Overview of Key Issues in Geriatric Mental Health

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Topics
You will learn about:

- Challenges of geriatric mental health
- Characteristics of positive geriatric mental health
- Characteristics of late life depression and anxiety disorders
- Evidence-based geriatric depression and anxiety screening tools
- Differences between delirium, depression and dementia
- Evidence-based cognitive and behavioral therapies for geriatric depression and anxiety
- Evidence-based pharmacologic treatment for geriatric depression and anxiety
- Suicide and older adults
- Late life Alcohol use
Demographics of Aging

Major changes are occurring in the demographics of aging populations.
- Nationally
- Wisconsin
Adults Aged 65+ Years 1900–2010 Projections to 2050

Millions

Marital Status

Figure 2: Marital Status of Persons 65+, 2015

- Married: 45% Women, 70% Men
- Widowed: 34% Women, 12% Men
- Divorced or Separated/Spouse Absent: 16% Women, 13% Men
- Single (never married): 5% Women, 5% Men
Women Live Longer
U.S. Population by Gender and Age (2000)

Living Arrangements, Women 65-84

% among women ages 65 to 84

<table>
<thead>
<tr>
<th>Year</th>
<th>Nursing home or other group quarters</th>
<th>Unmarried, living with other family or non-family</th>
<th>Unmarried, living with own children</th>
<th>Living with spouse</th>
<th>Living alone</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>7</td>
<td>41</td>
<td>38</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>2000</td>
<td>6</td>
<td>43</td>
<td>35</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>2014</td>
<td>8</td>
<td>46</td>
<td>30</td>
<td>13</td>
<td>13</td>
</tr>
</tbody>
</table>
Living Arrangements, Women 85+

% among **women** ages 85 and older

- **1990**
  - Nursing home or other group quarters: 8%
  - Unmarried, living with other family or non-family: 16%
  - Unmarried, living with own children: 16%
  - Living with spouse: 41%
  - Living alone: 7%

- **2000**
  - Nursing home or other group quarters: 6%
  - Unmarried, living with other family or non-family: 16%
  - Unmarried, living with own children: 9%
  - Living with spouse: 44%
  - Living alone: 7%

- **2014**
  - Nursing home or other group quarters: 7%
  - Unmarried, living with other family or non-family: 23%
  - Unmarried, living with own children: 12%
  - Living with spouse: 46%
  - Living alone: 7%
## Finance Satisfaction 65+

### Older adults living alone less likely to say they are financially comfortable than those living with others

% of adults ages 65 and older saying they...

- Live comfortably
- Meet basic expenses with a little left over for extras
- Just meet basic expenses
- Don’t even have enough to meet basic expenses

<table>
<thead>
<tr>
<th></th>
<th>Living alone</th>
<th>Living with others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Live comfortably</td>
<td>33</td>
<td>49</td>
</tr>
<tr>
<td>Meet basic expenses</td>
<td>24</td>
<td>28</td>
</tr>
<tr>
<td>Just meet basic</td>
<td>25</td>
<td>16</td>
</tr>
<tr>
<td>Don’t meet basic</td>
<td>12</td>
<td>5</td>
</tr>
</tbody>
</table>
Disabilities 65+

**Figure 9: Percentage of Persons 65+ with a disability, 2014**

- Independent living difficulty: 15%
- Self-care difficulty: 8%
- Ambulatory difficulty: 23%
- Cognitive difficulty: 9%
- Vision difficulty: 7%
- Hearing difficulty: 15%
- Any disability: 36%

Source: U.S. Census Bureau, American Community Survey.
What About Geriatric Mental Health?
New Life to Added Years

“It is not enough for a great nation merely to have added new years to life--our objective must also be to add new life to those years.”

◦ John F. Kennedy
Positive Mental Health and Aging

Successful aging is an adaptation process that
- Minimizes loss
- Maximizes gains

Strategies for adaptation/SOC Baltes and Baltes
- Selection
- Optimization
- Compensation
Geriatric Mental Health

What is your definition of geriatric mental health?

What are some characteristics?

◦ Pair up with a colleague and discuss.
Positive Mental Health

WHO (2003) defines mental health as:

- “a state of well being whereby individuals recognize their abilities, are able to cope with the normal stresses of daily life and make a contribution to their families and communities.”
Positive Mental Health and Aging
Changing Societal Perspectives

<table>
<thead>
<tr>
<th>Traditional - Static</th>
<th>Productive - Process</th>
</tr>
</thead>
<tbody>
<tr>
<td>◦ Deterioration</td>
<td>◦ Hopeful</td>
</tr>
<tr>
<td>◦ Disability</td>
<td>◦ Growth</td>
</tr>
<tr>
<td>◦ Institutionalization</td>
<td>◦ Contribution</td>
</tr>
<tr>
<td>◦ Unable to learn</td>
<td>◦ Interdependence</td>
</tr>
<tr>
<td>◦ Preparing for deterioration</td>
<td>◦ Adjustment to change</td>
</tr>
<tr>
<td>◦ Passivity</td>
<td>◦ Empowerment – Person Centered</td>
</tr>
<tr>
<td>◦ Disengagement</td>
<td>◦ Connectedness</td>
</tr>
<tr>
<td>◦ Lack of meaning</td>
<td>◦ Well being</td>
</tr>
<tr>
<td>◦ Focus on past</td>
<td>◦ What the future still can be</td>
</tr>
<tr>
<td>◦ Sedentary life</td>
<td>◦ Strengths and abilities</td>
</tr>
<tr>
<td>◦ Receiving</td>
<td>◦ Therapeutic rehabilitation</td>
</tr>
<tr>
<td>◦ Deficits</td>
<td>◦ Confronting challenges</td>
</tr>
<tr>
<td>◦ Isolation</td>
<td></td>
</tr>
</tbody>
</table>
Video

The Secrets Of Successful Aging
Arizona Public Media
Geriatric Mental Illness
ADULTS WITH MENTAL ILLNESS WILL DOUBLE FROM 2000 TO 2030.

Projected Growth of 65 and Over Population with Mental Disorders: 2000 to 2030

Gaps in Treatment

Treatment for Mental Illness Among Older Adults

- 7 million All Older Adults with Mental Illness Receive Treatment
- 3.5 million Treatment from Physician
- 1.93 million Treatment from Mental Health Professionals
- 1.57 million

Number in Millions
Mental MH Professionals

<table>
<thead>
<tr>
<th></th>
<th>Number of Specialists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatric Psychiatrists</td>
<td>Current: 2,425</td>
</tr>
<tr>
<td></td>
<td>Estimated: 4,400</td>
</tr>
<tr>
<td>Geropsychologists</td>
<td>Current: 450</td>
</tr>
<tr>
<td></td>
<td>Estimated: 4,400</td>
</tr>
<tr>
<td>Geriatric Social Workers</td>
<td>Current: 6,000</td>
</tr>
<tr>
<td></td>
<td>Estimated: 32,600</td>
</tr>
</tbody>
</table>

- 2030
Complexity

- More often report somatic symptoms
- May be considered part of normal aging
- Cognitive impairment may interfere with diagnosis
- Practitioners may focus more on physical symptoms
- Complex psych-social history
- Lost medical records
- Multiple Chronic Conditions
- Poly Pharmacy
- Life style and habits
- Poor access
- Low income
- Misunderstanding
- Under-diagnosed and Under-reported
Chronic Conditions and Mental Distress - Older Adults

<table>
<thead>
<tr>
<th>Condition</th>
<th>Frequent mental distress</th>
<th>Some or no mental distress</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes or pre-diabetes</td>
<td>30%</td>
<td>18%</td>
</tr>
<tr>
<td>Heart attack</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Coronary disease</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Stroke</td>
<td>10%</td>
<td>5%</td>
</tr>
</tbody>
</table>
Geriatric Mental Illness

• Most Common Disorders in Aging
  • Depressive disorders
  • Anxiety disorders
  • Bipolar
  • PTSD
  • Schizophrenia
  • Substance abuse
Geriatric Mental Illness

• Prevalence

• Depression: 3-20%
  ◦ MDD:  1-6%  Major depressive disorder (Community)
  ◦ MD:  8-13%  Minor depressive disorder (Community)
  ◦ Depressive Symptoms: up to 20% in general population

• Source: Mark Snowden MD – Geriatric Depression Conference UW Madison, 10/13
Geriatric Mental Illness

Prevalence

- General Anxiety Disorder/GAD: 7.3%, co-morbid w/GD
  - Phobias: 3.1%
  - Panic Disorder: 1.0%
  - Obsessive Compulsive Disorders: 0.6%
Depression as we get older

VIDEO: Mental Illness and Aging
Signs of Depression

MentalHealthHumor.com

By: Chato B. Stewart
Geriatric Depression: Prevalence

- Community
- Primary care
- Acute hospital
- Nursing home

- Major depressive episode
- Depressive symptoms
“Everyone feels sad or blue sometimes. It is a natural part of life. But when the sadness persists and interferes with everyday life, it may be depression. Depression is not a normal part of growing older. It is a treatable medical illness, much like heart disease or diabetes.”

Geriatric Mental Health Foundation
Geriatric Depression: Undertreated

• Undertreated in primary care
• Patients/providers perceive depression “normal”
  • Poor outcomes in health conditions
  • Increased suffering
  • Increased cost
  • Continued misunderstanding
Geriatric Depression: Under-recognized and Undertreated
Geriatric Depression: Risks

- Unrecognized and/or Under-treated
  - Chronic Conditions may Mask Depression
  - Physical dysfunction
  - Healthcare costs
  - Caregiver burden
  - Isolation
  - Risk for Cognitive change, Diabetes and Cardiovascular Disease
  - Risk for Suicide
  - Poor Quality of Life and Suffering
Geriatric Depression: DSM V

• Major Depressive Disorder
  • More intense than being blue
  • Lasts for an extended time
  • Dysfunction
    ◦ Must have 1 of these 2
      ◦ Depressed mood, more often than not, for 2W
      ◦ Loss of interest
  • Plus these other symptoms to equal 5 total
    ◦ Sleep, energy, appetite, worthlessness, concentration, suicidal ideation, helpless, hopeless, guilt, agitation, guilt, fatigue etc.
Geriatric Depression: More to it,...

DSM V,...A “sterile” definition

We must consider the whole person

“Deep depression is embodied emotional suffering. It is not simply a state of mind or a negative view of life but something that affects our physical being as well.”
Geriatric Depression: Atypical

Geriatric depression is different

“, ...we do know that people with geriatric depression present with more extreme weight loss, hypochondriacal preoccupation, trouble falling asleep, agitation, and preoccupation with guilt.”

(Brown et al., 1984)
Geriatric Depression: Atypical Presentation

- More often report somatic symptoms
- May be considered part of normal aging
- Cognitive impairment may interfere with diagnosis
- Practitioners may focus more on physical symptoms
- Less often report depressed mood, guilt
- May present with “masked” depression cloaked in preoccupation with physical concerns and complicated by overlap of physical and emotional symptoms
Geriatric Depression: Depressive Symptoms/Not Disorder

Characteristics
- More common than MDD among persons 60+
- 10-25% of community dwelling population (Zarit and Zarit, 2007).
- Uncomfortable mood i.e., irritable, sad, restless, unsettling feelings
Geriatric Depression: Non Dysphoric

• Depressive ideation without mood disturbance
  ◦ Absence of a sad or despondent mood or anhedonia
  ◦ Absence of mania or agitation

• Right hemisphere damage
  ◦ Interrupts emotion processing mechanisms of the brain
Geriatric Depression: Pseudo Dementia

• Low motivation
• Difficulty in making decision and concentrating
  ◦ Confused thinking
  ◦ Loss of memory
• Difficulty acting on ideas
Geriatric Depression: Alzheimer’s

- Significantly depressed mood
  - 20-40% have depression
- Anhedonia
- Sleep problems
- Appetite changes
- Social withdrawal and isolation
- Agitation
- Apathy
Geriatric Depression: Vascular

Vascular Depression Hypothesis

- Depressive symptoms often co-occur with vascular disease
- Evidence suggests that vascular disease is a greater risk and severity for:
  - Cognitive Decline
  - Dementia
Depression: How it sounds

Lack of feelings of sadness

- Withdrawal a common symptom
  - “It’s too much trouble”
  - “I just don’t feel well enough”
  - “I don’t have the energy”
  - “Everything is just so frightening these days”
  - “I just do not have a reason to get up”
  - “It is just too confusing for me to go”
Geriatric Depression: Symptoms

Anhedonia

- Pacing, Fidgeting
- Isolation and Withdrawal
- Messy Appearance

Persistent Negativity and Apathy

- Constipation
- GI Problems

Frequent Visits to Doctor with NS Illness
Geriatric Depression: Presentation

Atypical Presentation

- More Complex Medical History
  - Co Morbidities May Lack\Base Line
- More Somatic
  - Wt. Loss
  - Hypochondriasis
- Depressed Mood not Reported
- Irritation, Agitation Restlessness
- More Complex Psychosocial History
  - Role loss, Shrinking Network, Depletion Syndrome
Geriatric Depression: Medication Management

- Response Rate Slower
- Decreased Metabolism
- Risk for ADR
- Nutritional Compromise
- Medication Adherence
- Multiple OTC RX Medications
Symptom Summary

- Memory and concentration problems
- Tendency to talk more about bodily symptoms
- Loss of interest is more common
- Social withdrawal is more common
- Irritability is more common
- Guilt and self deprecation
- **Somatization** is more common
Etiology: Sources
Geriatric Depression: Social and Behavioral

- Poor social support
- Low engagement behavior
- Functional challenges
- Loneliness and Isolation
- Lack of access
Geriatric Depression: Psycho-dynamics

- Depletion Syndrome
- Substitution/Compensation
  - Internal and external exhaustion
- Selective Optimization w/ Compensation/SOC
  - An antidote to depletion via careful selection of activities that enhance internal strengths and defend against depletion

(Baltes and Baltes, 1990)
Geriatric Depression: Depletion

Too Many Losses + Few or No Resources

- Sources of loss:
  - Loved ones
  - Roles
  - Responsibilities
  - Relationships
  - Meaning,
  - Opportunity
  - Contribution
Geriatric Depression: Biological

Genetics
- Familial tie hard to substantiate in late life

Vascular risk
- Vascular lesions may contribute to a risk

Dementias

Endocrine changes

Serotonin activity in the brain
Geriatric Depression: Major Medical Illness

- COPD
- Cancers
- Endocrine disorder
- Neuro-degenerative disorders
- Congestive Heart Failure
- Mental Illness
65+ with Chronic conditions,

Source of data: U.S. Census Bureau, Older Americans Update 2006: Key Indicators of Well-Being, May 2006.
Geriatric Depression: Pain

![Graph showing percentage of people troubled by pain based on depressive symptoms.]

- None: 10%
- Mild: 30%
- Mod-Severe: 50%
Geriatric Depression: Distorted Thinking

- Lacks awareness of excessive negativity
  - Automatic thinking
    - Unrealistic expectations
    - Overreaction to adverse events
    - Over personalize an event
  - Fear and anxiety are heightened
Geriatric Depression: Environment

- Living Environment Unsafe
- Changes in living arrangements
- Physical Mobility and Access
- Depleción of internal resources
- Lack of social network support
- Excessive stress/environmental
- Physical Isolation
Geriatric Depression: Spiritual and Religious

Religious Practice

◦ Unresolved conflicts
◦ Religious practice associated with less depression in older adults when part of person’s traditional value system
◦ Some researchers believe that “religious coping” is associated with physical and emotional wellbeing

(Koneig et., al., 2012)
Geriatric Depression
Assessment and Screening
Geriatric Depression

Key Player

◦ Primary Care Provider
◦ Internal Medicine
◦ Family Practice
Geriatric Depression: Physician Work-up

Careful Interview and physical assessment

◦ Complete Medical Exam
◦ Screen for Hearing and Vision
◦ Lab workup
◦ Medication Review
Geriatric Depression: Physical Assessment

Physical and Mental Health History
◦ Doctor(s)
◦ Agencies
◦ Medication regimen and adherence
◦ Gait and balance
◦ ADLs & IADLs
◦ Falls, ER visits, Infections
◦ Pain
◦ SUDS
Geriatric Depression: Psycho-social Assessment

*Family, Friends
  Contact
  Ethnicity

Social Relationships
  Contact

Transportation
  types

*Living conditions
  home
  Neighborhood
  Safety

Belief systems
  Practice
  Concerns

Legal and Financial
Geriatric Depression: Evidence-Based Screening

Screening Tools

- GDS
- PHQ-9
- MOCA/Montreal Cognitive Assessment
- GAD-7
- Determining Your Nutrition
- Lawton for ADLS
- ALSAR IADLS
- Pain Assessment
- ACE Card for Delirium
- Get up and Go Test
- Medication Reconciliation
## PHQ-9: Patient Health Questionnaire

Over the last 2 weeks, how often have you been bothered by any of the following?

<table>
<thead>
<tr>
<th>Question</th>
<th>Not at all (0)</th>
<th>Several days (1)</th>
<th>More than half the days (2)</th>
<th>Nearly every day (3)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless?</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep or sleeping too much?</td>
<td></td>
<td>x</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>4. Feeling tired or having little energy?</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>5. Poor appetite or over eating?</td>
<td></td>
<td>x</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Feeling bad about yourself-or that you are a failure or have let yourself or your family down?</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching TV?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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?</td>
<td></td>
<td></td>
<td></td>
<td>x</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way?</td>
<td>x</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Column Scores**

**Severity Score:**
Geriatric Depression Scale

Choose the best answer that you have felt over the past 2 weeks
May ask directly or have someone fill it out

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are you basically satisfied with your life?</td>
<td>Yes/No</td>
</tr>
<tr>
<td>2</td>
<td>Have you dropped many of your activities and interests?</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Do you feel that your life is empty?</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Do you often get bored?</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Are you in good spirits most of the time?</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Are you afraid that something bad is going to happen to you?</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Do you feel happy most of the time?</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Do you often feel helpless?</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Do you prefer to stay at home?</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Do you feel that you have more problems with memory than most?</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Do you think it is wonderful to be alive now?</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Do you feel worthless the way you are now?</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Do you feel full of energy?</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Do you feel that your situation is hopeless?</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Do you think that most people are better off than you are?</td>
<td></td>
</tr>
</tbody>
</table>

Scoring: Assign 1 point if you answer accordingly. 5 or more points indicates a possible depression.
Numbers 2, 3, 4, 6, 8, 9, 10, 12, 14, 15 = YES
Numbers 1, 5, 7, 11, 13 = NO

Adapted from Yesavage JA, Brink TL, Rose TL, et al.
Geriatric Depression: Mnemonic

- Sleep disturbance
- Interest diminished
- Guilt excessive and inappropriate
- Energy diminished
- Concentration impaired
- Appetite disturbance
- Psychomotor disturbance
- Suicidal ideation
Video: Depression in Older People
Late Life Anxiety
Depression and GAD Overlap

- Worry
- Anxiety
- Muscle tension
- Palpitations
- Sweating
- Dry mouth
- Nausea

- Sleep disturbance
- Psychomotor agitation
- Concentration difficulty
- Irritability
- Fatigue

- Depressed mood
- Anhedonia
- Appetite disturbance
- Worthlessness
- Suicidal ideation
Depression and Anxiety Disorders

There is considerable overlap among symptoms of depression and anxiety disorders.

Late Life Anxiety

Depression as Co morbid

- 36% with MDD have Anxiety Disorder
- 13% with Anxiety Disorder had MDD (LASA Study)
- Comorbid cases show higher severity of illness
- Comorbidity associated with somatic illness
- Show poor outcomes in physical and mental health
- High cost for untreated
Late Life Anxiety

Generalized Anxiety Disorder/GAD

- GAD most common of the anxiety disorders in the older adults
- Challenging to Treat
Late Life Anxiety

Early Onset
- Most common
- Childhood and early adulthood
- May be long standing and in “remission”

Late Life Onset
- Psychosocial adjustment
- Losses
- Medical conditions i.e., poor health
- Comorbid psychiatric illness
Generalized Anxiety Disorder (GAD)

Apprehension:
- unwarranted, excessive or unrealistic
- persistent: 6+ months duration
- frequent (more days than not)

3 or more symptoms:
- restlessness/keyed/on edge
- poor concentration/mind going blank
- insomnia
- muscle tension
- easy fatigability
Late Life Anxiety: Psychological

Psychological:
  ◦ Apprehension
  ◦ Vigilant

Psychomotor signs:
  ◦ tremulousness, twitching, feeling shaky
  ◦ muscle tension, aching, soreness (including tight chest or chest pain)
  ◦ restlessness
  ◦ easily fatigued
Late Life Anxiety: Adjustment Disorder

Situational:
- more likely to occur in unfamiliar settings

Adjustment disorder with anxiety:
- in response to a crisis, e.g. divorce, financial
- in response to less severe stressors, e.g.
  - relocation (one LTCF room to another)
  - new illness (even if not severe or disabling)
- occurs within 3 months of the stressor
- acute, chronic (more than 6 months)
Late Life Anxiety: Vigilant Signs

Feeling keyed, on edge
Exaggerated startle response
Poor concentration, ‘mind goes blank’
Insomnia
Irritability
Late Life Anxiety: Medical Factors

Medical Conditions
- CHF, MI, COPD, Endocrine disorder i.e., thyroid disease, Alzheimer’s
- Drug Interactions
- ADRs
- Toxicity
- Misuse and Abuse
- Movement Disorders
- Parkinson’s
- Co Morbid Depression, Dementia
Late Life Anxiety: Psycho-social Factors

- Financial loss
- Personal possessions
- Relocation
- Isolation
- Extreme stress or trauma
- Prolonged stress
- Bereavement and complicated grief
- Alcohol, caffeine, drugs
- Family history
- Fears i.e., falling, illness, death, family problems etc.
Generalized Anxiety Disorder - GAD-7

Over the past two weeks, how often have you been bothered by the following problems?

<table>
<thead>
<tr>
<th>Feeling nervous, anxious, or on edge</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Not being able to stop or control worrying</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>2</td>
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</table>

**Total GAD-2 score**

Worrying too much about different things

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Having trouble relaxing

<table>
<thead>
<tr>
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<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Being so restless that it is hard to sit still

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Becoming easily annoyed or irritable

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

Feeling afraid, as if something awful might happen

<table>
<thead>
<tr>
<th>Not at all</th>
<th>Several days</th>
<th>More than one half of the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Total GAD-7 score**

- **Self rated**
- **Specific for GAD but useful to detect an anxiety disorder in depression**
- Can be used to monitor treatment progress

<table>
<thead>
<tr>
<th>TOTAL SCORE</th>
<th>Provisional Diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>Minimal anxiety</td>
</tr>
<tr>
<td>5-9</td>
<td>Mild anxiety</td>
</tr>
<tr>
<td>10-14</td>
<td>Moderate anxiety</td>
</tr>
<tr>
<td>15-21</td>
<td>Severe anxiety</td>
</tr>
</tbody>
</table>

*GAD-2 is the first 2 questions of the GAD-7*
Late Life Anxiety

Dyad Exercise: Pair up with one person

- What is the most prevalent type of anxiety in older adults?
- What are some of the symptoms of geriatric anxiety?
- What type of prescribed medications are recommended for geriatric anxiety?
- What type of psychotherapies?
- What evidence-based screening tool is recommended for geriatric anxiety?
Treatment

Depression & Anxiety

- Pharmacotherapy
- Psychotherapy
Treatment

Multimodal approach

- Primary Care Provider
- Medical evaluation
- Medication
- Cognitive Behavioral Therapy
- Care Management
- Social Support
- Engagement
- Physical Activity
- Diet
- Environment
Treatment

Physical Work-up is essential

- History
- Labs
- Clinical Evaluation
Treatment

Pharmacotherapy for Depression and Anxiety

- **Antidepressants**
  - **SSRI’S-Selective Serotonin Reuptake Inhibitors**
    - Fluoxetine/Prozac, Paroxetine/Paxil, Sertraline/Zoloft, Citalopram/Celexa, Escitalopram/Lexapro
  - **SNRI’s**
    - Duloxetine, venlafaxine
  - **Newer Ads**
    - Bupropione, Mirtrazapine
  - **Tricyclics**
    - Nortriptyline
Treatment

Guidelines for Older Adults

- **START LOW AND GO SLOW!!!!**
- Longer time to take effect
  - Initial trial at least 4-6 weeks
- Change or add only one drug at a time
- Consult for ADRs with other non-psychotropic medications
- SSRIs preferred when co morbidities present
Medications can produce psychiatric symptoms in older adults
(Adapted from Desai, 2004)

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Indication</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antihistamines: Diphenhydramine</td>
<td><strong>Allergies</strong></td>
<td>Delirium, Visual Hallucinations</td>
</tr>
<tr>
<td>(Benadryl) sold OTC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antihypertensives</td>
<td>Hypertension</td>
<td>Depression, Hallucinations</td>
</tr>
<tr>
<td>Benzodiazepines</td>
<td>Anxiety</td>
<td>Delirium, Dementia, Hallucinations</td>
</tr>
<tr>
<td>Tri-cyclic Antidepressants</td>
<td>Depression, anxiety, itching, urinary incontinence, neuropathic pain</td>
<td>Delirium, Hallucinations</td>
</tr>
<tr>
<td>Selective Serotonin Reuptake</td>
<td>Depression</td>
<td>Agitation, Sleep Disturbances, Anxiety</td>
</tr>
<tr>
<td>Inhibitors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Psychosis</td>
<td>Delirium, Hallucinations, Anxiety</td>
</tr>
</tbody>
</table>
Medications can produce psychiatric symptoms in older adults
(Adapted from Desai, 2004)

<table>
<thead>
<tr>
<th>Drug Class</th>
<th>Indication</th>
<th>Side Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Analgesics</td>
<td>Pain</td>
<td>Delirium</td>
</tr>
<tr>
<td>Antispasmoditics</td>
<td>Urinary incontinence</td>
<td>Cognitive impairment</td>
</tr>
<tr>
<td>Anticonvulsants</td>
<td>Tremors</td>
<td>Delirium, Dementia</td>
</tr>
<tr>
<td>Irritable bowel syndrome</td>
<td>IBS-related pain, diarrhea</td>
<td>Delirium, Hallucinations</td>
</tr>
<tr>
<td>Corticosteroids</td>
<td>Inflammation</td>
<td>Hallucinations, depression, mania, delirium, Anxiety</td>
</tr>
<tr>
<td>Anti-Parkinson’s Medications</td>
<td>Parkinson’s Disease</td>
<td>Psychosis, delirium, depression</td>
</tr>
<tr>
<td>Interferon-A</td>
<td>Antiviral Medication</td>
<td>Depression, Delirium</td>
</tr>
<tr>
<td>Digoxin/Digitalis</td>
<td>Heart Medication</td>
<td>Delirium, Depression, Visual Hallucinations</td>
</tr>
<tr>
<td>Antitussives such as</td>
<td>Decongestant (sold OTC)</td>
<td>Delirium, Visual Hallucinations</td>
</tr>
<tr>
<td>Dextromethorphan sold OTC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Treatment

Psychotherapy - Empirically Efficacious:
- Behavioral Therapy
  - Behavioral Activations/BA
- Cognitive Behavioral Therapy/CBT
- Problem Solving
- Interpersonal/IP
- Supportive
  - All have psycho-educational components
Treatment – Behavioral Activation

No Treatment

Negative Avoidant Behavior → Depression Worsens

Behavioral Activation

Positive Replacement Behavior → Depression Subsides
Treatment-Behavioral Activation

Treatment is: Outside In

- Recognize the role that behavior plays in activating depression
- Focus on behavioral change
  - Do not focus on feelings
  - Identify behaviors that increase:
    - Physical activity
    - Social interaction
    - Record activity daily
    - Monitor with therapist
Treatment

Behavioral Therapy

- Mood is directly related to everyday behavior
- Goal of BT
  - Increase the number of behaviors that are pleasant and enjoyable
  - Learn to monitor and chart their own mood and behavior
Treatment

Varies by classification, intensity and severity

◦ May start with antidepressents
◦ Add psychotherapy later
◦ Monitoring
◦ Collaboration with providers
◦ ECT – for morbidly depressed
Suicide in Older Adults
U.S. Suicide Rates - Ages 65+, By Race

![Bar chart showing suicide rates by age and race for those 65 and over. The chart indicates higher rates among older adults compared to younger groups.](chart.png)
Elder Suicide Fact Sheet

- Disproportionate number of suicides
- Highest rate of any age group
- 85% - male
- Low attempt to completion ratio
- After age 60 rate declines for women
- Firearms most common means
- 66%-90% have diagnosable mental illness
- 2-4% completed suicides are terminally ill
Be aware of warning signs/ risk factors
Don’t be afraid to ask THE QUESTION/ QPR
Ask if they have a Plan
Keep them talking
Encourage them to get help/ Offer to make the call with them
Immediate danger, call 911
Case Study

The Martins have been married for 57 years. Mr. Martin has been caring for his wife with severe osteoarthritis and congestive heart failure. He is struggling due to his own functional disabilities. He also has had a history of major depression. This year his pension fund was reduced significantly and he is unable to pay for his wife’s expensive medicines. He seems to have lost interest in playing cards with his friends at church and has decided to rewrite his will. One day he says to his wife: “Betty I am just in the greatest mood and know that things will get better for us”.

How would you address these issues with Mr. And Mrs. Martins?
Delirium in Older Adults
Delirium in Older Adults

Acute cognitive medical illness

- Rapid and sudden onset in the brain
- 30% of general hospitalized elderly
- 60-80% in ICU
- 10-50% during surgical hospitalization
- 60% in NF may have delirium
Delirium in Older Adults

Often not recognized, dx or treated

- Misdiagnosed as dementia or depression in elderly
- Post treatment symptoms may persist up to 6 months
- Untreated or improperly treated can result in death
Delerium in Older Adults

Presentation

◦ Possible hallucinations
  ◦ Seeing or hearing things not present/do not exist
◦ Often starts at night
  ◦ Dreams, nightmares
◦ Hyper alert
  ◦ Agitated, restless, increase in respiratory rate and pulse
◦ Hypo alert
  ◦ Quiet, listless, mutters to self, drifts to sleep easily
Delirium in Older Adults

Alzheimer’s Dementia
- No sudden onset
- Steady progression
- Clear until late stages
- Inattention
Delirium in Older Adults

Medication change
Respiratory infection
undiagnosed pain
CHF
COPD causing hypoxia
Dehydration
Medication change
Medication w/ anticholenergic effect
  ◦  Interferes with function of primary organs: lungs, kidney, heart, digestive system, brain (memory)

- UTI
- Medication Change
- Renal insufficiency
- Anemia
- SUDS
- Recent surgery
- Sensory impairment
- Cataract, hearing loss
- Withdrawal syndrome

Delirium in Older Adults

- Marked psychomotor changes (hyperactive or hypoactive)
- Sleep-wake cycle disturbed
- Altered and changing level of consciousness
- Strikingly short attention span
  - Acute
  - Reversible if treated
- Psychomotor changes occur late in the illness unless depression or apathy develops
- Consciousness not clouded until terminal stage
- Attention span not characteristically reduced
  - Chronic
  - Irreversible

Delerium in Older Adults

Treatment Recommendations

- Uninterrupted Rest
- Sleep hygiene
- Proper diagnosis
- Lab workups
- Treat acute conditions
- Review of all medications
- Safe environment
  - Restraint Free
- Reorientation to time and place
- Rehydrate and nourishment
- Music therapy, massage, aroma therapy
Video

Understanding Delirium

Discussion
Alcohol Use Problems and Older Adults
Alcohol Misuse and Abuse

Categories

◦ USE
  ◦ Following prescribed aged related guidelines
◦ Misuse – 1 in 5 older adults
  ◦ Risky drinking
◦ Abuse
  ◦ Chronic
    ◦ Heavy
    ◦ Binge
Use - Older Adults

How is use Different?

- Metabolize alcohol more slowly
- Metabolize RX and OTC medications slowly
- At least one chronic illness
- Prone to falls, accidents
- More likely to drink alone and at home
- Isolation
- Prescription drug misuse
- Too much or too little or mixing
- Multiple medications
- Multiple RX + Alcohol = ADRs
30 Day Binge Drinking Among Wisconsin Older Adults by Gender Risk Factor Surveillance System (BRFSS),

<table>
<thead>
<tr>
<th>Region</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wisconsin</td>
<td>14.4%</td>
<td>23.2%</td>
</tr>
<tr>
<td>Region 5</td>
<td>10.4%</td>
<td>18.1%</td>
</tr>
<tr>
<td>Regions 4-5</td>
<td>8.2%</td>
<td>15.1%</td>
</tr>
<tr>
<td>USA</td>
<td>9.4%</td>
<td>16.0%</td>
</tr>
</tbody>
</table>
Bing Drinking of Older Wisconsinites by Age Group

<table>
<thead>
<tr>
<th></th>
<th>Percent Reporting Binge Drinking</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>50-64 years</strong></td>
<td>Wisconsin: 24.0%</td>
</tr>
<tr>
<td></td>
<td><strong>65 and older</strong></td>
</tr>
</tbody>
</table>
Substance Use by Older Wisconsinites

<table>
<thead>
<tr>
<th>Substance</th>
<th>Wisconsin</th>
<th>Region 5</th>
<th>Region 4-5</th>
<th>USA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heroin</td>
<td>2.9%</td>
<td>17.6%</td>
<td>12.1%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Opiates / Synthetics</td>
<td>4.1%</td>
<td>8.0%</td>
<td>9.8%</td>
<td>8.1%</td>
</tr>
<tr>
<td>Marijuana</td>
<td>12.1%</td>
<td>16.9%</td>
<td>16.1%</td>
<td>16.0%</td>
</tr>
<tr>
<td>Cocaine</td>
<td>14.9%</td>
<td>25.4%</td>
<td>25.4%</td>
<td>25.2%</td>
</tr>
<tr>
<td>Alcohol</td>
<td>92.3%</td>
<td>72.6%</td>
<td>72.0%</td>
<td>74.2%</td>
</tr>
</tbody>
</table>
Mortality Rates d/t Alcohol Related Falls

Wisconsin

In the 2016 report from DHS, there were 429 deaths from alcohol-related falls in the state in 2015. The agency estimates that 85 percent of those fatalities occurred in the 65 and older age group.
Alcohol Use – Older Adults

Warning Signs
- Falls, bruises, burns
- Incontinence (not baseline)
- Poor hygiene
- Strange response to medications
- Poor nutrition i.e., eating junk food only
- Mood swings
- Problems with money, police
- Anxiousness
- Depression
- Memory or thinking problems
Alcohol Use - Older Adults

Alcohol use can worsen the following:

- Liver disease
- Cardiovascular disease
- Diabetes
- Ulcers
- GI problems
- Sleep problems
- Gait Disorders
- Gout
Alcohol Abuse

What is a standard drink?
Alcohol Abuse

• Older women are at great risk
  • Metabolize alcohol differently
    • lack of water increases the concentration of alcohol in their bodies
  • More older American women than ever are drinking
    ◦ The prevalence of binge drinking among older women is increasing dramatically, faster than older men (source: CBS news 3/29/17)
Alcohol Abuse

Problem Drinking in Older Adults

NIHSeniorHealth
Alcohol Abuse

Older men are at risk

- Suicide
- SUDS
- Mental Illness
- Life losses
- Major Medical Illness
- HX of Suicide
Medications and Alcohol

• Dangerous RX with Alcohol
  • Benzodiazepines i.e., Valium, Ativan or Centrax
  • Sleeping Medications i.e., Ambien
  • Pain Medications i.e., Codeine, Percoset
  • Antipsychotic Medications
  • Antiseizure Medications
  • Antihistamines both otc and RX
  • Aspirin
SUDS Intervention: SBIRT

**Screening**
- Quickly assess the severity of substance use and identify the appropriate level of treatment.

**Brief Intervention**
- Increase insight and awareness of substance use; motivation toward behavioral change.

**Referral to Treatment**
- Provide those identified as needing more extensive treatment with access to specialty care.
SUDS Intervention

• SBIRT

• Brief Treatment for individuals at:
  • MODERATE TO HIGH RISK,
  • Emphasizes Motivations to Change
  • Client Empowerment.

• Referral to Treatment: for those whose screening indicates a SEVERE PROBLEM or dependence
SUDS Intervention: SBIRT

SBIRT Pocket Guide

Alcohol Use Among Older Adults

Pocket Screening Instruments for Health Care and Social Service Providers

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administration
Center for Substance Abuse Treatment
www.samhsa.gov
Risky Drinking

For healthy **men up to age 65** –
- More than **4** drinks in a **day** AND
- More than **14** drinks in a **week**

For all healthy **women** and healthy **men** over age **65**
- More than **3** drinks in a **day** AND
- More than **7** drinks in a **week**

*As recommended by NIAAA*
SUDS Intervention: SBIRT

SBIRT Example Video

SBIRT for alcohol use: older man
Case Study

Arthur is 76 year old Korean War Veteran who has post stroke (left side paralysis) cardiovascular disease. He is also diabetic, has symptoms of depression, sleep problems (can not fall asleep), memory impairment and may be mis-using alcohol.

Medications are:

- Statin, Anti hypertensive, Insulin, Ambien (sleep), Anti coagulant, Aspirin
- How will you begin working with Arthur?
Alcohol Use - Older Adults

Think Prevention

- Know Risk Factors
- Use Screening Tools
- Work with Primary Care Provider
- Family and Friendship Support
- Supportive Services
- Information
- Education
Resources

Older Adults and Alcohol
  ◦ https://pubs.niaaa.nih.gov/publications/olderAdults/olderAdults.pdf

Alcohol Use Among Older Adults: Pocket Screening Instruments for Health Care and Social Service Providers
  ◦ https://store.samhsa.gov/shin/content/SMA02-3621/SMA02-3621.pdf

Get Connected
  ◦ https://store.samhsa.gov/shin/content/SMA03-3824/SMA03-3824.pdf
Remember,...

“It is not enough for a great nation merely to have added new years to life--our objective must also be to add new life to those years.”

◦ John F. Kennedy
References - SUDS

- SAMHSA – Substance Abuse and Mental Health Services Administrations
- National Institute on Drug Abuse
- National Institute on Alcohol Abuse and Alcoholism
- US Census Bureau
- Wisconsin DHS Demographic Report
- Wisconsin 2016 Epidemiological Profile on Alcohol and other Drugs
- Wisconsin Academy State Profile 2012
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• SAMHSA, www.samhsa.gov (federal site on substance use disorders and mental health).
  U.S. Department of Health and Human Services, Older Adults and Mental Health: Issues and Opportunities (Rockville, MD: 2001)
  Wisconsin Department of Health Services, Division of Long Term Care, 2009.