold symptoms
- Symptoms may emerge at retirement
- Clinicians less likely to detect PTSD in older adults
- Increased risk for:
  - Health conditions
  - Cognitive impairment
  - Suicide

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Evidence-Based Treatment for PTSD

- Prolonged Exposure
- Narrative Exposure Therapy
- Cognitive Processing Therapy

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Stand up, Stretch, Walk Around!

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Cognition

Decline in some areas is normal; dementia is not normal aging

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Normal Aging

- Attention
  - Sustained: stable
  - Selective: slows
  - Divided: declines
- Memory – some decline
  - Storage, Encoding, Retrieval
- Language – well preserved
- Processing speed – declines
- Visuospatial abilities – stable
- Executive function
  - Abstraction, mental flexibility, response inhibition: declines
  - Judgment, problem-solving: stable

*Impact of hearing loss

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Treatable Cognitive Impairment

- Depression
- Delirium
  - Acute brain failure
  - Waxes and wanes
  - Attention, arousal, orientation, hallucinations, sleep-wake disturbance
  - Hyperactive, hypoactive, mixed
  - Caused by medication change, infection, pain, anesthesia, acute illness; often multiple factors
  - Dementia is a risk factor

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Dementia: Umbrella for multiple diseases

- Alzheimer's Disease
  - Most common: 60-80% of cases
  - Memory loss primary, naming
  - Poor awareness
- Vascular disease
  - 5-10% of cases
  - Stroke or microvascular disease
- Dementia with Lewy Bodies
  - 4-16% of cases
  - Attention, complex thinking, visual hallucinations
- Frontotemporal degeneration
  - 5-10% of cases
  - Changes to personality, behavior

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Screening Tools for Cognitive Impairment

Mini Mental Status Exam (MMSE)	Montreal Cognitive Assessment (MoCA)	St. Louis University Mental Status Exam (SLUMS)	**Delirium Screening**
30 items	30 items	30 items	Confusion Assessment Method (CAM)
Not in public domain anymore	Public domain; requires paid training	Public domain	4AT UB-2

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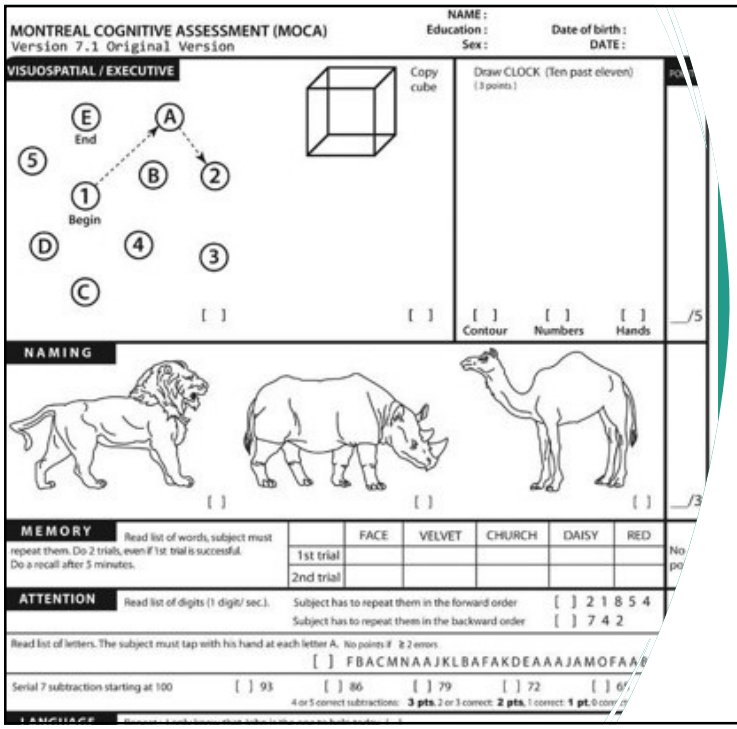

Assessing cognition

- Screening
- Clinical interview
  - Collateral information
  - Daily activities
- Medical evaluation
- Neuropsychological evaluation

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Managing Cognitive Impairment: Communication

- Remove distractions
- Use short sentences and provide time to process
- Ask one question at a time
- Avoid elderspeak!
- AD: do not remind; just repeat
- Other: provide context to trigger memory

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Managing Cognitive Impairment: Behaviors

- Sometimes the only way a person can communicate
- Identify cause
  - Pain, emotion, environment, boredom, need for interaction
  - Caregivers or environment may reinforce the behavior
- Try to meet the need
- Medication only if safety risk to self or other – last resort

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Dementia Prevention

- Smoking cessation
- Controlling chronic conditions (diabetes, high blood pressure) high cholesterol.
- Regular physical exercise
- Heart-healthy diet
- Mediterranean diet
- MIND diet
- Remaining cognitively active and socially engaged
- Healthy sleep habits

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Grief and End of Life

Sadness is normal; prolonged dysfunction is not

Talking about end of life is difficult and important

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Normal Grief vs. Prolonged Grief Disorder

Normal grief

- Sadness
- Stunned, shocked
- Lonely
- Intense emotions dissipate over time
- Willingness to reinvest in relationships

Prolonged Grief Disorder

- Longing and yearning for the deceased
- Behavioral symptoms, including
  - Identity disruption
  - Disbelief regarding death
  - Avoidance of reminders
  - Numbness
  - Meaninglessness
  - Intense loneliness
- Clinically significant impairment daily for 6 months – 1 year

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Evidence-Based Interventions

- Cognitive Behavioral Therapy
- Interpersonal Psychotherapy
- Complicated Grief Therapy
- Support groups

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Goals of Care Conversations

- Clarify medication conditions, treatment options, and preferences
- Increased dignity, fewer unwanted interventions, earlier hospice referrals
- Less regret, prolonged grief

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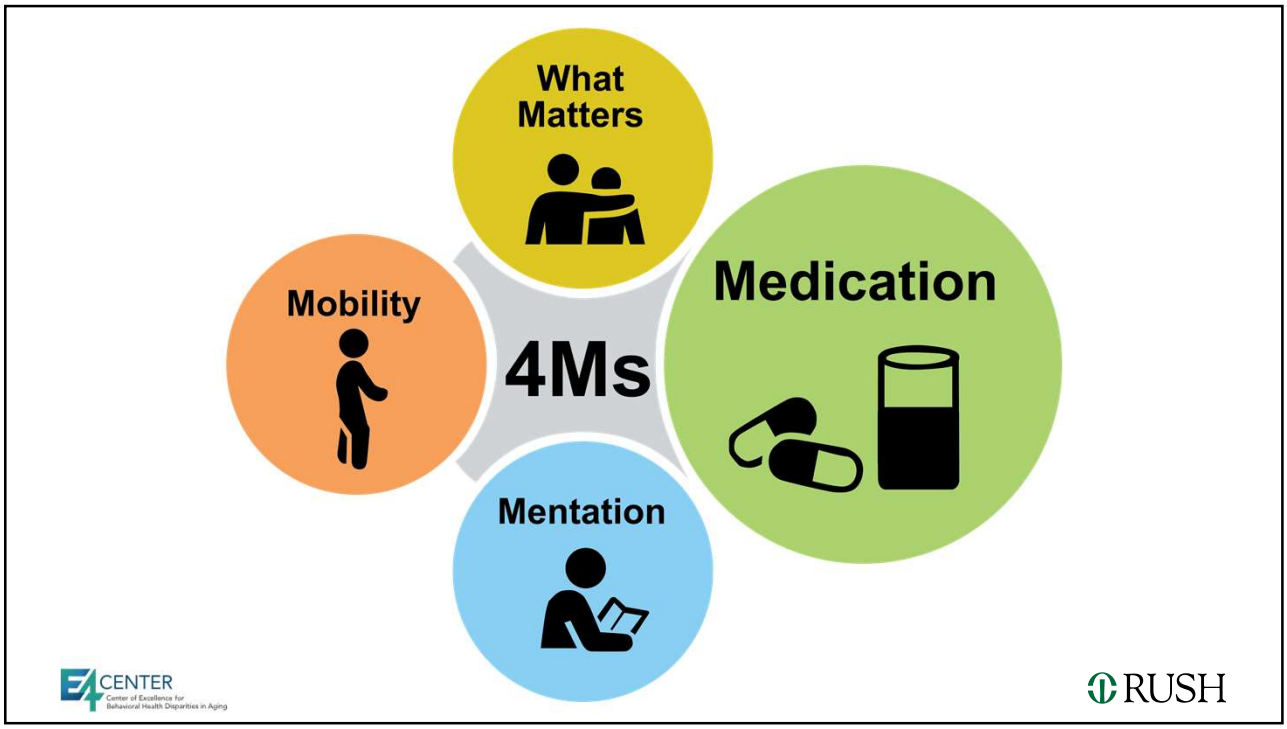

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Pharmacology

Be aware of side effects; reduce polypharmacy

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Polypharmacy

Common in older adults

- 36% are prescribed 5+ drugs
- 20% of drugs used may be inappropriate
- 42% of patients fail to inform providers about the use of complementary and alternative medications
- 40% of over-the-counter drugs purchased by older adults

POLYPHARMACY IS COMMON AND POSES RISK

Michael Koronkowski, PharmD

Qato DM, et al. 2016; Roughhead EE, et al. 2007; Jou A, et al. 2016; Nahin R, et al. 2009

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Normal Aging and Medications

- Pharmacokinetics: Absorption, distribution, metabolism, and elimination
  - Substances take longer to clear
  - Substances may build up
  - Kidneys shrink with age
  - Slower metabolism
- Pharmacodynamics: what drugs do to the body
  - Increased side effects
  - Increased drug interactions

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CLINICAL INVESTIGATION

American Geriatrics Society 2019 Updated AGS Beers Criteria® for Potentially Inappropriate Medication Use in Older Adults

*By the 2019 American Geriatrics Society Beers Criteria® Update Expert Panel**

- **Antihistamines**
- Antiparkinsonian Agents
- Skeletal Muscle Relaxants
- Antidepressants
- Antipsychotics
- Antiarrhythmics
- Antimuscarinics
- Antiemetic
- **Opioids**
- **Benzodiazepines**

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Side effects to watch for

- **Anticholinergic**
  - Blocks acetylcholine
  - Dry mouth (note ill-fitting dentures), confusion, falls, urinary retention, hallucinations, and delirium
- **Sleep medications**
  - *Anticholinergic effects*
  - physical and psychological dependency, memory impairment, disinhibition, paradoxical agitation
  - Melatonin: vivid dreams or nightmares, drowsiness, dizziness, irritability, and stomach cramps
- **Tricyclic antidepressants**
  - *Anticholinergic effects*
  - Sedation, cardiac rhythm abnormalities, orthostatic hypotension, hypertension, tremor, decreased seizure threshold, agitation, and insomnia
- **Benzodiazepines**
  - Enhances GABA
  - Cognitive decline, fall risk
  - Sedation, falls, trauma, and delirium, when prescribed with opioids
  - Must taper under medical supervision

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Talk with the patient and prescriber

- *I notice that you're having a harder time than usual organizing your thoughts today – do you notice that?*
- *Perhaps we could talk with your doctor about that*
- *Mrs. Jones was really confused in her visit with me today, and that's so unusual. I noticed that she recently started Ditropan – might that be having an effect?*

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COMING SOON!
Foundational Competencies in Older Adult Mental Health
Online Certificate Program

- Attitudes about older adults and aging
- Adult development
- Depression
- Suicide
- Anxiety
- Trauma and PTSD
- Substance use
- Psychopharmacology
- Cognition
- Common life issues
- End of life and grief
- Practice Issues
- [coming soon: Serious Mental Illness]

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