Enhancing Mental and Behavioral Health in Later Life

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Reported rapidly growing burdens:
Mental, neurological and substance use disorders

✓ Common in all countries
✓ Significantly impaired functioning
✓ Increased mortality, morbidity, and disability
✓ Stigma and human rights violations
Geriatric Mental Health

About 1 in 5 older adults (7 million) experience mental health conditions

Fewer than 1 in 6 of those elders receive any type of mental health attention

- Chronic mental illnesses do not vanish when clients reach old age
- Mental disorders can appear or reappear in old age
- Long-standing diagnoses can become further complicated by new disorders
- Mental disorders are further complicated by medical problems and disabilities
Under-recognition of Geriatric Mental Disorders

- Older adults underreport symptoms of mental disorders or express awareness of these symptoms through descriptions of somatic (bodily) complaints
- Symptoms of mental disorders and medical illnesses often overlap
- People with mental disorders often also have complex medical conditions
- Some changes which occur normally with aging are similar to symptoms of mental disorders such as depression
- Mental health systems often lack sufficient numbers of providers with geriatrics expertise
- Aging service systems often lack sufficient numbers of providers with mental health expertise
Geriatric Disorders: Anxiety

Anxiety disorders include generalized and acute anxiety disorders, panic disorders, phobias, obsessive-compulsive disorders, PTSD, and anxiety disorders related to substance use or medical conditions.

- About 10% of older adults experience one or more anxiety disorders.
- Anxiety among older adults commonly occurs with other mental disorders including depression and substance use.
- Anxiety among older adults commonly occurs with a wide array of medical conditions including cardiac, endocrine, pulmonary, and neurological disorders.
- Untreated anxiety disorders increase risks for physical illness and decrease functioning, which increases rates of disability.
Interventions: Anxiety

- Collaborate with older adult in setting goals
- Focus on supporting autonomy and dignity to preserve personhood
- Coordinate with family and inter-professional “team” (medical & social services)

Psychotherapy

- Cognitive-Behavioral Therapy (Mohlman et al., 2003)
- Multicomponent treatment: Education; Relaxation training; Cognitive therapy techniques; Problem solving skills building; Progressive exposure; and Sleep management techniques (Stanley et al., 2003)

Medication/psychotherapy combination treatment for more severe cases

- Refer to Zarit & Zarit, 2007
Geriatric Disorders: Depression

- Major Depressive Disorder occurs among 1-5% of older adults
  - Prevalence is higher among older adults with serious medical problems, those living in nursing homes, recent immigrants, and those with more social stress

- Clinically significant depressive symptoms occur among 10-25% of older adults
  - Clinical significance means symptoms interfere with function and require treatment
  - Depressive symptoms commonly occur with other disorders - anxiety and dementia

- Somatic complaints are more common than reports of depressed mood (i.e., bodily pains rather than feelings of sadness)

- Cognitive symptoms are prominent in older adults during major depressive episode (e.g., disorientation, memory loss, and distractibility)
Geriatric Disorders: Suicide

- The elderly make up 13% of the population but account for 20% of all suicides.
- In 2010, there were 5,994 elderly suicides, or about 16 per day.
- The rate of suicide among older men is 5.25 times higher for older women.
- Older adults often do not give warnings about suicide and seldom seek mental health treatment.
- Physicians are less likely to offer treatment for depression to older patients.
- Firearms were the most common means (71.3%) used for completing suicide among the elderly.
Geriatric Disorders: Suicide

Although older adults attempt suicide less often than those in other age groups, they have a much higher completion rate.

Suicide Attempts (All Ages)
- 99% Not Completed
- 1% Completed

Suicide Attempts (Age 65+)
- 75% Not Completed
- 25% Completed

Why?
- More health problems and frailty
- Tend to keep plans private and avoid interventions
- Less likely to live with others or to be detected immediately after attempt
- More likely to use a firearm as the method of suicide
**Interventions: Depression**

- Collaborate with older adult in setting goals
- Focus on supporting autonomy and dignity to preserve personhood
- Coordinate with family and inter-professional “team” (medical & social services)

**Psychotherapy**

- Behavioral Therapy (Lewinsohn et al., 1992)
- Cognitive-Behavioral Therapy (Beck et al., 1979)
- Interpersonal Psychotherapy (Klerman et al, 1984)

Medication/psychotherapy combination treatment for more severe cases

- Refer to Zarit & Zarit, 2007
Geriatric Disorders: Dementia

• Dementia = Neurocognitive disorder

• Generic term, not the name of a specific illness

• “Multiple intellectual losses in the awake state”

• Diseases of dementia currently afflict an estimated 5.5 million people in the U.S. and 24 million people worldwide

• Dementia is the 6th leading cause of death in the U.S., and is present in 1/3rd of older adults at the time of death

• Symptoms always caused by brain disease, damage or dysfunction

• Thus, very common but not “normal aging” process
Geriatric Disorders: Dementia

• Over 60 diseases and conditions can cause dementia

• Alzheimer’s disease is the leading cause of progressive dementia, followed by cerebrovascular diseases and Lewy Body disease

• Other progressive disorders include Parkinson disease, frontotemporal disorders, Huntington’s disease, Picks disease, Creutzfeldt-Jakob disease, and many others

• Combination pathologies are very common

• Categories of symptomatic dysfunction include losses in intellectual, behavioral, psychiatric, emotional, and functional domains
Geriatric Disorders: Dementia

Dementia is NOT a normal part of the aging process

PET scan from a 20-year-old

PET scan from an 80-year-old

Alzheimer’s disease causes widespread death of neurons

PET scan of a healthy brain

PET scan of an AD brain

PET scans show the use of glucose by brain cells during the few minutes of the scan

Healthy, active brain cells use the glucose a lot

Impaired or dysfunctional brain cells use very little glucose or none at all

In these images, bright red indicates a lot of activity, yellow means slightly less activity, light blue is minimal activity, and dark purple is no activity
Geriatric Disorders: Dementia

- Neurobiological etiology is the primary difference between these conditions
- Symptoms are usually similar across conditions
- Often difficult to distinguish from psychotic disorders among the elderly
- Sequence of symptom presentation is different from disease to disease and inconsistent from person to person
- Overall care needs are nearly identical for all dementias, although arising at unpredictable times and in irregular order
- The syndrome creates devastation in nearly every domain of human existence for patients, with serious negative impacts which reverberate through families
Interventions: Dementia

• Supportive psychoeducation for patients

• Multi-component supportive psychoeducation for caregivers
  – Coping and self-care techniques
  – Care, communication, activities engagement, and behavior management techniques
  – Environmental adaptations and safety planning

• Group counseling and mediated care coordination meetings for families in conflict

• Frequent reassessment of patient and caregiver needs
  – Mental health (emotional and behavioral concerns)
  – Care and Respite Services
  – Safety
  – Resources

• Pharmacological treatments: Cholinesterase Inhibitor and NMDA Receptor Antagonist, with many others in the research pipeline

• Pharmacological management of symptoms which do not respond to environmental and caregiving interventions
Geriatric Disorders: Substance Use

- Almost 20% of older Americans drink alcohol or use medications unsafely
- Providers often fail to assess for or detect problematic substance use in the elderly
  - They hold inaccurate assumptions about how addicts look and act
  - They wrongly ascribe symptoms of substance abuse to mental or neurological illness
- Substance dependence is disabling, dangerous, and disruptive
  - Problems include falls, fatigue, insomnia, depression, anxiety, cognitive impairment, expressive aphasia, incontinence, malnutrition, impacts on effectiveness and safety of prescribed medications, and self-neglect of personal needs and medical routines
- Addictions cause serious problems with relationships, money, housing, and the law
Interventions: Substance Use

- Collaborate with older adult in setting goals
- Focus on supporting autonomy and dignity to preserve personhood
- Coordinate with family and inter-professional “team” (medical & social services)

Careful attention to detoxification risks (Fingerhood, 2000)

Psychotherapy
- Educational sessions and motivational counseling (Bartels et al., 2002)
- Cognitive-Behavioral Therapy (Morin, 2004)
- Group Therapy (Center for Substance Abuse Treatment, 1998)
Geriatric Disorders: Social Isolation

• Many older adults lack meaningful social ties to friends, families, and neighbors

• 11 million older adults (28%) live alone

• Social isolation is associated with increased rates of:
  – Cognitive impairment
  – Anxiety & depression
  – Poor self-rated health and well-being
  – Neglect of desired health practices
  – Functional disability
  – Hospitalization
  – Morbidity and all-cause mortality

• Social health is often overlooked by providers in health settings
Geriatric Mental Health

MNS disorders pose high risk for negative outcomes among older adults and families.

Geriatric mental health issues complicate the delivery of care services.

Strategies for intervention must include supporting older adults’ strengths, preferences, culturally-informed expectations, and family systems.

Pharmacological treatments must be overseen by providers with expertise in geriatric medicine and psychiatry to account for late life changes in sensitivity, polypharmacy, and common comorbidities.

As social workers, we work to build competent care systems, and so increasing capacity around issues of geriatric mental health must be a high priority.
CONTEXT: Urgent Need for Change

Public Awareness & Education

Service Development

Advocacy & Policy Development

Research & Dissemination
Service Development

**Simple Goal**-
Get the right workers….
with the right skills….
in the right place….
doing the right things!

- Sufficient numbers of workers
- Adequate and appropriate training
Our Role in Service Development

- Older people “maintain a fragile balance between independence and dependence”\(^1\)
- MNS disorders are “the leading cause of combined disability and death of women and the second highest of men”\(^2\)
- Older adults with MNS disorders interact with providers in health, mental health and aging service settings
- Yet under-reporting, misdiagnosis, lack of treatment, and medical and mental health crises are common

We MUST overcome a number of challenges in order to build the capacity of our professional care systems, including our own work as practitioners, to respond to older adults’ needs related to MNS disorders

\(^1\) Zarit & Zarit, 2007
\(^2\) IOM, 2006
Challenges Confronting Providers

- Clients with mental disorders often have fewer social resources and greater impairment
- They require more from their social service providers, including effort, time, advanced planning, and skill
- These demands limit our availability for other clients in the caseload
- Social workers may feel overwhelmed or intimidated by clients with mental illness
- They may feel ambivalent and ill-prepared to respond to the unique needs of these clients
Recommendation
Frequently Review Mental Disorders

Use your expertise to:

Help to translate information to clients and families
- Describe disorders using simple lay language, not diagnostic criteria

Help service teams to understand impacts of symptoms on clients’ lives
- “What do you think it is like to feel worthless or depressed on a daily basis?”

Help to professionalize the service environment
- “I know you’re just joking around in the office, but I worry that talking about this client as “totally crazy” makes it easy to lose focus on how we can better address her emotional needs through our work.”
Recommendation
Provide a Supportive Relationship

Use each interaction as a clinical intervention

- Reflective listening
- Engaging body language
- Responsive emotions
- Empowering messages
Recommendation
Plan to Confront Risk

Inebriation causes strange behaviors, and may jeopardize your safety.

Erratic behavior may include intimidation, hostility, and unpredictability.

Talk with agency supervisors and managers about:

- **Client risk** – Crisis intervention; Stabilization goals; Referrals
- **Safety** – Expectations about when to stay and when to leave
- **Care plan adjustments** – Two worker visits; client reassignment
- **Agency liability** – Managerial concerns and priorities
Recommendation
Advocate for Resources to Increase Capacity

Consider opportunities for advocacy within your own agencies in order to improve ability to serve older clients with complex mental health needs.

Be sure to fight for:

- Appropriate staffing levels
- Safety measures
- Assessment instruments
- Referral-related resource guides
- Time for individual and group supervision sessions
- In-service training programs
**Recommendation**

Multiple Levels of Response to Risk

**Urgency of responding to significant risks**-

**Obligations**
- Determine if any reports need to be made to protective services, police, or if family members or contract agencies need to be notified

**Options**
- Review options for mobilization of formal and informal resources

**Opportunities**
- What can you do differently in your own work?
Recommendation
Build Expertise

Where can you find information?

• Find a comprehensive text

• Engage professional literature
  – The Journal of Gerontological Social Work

• Find local agencies offering relevant continuing education content
  – Geriatrics Workforce Enhancement Programs

• NASW Specialty Practice Section on Aging
References


Questions & Answers