Aging and Long Term Care CE Course
3 Hours/Units

Table of Contents:

1. Aging, Demographic Information, Stigma, and Culture

Nearly one in five older adults have one or more mental health or substance use conditions (referred to in this document under the umbrella term, "behavioral health"). About 16 percent of women and 11 percent of men age 65 and older experience symptoms of depression.iii The majority of older adults' behavioral health issues are identified and treated in primary care settings instead of specialty behavioral health settings. Older adults are distinct from other populations in key ways:

➡ **Complex chronic health conditions**. Older adults are more likely than any other age group to have complex chronic health conditions, including mental health conditions, substance use disorders and

cognitive impairments. About two-thirds of older adults have two or more chronic conditions.

➡ **Drug use and abuse.** Older adults receive a high proportion of prescription drugs in the U.S. due to increased likelihood of being prescribed long-term and multiple medications. Improper use is common, whether because of cognitive decline or attempting to save money by using their medications

✓ **THE NUMBER OF AMERICANS AGE 65 AND OLDER INCREASED BY 25 PERCENT FROM 2003 TO 2013 AND THE NEXT 25 YEARS PROMISE ANOTHER 50 PERCENT INCREASE. FROM 2018 TO 2038, THE NUMBER OF AMERICANS AGE 85 AND OLDER IS EXPECTED TO MORE THAN DOUBLE FROM 6 MILLION TO 14.6**

sparingly or taking another person's remaining medications. Additionally, commonly prescribed medications – opioids for pain and benzodiazepines used to treat anxiety and sleep disorders – are addictive and can increase the risk of falls and memory/retention issues affecting up to 17 percent of older adults. Co-morbid health conditions, age-related changes in drug metabolism; potential interactions with prescribed drugs, over-the-

counter medications, dietary supplements and alcohol; and cognitive decline make drug misuse a special concern.

- **Health disparities.** Life expectancy and overall health have improved for most Americans in recent years, but factors related to economic status, race, sexual orientation, gender identity and rural status, as well as limited access to adequate housing and transportation services, keep many older adults from benefiting from these gains.
- **Safety concerns.** Individuals become more frail as they age and their risk of falls and injury increases. One in every three adults aged 65 or older falls each year and falls are the leading cause of both fatal and nonfatal injuries for older adults.
- **Loss is common.** Some older adults may experience loss. Loss of spouses, friends, physical functioning, independence, routine and sense of purpose affects overall health, including mental health and substance use. Health care providers and older adults often mistake depression for a natural response to aging. This can lead providers to not screen for or treat depression and older adults to not seek help.
- **Elder abuse.** Elder abuse is a serious problem, with an estimated 8 to 10 percent of older adults experiencing abuse, not including financial exploitation. Other estimates found that between one and two million older adults are mistreated each year, while only 27 percent of hospital emergency departments have elder abuse protocols (compared with 75 percent for child abuse).
- **Negative attitudes and discrimination toward people with behavioral health concerns.** These attitudes can be a barrier for all age groups. Generational and cultural differences may be a barrier to identifying concerns, treatment follow-through and active engagement in behavioral health treatment.

While providers, family members, peers and community stakeholders must be aware of these concerns, it is also important to be skeptical of antiquated stereotypes and assumptions about older adults' health status. Older adults remain physically active for longer than ever before, continue to be active learners and frequently use health technologies to manage their health. Most older adults do not have a cognitive impairment. Recovery from depression, back pain and other injuries or illnesses is the norm. The overall category of older adults (age 65 and older) is further

SALLY IS 83 and recently fractured a hip. She has severe osteoporosis, high blood pressure, chronic pain and a history of depression. She is cared for by her daughter who is trying to get her to move into an assisted living center, but Sally refuses, saying she can live on her own. Using a standardized screening tool, Sally's integrated primary and behavioral health care program identified increasing depressive symptoms. An assessment for pain management prompted a full review of medications for effectiveness and risk of abuse, leading to changes in her prescriptions to decrease side effects and increase function. An in-house social worker provided support and intervention for Sally and her daughter regarding care decisions and ultimately connected them with an external caregiver sup-port provider. Together, they identified the resources Sally needed in her home to manage her health.

divided into subgroups – "young old" (65-74 years), "middle old" (75-84 years) and "oldest old" (85+ years) – to help understand variability in patient's experiences. However, it is important to consider an individual's functional age as well as their chronological age. Patient-centered care requires that you treat all of your patients, regardless of age, as individuals with unique strengths, histories and needs. Successful practices establish outcome measures that meet the range of behavioral health and primary care needs of older populations.

CAREGIVER CONCERNS: UNDERSTANDING THE ROLE OF THE FAMILY

As some adults age, they may begin to rely more heavily on spouses, children, grandchildren and other loved ones for assistance with daily living activities and navigating the health care system. Unlike the pediatric population, where parents legally and functionally act as caregiver and decision-maker for their child, caregiver relationships for older adults are much less straightforward and obvious. In conditions like dementia, capacities are slowly lost and there is often not a clear point at which patients require surrogate decision-makers.

Family caregivers, as well as paid home health workers, often advocate for their loved one in addition to providing needed care to compensate for workforce shortages and gaps in service. Primary care providers integrating behavioral health must support patient empowerment, encouraging as much patient control over treatment and life decisions as possible, while also building caregivers into decision-making to improve outcomes. Providers must not only care for the patient, but also the caregiver; one-third of caregivers report their health as being fair to poor. Caregivers need resources on mental health and substance use disorders, including support on how to handle their stress and obtain treatment for behavioral health concerns and other chronic conditions. The best models for promoting the caregiver relationship and supporting caregivers are those that are easy to access and culturally informed.

Behavioral Health and Physical Health

In older adults, physical, behavioral and cognitive conditions often present differently than younger adults. To assist in understanding these differences, keep in mind that:

➡**Physical health conditions** often present as behavioral health concerns or cognitive impairments.

➡**Behavioral health conditions** often present as physical conditions or cognitive impairments.

➡**Many medications have side effects** that may present as symptoms of another illness. The interaction of multiple medications can exacerbate symptoms and even cause health problems. Further, sometimes having a condition, such as dementia, prevents older adults from being able to take medications for other conditions due to potential interactions.

➡ **Depression often occurs with physical health conditions.** Symptoms of dementia and delirium frequently emerge in conjunction with many behavioral health and physical health conditions.

Ensuring an Integrated Behavioral Health and Primary Care Workforce for an Aging Population

Given the unique and complex needs of older adults, what can be done to ensure that the safety-net primary care workforce is prepared to meet the behavioral health needs of this aging population? Since it is unlikely that there will ever be enough specialty behavioral health providers, primary care organizations are now focusing on adapting their systems and expanding their existing workforce skill sets to include behavioral health. The coordination of primary and behavioral health services is also called integrated care. The SAMHSA-HRSA Center for Integrated Health Solutions describe the Core Competencies for Integrated Behavioral Health and Primary Care. The following lists specific strategies for serving older adults as they relate to each of the core competencies:

1. Interpersonal Communication

Provide anticipatory guidance for patients and caregivers, especially related to advanced care planning. Actively engage family members who may not accompany patients to appointments but are part of the patient's care. Accommodate for the impact of dementia, language and hearing barriers. Avoid confusing medical terminology. Clearly explain medication and treatment options, repeat when necessary and provide in writing using friendly, helpful, accessible language. Tap into the patient's strengths to promote self-management and communicate positive views of aging. Recognize sensory changes that occur with age such as diminished peripheral vision and differential auditory strength.

2. Collaboration and Teamwork

Recognize that one provider cannot address all medical and behavioral health needs in 15-20 minutes. Use an informed team approach to provide comprehensive services, with all team members aware of their responsibilities. Train non-medical staff to conduct environmental, social

and medical histories and screenings. Establish working relationships with other internal and external members of the care team. Listen to patient and caregiver and recognize that the desired outcome for older adults may be a change in function, not a change in symptoms. Refer to specialty behavioral health care or aging services as needed or use telebehavioral health, especially in rural settings.

3. Screening and Assessment. Screen for depression, anxiety, substance use, chronic pain, risk of falls — including any recent stressful events that can elevate risk of a fall— and abuse. Identify general health concerns that affect or manifest as behavioral health symptoms. Be cognizant of gender differences in prevalence of behavioral health conditions— women are more likely to experience depression, dementia and trauma, while men are more likely to abuse alcohol and prescription drugs. It is especially important that providers differentiate between depression, delirium and dementia. Implement a protocol for suspected abuse and ensure that all members of the care team, including front desk staff, know the warning signs of elder abuse. Be aware of the risk of pain medication abuse/opioid dependency. Monitor for suicide risk. Have a consultation arrangement in place with geriatric mental health and substance use disorder specialists that includes conducting a medication review.

CONSIDER USING NON-CLINICAL LANGUAGE

to discuss behavioral health systems (e.g., "stressed" instead of "anxious," "sad" instead of "depressed").

4. Care Planning and Care Coordination. Engage unpaid and paid caregivers in care planning. Identify and use aging system resources like peer support and advanced care planning supports (see "Resources" for additional ideas). Collaborate with the pharmacist to ensure proper prescribing and dosage to avoid medication risks. Older adults may need

additional help accessing follow-up care. Employ warm hand-offs to ensure continuity of care. Recognize the appropriate-ness of short, time-limited interventions for addressing many mental health and substance use concerns (e.g., Florida BRITE).

5. Intervention. Understand common ailments of older adults that should trigger a primary care evaluation. Physical symptoms are often caused by stress, trauma, loss and mental health conditions while physical health conditions may manifest as behavioral concerns. Implement evidence-based practices that are known to be effective for older adults and refer to specialist behavioral health providers who use best practices in your community (see "Resources" for suggestions). Avoid inappropriately prescribing antipsychotics to alter behavior in older adults with cognitive impairments.

6. Cultural Competence and Adaptation. Check if your physical space is accessible for older adults (e.g., wider doorways, exam rooms with space for caregivers, handrails, smooth transitions at doorways). Recognize and respect cultural differences with patient and caregiver involvement. Understand the role negative attitudes and discrimination can play for various cultural groups and older adults. Accommodate generational differences in use of technology and cultural acceptance of questioning or not questioning providers. Use formal and informal community resources to overcome geographic and transportation barriers in rural areas.

7. Systems-Oriented Practice. Understand and explain Medicare benefits, including Part D and preventive benefits (e.g., alcohol misuse screening, depression screening) to patients and their caregivers. Coordinate benefits for dually eligible Medicaid/Medicare beneficiaries, including certain social services that are available with lower cost sharing. As the health care landscape changes (for instance, accountable care organizations [ACOs] are established), ensure that a staff member is equipped to help patients understand and use their benefits.

8. Practice-Based Learning and Quality Improvement. Measure patient and family caregiver satisfaction. Provide continual staff training related to major competencies and best practices for older adults. Learn to recognize

behavioral disorders. Monitor avoidable negative health outcomes that are more prevalent with older adults and implement quality improvement protocols (e.g., injuries, infections, adverse reactions to multiple medications).

9. Informatics. Establish electronic health records that include multiple providers, all prescriptions, social service notes and clinical decision support tools. Use large print informational materials. Ensure kiosks and other touchpad technologies have large buttons. Address privacy concerns related to sharing health information.

Evidence-based guidelines are a great resource for identifying clinical, organizational and systems level changes to improve care for older adults. The National Coalition on Mental Health and Aging has compiled a directory of competencies, standards and guidelines for providers working with older adults encountering behavioral health concerns. Many other national provider organizations have practice guidelines and protocols to consider when working with older adults (See the resource chapter at the end of this course).

The Role of the Community

Primary care providers are not alone in caring for the aging population. Caregivers, neighbors, friends and community-based organizations also play a vital part in supporting older adults' prima-ry and behavioral health. Rural communities with workforce shortages are of special concern and older adults may have to depend on community partnerships and existing informal networks of friends and neighbors to promote healthy behaviors and allow them to remain in their own homes and engaged in community life. As part of care coordination, providers must know the community resources equipped to address social determinants of health, elder abuse and isolation, and appropriately connect patients to those services.

Your community may have the following organizations and services available to serve as partners in the health promotion and disease prevention of older adults:

- ✓ Adult protective services
- ✓ Nutrition programs
- ✓ Senior centers
- ✓ Transportation services

The Eldercare Locater can help you find these resources in your community. In addition, Mental Health First Aid for Older Adults provides community members with the required tools to identify a behavioral health problem and get their neighbor, friend or loved one help. A more informed community can be integral to addressing gaps in services and promoting the health of all its citizens, especially older adults with potential mental health and substance use concerns.

Older Adults Resources: Behavioral Health Identification and Treatment

The Treatment of Depression in Older Adults : Evidence-Based Practices KITs — A SAMHSA publication that provides an array of evidence-based programs to treat depression and dysthymia

Substance Abuse by "Mature" Adults: Is Your Patient Using or Abusing? — A video with Louis A. Trevisan, MD that describes how to identify and address substance abuse in older adults

Preventing Suicide in Older Adults — An issue brief from SAMHSA and the Administration on Aging to help health care and social service organizations develop strategies to prevent suicide in older adults

Promoting Emotional Health and Preventing Suicide: A Toolkit for Senior Living Communities — A SAMHSA publication that includes guidelines for integrating suicide prevention into ongoing programs, hands-on tools, and training manuals for senior living communities

Evidence-Based integrated Care Practices for Older Adults Improving Mood-Promoting Access to Collaborative Treatment (IMPACT) —

Collaborative care approach to treat depression or dysthymia that involves a trained depression care manager, patient, primary care provider and psychiatrist.

Wellness Initiative for Senior Education (WISE) — Health promotion program related to health behaviors, the aging process, managing care, medication management and signs of alcohol misuse and depression.

EnhanceWellness — Helps older adults with chronic health conditions manage their illness and avoid psychiatric medications, physical inactivity, depression and social isolation.

Senior Reach — Training for community partners to identify older adults experiencing mental health and related concerns and help get them into recovery-oriented behavioral health treatment.

Healthy IDEAS (Identifying Depression, Empowering Activities for Seniors) – A program that integrates depression awareness and management into existing case management services.

Program to Encourage Active, Rewarding Lives (PEARLS) — Community-based intervention for individuals with depression or dysthymia that helps reduce symptoms and suicidal ideation through problem-solving, social and physical activation and pleasant activity scheduling.

Prevention of Suicide in Primary Care Elderly: Collaborative Trial (PROSPECT) — Primary care intervention to recognize depression and suicidal risk and manage treatment.

Resources for Enhancing Alzheimer's Caregiver Health II (REACH II) — At home and telephone-based intervention to reduce caregiver

SAM'S SON brought him to see his primary care provider saying that Sam was increasingly confused over the past week. His wife died last month and now Sam lives alone, but his children check in on him daily. Sam's primary care provider evaluated him for physical causes of confusion (e.g., dehydration, urinary tract infection, stroke) and for depression. His primary care provider also asked Sam's son about his own level of stress. As a result, the provider connected Sam with their in-house counselor to provide grief counseling for Sam and identified outside resources to support Sam's son as a caregiver.

burden and depression, improve self-care and offer social support.

Brief Screens for Providers

- Depression Screen — Patient Health Questionnaire (PHQ-9)
- Anxiety Screen — Generalized Anxiety Disorder 7-item scale (GAD-7)
- Cognitive Measure for Dementia — The Mini-Cog
- Cognitive Impairment Screen — Montreal Cognitive Assessment (MoCA)
- Dementia Functional Assessment — Functional Activities Questionnaire (FAQ)
- Delirium Assessment Tool — The Confusion Assessment Methods
- Diagnostic Algorithm (The CAM) Brief Alcohol Screen — Alcohol Use Disorders Identification Test (AUDIT-C)
- Opioid Abuse/Chronic Pain Medication Abuse Screen — The Opioid Risk Tool (ORT)

Integrated Care Workforce Resources

Association for Gerontology in Higher Education — Online Directory of Educational Programs in Gerontology and Geriatrics

National Institute on Aging - Talking with Your Older Patient

SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) — Workforce Resources

Organizations Related to Care for Older Populations

AARP — www.aarp.org/health
Administration for Community Living — www.acl.gov
Elder Abuse Resources — www.aoa.acl.gov
The American Geriatrics Society — www.americangeriatrics.org
American Association for Geriatric Psychiatry — www.aagponline.org
Caregiver Action Network — www.caregiveraction.org

Center for Medicare and Medicaid Services — www.CMS.gov
Family Caregiver Alliance-National Center on Caregiving — https://caregiver.org/national-center-caregiving
National Alliance for Caregiving — www.caregiving.org
National Clearinghouse on Abuse in Later Life — www.ncall.us
National Council on Aging — www.ncoa.org
National Institute on Aging — www.nia.nih.gov
Veterans Administration — www.va.gov/geriatrics

Aging is defined as "the accumulation of changes in an organism over time." Aging is also a multidimensional process of physical, psychological, and social change *(Masoro E.J. & Austad S.N. eds: Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA).* Some dimensions of aging grow and expand over time, while others decline. For example, although reaction time may decrease with age, knowledge of world events and wisdom may increase. Research shows that even late in life potential exists for physical, mental, and social growth and development *(Strawbridge, W.J., Wallhagen, M.I. & Cohen, R., Successful aging and well-being: Self-rated compared with Rowe and Kahn, The Gerontologist).* Aging is an important part of all human societies which not only reflects the biological changes that occur, but also the cultural and societal conventions *(Masoro E.J. & Austad S.N.. eds: Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA).*

Population
The demographics of aging continue to change dramatically. The older population is growing rapidly, and the aging of the "Baby Boomers" born between 1946 and 1964, are accelerating this growth. This large population of older Americans will be more racially diverse and better educated than previous generations. Another significant trend is the increase in the proportion of men age 85 and over who are veterans.

"WHAT DOES THIS MEAN FOR MY PRACTICE?

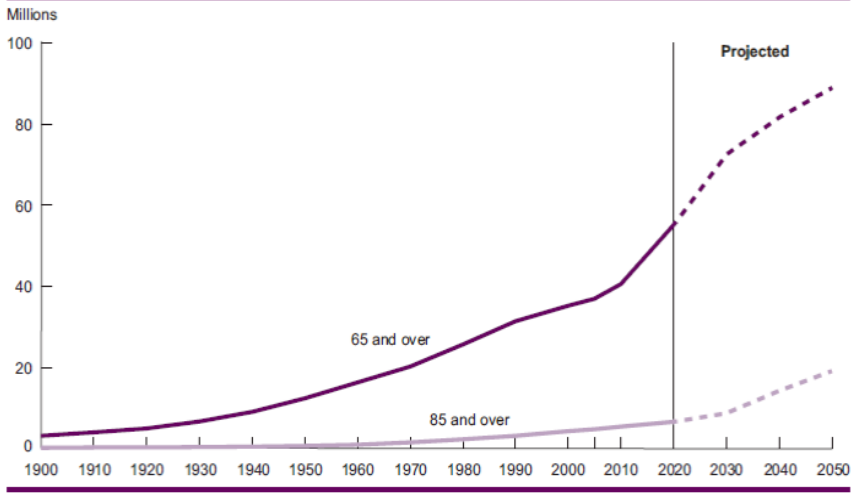
If you serve 100 adults 65 and older, it is likely that 20 of them have a behavioral health condition.

In 2010, there were 40 million people age 65 and over in the United States, accounting for 13 percent of the total population. The older population in 2030 is projected to be twice as large as in 2000, growing from 35 million to 72 million and representing nearly 20 percent of the total U.S. population (See "Indicator 1: Number of Older Americans").

INDICATOR 1 **Number of Older Americans**

The growth of the population age 65 and over affects many aspects of our society, challenging families, businesses, health care providers, and policymakers, among others, to meet the needs of aging individuals.

Population age 65 and over and age 85 and over, selected years 1900–2010 and projected 2020–2050



NOTE: These projections are based on Census 2000 and are not consistent with the 2010 Census results. Projections based on the 2010 Census will be released in late 2012.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, *Census 2000 Summary File 1;* U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S.: April 1, 2000 to July 1, 2010 (US-EST00INT-01); U.S. Census Bureau, 2011. *2010 Census Summary File 1;* U.S. Census Bureau, Table 2: Projections of the population by selected age groups and sex for the United States: 2010–2050 (NP2008-t2).

In 1965, 24 percent of the older population had graduated from high school, and only 5 percent had at least a Bachelor's degree. By 2010, 80 percent were high school graduates or more, and 23 percent had a Bachelor's degree or more (See "Indicator 4: Educational Attainment").

Economics

There have been decreases in the proportion of older people living in poverty or in the low-income group just above the poverty line, both in recent years and over the longer term. Among older Americans, the share of income coming from earnings has increased since the mid-1980s, partly because more people, especially women, continue to work past age 55. In addition, net worth has increased almost 80 percent, on average, for older Americans.

Although most older Americans live in adequate, affordable housing, some live in costly, physically inadequate, or crowded housing. Additionally, major inequalities continue to exist: older blacks and people without high school diplomas report smaller economic gains and fewer financial resources overall.

Over the past four decades, labor force participation rates have risen for women age 55 and over. This trend continued during the recent recession. Among men age 55 and over, the rise in participation rates that started in the mid-1990s also has continued, although to a smaller extent. As "Baby Boomers" approach older ages, they are remaining in the labor force at higher rates than previous generations.

In recent years, approximately 40 percent of older American households had housing cost burden (expenditures on housing and utilities that exceed 30 percent of household income). In addition to having cost burden as the most dominant housing problem, crowded housing was also fairly prevalent for some older American households with children in their homes.

Health Status

Americans are living longer than ever before, yet their life expectancies lag behind those of other developed nations. Death rates for certain diseases have declined over time, while others have increased. Older age is often accompanied by increased risk of certain diseases and disorders. Large proportions of older Americans report a variety of chronic health conditions such as hypertension and arthritis. Nevertheless, most people age 65 and over report their health as good, very good, or excellent.

Life expectancy at age 65 in the United States was lower than that of many other industrialized nations. Women age 65 in Japan could expect to live on average 3.7 years longer than women in the United States. Among men, the difference was 1.3 years. Death rates for heart disease and stroke have declined by slightly more than 50 percent since 1981. Death rates for chronic lower respiratory disease increased by 57 percent in the same time period.

The prevalence of certain chronic conditions differ by sex. Women report higher levels of arthritis than men (56 percent versus 45 percent). Men report higher levels of heart disease (37 percent versus 26 percent).

In recent years, 76 percent of people age 65 and over rated their health as good, very good, or excellent. Non-Hispanic Whites were more likely to report good health than their non-Hispanic Black or Hispanic counterparts.

Health Risks and Behaviors

Social and lifestyle factors can affect the health and well-being of older Americans. These factors include preventive behaviors such as cancer screenings and routine vaccinations along with diet, physical activity, obesity, and cigarette smoking. The quality of the air where people live also affects health. Many of these health risks and behaviors have shown long-term improvements, even though recent estimates indicate no significant changes.

The proportion of leisure time that older Americans spent socializing and communicating—such as visiting friends or attending or hosting social events—declined with age. For Americans age 55–64, about 11 percent of leisure time was spent socializing and communicating compared with 8 percent for those age 75 and over.

End of Life

In the last decade there has been a substantial rise in the use of hospice services among older Americans. During that time, there has also been a smaller increase in the use of intensive care unit (ICU) and coronary care unit (CCU) services at the end of life. The percent of deaths among older

Americans that occurred in hospitals declined over the last 20 years, with an increase in the percent dying at home.

With improved diet, physical fitness, public health, and health care, more adults are reaching age 65 in better physical and mental health than in the past. Trends show that the prevalence of chronic disability among older people is declining. While some disability is the result of more general losses of physiological functions with aging (i.e., normal aging), extreme disability in older persons, including that which stems from mental disorders, is not an inevitable part of aging (*Cohen, Rowe & Kahn*). Normal aging is a gradual process that ushers in some physical decline, such as decreased sensory abilities (e.g., vision and hearing) and decreased pulmonary and immune function (*Miller, Carman*). With aging come certain changes in mental functioning, but very few of these changes match commonly held negative stereotypes about aging (Cohen, Rowe & Kahn). In normal aging, important aspects of mental health include stable intellectual functioning, capacity for change, and productive engagement with life. Cognition subsumes intelligence, language, learning, and memory. With advancing years, cognitive capacity with aging undergoes some loss, yet important functions are spared. Moreover, there is much variability between individuals, variability that is dependent upon lifestyle and psychosocial factors (Gottlieb). Most importantly, accumulating evidence from human and animal research finds that lifestyle modifies genetic risk in influencing the outcomes of aging (Finch & Tanzi). This line of research is beginning to dispel the pejorative stereotypes of older people as rigidly shaped by heredity and incapable of broadening their pursuits and acquiring new skills.

Cognitive Impact

Deterioration and/or decline occur in many cognitive processes throughout the lifespan. A great deal of research has focused on memory and aging, and has found decline in many types of memory with aging, but not in semantic memory or general knowledge such as vocabulary definitions, which typically increases or remains steady. Early studies on changes in cognition with age generally found declines in intelligence in the elderly, but studies were cross-sectional rather than longitudinal and thus results may be an artifact of cohort rather than a true example of decline. Intelligence may decline with age, though the rate may vary depending on the type, and may

in fact remain steady throughout most of the lifespan, dropping suddenly only as people near the end of their lives. Individual variations in rate of cognitive decline may therefore be explained in terms of people having different lengths of life *(Mather, M., & Carstensen, L. L., Aging and motivated cognition: The positivity effect in attention and memory. Trends in Cognitive Sciences)*.

Racial and Ethnic Minority Groups

One-fifth of older adults are currently members of racial or ethnic minority groups (8% African American, 7% Hispanic/Latino, 3% Asian, and 1% AI/AN, Native Hawaiian, or Pacific Islander), and it is projected that 42% of the older adult population will be members of racial or ethnic minority groups by 2050. Substantial work is needed to identify diverse groups of older adults and engage them in behavioral health services. It is estimated that up to one-fifth of older adults (5.6 to 8 million people) are experiencing one or more mental health or substance use conditions. Older women are more likely to have a mental health disorder, and older men are more likely to have a substance misuse/abuse disorder. The rate of suicide among older men surpasses the rate among older women, and the suicide rate of Caucasian men ages 85 and older is more than four times the national rate.

The prevalence of behavioral health conditions differs across and within racial and ethnic groups of older adults. Differences may be explained by factors such as immigration status, gender, education and income levels, perceived financial strain, life events, and region of the country.

For example:

- One study found that, among Latinos and Latinas, acculturation is positively correlated with large and frequent alcohol consumption and high rates of drug abuse.
- A recent secondary analysis of the National Institute of Mental Health Collaborative Psychiatric Epidemiological Studies data set compared the rates of lifetime and 12-month psychiatric disorders among several older adult populations. The analysis found that the rates of depressive disorders are significantly higher among Latinos than the

rates are among non-Latinos, attesting to the increased illness burden of common mental disorders among Latinos.

Table 1. Lifetime and 12-Month Prevalence Rates of Mental Disorders Among Older Adults

	Caucasians (N = 831)	Latinos (N = 420)	Asians (N = 260)	African Americans (N = 671)	Afro Caribbeans (N = 193)
Depressive Disorder, Lifetime	12.2%	16.4%	7.7%	5.4%	8.1%
Anxiety Disorder, Lifetime	13.5%	15.3%	10.9%	11.9%	11.2%
Depressive Disorder, past 12 months	3.2%	8.0%	2.1%	2.3%	4.6%
Anxiety Disorder, past 12 months	5.6%	6.8%	7.0%	6.6%	1.a%

Source: Jimenez DE, Alegría M, et al. (2010). Prevalence of psychiatric illnesses in older ethnic minority adults. *Journal of the American Geriatrics Society*, 58, 256–264.

- Behavioral health conditions are less prevalent among African Americans ages 55 and older who live in the South, compared with those living in other regions of the country.

- Major depression is more prevalent among Cuban Americans and Puerto Ricans between ages 65 and 74 than it is among Mexican Americans in the same age group, and the rate is higher among Puerto Ricans ages 75 and older than it is for other similar-aged older Latino subgroups.

- Major depression is more prevalent among Chinese Americans between ages 65 and 74 compared with Filipino and Vietnamese Americans of the same age, but it is less prevalent among Chinese Americans ages 75 and older compared with similarly aged Filipino and Vietnamese Americans.

- When compared with older Caucasians, elderly AI/AN populations have higher rates of chronic diseases, such as diabetes and liver and kidney diseases, which are exacerbated with drinking.

- Despite the need for mental health services, older African Americans and Latinos are not seeking mental health services at the same rate as their non-Latino Caucasian counterparts. Results of a study of disparities in mental health service use showed that treatment initiation and adequacy were lower for older Latinos and African Americans than they were for older non-Latino Caucasians. These disparities persist even after adjusting for need (mental and physical health conditions), demographic characteristics (e.g., socio-economic status, education level), and insurance coverage.

- Beliefs about the causes of mental illness and stigma associated with mental health services may explain some disparities in the rates of use of mental health services among elderly racial/ethnic minorities. Analyses of baseline data collected for the Primary Care Research in Substance Abuse and Mental Health for the Elderly study indicate that African Americans view the loss of family and friends, stress over money, and general stress or worry as the primary causes of their mental disorders. Asian Americans believe that mental disorders are caused by medical illness, cultural differences, and family issues. Latinos believe that the loss of family and friends, family issues, and migration cause mental disorders. In addition, a greater proportion of older Latinos expressed more shame or embarrassment for having a mental disorder than other older populations, and more Latinos felt that people would think differently of them if they sought mental health treatment than did their non-Latino Caucasian counterparts.

- The rates of depression, suicidality, and substance (particularly alcohol and tobacco) misuse are higher in the older LGBT population than they are in the overall aging population. Although data are limited, a large study of LGBT individuals found that 31% were depressed. There appears to be an elevated risk of suicide attempts and suicidality among older gay men and lesbians and high rates of victimization. Rates of heavy drinking and smoking are reported to be much higher among LGBT older adults compared with the older population as a whole.

- Older adults living in rural areas have a much higher prevalence of major mental disorders, including high rates of depression, suicidality, and alcohol problems, than do other older populations. One reason for this is the difficulty of providing services in rural settings.

Reaching Older Adults and Engaging Them in Prevention Services and Early Interventions

Reaching older adults and engaging them in services to prevent and address depression and substance abuse can be challenging. The high prevalence of certain mental disorders, low use of mental health services, differing beliefs about mental health issues, and the stigma associated with mental illness illustrate the need to create culturally appropriate interventions for older racial/ethnic minorities. To address these challenges, effective, nontraditional approaches are likely needed such as:

- Providing education on prevention of behavioral health conditions;
- Providing universal and selective screening for depression, alcohol use, and psychoactive medication use/misuse;
- Training community members to be gatekeepers who can identify and refer at-risk older adults to behavioral health providers;
- Recruiting organizations trusted by leaders of the target population to conduct outreach in partnership with aging services, primary care, and behavioral health programs.

When applied within the context of culturally appropriate language and norms, the following strategies can be effective in reducing barriers to care and increasing engagement of older adults:

- Using nonjudgmental motivational approaches;
- Empowering and engaging the older adult in decision-making;
- Avoiding stigmatizing terms (e.g., alcoholic, addict);
- Working with older adults in the setting they prefer (e.g., primary care, senior center, home);

- Using an active "warm hand-off " from the primary clinician to the person addressing behavioral health concerns;
- Engaging professionals who have a trusted relationship with the older adult;
- Taking an educational prevention/intervention approach to engaging the older adult;
- Addressing physical barriers (e.g., providing assistance with transportation); and
- Tailoring approaches to cultural views while maintaining fidelity to essential components of evidence-based practices.

Cultural Competence

The culture from which people come affects all aspects of behavioral health and illness, including the types of stresses they confront, whether they seek help, the types of help they seek, the symptoms and concerns they bring to clinical attention, and the types of coping styles and social supports they possess. Culture also affects individuals' exposures to behavioral health risk factors, health status, and the quantity and quality of health care resources available to them. Cultural considerations include race and ethnicity, country of origin, gender, sexual orientation, age cohort, religious affiliation, and physical and cognitive ability.

For the individual provider, cultural competence involves awareness and acceptance of difference, awareness of one's own cultural values, understanding the dynamics of difference, development of cultural knowledge, and ability to adapt practice to the cultural context of the client. For the provider organization, culturally sensitive elements include valuing diversity, conducting self-assessment, managing for the dynamics of difference, institutionalizing cultural knowledge, and adapting policies, structures, and services.

Competence at addressing diverse cultures can support and strengthen behavioral health services. Older adults and their providers can build on the skills that older adults have developed over their lifetime. Many older adults have learned important ways of coping with life's stressors and have developed impressive resilience that is informed not only by their experiences but also by specific cultural beliefs and values.

The extent to which an organization's behavioral health services are culturally appropriate and relevant affects its quality of care, service usage, rate of treatment dropout, and health care outcomes. "Cultural competency is one of the main ingredients in closing the disparities gap in health care." Therefore, it is critical to ensure that the design, adaptation, training, and delivery of behavioral health services are culturally relevant. Many aging services, behavioral health and primary care providers, community leaders, and consumers have learned how to adapt proven outreach and engagement strategies and evidence-based behavioral health interventions to improve health outcomes with diverse groups of older adults.

Defining Cultural Terms

- **Culture**: Integrated patterns of human behavior that include the language, thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups.
- **Competence:** Capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
- **Cultural and linguistic competence:** A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.

Many community organizations provide culturally appropriate behavioral health services to older adults. These organizations include aging services providers, behavioral health providers, community centers, and counseling centers. Examples of strategies and adaptations that organizations have made to improve outreach to and engagement of specific groups of older adults are listed below.

Area Agency on Aging
(AAA) Offers behavioral health services with cultural adaptions

http://www.esmv.org/specializedservices.

Suicide Prevention Call
Service engages older men
Professional counseling and referrals are also available.
http://www.eldercommunitycare.org/index.htm

Alcohol and Drug Council
Engages older African Americans
www.council-houston.org/family-friends/seniors-2/

Senior Center
Engages older African Americans with Depression
Information about Beat the Blues Training is available from
Laura Gitlin, PhD, at Johns Hopkins University
lgitlin1@jhu.edu

Community Center
Addresses Depression in older Latinos
http://www.unitedcc.org/Default/ProgramsServices/HumanServices/

Stigma
In American society, where youth is highly valued, growing old and experiencing a mental illness at the same time can impose barriers to getting better and living a valued and productive life because society, institutions, and individuals, knowingly or unknowingly, stigmatize and discriminate against older adults with mental illnesses. SAMHSA has convened two roundtables of mental health services consumers, researchers, older adults, media representatives, grant writers, advocates, and practitioners. In the roundtables the participants discussed four topics:

- Research findings on older adults and mental health
- Manifestations of stigma and discrimination
- Barriers to eliminating stigma
- Strategies to overcome the barriers.

Research Findings on Older Adults and Mental Health

Demographic trends tell us that the number of older adults with mental illnesses will climb in the next 15 years, but research shows that the stigma of having a mental illness is getting worse, not better. The Indiana Consortium for Mental Health Services Research Project (*Pescosolido et al.*) found that over the past 40 years, Americans have acquired a greater and more sophisticated knowledge of mental illnesses. Americans are able to identify different types of mental illness, and many believe that treatment works. In that time, however, the stigma has intensified in some ways. About three-quarters of Americans do not want to work alongside someone with a mental illness nor do they wish such a person to marry into their family (*Pescosolido et al*.). More people today believe that someone with a mental illness is dangerous to himself or herself and to others than they did in the 1950s, the research found (*Pescosolido et al.*).

Manifestations of Stigma and Discrimination

Roundtable participants identified three types of stigma and discrimination:

- **Self-stigma-**older adults may be fearful of acknowledging their own mental illnesses;
- **Public stigma-**providers, employers, and the general public view older adults with;
- **Mental illnesses**-as people who will not get better with treatment, or worse, people who are not worth treating;
- **Institutional stigma-**assumptions about older adults with mental illnesses are translated into public policy and funding decisions that stigmatize and discriminate against these individuals.

2. Long Term Care

Long-Term Care Services

Long-term care services include a broad range of health, personal care, and supportive services that meet the needs of frail older people and other adults whose capacity for self-care is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related conditions. Historically, the term “long-term care” has been used to refer to services and supports to help frail older adults and younger persons with disabilities

maintain their daily lives. Recently, alternative terms have gained wider use, including “long-term services and supports.” The Patient Protection and Affordable Care Act *(ACA, P.L. 111-148, as amended*) uses the term “long-term services and supports and defines the term to include certain institutionally based and non-institutionally based long-term services and care services” to reflect both the changing vocabulary and the fact that these services can include both health care-related and non-health care-related services.

Long-term care services include assistance with activities of daily living (ADLs; dressing, bathing, and toileting), instrumental activities of daily living (IADLs; medication management and housework), and health maintenance tasks. Long-term care services assist people to improve or maintain an optimal level of physical functioning and quality of life, and can include help from other people and special equipment or assistive devices. The need for long-term care services is generally defined based on functional limitations (need for assistance with or supervision in ADLs and IADLs) regardless of cause, age of the person, where the person is receiving assistance, whether the assistance is human or mechanical, and whether the assistance is paid or unpaid.

Individuals may receive long-term care services in a variety of settings:

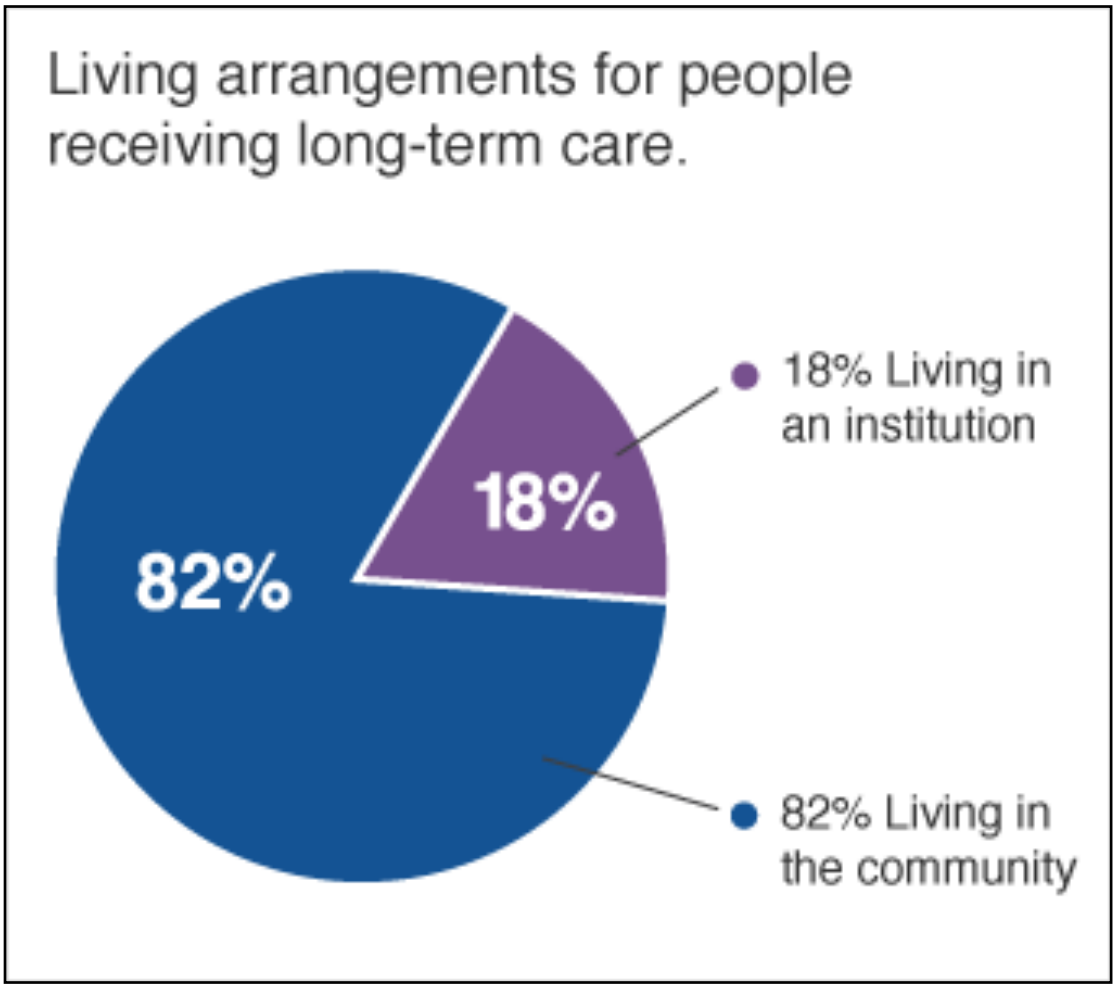
- In the community, such as at an adult day services center in the home, for example, from a home health agency, hospice, or family and friends
- In institutions, such as in a nursing home or skilled nursing facility
- In other residential settings, for instance, in an assisted living or similar residential care community.

The most common type of long-term care is personal care—help with everyday activities, also called "activities of daily living." These activities include bathing, dressing, grooming, using the toilet, eating, and moving around—for example, getting out of bed and into a chair.

Long-term care also includes community services such as meals, adult day care, and transportation services. These services may be provided free or for a fee.

People often need long-term care when they have a serious, ongoing health condition or disability. The need for long-term care can arise suddenly, such as after a heart attack or stroke. Most often, however, it develops gradually, as people get older and frailer or as an illness or disability gets worse.

Home-Based Long-Term Care Services



Home-based long-term care includes health, personal, and support services to help people stay at home and live as independently as possible. Most long-term care is provided either in the home of the person receiving services or at a family member's home. In-home services may be short-term

—for someone who is recovering from an operation, for example—or long-term, for people who need ongoing help.

Most home-based services involve personal care, such as help with bathing, dressing, and taking medications, and supervision to make sure a person is safe. Unpaid family members, partners, friends, and neighbors provide most of this type of care.

Home-based long-term care services can also be provided by paid caregivers, including caregivers found informally, and healthcare professionals such as nurses, home health care aides, therapists, and homemakers, who are hired through home health care agencies. These services include: home health care, homemaker services, friendly visitor/ companion services, and emergency response systems.

Home Health Care

Home health care involves part-time medical services ordered by a physician for a specific condition. These services may include nursing care to help a person recover from surgery, an accident, or illness. Home health care may also include physical, occupational, or speech therapy and temporary home health aide services. These services are provided by home health care agencies approved by Medicare, a government insurance program for people over age 65.

Homemaker and Personal Care Services

Home health agencies offer homemaker and personal care services that can be purchased without a physician's order. Homemaker services include help with meal preparation and household chores. Personal care includes help with bathing and dressing. Agencies do not have to be approved by Medicare to provide these kinds of services.

Friendly Visitor and Senior Companion Services

Friendly visitor/companion services are usually staffed by volunteers who regularly pay short visits (less than 2 hours) to someone who is frail or living alone. You can also purchase these services from home health agencies.

Senior Transportation Services

Transportation services help people get to and from medical appointments, shopping centers, and other places in the community. Some senior housing complexes and community groups offer transportation services. Many public transit agencies have services for people with disabilities. Some services are free. Others charge a fee. Learn more about transportation services from the Eldercare Locator.

Emergency Medical Alert Systems

Emergency response systems automatically respond to medical and other emergencies via electronic monitors. The user wears a necklace or bracelet with a button to push in an emergency. Pushing the button summons emergency help to the home. This type of service is especially useful for people who live alone or are at risk of falling. A monthly fee is charged.

Making Financial Decisions for Long-Term Care

Long-term care can be expensive. Americans spend billions of dollars a year on various services. How people pay for long term care depends on their financial situation and the kinds of services they use. Often, they rely on a variety of payment sources, including:

- Personal funds, including pensions, savings, and income from stocks
- Government health insurance programs, such as Medicaid (Medicare does not cover long-term care but may cover some costs of short-term care in a nursing home after a hospital stay.)
- Private financing options, such as long-term care insurance
- Veterans' benefits
- Services via the Older Americans Act

To find home-based services, contact Eldercare Locator at **1-800-677-1116** or visit https://eldercare.acl.gov. Or call the local Area Agency on Aging, Aging and Disability Resource Center, department of human services or aging, or a social service agency.

It is difficult to predict how much or what type of long-term care a person might need. Several things increase the risk of needing long-term care.

- **Age.** The risk generally increases as people get older.
- **Gender.** Women are at higher risk than men, primarily because they often live longer.
- **Marital status.** Single people are more likely than married people to need care from a paid provider.
- **Lifestyle.** Poor diet and exercise habits can increase a person's risk.
- **Health and family history.** These factors also affect risk.

Residential Facilities, Assisted Living, and Nursing Homes

At some point, support from family, friends, and local programs may not be enough. People who require help full-time might move to a residential facility that provides many or all of the long-term care services they need.

Facility-based long-term care services include: board and care homes, assisted living facilities, nursing homes, and continuing care retirement communities.

Some facilities have only housing and housekeeping, but many also provide personal care and medical services. Many facilities offer special programs for people with Alzheimer's disease and other types of dementia.

Board and Care Homes

Board and care homes, also called residential care facilities or group homes, are small private facilities, usually with 20 or fewer residents. Rooms may be private or shared. Residents receive personal care and meals and have staff available around the clock. Nursing and medical care usually are not provided on site.

Assisted Living

Assisted living is for people who need help with daily care, but not as much help as a nursing home provides. Assisted living facilities range in size from as few as 25 residents to 120 or more. Typically, a few "levels of care" are offered, with residents paying more for higher levels of care.

Assisted living residents usually live in their own apartments or rooms and share common areas. They have access to many services, including up to three meals a day; assistance with personal care; help with medications, housekeeping, and laundry; 24-hour supervision, security, and on-site staff; and social and recreational activities. Exact arrangements vary from state to state.

Nursing Homes

Nursing homes, also called skilled nursing facilities, provide a wide range of health and personal care services. Their services focus on medical care more than most assisted living facilities. These services typically include nursing care, 24-hour supervision, three meals a day, and assistance with everyday activities. Rehabilitation services, such as physical, occupational, and speech therapy, are also available.

Some people stay at a nursing home for a short time after being in the hospital. After they recover, they go home. However, most nursing home residents live there permanently because they have ongoing physical or mental conditions that require constant care and supervision.

Continuing Care Retirement Communities (CCRCs)

Continuing care retirement communities (CCRCs), also called life care communities, offer different levels of service in one location. Many of them offer independent housing (houses or apartments), assisted living, and skilled nursing care all on one campus. Healthcare services and recreation programs are also provided.

In a CCRC, where you live depends on the level of service you need. People who can no longer live independently move to the assisted living facility or sometimes receive home care in their independent living unit. If necessary, they can enter the CCRC's nursing home.

There are many sources of information about facility-based long-term care. A good place to start is the Eldercare Locator at **1-800-677-1116** or https://eldercare.acl.gov. Another resource is the local Area Agency on Aging, Aging and Disability Resource Center, department of human services or aging, or a social service agency.

For More Information About Facility-Based Long-Term Care

Centers for Medicare & Medicaid Services
800-633-4227 (toll-free)
877-486-2048 (TTY/toll-free)

https://www.cms.gov/
www.medicare.gov

Eldercare Locator
800-677-1116 (toll-free)
eldercarelocator@n4a.org
https://eldercare.acl.gov

National Association of Area Agencies on Aging
202-872-0888
info@n4a.org
www.n4a.org

Paying for LTC

Finding a way to pay for long-term care services is a growing concern for older adults, persons with disabilities, and their families, and is a major challenge facing state and federal governments. Medicaid finances a major portion of paid, long-term care services, followed by Medicare and out-of-pocket payments by individuals and families. However, the distribution of financing sources varies by provider sector and by population. For example, most residents pay out-of-pocket for assisted living, with a small percentage using Medicaid to help pay for services. In contrast, the largest single payer for long-term nursing home care is Medicaid, whereas Medicare finances hospice costs and a major portion of the costs for short-stay, post-acute care in skilled nursing facilities for Medicare beneficiaries (Federal Interagency Forum on Aging-Related Statistics). The number of people using nursing facilities, alternative residential care places, or home care services is projected to increase from 15 million in 2000 to 27 million in 2050. Most of this increase will be due to growth in the older adult population who need such services (*HHS*). Although people of all ages may need long-term care services, the risk of needing these services increases with age. Recent projections estimate that over two-thirds of individuals who reach age 65 will need long-term care services during their lifetime (*Kemper, Komisar, & Alecxih*). Largely due to aging baby boomers, the population is expected to become much older, with the number of Americans over age 65 projected to more than double, from 40.2 million in 2010 to 88.5 million in 2050

(*Vincent & Velkoff*). The estimated increase in the number of the "oldest old" —those aged 85 and over—is even more striking. The oldest old are projected to almost triple, from 6.3 million in 2015 to 17.9 million in 2050, accounting for 4.5% of the total population *(U.S. Census Bureau*).

This oldest old population tends to have the highest disability rate and need for long-term care services, and they also are more likely to be widowed and without assistance with ADLs (*Feder & Komisar,; Houser, Fox-Grage, & Ujvar*i). Decreasing family size and increasing employment rates among women may reduce the traditional pool of family caregivers, further stimulating demand for paid long-term care services (*Congressional Budget Office*). Among persons who need long-term care services, adults aged 65 and over are more likely than younger adults to receive paid help (*Kaye, Harrington, & LaPlante*). Recent studies project that the number of older adults using paid, long-term care services will grow substantially (*Johnson, Toohey, & Wiener, Kaye)*. A substantial share of paid, long-term care services is publicly funded through programs such as Medicaid and Medicare; accurate, timely statistical information can help guide those programs and inform relevant policy decisions.

The National Study of Long-Term Care Providers

The long-term care services delivery system in the United States has changed substantially over the last 30 years. For example, although nursing homes are still a major provider of long-term care services, there is growing use of skilled nursing facilities for short-term, post-acute care and rehabilitation (*Decker*). Further, consumers' desire to stay in their own homes, and federal and state policy developments (e.g., the Supreme Court's Olmstead ruling, introduction of the Medicare Prospective Payment System, and balancing Medicaid-financed services from institutional to non-institutional settings) have led to growth in a variety of home- and community-based alternatives (*Doty, Wiener*). The major sectors of paid, long-term care services providers now also include adult day services centers, assisted living and similar residential care communities, home health agencies, and hospices.

Long-term care services provided by paid regulated providers are an important component of personal health care spending in the United States. Estimates of expenditures for paid long-term care services vary, depending on what types of providers, populations, and services are included. According to a recent estimate, total national spending for paid long-term care services was almost $339 billion, with public spending accounting for about 72% of this amount. The cost of long-term care services varies by the type of paid care provided and the type of provider or sector (e.g., adult day services centers, assisted living and similar residential care communities, home health agencies, or hospices). Finding a way to pay for long-term care services is a growing concern for older adults, other persons with disabilities, and their families, and it is a major challenge facing state and federal governments. People who use paid long-term care services, through home and community-based services or institutional care, are among the most costly participants in Medicare and Medicaid programs. Medicaid finances the largest portion of paid long-term care services, followed by Medicare, out-of-pocket payments by individuals and families, other private sources, private insurance, and other public programs.

Medicaid finances a variety of long-term care services through multiple mechanisms (e.g., Medicaid State Plan, home and community-based services waiver program, and other options for community-based long-term care services), including an array of home and community-based services and institutional services.

Experts disagree on whether Medicare expenditures for skilled nursing facilities and home health agencies, since they are post-acute services, should be considered long-term care services. This section includes Medicare-certified skilled nursing facilities and home health agencies, which are often referred to as post-acute care services.

The distribution of the different financing sources described previously varies by long-term care services sector and population. For example, most residents pay out of pocket for assisted living and similar residential care communities, with a small percentage using Medicaid to help pay for services. In contrast, the largest single payer for long-term nursing home care is Medicaid, whereas Medicare finances hospice costs and a major portion of the costs for short-stay post-acute care in skilled nursing facilities for Medicare beneficiaries.

Although people of all ages may need long-term care services, the risk of needing these services increases with age. The number of Americans over age 65 is projected to shift from 47.8 million in 2015 to over 87.9 million in 2050, representing an increase of 84% and comprising 22% of the population. The population aged 85 and over is projected to triple, from 6.3 million in 2015 to over 18.9 million in 2050, and will account for almost 5% of the U.S. population. This "oldest old" population tends to have the highest disability rate and highest need for long-term care services, and is also more likely to be widowed and without someone to provide assistance with daily activities. The number of older people in the United States with significant physical or cognitive disabilities is projected to increase from 6.3 million in 2015 to 15.7 million in 2065.

Decreasing family size and increasing employment rates among women may reduce the traditional pool of family caregivers, further stimulating demand for paid long-term care services. Among persons who need long-term care services, adults aged 65 and over are more likely than younger adults to receive paid help. Results from the National Health and Aging Trends study show that of the 10.9 million older adults who reported receiving help with daily activities in a given month, about 3 in 10 received paid help. Recent projections using microsimulation modeling estimate that about one-half of Americans reaching age 65 will need long-term care services and will incur, on average, $138,000 in long-term care costs. The average projected length of needing long-term Providers

The long-term care services delivery system in the United States has changed substantially over the last 30 years. For example, although nursing homes are still a major provider of long-term care services, there has been growing use of skilled nursing facilities for short-term post-acute care and rehabilitation. Additionally, consumers' desire to stay in their own homes, as well as federal and state policy developments, have led to growth in a variety of home- and community-based alternatives. Examples of these federal and state policy developments include the Supreme Court's Olmstead decision; introduction of the Medicare Prospective Payment System; and a variety of initiatives to encourage balancing of Medicaid-financed services from institutional to non-institutional settings, such as Money Follows the Person, Community First Choice Option, and the Balancing Incentives Payment Program.

The major sectors of paid long-term care services providers now also include adult day services centers, assisted living and similar residential care communities, home health agencies, and hospices.

3. Aging and Mental Health

Research Findings on Older Adults and Mental Health
The roundtables reviewed the research findings on older adults and mental health. Many facts were found that must be taken into account when developing action plans for the future of mental health care for older adults. Some of the trends for older adults and mental illnesses are illustrated here.

Mental Illnesses in Older Adults
It is estimated that by 2030, more than 15 million older adults will experience a mental illness. That is nearly double the current number (*Jeste et al.*). These projections are largely based on the aging of the "baby boomer" cohort and greater longevity. Prevalence of Mental Disorders at Age 65+One-quarter of today's older adults experience some mental disorder, including dementia. About 16 percent have psychiatric disorders, and about 10 percent have dementia. A third of those with dementia exhibit psychosis and/or depression, and they represent about 3 percent of the total elderly population (*Jeste et al.*).

Depression is Associated with Worse Health Outcomes
Depression can strike an older adult after he or she has suffered a hip fracture or heart attack or has been diagnosed with cancer; as a result of these co-occurring illnesses, older adults are at increased risk of poor recovery (*Mossey et al., Penninx et al., Evans et al.*). Mortality rates also increase for those with depression and myocardial infarction and those with depression who are long-term care residents. In general, older adults with mental illnesses experience high medical co-morbidity.

Depression in Older Adults and Health Care Costs
Older adults with significant depression have total health care costs that are roughly 50 percent higher than those without depression. They have a higher use of services in all categories of medical care, including inpatient admissions, outpatient visits, laboratory tests, emergency department visits,

the number of prescriptions, and ancillary and optometry visits (*Unützer et al.*).

Key Facts

- ✦ Mental health and well-being are as important in older age as at any other time of life.
- ✦ Mental and neurological disorders among older adults account for 6.6% of the total disability (DALYs) for this age group.
- ✦ Approximately 15% of adults aged 60 and over suffer from a mental disorder.

Older adults make important contributions to society as family members, volunteers and as active participants in the workforce. While most have good mental health, many older adults are at risk of developing mental disorders, neurological disorders or substance use problems as well as other health conditions such as diabetes, hearing loss, and osteoarthritis. Furthermore, as people age, they are more likely to experience several conditions at the same time.

Over 20% of adults aged 60 and over suffer from a mental or neurological disorder (excluding headache disorders) and 6.6% of all disability (disability adjusted life years-DALYs) among people over 60 years is attributed to mental and neurological disorders. These disorders in older people account for 17.4% of Years Lived with Disability (YLDs). The most common mental and neurological disorders in this age group are dementia and depression, which affect approximately 5% and 7% of the world's older population, respectively. Anxiety disorders affect 3.8% of the older population, substance use problems affect almost 1% and around a quarter of deaths from self-harm are among people aged 60 or above. Substance abuse problems among older people are often overlooked or misdiagnosed. Mental health problems are under-identified by health-care professionals and older people themselves, and the stigma surrounding these conditions makes people reluctant to seek help.

Risk Factors for Mental Health Problems Among Older Adults

There may be multiple risk factors for mental health problems at any point in life. Older people may experience life stressors common to all people, but also stressors that are more common in later life, like a significant ongoing loss in capacities and a decline in functional ability. For example, older adults may experience reduced mobility, chronic pain, frailty or other health problems, for which they require some form of long-term care. In addition, older people are more likely to experience events such as bereavement, or a drop in socioeconomic status with retirement. All of these stressors can result in isolation, loneliness or psychological distress in older people, for which they may require long-term care.

Mental health has an impact on physical health and vice versa. For example, older adults with physical health conditions such as heart disease have higher rates of depression than those who are healthy. Additionally, untreated depression in an older person with heart disease can negatively affect its outcome.

Older adults are also vulnerable to elder abuse - including physical, verbal, psychological, financial and sexual abuse; abandonment; neglect; and serious losses of dignity and respect. Current evidence suggests that 1 in 6 older people experience elder abuse. Elder abuse can lead not only to physical injuries, but also to serious, sometimes long-lasting psychological consequences, including depression and anxiety.

Dementia and Depression Among Older People as Public Health Issues

Dementia

Dementia is a syndrome, usually of a chronic or progressive nature, in which there is deterioration in memory, thinking, behavior and the ability to perform everyday activities. It mainly affects older people, although it is not a normal part of aging. It is estimated that 50 million people worldwide are living with dementia with nearly 60% living in low- and middle-income countries. The total number of people with dementia is projected to increase to 82 million in 2030 and 152 million in 2050.

There are significant social and economic issues in terms of the direct costs of medical, social and informal care associated with dementia. Moreover, physical, emotional and economic pressures can cause great stress to families and carers. Support is needed from the health, social, financial and legal systems for both people with dementia and their carers.

Depression

Depression can cause great suffering and leads to impaired functioning in daily life. Unipolar depression occurs in 7% of the general older population and it accounts for 5.7% of YLDs among those over 60 years old. Depression is both underdiagnosed and undertreated in primary care settings. Symptoms are often overlooked and untreated because they co-occur with other problems encountered by older adults.
Older people with depressive symptoms have poorer functioning compared to those with chronic medical conditions such as lung disease, hypertension or diabetes. Depression also increases the perception of poor health, the utilization of health care services and costs.
Treatment and Care Strategies to Address Mental Health Needs of Older People
It is important to prepare health providers and societies to meet the specific needs of older populations, including:

- Training for health professionals in providing care for older people;
- Preventing and managing age-associated chronic diseases including mental, neurological and substance use disorders;
- Designing sustainable policies on long-term and palliative care; and
- Developing age-friendly services and settings.

Health Promotion

The mental health of older adults can be improved through promoting Active and Healthy Aging. Mental health-specific health promotion for older adults involves creating living conditions and environments that support wellbeing and allow people to lead a healthy life. Promoting mental health depends largely on strategies to ensure that older people have the necessary resources to meet their needs, such as:

DEFINITIONS

The definition of **serious mental illnesses** (SMIs) includes one or more diagnoses of mental disorders combined with significant impairment in functioning. Schizophrenia, bipolar illness, and major depressive disorder are the diagnoses most commonly associated with SMI, but people with one or more other disorders may also fit the definition of SMI if those disorders result in functional impairment.[15]

Geriatric mental health workforce refers to the range of personnel providing services to older adults with mental health conditions.[5]

The terms "**older adult**" and "**geriatric population**" refer to individuals age 65 and older.[5]

Co-occurring Conditions

As a normal course of aging, older adults experience changes to their physical health, mental health, and cognitions. Interactions among these age-related factors can result in "spiral" or "cascade" of decline in physical, cognitive, and psychological health.[18]

A 2006 report of the National Association of State Mental Health Program Directors indicates that people with SMI die earlier than the general population and are at higher risk for multiple adverse health outcomes.[19] There may be a number of reasons.

Older adults with an SMI have substantially higher rates of diabetes, lung disease, cardiovascular disease, and other comorbidities that are associated with early mortality, disability, and poor function.[20] They also have significant impairments in psychosocial functioning.[21] Older adults with SMI account for disproportionately high costs and service use.[20,21] Lifestyle and behaviors (e.g., tobacco and alcohol use, sedentary) may put older adults with SMI at greater risk for metabolic side effects of antipsychotic medications and lead to obesity and chronic physical health conditions.[20]

Among older adults, the rate of substance use disorders is reported as .2 to 1.9 percent.[5,22,59] Approximately 1.4 percent of older women and 2.2 percent of older men reported past-year use of illicit drugs, including marijuana, cocaine, heroin, and prescription psychotherapeutic medications, such as pain relievers and antianxiety medications that are used for nonmedical purposes.[5] The 2016 National Survey of Drug Use and Health data indicate that there are approximately 863,000 older adults with a substance use disorder involving illicit drugs or alcohol, but only 240,000 (approximately 27 percent) received treatment for their substance use problem.[59] Prevalence rates for older-adult at-risk drinking (defined as more than 3 drinks per occasion; more than 7 drinks per week) are estimated to be 16.0 percent for men and 10.9 percent for women.[22] For individuals who are 50 years old and up, misuse of opioids is projected to be 2 percent.[24]

In 2013, more than 7,000 people age 65 or older died by suicide.[25] Suicide rates are particularly high among older men, although suicide attempts are more common among older women.[25] Suicide attempts are more likely to result in death among older adults than among younger people.[25]

Statistics Relevant to Older Adults with SMI

4.8%

of older adults are living with a serious mental illness[5]

.2% ▸ bipolar disorder[5]

.2 - .8% ▸ schizophrenia[5]

3 - 4.5% ▸ depression[5]

People aged 65 and older account for **17.9%** of suicide deaths[17]

- Providing security and freedom;
- Adequate housing through supportive housing policy;
- Social support for older people and their caregivers;
- Health and social programs targeted at vulnerable groups such as those who live alone and rural populations or who suffer from a chronic or relapsing mental or physical illness;
- Programs to prevent and deal with elder abuse; and
- Community development programs.

Interventions

Prompt recognition and treatment of mental, neurological and substance use disorders in older adults is essential. Both psychosocial interventions and medicines are recommended.
There is no medication currently available to cure dementia but much can be done to support and improve the lives of people with dementia and their caregivers and families, such as:

- Early diagnosis, in order to promote early and optimal management;
- Optimizing physical and mental health, functional ability and well-being;
- Identifying and treating accompanying physical illness;
- Detecting and managing challenging behavior; and
- Providing information and long-term support to carers.

Mental Health Care in the Community

Good general health and social care is important for promoting older people's health, preventing disease and managing chronic illnesses. Training all health providers in working with issues and disorders related to aging is therefore important. Effective, community-level primary mental health care for older people is crucial. It is equally important to focus on the long-term care of older adults suffering from mental disorders, as well as to provide caregivers with education, training and support.

An appropriate and supportive legislative environment based on internationally accepted human rights standards is required to ensure the highest quality of services to people with mental illness and their caregivers.

WHO Response

WHO supports governments in the goal of strengthening and promoting mental health in older adults and to integrate effective strategies into policies and plans. The Global strategy and action plan on aging and health was adopted by the World Health Assembly in 2016. One of the objectives of this global strategy is to align the health systems to the needs of older populations, for mental as well as physical health. Key actions include: orienting health systems around intrinsic capacity and functional ability, developing and ensuring affordable access to quality older person-centred and integrated clinical care, and ensuring a sustainable and appropriately trained, deployed, and managed health workforce.

The Comprehensive Mental Health Action Plan for 2013-2020 is a commitment by all WHO Member States to take specific actions to promote mental well-being, prevent mental disorders, provide care, enhance recovery, promote human rights and reduce the mortality, morbidity and disability for persons with mental disorders including in older adults. It focuses on 4 key objectives to:

- Strengthen effective leadership and governance for mental health;
- Provide comprehensive, integrated and responsive mental health and social care services in community-based settings;
- Implement strategies for promotion and prevention in mental health; and
- Strengthen information systems, evidence and research for mental health.

Depression, psychoses, suicide, epilepsy, dementia and substance use disorders are included in the WHO Mental Health Gap Action Program (mhGAP) that aims to improve care for mental, neurological and substance use disorders through providing guidance and tools to develop health services in resource-poor areas. The mhGAP package consists of interventions for prevention and management for each of these priority conditions in non-specialized health settings including in those for older people.

In May 2017, the World Health Assembly endorsed the *Global action plan on the public health response to dementia 2017-2025*. The Plan provides a comprehensive blueprint for action – for policy-makers, international, regional and national partners, and WHO – in areas such as, increasing awareness of dementia and establishing dementia-friendly initiatives; reducing the risk of dementia; diagnosis, treatment and care; research and innovation; and support for dementia carers. It aims to improve the lives of people with dementia, their carers and families, while decreasing the impact of dementia on individuals, communities and countries. As part of the efforts to operationalize the Plan, an international surveillance platform, the Global Dementia Observatory, has been established for policy-makers and researchers to facilitate monitoring and sharing of information on dementia policies, service delivery, epidemiology and research.

Fortunately, the past 15 to 20 years have been marked by rapid growth in the number of clinical, research, and training centers dedicated to the mental illness- and mental health-related needs of older people. As evident in this section, much has been learned. The section reviews, first, normal developmental milestones of aging, highlighting the adaptive capacities that enable many older people to change, cope with loss, and pursue productive and fulfilling activities. The section then considers mental disorders in older people—their diagnosis and treatment, and the various risk factors that may complicate the course or outcome of treatment. Risk factors include co-occurring, or co-morbid, general medical conditions, the high numbers of medications many older individuals take, and psychosocial stressors such as bereavement or isolation. These are cause for concern, but, as the section notes, they also point the way to possible new preventive interventions. The goal of such prevention strategies may be to limit disability or to postpone or even eliminate the need to institutionalize an ill person (*Lebowitz & Pearson, in press*). The section reviews gains that have been realized in making appropriate mental health services available to older people and the challenges associated with the delivery of services to this population. The advantages of a decisive shift away from mental hospitals and nursing homes to treatment in community-based settings today are in jeopardy of being undermined by fragmentation and insufficient availability of such services (*Gatz & Smyer, Cohen & Cairl*). The section examines obstacles and opportunities in the service delivery sphere, in part through the

lens of public and private sector financing policies and managed care. Finally, the section reviews the supports for older persons that extend beyond traditional, formal treatment settings. Through support networks, self-help groups, and other means, consumers, families, and communities are assuming an increasingly important role in treating and preventing mental health problems and disorders among older persons.

With improved diet, physical fitness, public health, and health care, more adults are reaching age 65 in better physical and mental health than in the past. Trends show that the prevalence of *chronic* disability among older people is declining (*Manton et al*.). While some disability is the result of more general losses of physiological functions with aging (i.e., normal aging), *extreme* disability in older persons, including that which stems from mental disorders, is not an inevitable part of aging (Cohen; Rowe & Kahn). Normal aging is a gradual process that ushers in some physical decline, such as decreased sensory abilities (e.g., vision and hearing) and decreased pulmonary and immune function *(Miller; Carman*). With aging come certain changes in mental functioning, but very few of these changes match commonly held negative stereotypes about aging (*Cohen, Rowe & Kahn*). In normal aging, important aspects of mental health include stable intellectual functioning, capacity for change, and productive engagement with life.

Cognition

Cognition subsumes intelligence, language, learning, and memory. With advancing years, cognitive capacity with aging undergoes some loss, yet important functions are spared. Moreover, there is much variability between individuals, variability that is dependent upon lifestyle and psychosocial factors (*Gottlieb*). Most important, accumulating evidence from human and animal research finds that lifestyle modifies genetic risk in influencing the outcomes of aging (*Finch & Tanzi*). This line of research is beginning to dispel the pejorative stereotypes of older people as rigidly shaped by heredity and incapable of broadening their pursuits and acquiring new skills.

One large, ongoing longitudinal study found high cognitive performance to be dependent on four factors, ranked here in decreasing order of importance:

education, strenuous activity in the home, peak pulmonary flow rate, and "self-efficacy," which is a personality measure defined by the ability to organize and execute actions required to deal with situations likely to happen in the future (*Albert et al*.).

Education, as assessed by years of schooling, is the strongest predictor of high cognitive functioning. This finding suggests that education not only has salutary effects on brain function earlier in life, but also foreshadows sustained productive behavior in later life, such as reading and performing crossword puzzles (*Rowe & Kahn*).

The coexistence of mental and somatic disorders (i.e., comorbidity) is common (*Kramer et al*.). Some disorders with primarily somatic symptoms can cause cognitive, emotional, and behavioral symptoms as well, some of which rise to the level of mental disorders. At that point, the mental disorder may result from an effect of the underlying disorder on the central nervous system (e.g., dementia due to a medical condition such as hypothyroidism) or an effect of treatment (e.g., delirium due to a prescribed medication). Likewise, mental problems or disorders can lead to or exacerbate other physical conditions by decreasing the ability of older adults to care for themselves, by impairing their capacity to rally social support, or by impairing physiological functions. For example, stress increases the risk of coronary heart disease and can suppress cellular immunity (*McEwen*). Depression can lead to increased mortality from heart disease and possibly cancer (*Frasure-Smith et al., Penninx et al*.).

A new model postulates that successful aging is contingent upon three elements: avoiding disease and disability, sustaining high cognitive and physical function, and engaging with life (*Rowe & Kahn*). The latter encompasses the maintenance of interpersonal relationships and productive activities, as defined by paid or unpaid activities that generate goods or services of economic value. The three major elements are considered to act in concert, for none is deemed sufficient by itself for successful aging. This new model broadens the reach of health promotion in aging to entail more than just disease prevention.

Descriptive research reveals evidence of the capacity for constructive change in later life (*Cohen*). The capacity to change can occur even in the face of mental illness, adversity, and chronic mental health problems.
Older persons display flexibility in behavior and attitudes and the ability to grow intellectually and emotionally. Time plays a key role. Externally imposed demands upon one's time may diminish, and the amount of time left at this stage in life can be significant. In the United States in the late 20th century, late-life expectancy approaches another 20 years at the age of 65. In other words, average longevity from age 65 today approaches what had been the average longevity from birth some 2,000 years ago. This leaves plenty of time to embark upon new social, psychological, educational, and recreational pathways, as long as the individual retains good health and material resources. In his classic developmental model, Erik Erikson characterized the final stage of human development as a tension between "ego integrity and despair" (*Erikson*). Erikson saw the period beginning at age 65 years as highly variable. Ideally, individuals at this stage witness the flowering of seeds planted earlier in the prior seven stages of development. When they achieve a sense of integrity in life, they garner pride from their children, students and protégés, and past accomplishments. With contentment comes a greater tolerance and acceptance of the decline that naturally accompanies the aging process. Failure to achieve a satisfying degree of ego integrity can be accompanied by despair.
Cohen (in press) has proposed that with increased longevity and health, particularly for people with adequate resources, aging is characterized by two human potential phases. These phases, which emphasize the positive aspects of the final stages of the life cycle, are termed *Retirement/Liberation* and *Summing Up/Swan Song*.

Retirement often is viewed as the most important life event prior to death. Retirement frequently is associated with negative myths and stereotypes (*Sheldon et al. Bass*). Cohen points out, however, that most people fare well in retirement. They have the opportunity to explore new interests, activities, and relationships due to retirement's liberating qualities. In the Retirement/ Liberation phase, new feelings of freedom, courage, and confidence are experienced. Those at risk for faring poorly are individuals who typically do not want to retire, who are compelled to retire because of poor health, or who experience a significant decline in their standard of living (*Cohen*). In

short, the liberating experience of having more time and an increased sense of freedom can be the springboard for creativity in later life.

Creative achievement by older people can change the course of an individual, family, community, or culture. In the late-life Summing Up/Swan Song phase, there is a tendency to appraise one's life work, ideas, and discoveries and to share them with family or society. The desire to sum up late in life is driven by varied feelings, such as the desire to complete one's life work, the desire to give back after receiving much in life, or the fear of time evaporating. Important opportunities for creative sharing and expression ensue. There is a natural tendency with aging to reminisce and elaborate stories that has propelled the development of reminiscence therapy for health promotion and disease prevention. The swan song, the final part of this phase, connotes the last act or final creative work of a person before retirement or death.

There is much misunderstanding about thoughts of death in later life. Depression, serious loss, and terminal illness trigger the sense of mortality, regardless of age. Contrary to popular stereotypes, studies on aging reveal that most older people generally do not have a fear or dread of death in the absence of being depressed, encountering serious loss, or having been recently diagnosed with a terminal illness (*Kastenbaum*). Periodic thoughts of death—not in the form of dread or angst—do occur. But these are usually associated with the death of a friend or family member. When actual dread of death does occur, it should not be dismissed as accompanying aging, but rather as a signal of underlying distress (e.g., depression). This is particularly important in light of the high risk of suicide among depressed older adults, which is discussed later in this chapter.

Loss

Many older adults experience loss with aging—loss of social status and self-esteem, loss of physical capacities, and death of friends and loved ones. But in the face of loss, many older people have the capacity to develop new adaptive strategies, even creative expression (*Cohen*). Those experiencing loss may be able to move in a positive direction, either on their own, with the benefit of informal support from family and friends, or with formal

support from mental health professionals. The life and work of William Carlos Williams are illustrative. Williams was a great poet as well as a respected physician. In his 60s, he suffered a stroke that prevented him from practicing medicine. The stroke did not affect his intellectual abilities, but he became so severely depressed that he needed psychiatric hospitalization. Nonetheless, Williams, with the help of treatment for a year, surmounted the depression and for the next 10 years wrote luminous poetry, including the Pulitzer Prize-winning *Pictures From Bruegel,* which was published when he was 79. In his later life, Williams wrote about "old age that adds as it takes away." What Williams and his poetry epitomize is that age can be the catalyst for tapping into creative potential (*Cohen*).

Loss of a spouse is common in late life. About 800,000 older Americans are widowed each year. Bereavement is a natural response to death of a loved one. Its features, almost universally recognized, include crying and sorrow, anxiety and agitation, insomnia, and loss of appetite (*Institute of Medicine [IOM]*). This constellation of symptoms, while overlapping somewhat with major depression, does not by itself constitute a mental disorder. Even though bereavement of less than 2 months' duration is not considered a mental disorder, it still warrants clinical attention. The justification for clinical attention is that bereavement, as a highly stressful event, increases the probability of, and may cause or exacerbate, mental *and* somatic disorders.

Bereavement is an important and well-established risk factor for depression. At least 10 to 20 percent of widows and widowers develop clinically significant depression during the first year of bereavement. Without treatment, such depressions tend to persist, become chronic, and lead to further disability and impairments in general health, including alterations in endocrine and immune function (*Zisook & Shuchter, Zisook et al.*). Several preventive interventions, including participation in self-help groups, have been shown to prevent depression among widows and widowers, although one study suggested that self-help groups can exacerbate depressive symptoms in certain individuals (*Levy et al.*).

Bereavement-associated depression often coexists with another type of emotional distress, which has been termed traumatic grief (*Prigerson et al., in press*). The symptoms of traumatic grief appear to be a mixture of symptoms of both pathological grief and posttraumatic stress disorder (*Frank et al.*). Such symptoms are extremely disabling, associated with functional and health impairment and with persistent suicidal thoughts, and may well respond to pharmacotherapy (*Zygmont et al.*). Increased illness and mortality from suicide are the most serious consequences of late-life depression. The dynamics around loss in later life need greater clarification. One pivotal question is why some, in confronting loss with aging, succumb to depression and suicide—which, as noted earlier, has its highest frequency after age 65—while others respond with new adaptive strategies. Research on health promotion also needs to identify ways to prevent adverse reactions and to promote positive responses to loss in later life. Meanwhile, despite cultural attitudes that older persons can handle bereavement by themselves or with support from family and friends, it is imperative that those who are unable to cope be encouraged to access mental health services. Bereavement is not a mental disorder but, if unattended to, has serious mental health and other health consequences.

Disorders

Older adults are encumbered by many of the same mental disorders as are other adults; however, the prevalence, nature, and course of each disorder may be very different. This section provides a general overview of assessment, diagnosis, and treatment of mental disorders in older people. Its purpose is to describe issues common to many mental disorders.

Assessment and diagnosis of late-life mental disorders are especially challenging by virtue of several distinctive characteristics of older adults. First, the clinical presentation of older adults with mental disorders may be different from that of other adults, making detection of treatable illness more difficult. For example, many older individuals present with somatic complaints and experience symptoms of depression and anxiety that do not meet the full criteria for depressive or anxiety disorders. The consequences of these sub-syndromal conditions may be just as deleterious as

the syndromes themselves. Failure to detect individuals who truly have treatable mental disorders represents a serious public health problem (*National Institutes of Health [NIH] Consensus Development Panel on Depression in Late Life*).

Detection of mental disorders in older adults is complicated further by high comorbidity with other medical disorders. The symptoms of somatic disorders may mimic or mask psychopathology, making diagnosis more taxing. In addition, older individuals are more likely to report somatic symptoms than psychological ones, leading to further under identification of mental disorders (*Blazer*). Primary care providers carry much of the burden for diagnosis of mental disorders in older adults, and, unfortunately, the rates at which they recognize and properly identify disorders often are low. With respect to depression, for example, a significant number of depressed older adults are neither diagnosed nor treated in primary care (*NIH Consensus Development Panel on Depression in Late Life, Unutzer et al*.). In one study of primary care physicians, only 55 percent of internists felt confident in diagnosing depression, and even fewer (*35 percent of the total*) felt confident in prescribing antidepressants to older persons (*Callahan et al*.). Physicians were *least* likely to report that they felt "very confident" in evaluating depression in other late-life conditions (*Gallo et al., in press*). Researchers estimate that an *unmet* need for mental health services may be experienced by up to 63 percent of adults aged 65 years and older with a mental disorder, based on prevalence estimates from the Epidemiologic Catchment Area (ECA) study (*Rabins*).

The large unmet need for treatment of mental disorders reflects *patient* barriers (e.g., preference for primary care, tendency to emphasize somatic problems, reluctance to disclose psychological symptoms), *provider* barriers (e.g., lack of awareness of the manifestations of mental disorders, complexity of treatment, and reluctance to inform patients of a diagnosis), and mental health delivery *system* barriers (e.g., time pressures, reimbursement policies).

Stereotypes about normal aging also can make diagnosis and assessment of mental disorders in late life challenging. For example, many people believe that "senility" is normal and therefore may delay seeking care for relatives

with dementing illnesses. Similarly, patients and their families may believe that depression and hopelessness are natural conditions of older age, especially with prolonged bereavement. Cognitive decline, both normal and pathological, can be a barrier to effective identification and assessment of mental illness in late life. Obtaining an accurate history, which may need to be taken from family members, is important for diagnosis of most disorders and especially for distinguishing between somatic and mental disorders. Normal decline in short-term memory and especially the severe impairments in memory seen in dementing illnesses hamper attempts to obtain good patient histories. Similarly, cognitive deficits are prominent features of many disorders of late life that make diagnosis of psychiatric disorders more difficult.

Prevention in mental health has been seen until recently as an area limited to childhood and adolescence. Now there is mounting awareness of the value of prevention in the older population. While the body of published literature is not as extensive as that for diagnosis or treatment, investigators are beginning to shape new approaches to prevention. Yet because prevention research is driven, in part, by refined understanding of disease etiology—and etiology research itself continues to be rife with uncertainty—prevention advances are expected to lag behind those in etiology.

There are many ways in which prevention models can be applied to older individuals, provided a broad view of prevention is used (*Lebowitz & Pearson, in press*). Such a broad view entails interventions for reducing the risk of developing, exacerbating, or experiencing the consequences of a mental disorder. Consequently, this section covers primary prevention (including the prevention of depression and suicide), treatment-related prevention, prevention of excess disability, and prevention of premature institutionalization. However, many of the research advances noted in this section have yet to be translated into practice. Given the frequency of memory complaints and depression, the time may soon arrive for older adults to be encouraged to have “mood and memory checkups” in the same manner that they are now encouraged to have physical checkups (N. Abeles, personal communication).

Primary prevention, the prevention of disease before it occurs, can be applied to late-onset disorders. Progress in our understanding of etiology, risk factors, pathogenesis, and the course of mental disorders stimulates and channels the development of prevention interventions. The largest body of primary prevention research focuses on late-life depression, where some progress has been documented. With other disorders, primary prevention research is in its infancy. Prevention in Alzheimer's disease might target individuals at increased genetic risk with prophylactic nutritional (e.g., vitamin E), cholinergic, or amyloid-targeting interventions. Prevention research on late-onset schizophrenia might explore potential protective factors, such as estrogen.

Depression is strikingly prevalent among older people. As noted below, at least 8 to 20 percent of older adults in the community and up to 37 percent in primary care settings experience symptoms of depression.
One approach to preventing depression is through grief counseling for widows and widowers. For example, participation in self-help groups appears to ameliorate depression, improve social adjustment, and reduce the use of alcohol and other drugs of abuse in widows (*Constantino, Lieberman & Videka-Sherman*). The efficacy of self-help groups approximates that of brief psychodynamic psychotherapy in older bereaved individuals without significant prior psychopathology (*Marmar et al*.). The battery of psychosocial and pharmacological treatments to prevent *recurrences* of depression (i.e., secondary prevention) is discussed later in this chapter under the section on depression. Depression is a foremost risk factor for suicide in older adults (*Conwell, Conwell et al.*). Older people have the highest rates of suicide in the U.S. population: suicide rates increase with age, with older white men having a rate of suicide up to six times that of the general population (*Kachur et al., Hoyert et al*.). Despite the prevalence of depression and the risk it confers for suicide, depression is neither well recognized nor treated in primary care settings, where most older adults seek and receive health care (*Unutzer et al.*). Studies described in the depression section of this chapter have found that undiagnosed and untreated depression in the primary care setting plays a significant role in suicide (*Caine et al.*). This awareness has prompted the development of suicide prevention strategies expressly for primary care. One of the first published suicide prevention studies, an uncontrolled experiment

conducted in Sweden, suggested that a depression training program for general practitioners reduces suicide (*Rihmer et al*.). Suicide interventions, especially in the primary care setting, have become a priority of the U.S. Public Health Service, with lead responsibility assumed by the Office of the Surgeon General and the National Institute of Mental Health. Depression and suicide prevention strategies also are important for nursing home residents. About half of patients newly relocated to nursing homes are at heightened risk for depression (*Parmelee et al.*).

Prevention of relapse or recurrence of the underlying mental disorder is important for improving the mental health of older patients with mental disorders. For example, treatments that are applied with adequate intensities for depression (*Schneider*) and for depression in Alzheimer's disease (*Small et al*.) may prevent relapse or recurrence. Substantial residual disability in chronically mentally ill individuals (*Lebowitz et al*.) suggests that treatment must be approached from a longer term perspective (*Reynolds et al.*). Prevention of medication side effects and adverse reactions also is an important goal of treatment-related prevention efforts in older adults. Comorbidity and the associated polypharmacy for multiple conditions are characteristic of older patients. New information on the genetic basis of drug metabolism and on the action of drug-metabolizing enzymes can lead to a better understanding of complex drug interactions (*Nemeroff et al.*). For example, many of the selective serotonin reuptake inhibitors compete for the same metabolic pathway used by beta-blockers, type 1C antiarrhythmics, and benzodiazepines (*Nemeroff et al.*). This knowledge can assist the clinician in choosing medications that can prevent the likelihood of side effects. In addition, many older patients require antipsychotic treatment for management of behavioral symptoms in Alzheimer's disease, schizophrenia, and depression. Although doses tend to be quite low, age and length of treatment represent major risk factors for movement disorders (*Saltz et al., Jeste et al.*). Recent research on older people suggests that the newer antipsychotics present a much lower risk of movement disorders, highlighting their importance for prevention (*Jeste et al., in press*). Finally, body sway and postural stability are affected by many drugs, although there is wide variability within classes of drugs (*Laghrissi-Thode et al.*). Minimizing the risk of falling, therefore, is another target for

prevention research. Falls represent a leading cause of injury deaths among older persons (IOM).

Prevention efforts in older mentally ill populations also target avoidance of excessive disability. The concept of excess disability refers to the observation that many older patients, particularly those with Alzheimer's disease and other severe and persistent mental disorders, are more functionally impaired than would be expected according to the stage or severity of their disorder. Medical, psychosocial, and environmental factors all contribute to excess disability. For example, depression contributes to excess disability by hastening functional impairment in patients with Alzheimer's disease (*Ritchie et al*.). The fast pace of modern life, with its emphasis on independence, also contributes to excess disability by making it more difficult for older adults with impairments to function autonomously. Attention to depression, anxiety, and other mental disorders may reduce the functional limitations associated with concomitant mental and somatic impairments. Many studies have demonstrated that attention to these factors and aggressive intervention, where appropriate, maximize function (*Lebowitz & Pearson, in press*).

Another important goal of prevention efforts in older adults is prevention of premature institutionalization. While institutional care is needed for many older patients who suffer from severe and persistent mental disorders, delay of institutional placement until absolutely necessary generally is what patients and family caregivers prefer. It also has significant public health impact in terms of reducing costs. A randomized study of counseling and support versus usual care for family caregivers of patients with Alzheimer's disease found the intervention to have delayed patients' nursing home admission by over 300 days (*Mittelman et al.*). The intervention also resulted in a significant reduction in depressive symptoms in the caregivers. The intervention consisted of three elements: individual and family counseling sessions, support group participation, and availability of counselors to assist with patient crises. The growing importance of avoiding premature institutionalization is illustrated by its use as one measure of the effectiveness of pharmacotherapy in older individuals. For example, clinical trials of drugs for Alzheimer's disease have begun using delay of institutionalization as a primary outcome (*Sano et al.*) or as a longer-term

outcome in a follow-up study after the double-blind portion of the clinical trial ended (*Knopman et al.*).

Treatment of mental disorders in older adults encompasses pharmacological interventions and psychosocial interventions. While the pharmacological and psychosocial interventions used to treat mental health problems and specific disorders may be identical for older and younger adults, characteristics unique to older adults may be important considerations in treatment selection. The special considerations in selecting appropriate medications for older people include physiological changes due to aging; increased vulnerability to side effects, such as tardive dyskinesia; the impact of polypharmacy; interactions with other comorbid disorders; and barriers to compliance. All are discussed below.

The aging process leads to numerous changes in physiology, resulting in altered blood levels of certain medications, prolonged pharmacological effects, and greater risk for many side effects (*Kendell et al*.). Changes may occur in the absorption, distribution, metabolism, and excretion of psychotropic medications (*Pollock & Mulsant*). As people age, there is a gradual decrease in gastrointestinal motility, gastric blood flow, and gastric acid production (*Greenblatt et al*.). This slows the *rate* of absorption, but the overall *extent* of gastric absorption is probably comparable to that in other adults. The aging process is also associated with a decrease in total body water, a decrease in muscle mass, and an increase in adipose tissue (*Borkan et al.*). Drugs that are highly lipophilic, such as neuroleptics, are therefore more likely to be accumulated in fatty tissues in older patients than they are in younger patients.

The liver undergoes changes in blood flow and volume with age. Phase I metabolism (oxidation, reduction, hydrolysis) may diminish or remain unchanged, while phase II metabolism (conjugation with an endogenous substrate) does not change with aging. Renal blood flow, glomerular surface area, tubular function, and reabsorption mechanisms all have been shown to diminish with age. Diminished renal excretion may lead to a prolonged half-life and the necessity for a lower dose or longer dosing intervals. Pharmacodynamics, which refers to the drug's effect on its target organ, also can be altered in older individuals. An example of aging-associated

pharmacodynamic change is diminished central cholinergic function contributing to increased sensitivity to the anticholinergic effects of many neuroleptics and antidepressants in older adults (*Molchan et al.)*. Because of the pharmacokinetic and pharmacodynamic concerns presented above, it is often recommended that clinicians "start low and go slow" when prescribing new psychoactive medications for older adults. In other words, efficacy is greatest and side effects are minimized when initial doses are small and the rate of increase is slow. Nevertheless, the medication should generally be titrated to the regular adult dose in order to obtain the full benefit. The potential pitfall is that, because of slower titration and the concomitant need for more frequent medical visits, there is less likelihood of older adults receiving an adequate dose and course of medication.

Older people encounter an increased risk of side effects, most likely the result of taking multiple drugs or having higher blood levels of a given drug. The increased risk of side effects is especially true for neuroleptic agents, which are widely prescribed as treatment for psychotic symptoms, agitation, and behavioral symptoms. Neuroleptic side effects include sedation, anticholinergic toxicity (which can result in urinary retention, constipation, dry mouth, glaucoma, and confusion), extrapyramidal symptoms (e.g., parkinsonism, akathisia, and dystonia), and tardive dyskinesia. Tardive dyskinesia is a frequent and persistent side effect that occurs months to years after initiation of neuroleptics. In older adults, tardive dyskinesia typically entails abnormal movements of the tongue, lips, and face. In a recent study of older outpatients treated with conventional neuroleptics the incidence of tardive dyskinesia after 12 months of neuroleptic treatment was 29 percent of the patients. At 24 and 36 months, the mean cumulative incidence was 50.1 percent and 63.1 percent, respectively (*Jeste et al.*). This study demonstrates the high risk of tardive dyskinesia in older patients even with low doses of conventional neuroleptics. Studies of younger adult patients reveal an annual cumulative incidence of tardive dyskinesia at 4 to 5 percent (*Kane et al*.).

Unlike conventional neuroleptics, the newer atypical ones, such as clozapine, risperidone, olanzapine, and quetiapine, apparently confer several

advantages with respect to both efficacy and safety. These drugs are associated with a lower incidence of extrapyramidal symptoms than conventional neuroleptics are. For clozapine, the low risk of tardive dyskinesia is well established (*Kane et al*.). The incidence of tardive dyskinesia with other atypical antipsychotics is also likely to be lower than that with conventional neuroleptics because extrapyramidal symptoms have been found to be a risk factor for tardive dyskinesia in older adults (*Saltz et al., Jeste et al.*). The determination of exact risk of tardive dyskinesia with these newer drugs needs long-term studies.

In addition to the effects of aging on pharmacokinetics and pharmacodynamics and the increased risk of side effects, older individuals with mental disorders also are more likely than other adults to be medicated with multiple compounds, both prescription and nonprescription (i.e., polypharmacy). Older adults (over the age of 65) fill an average of 13 prescriptions a year (for original or refill prescriptions), which is approximately three times the number filled by younger individuals (*Chrischilles et al.*). Polypharmacy greatly complicates effective treatment of mental disorders in older adults. Specifically, drug-drug interactions are of concern, both in terms of increasing side effects and decreasing efficacy of one or both compounds.

Compliance with the treatment regimen also is a special concern in older adults, especially in those with moderate or severe cognitive deficits. Physical problems, such as impaired vision, make it likely that instructions may be misread or that one medicine may be mistaken for another. Cognitive impairment may also make it difficult for patients to remember whether or not they have taken their medication. Although in general, older patients are more compliant about taking psychoactive medications than other types of drugs (*Cooper et al.*), when noncompliance does occur, it may be less easily detected, more serious, less easily resolved, mistaken for symptoms of a new disease, or even falsely labeled as “old-age” symptomatology. Accordingly, greater emphasis must be placed on strict compliance by patients in this age group (*Lamy et al.).* Medication noncompliance takes different forms in older adults, that is, overuse and abuse, forgetting, and alteration of schedules and doses. The most common type of deliberate noncompliance among older adults may be the underuse of the prescribed drug, mainly

because of side effects and cost considerations. Factors that contribute to medication noncompliance in older patients include inadequate information given to them regarding the necessity for drug treatment, unclear prescribing directions, suboptimal doctor-patient relationship, the large number of times per day drugs must be taken, and the large number of drugs that are taken at the same time (Lamy et al.). Better compliance may be achieved by giving simple instructions and by asking specific questions to make sure that the patient understands directions.

Several types of psychosocial interventions have proven effective in older patients with mental disorders, but the research is more limited than that on pharmacological interventions (*see Klausner & Alexopoulos, in press*). Both types are frequently used in combination. Most of the research has been restricted to psychosocial treatments for depression, although, as discussed below, there is mounting interest in dementia. For other mental disorders, psychosocial interventions found successful for younger adults are often tailored to older people in the practice setting without the benefit of efficacy research. Despite the relative paucity of research, psychosocial interventions may be preferred for some older patients, especially those who are unable to tolerate, or prefer not to take, medication or who are confronting stressful situations or low degrees of social support (*Lebowitz et al*.). The benefits of psychosocial interventions are likely to assume greater prominence as a result of population demographics: as the number of older people grows, progressively more older people in need of mental health treatment—especially the very old—are expected to be suffering from greater levels of comorbidity or dealing with the stresses associated with disability. Psychosocial interventions not only can help relieve the symptoms of a variety of mental disorders and related problems but also can play more diverse roles: they can help strengthen coping mechanisms, encourage (and monitor) patients' compliance with medications, and promote healthy behavior (*Klausner & Alexopoulos, in press*).

New approaches to service delivery are being designed to realize the benefits of established psychosocial interventions. Many older people are not comfortable with traditional mental health settings, partially as a result of stigma (*Waters*). In fact, many older people *prefer* to receive treatment for

mental disorders by their primary care physicians, and most older people *do* receive such care in the primary care setting (*Brody et al., Unutzer et al*.). Since older people show willingness to accept psychosocial interventions in the primary care setting, new models are striving to integrate into the primary care setting the delivery of specialty mental health services. The section of this chapter on service delivery discusses new models in greater detail.

A problem common to both pharmacological and psychosocial interventions is the disparity between treatment efficacy, as demonstrated in randomized controlled clinical trials, and effectiveness in real-world settings. While this problem is certainly not unique to older people, this problem is especially significant for older people with mental disorders. Older people are often under-treated for their mental disorders in primary care settings (Unutzer et al.). When they do receive appropriate treatment, older people are more likely than other people to have co-morbid disorders and social problems that reduce treatment effectiveness (*Unutzer et al.*). An additional overlay of barriers, including financing and systems of care, is discussed later in this chapter.

Other Mental Disorders in Older Adults

Anxiety Disorders

Anxiety symptoms and syndromes are important but understudied conditions in older adults. Overall, community-based prevalence estimates indicate that about 11.4 percent of adults aged 55 years and older meet criteria for an anxiety disorder in 1 year (Flint). Phobic anxiety disorders are among the most common mental disturbances in late life according to the ECA study. Prevalence studies of panic disorder (0.5 percent) and obsessive-compulsive disorder (1.5 percent) in older samples reveal low rates (*Copeland et al., Copeland et al., Bland et al., Lindesay et al.*). Although the National Comorbidity Survey did not cover this age range, and the ECA did not include this disorder, other studies showed a prevalence of generalized anxiety disorder in older adults ranging from 1.1 percent to 17.3 percent higher than that reported for panic disorder or obsessive-compulsive disorder (*Copeland et al., Skoog*). Worry or “nervous tension,” rather than specific

anxiety syndromes may be more important in older people. Anxiety symptoms that do not fulfill the criteria for specific syndromes are reported in up to 17 percent of older men and 21 percent of older women (*Himmelfarb & Murrell*). In addition, some disorders that have received less study in older adults may become more important in the near future. For example, post-traumatic stress disorder (PTSD) is expected to assume increasing importance as Vietnam veterans age. At 19 years after combat exposure, this cohort of veterans has been found to have a PTSD prevalence of 15 percent (*cited in McFarlane & Yehuda*). As affected patients age, there is a continuing need for services. In addition, research has shown that PTSD can manifest for the first time long after the traumatic event (*Aarts & Op den Velde*), raising the specter that even more patients will be identified in the future.

The effectiveness of benzodiazepines in reducing *acute* anxiety has been demonstrated in younger and older patients, and no differences in the effectiveness have been documented among the various benzodiazepines. Some research suggests that benzodiazepines are marginally effective at best in treating *chronic* anxiety in older patients (*Smith et al*.). The half-life of certain benzodiazepines and their metabolites may be significantly extended in older patients (particularly for the compounds with long half-life). If taken over extended periods, even short-acting benzodiazepines tend to accumulate in older individuals. Thus, it is generally recommended that any use of benzodiazepines be limited to discrete periods (less than 6 months) and that long-acting compounds be avoided in this population. On the other hand, use of short-acting compounds may predispose older patients to withdrawal symptoms (*Salzman*). Side effects of benzodiazepines may include drowsiness, fatigue, psychomotor impairment, memory or other cognitive impairment, confusion, paradoxical reactions, depression, respiratory problems, abuse or dependence problems, and withdrawal reactions. Benzodiazepine toxicity in older patients includes sedation, cerebellar impairment (manifested by ataxia, dysarthria, incoordination, or unsteadiness), cognitive impairment, and psychomotor impairment (*Salzman*). Psychomotor impairment from benzodiazepines can have severe consequences, leading to impaired driver skills and motor vehicle crashes (*Barbone et al*.) and falls (*Caramel et al*.). Buspirone is an anxiolytic (antianxiety) agent that is chemically and pharmacologically distinct from

benzodiazepines. Controlled studies with younger patients suggest that the efficacy of buspirone is comparable to that of the benzodiazepines. It also has proven effective in studies of older patients. On the other hand, buspirone may require up to 4 weeks to take effect, so initial augmentation with another antianxiety medication may be necessary for some acutely anxious patients (*Sheikh*). Significant adverse reactions to buspirone are found in 20 to 30 percent of anxious older patients (Napoliello, Robinson et al.). The most frequent side effects include gastrointestinal symptoms, dizziness, headache, sleep disturbance, nausea/vomiting, uneasiness, fatigue, and diarrhea. Still, buspirone may be less sedating than benzodiazepines (*Salzman, Seidel et al*.). Although the efficacy of antidepressants for the treatment of anxiety disorders in late life has not been studied, current patterns of practice are informed by the efficacy literature in adults in midlife.

Although schizophrenia is commonly thought of as an illness of young adulthood, it can both extend into and first appear in later life. Diagnostic criteria for schizophrenia are the same across the life span. Symptoms include delusions, hallucinations, disorganized speech, disorganized or catatonic behavior (the so-called "positive" symptoms), as well as affective flattening, alogia, or avolition (the so-called "negative" symptoms). Symptoms must cause significant social or occupational dysfunction, must not be accompanied by prominent mood symptoms, and must not be uniquely associated with substance use.

One-year prevalence of schizophrenia among those 65 years or older is reportedly only around 0.6 percent, about one-half the 1-year prevalence of the 1.3 percent that is estimated for the population aged 18 to 54. The economic burden of late-life schizophrenia is high. A study using records from a large California county found the mean cost of mental health service for schizophrenia to be significantly higher than that for other mental disorders (*Cuffel et al*.); the mean expenditure among the oldest patients with schizophrenia (> 74 years old) was comparable to that among the youngest patients (age 18 to 29). While long-term studies have shown that use of nursing homes, state hospitals, and general hospital care by patients with all mental disorder diagnoses has declined in recent decades, the rate of decline is lower for older patients with schizophrenia (*Kramer et al., Redick*

et al.). The high cost of these settings contributes to the greater economic burden associated with late-life schizophrenia.

Studies have compared patients with late onset (age at onset 45 years or older) and similarly aged patients with earlier onset of schizophrenia (*Jeste et al.*) both were very similar in terms of genetic risk, clinical presentation, treatment response, and course. Among key differences between the groups, patients with late-onset schizophrenia were more likely to be women in whom paranoia was a predominant feature of the illness. Patients with late-onset schizophrenia had less impairment in the specific neurocognitive areas of learning and abstraction/ cognitive flexibility and required lower doses of neuroleptic medications for management of their psychotic symptoms. These and other differences between patients with early- and late-onset illness suggest that there might be neurobiologic differences mediating the onset of symptoms (*DeLisi, Jeste et al., in press*).

The original conception of "dementia praecox," the early term for schizophrenia, emphasized progressive decline (*Kraepelin*); however, it now appears that Kraepelin's picture captures the outcome for a small percentage of patients, while one-half to two-thirds significantly improve or recover with treatment and psychosocial rehabilitation. Although the rates of full remission remain unclear, some patients with schizophrenia demonstrate remarkable recovery after many years of chronic dysfunction (*Nasar)*. Research suggests that a factor in better long-term outcome is early intervention with antipsychotic medications during a patient's first psychotic episode.

A cross-sectional study that compared middle-aged with older patients, all of whom lived in community settings, found some similarities and differences (*Eyler-Zorrilla et al*.). The older patients experienced less severe symptoms overall and were on lower daily doses of neuroleptics than middle middleaged patients who were similar in demographic, clinical, functional, and broad cognitive measures. In addition, positive symptoms were less prominent (or equivalent) in the older group, depending on the measure used. Negative symptoms were more prominent (or equivalent) in the older group, and older patients scored more poorly on severity of dyskinesia. Older patients were impaired relative to middle-aged ones on

two measures of global cognitive function. This finding, however, appeared to reflect a normal degree of decline from an impaired baseline, as the degree of change in cognitive function with age in the patient group was equivalent to that seen in the comparison group. A recent study used the Direct Assessment of Functional Status scale (DAFS) (*Loewenstein et al*.) to compare the everyday living skills of middle-aged and older adults with schizophrenia with those of people without schizophrenia of similar ages *(Klapow et al.).* The patients exhibited significantly more functional limitations than the controls did across most DAFS sub-scales. In another recent study that used a measure of overall disease impact, the Quality of Well-Being Scale, older outpatients with schizophrenia manifested significantly lower quality of well-being than did comparison subjects, and their scores were slightly worse than those of ambulatory AIDS patients (*Patterson et al*.). Thus, while schizophrenia may be less universally deteriorating than previously has been assumed, older patients with the disorder continue nonetheless to exhibit functional deficits that warrant research and clinical attention.

Recent studies support a neurodevelopmental view of late-onset schizophrenia (*Jeste et al.*). Equivalent degrees of childhood maladjustment have been found in patients with late-onset schizophrenia and early onset schizophrenia, for example, suggesting that some liability for the disorder exists early in life. Equivalent degrees of minor physical anomalies in patients with late-onset schizophrenia and early-onset schizophrenia suggest the presence of developmental defects in both groups (*Lohr et al*.). The presence of a genetic contribution to late-onset and early-onset schizophrenia is evident in increased rates of schizophrenia among first-degree relatives (*Rokhlina, Castle & Howard, Castle et al*.).

If late-onset schizophrenia is neurodevelopmental in origin, an explanation for the delayed onset may be that late-onset schizophrenia is a less severe form of the disorder and, as such, is less likely to manifest early in life. Recent research suggests that in several arenas— for example, neuropsychological impairments in learning, retrieval, abstraction, and semantic memory as well as electroencephalogram abnormalities—the

deficits of patients with late-onset schizophrenia are less severe (*Heaton et al., Jeste et al., Olichney et al., Paulsen et al.*). Also, negative symptoms are less pronounced and neuroleptic doses are lower in patients with late-onset schizophrenia (*Jeste et al*.). The etiology and onset of schizophrenia in younger adults often are explained by a diathesis-stress model in which there is a genetic vulnerability in combination with an environmental insult (such as obstetric complications), with onset triggered by maturational changes or life events that stress a developmentally damaged brain (*Feinberg, Weinberger, Wyatt)*. Under this multiple insult model, patients with late onset schizophrenia may have had fewer insults and thus have a delayed onset. An alternative or complementary explanation for the delayed onset in late-onset schizophrenia is the possibility that these patients possess protective features that cushion the blow of any additional insults. The preponderance of women among patients with late-onset schizophrenia has fueled hypotheses that estrogen plays a protective role. The view of late-onset schizophrenia as a less severe form of schizophrenia, in which the delayed onset results from fewer detrimental insults or the presence of protective factors, suggests a continuous relationship between age at onset and severity of liability. An alternative view is that late-onset schizophrenia is a distinct neurobiological subtype of schizophrenia. The preponderance of women and of paranoid subtype patients seen in late-onset schizophrenia supports this view. These two etiologic theories of late-onset schizophrenia call for further research.

Pharmacological treatment of schizophrenia in late life presents some unique challenges. Conventional neuroleptic agents, such as haloperidol, have proven effective in managing the "positive symptoms" (such as delusions and hallucinations) of many older patients, but these medications have a high risk of potentially disabling and persistent side effects, such as tardive dyskinesia (*Jeste et al., in press*). The cumulative annual incidence of tardive dyskinesia among older outpatients (29 percent) treated with relatively low daily doses of conventional antipsychotic medications is higher than that reported in younger adults (*Jeste et al., in press*). Recent years have witnessed promising advances in the management of schizophrenia. Studies with mostly younger schizophrenia patients suggest that the newer "atypical" antipsychotics, such as clozapine, risperidone,

olanzapine, and quetiapine, may be effective in treating those patients previously unresponsive to traditional neuroleptics. They also are associated with a lower risk of extrapyramidal symptoms and tardive dyskinesia (*Jeste et al., in press*). Moreover, the newer medications may be more effective in treating negative symptoms and may even yield partial improvement in certain neurocognitive deficits associated with this disorder (*Green et al*.). The foremost barriers to the widespread use of atypical antipsychotic medications in older adults are (1) the lack of large-scale studies to demonstrate the effectiveness and safety of these medications in older patients with multiple medical conditions, and (2) the higher cost of these medications relative to traditional neuroleptics (Thomas & Lewis).

Older adults with severe and persistent mental disorders (SPMD) are the most frequent users of long term care either in community or institutional settings. SPMD in older adults includes lifelong and late-onset schizophrenia, delusional disorder, bipolar disorder, and recurrent major depression. It also includes Alzheimer's disease and other dementias (and related behavioral symptoms, including psychosis), severe treatment-refractory depression, or severe behavioral problems requiring intensive and prolonged psychiatric care.

4. Geriatric Clinical Considerations

Butler, Lewis, and Sunderland noted that a "demographic revolution" is underway in the United States in which members of the so-called "baby boomer" generation entering the period after age 65 will eventually comprise about 20 percent of the national population. Older individuals, male and female, wealthy and poor, urban and rural, will consume a disproportionate level of care resources in the coming decades.

This "demographic revolution" demands that counselors and therapists develop effective intervention strategies for assisting older clients in coping with the myriad issues that confront the elderly. This following will address some of the key issues related to this process, including ageism itself, counter transference and transference issues in counseling, psychiatric

problems including dementia, assessment techniques, and "best practice" interventions.

Ageism is a general term that encapsulates the prejudices and stereotypes that are applied to older people purely on the basis of their age (*Butler, et al*). Ageism is a construct that functions to "pigeonhole" people in much the same manner as sexism and racism; in essence, ageism is a way of thinking about the elderly that marginalizes them, demeans them, and isolates them. Ageism begins in childhood, according to *Butler, et al*, and represents in part an attempt by younger people to shield themselves from the recognition that they, too, will eventually age and confront the inevitability of death and physical decline.

The effects of ageism are numerous and potentially debilitating. Ageism can constitute the societal sacrifice of older people for the sake of younger people. In the workplace and in the family unit, older individuals (i.e., those over age 65, which is an admittedly arbitrary cutoff for defining the "elderly") are often dismissed as unable to make adequate contributions to the group. Ageism also encompasses the assumption, common even among counselors and other caregivers, that older individuals have lost much of the capacity for self-management and self-care that characterizes younger individuals.

Agism also incorrectly assumes that the process of aging is invariably associated with a decline in mental and physical competencies. It can and does provide a rationalized excuse for forcing older workers to retire. In the United States, federal legislation has been enacted to prevent age discrimination in the workplace, but many older workers still find that they are devalued and passed over for promotions or other benefits simply because of negative assumptions regarding their age and its putative impact upon performance (*Butler, et al*).

In the context of counseling and therapy, ageism can negatively impact upon the capacity of professional caregivers to work effectively with clients. Attributions of individual traits, behaviors, needs, or other issues addressed in the context of counseling can distort the process itself. For mental health

caregivers, serving the older client necessitates coming to terms with one's own fears and anxieties regarding the aging process (*Butler, et al*).

Counter-transference and Transference

In providing services to the older client, a counselor must be aware of the issues associated with both transference and counter-transference. Counter-transference is described by *Butler, et al* as follows:

> *Counter-transference in the classic sense occurs when mental Health personnel find themselves perceiving and reacting to older persons in ways that are inappropriate and reminiscent of previous patterns of relating to parents, siblings, and other key childhood figures. Love and protectiveness may vie with hate and revenge. Ageism takes this a step further. Mental health personnel not only have to deal with leftover feelings from their perceptions of older persons, but they must also be aware of negative cultural attitudes toward older persons.*

Central to the therapeutic relationship, regardless of the age, gender, or ethnicity of the client and therapist, are the processes of both transference and counter-transference. In transference, as the class lectures and discussions demonstrated, clients often come to regard their counselor or therapist as an authority figure or another or loved or hated figure from the past. Often, clients will transfer their previous attitudes toward significant others in their lives to the therapist.

The older client may display an overwhelming desire to please the analyst, or may also display resentment and hatred even though the analyst has done nothing to provoke such emotions. Transference allows the therapist to identify a pattern of the unconscious problems that the client is experiencing and can therefore be valuable in facilitating the therapeutic process.

Counter-transference may be more difficult in the context of dealing with older clients. *Butler, et al* pointed out that some aged clients may stimulate therapists' fears about his or her own old age, arouse the therapist's conflicts about relationships with parental figures, or suggest to the therapist that intervention is wasted effort because the older client may be nearing death.

When therapists working with elderly clients allow negative attitudes to intervene, therapy cannot be successful.

In other words, therapists must avoid negative counter-transference based on ageism as well as an unconscious over identification with older people. Certainly, the therapist working with older patients must recognize that simply being elderly does not mean that an individual's capacity for enjoying life, making a meaningful contribution to family and society, or participating competently in problem resolution cannot occur.

Psychiatric Problems, Dementia

Older individuals may present for treatment with any one of a number of psychiatric problems. Anxiety of an acute or chronic nature, substance abuse engendered by over-medication, depression, difficulties with activities of daily life (ADLs), and social isolation are among these problems. Older adults may experience all of the neuroses and psychoses that are found in younger patients, including schizophrenia and paranoid disorders manifested by delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, or negative symptoms (*Butler, et al*).

Mood disorders, including major depressive disorder, bipolar disorder, and dysthymic disorder are also observed in older individuals, as are the various somatoform and personality disorders. *Butler, et al* reported that the American Psychiatric Association estimates that between 15 and 25 percent of all individuals over the arbitrary age of 65 suffer from symptoms of mental illness. Of those older people with mental disorders, depression appears to be the most common primary diagnosis.

Dementia is one of the most frequently observed forms of mental illness in older patients. While it is certainly true that there are often organic explanations for psychoses suffered by older individuals, it is also true that the vast majority of older individuals suffering from psychiatric disorders do not have mental problems as a result of physiological conditions. It is all too often assumed that any psychiatric symptoms that arise in later life are secondary to the problems of aging itself. Because this is the case, older patients, including those in residential or institutional facilities who are known to have psychiatric disorders tend to be undertreated.

It is fallacious to assume that the physical health problems that emerge as individual's age invariably give rise to psychiatric disorders (*Butler, et al*). It is far more likely that older individuals experience psychiatric problems as a consequence of legitimate fear of being alone, a sense of social isolation, a feeling of worthlessness, and any number of other anxiety-producing sociocultural or familial situations. Mood disturbances such as depression are of particular significance because the depressed individual also experiences sleep disturbance, appetite and weight changes, decreased concentration, feelings of fatigue or loss of energy, psychomotor disturbances, and recurrent thoughts of death (*Butler, et al*).

For the older individual it may very well be that this type of mental illness (i.e., depression) exacerbates physiological anomalies or health problems. Dementia and the various psychoses, according to discussions in class and lectures, represent a break in the ability to manage the activities of daily living and a lack of reality testing. This may occur in the older person as a consequence of multiple losses within a close time period or as a reaction to certain extreme stresses.

In other words, the therapist or counselor working with the older individual must recognize that these individuals will manifest many of the same presenting problems exhibited by younger clients. Dismissing these problems as an artifact of the aging process or declining health status is inappropriate. The older individual is as worthy of intervention as any other client.

Assessments

Older clients should be as thoroughly assessed or evaluated as any other particular population. Geriatric assessment is a multidisciplinary evaluation in which the multiple problems of older persons are identified, described, and explained. The resources and strengths of the individual are identified, service needs assessed, and a coordinated care plan developed in order to focus interventions (*Butler, et al*).

It is important to recognize that the older individual needs a multidisciplinary assessment in which a number of professionals pool their

knowledge and expertise to construct as complete profile of the psychiatric, physical, social, financial, and other problems of the older client as is possible. Such assessments fulfill preventive and screening functions as well as diagnostic functions.

For therapists working with geriatric patients, assessment and evaluation procedures and tools are important elements in the avoidance of counter-transference. A thorough assessment as described above can help a therapist to overcome any preconceptions or stereotypes that he or she may possess regarding the aged. Medical as well as psychiatric assessment and the taking of a complete case history combine to assist the therapist in developing an effective intervention plan.

Interventions

Interventions designed to meet the needs of older clients can range from pharmaceutical treatment to psychotherapy and environmental therapy, other somatic therapies, cognitive and behavioral therapies, reality-orientation, re-motivation, and rehabilitation programs, to assistance with ADLs. What is essential in designing any intervention for the older client is pinpointing what is threatening the client and what they are reacting to.

The counselor should be careful not to argue with the client or attempt to impose his or her version of what is or is not the truth about the problem as the client sees it. Doing so can increase the fear of the older adult and jeopardize the development of the kind of rapport needed in the therapeutic relationship. The goal of intervention, whatever form it might take, is to contain any paranoid, anxious, or other self-damaging reaction that the older client has to his or her problems. A related goal is addressing the underlying problem and ensuring that interventions designed to ameliorate or eliminate that problem are forthcoming.

Process becomes more important than content in this therapist/client relationship. Process may be defined as dealing with or addressing the underlying verbal or nonverbal feelings expressed by the client. Warmth and empathy without condescension are essential aspects of the therapist's behavior and attitudes. Realistic treatment goals should be set via consultation with the client and other caregivers. Assisting the older person

who has lost a loved one, for example, may involve addressing issues of guilt and atonement as well as the client's personal fears regarding illness or death. In any event, interventions that are successful with older clients are those that are framed to meet specific needs and result in positive improvements in mood, affect, outlook, and functioning.

The field of geriatric counseling is an increasingly important practice focus because of the aging of the American population. It is likely that members of the care giving professions will devote even more time to research on the best practices for treating this population effectively.

What emerges from this discussion is the recognition that the older individual is entitled to caring, supportive, and non-prejudicial service from a counselor. Moving from a thorough assessment of the client's need to a multidisciplinary set of interventions offered in an empathetic and caring manner is essential. Avoiding counter-transference is necessary and can be helpful to the therapist in confronting his or her own concerns regarding the aging process.

5. References

AARP, Staying Ahead of the Curve.

Albright, Ada, Bonnie Brandl, Julie Rozwadowski, and Mary K. Wall. *Building a Coalition to Address Domestic Abuse in Later Life.* National Clearinghouse on Abuse in Later Life and AARP Foundation National Legal Training Project, www.ncall.us/docs/BuildingCoalitionParticipantRev.pdf

Alexopoulos, G. S., Raue, P., Areán, P. Problem-solving therapy versus supportive therapy in geriatric major depression with executive dysfunction. American Journal of Geriatric Psychiatry, 11(1), 46–52.

Alexopoulos, G. S., Raue, P. J., Kanellopoulos, D., et al. Problem solving therapy for the depression-executive dysfunction syndrome of late life. International Journal of Geriatric Psychiatry, 23(8), 782–788.

Areán, P., Julian, L., & Raue, P. PST for older adults with depression and executive dysfunction. Unpublished manuscript.

Areán, P., & Dwyer, E. V. Problem solving therapy for homebound elderly. Unpublished manuscript.

"The Art of Active Listening,"*Aging I&R Tip Sheet No. 5.* Washington, DC: National Association of State Units on Aging. Schechter, Susan. *Guidelines for Mental Health Practitioners in Domestic Violence Cases*. Washington, DC

Bath, P.A., Differences between older men and woman in the Self-Rated Health/ Mortality Relationship. The Gerontologist, 43 387-94

Brandl, Bonnie*,* Carmel Dyer, Candice Heisler, Joanne Otto, Lori Stiegel, and Randy Thomas. *Elder Abuse: A Multidisciplinary Approach.* New York: Springer, in press.

Carreira, K., Miller, M. D., Frank, E., et al., A controlled evaluation of monthly maintenance interpersonal psychotherapy in late-life depression with varying levels of cognitive function. International Journal of Geriatric Psychiatry. DOI: 10.1002/gps.2031.

Charles, S.T., Reynolds, C.A., & Gatz, M., Age-related differences and change in positive and negative affect over 23 years. *Journal of Personality and Social Psychology*, 80, 136-151.

Clingan-Fisher, Deanna. "Elder Abuse and the Legal Services Connection,"

Colello, Girvan, Mulvey, & Talaga, 2012; Genworth Financial, 2012; MetLife Mature Market Institute, 2012.

Commission on Long-Term Care, 2013; Reinhard, Kassner, Houser, & Mollica, 2011.

Craik & T.A. Salthouse (Eds.), *The Handbook of Aging and Cognition* (pp. 293-357). Mahwah, NJ: Erlbaum

Federal Interagency Forum on Aging-Related Statistics 2012 http://www.agingstats.gov, Older Americans 2012: Key Indicators of Well-

Being.

Floyd, M., Scogin, F., McKendree-Smith, N. L., et al. (2004). Cognitive therapy for depression: a comparison of individual psychotherapy and bibliotherapy for depressed older adults. Behavior Modification, 28 (2), 297–318.

Haringsma, R., Engels, G. I., Cuijpers, P., et al., Effectiveness of the Coping With Depression (CWD) course for older adults provided by the community-based mental health care system in the Netherlands: a randomized controlled field trial. International Psychogeriatrics, 18(2), 307–325.

Interpersonal psychotherapy for elderly patients in primary care. American Journal of Geriatric Psychiatry, 14(9), 777–786.van Schaik, D. J., van Marwijk, H. W., Beekman, A. T., et al., Interpersonal psychotherapy (IPT) for late-life depression in general practice

The Journals of Gerontology, Series A. Biological Sciences and Medical Sciences, 51(4), M172–178.van Schaik, A., van Marwijk, H., Ader, H., et al..

Kaye, H. S., Harrington, C., & LaPlante, M. P. (2010). Long-term care: who gets it, who provides it, who pays, and how much? Health Affairs, 29(1), 11-21

Laidlaw, K., Davidson, K., Toner, H., et al, A randomized controlled trial of cognitive behavior therapy vs. treatment as usual in the treatment of mild to moderate late life depression. International Journal of Geriatric Psychiatry, 23(8), 843–850.

Masoro E.J. & Austad S.N. (eds.): Handbook of the Biology of Aging, Sixth Edition. Academic Press. San Diego, CA, USA, 2006. ISBN 0-12-088387-2

National Aging Information and Referral Support Center. “The Art of Active Listening,”*Aging I&R Tip Sheet No. 1.* Washington, DC: National Association of State Units on Aging.

National Coalition Against Domestic Violence, *Older Americans 2012: Key Indicators of Well- Being*

Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Saltman, R.B.; Dubois, H.F.W.; Chawla, M., "The Impact Of Aging On Long-term Care In Europe And Some Potential Policy Responses

Saltzman LE, Fanslow JL, McMahon PM, Shelley GA. Intimate partner violence surveillance: uniform definitions and recommended data elements, version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.

Strawbridge, W.J., Wallhagen, M.I. & Cohen, R.D., Successful aging and well-being: Self-rated compared with Rowe and Kahn. The Gerontologist.

Stone, R.I., & Benson, W.F., Financing and organizing health and long term care services. In Prohaska, T. R., Anderson, L. A., & Binstock, R. H. (Eds.). (2012). Public Health for an Aging Society. Boston. Johns Hopkins University Press.

U.S. Department of Health and Human Services, *AHCPR Research on Long-term Care*

Valdiserri, R. O., HIV/AIDS stigma: an impediment to public health. American Journal of Public Health, 92, 341–342.

World Health Organization, *Aging and Life Course*

WHO, Second Generation Surveillance for HIV/AIDS

World Health Organization, EXECUTIVE BOARD EB124/6
124th Session 20, Provisional agenda item 4.3.

WHO/UNAIDS/UNICEF (2011) ‘Global HIV/AIDS Response: Epidemic update and health sector progress towards Universal Access 2011’ - 2011
Zacks, R.T., Hasher, L., & Li, K.Z.H. Human memory. In F.I.M.

SMI References

1. Vespa, J., Armstrong,D.M.,&Medina,L. (2018). Demographic turning points for the United States: population projections for2020 to 2060.*Current Population Reports*,Report Number P25-1144, U.S. Census Bureau.

2. Administration on Aging, Administration for Community Living.(2018). *2017profile of older Americans.*Washington, DC: U.S.Department of Health and Human Services.

3.U.S. Census Bureau.(2017). The nation's older population isstill growing: thenation’s population isbecoming more diverse.Release Number: CB17-100.

4. Hudson C.G. (2012). Declines in mental illness over the adult years: an enduring finding or methodological artifact *AgingMentalHealth*,*16*(6),735-52.5.IOM (Institute of Medicine).(2012).*The mental health and substance use workforce for older adults: inwhose hands?* Washington, DC: The National Academies Press.

5.American Psychological Association.(2014). Guidelines for psychological practice with older adults.*American Psychologist,69*(1),34-65.

6.Lehmann S.W., Brooks W.B., Popeo D., Wilkins K.M.,&Blazek M.C. (2017).Development of geriatric mental health learningobjectives for medical students: A response to the institute of medicine 2012 report.*The American Journal of GeriatricPsychiatry*,*25*(10),1041-7.

7.Liebel D.V.,&Powers B.A.(2015).Home health care nurse perceptions of geriatric depression and disability caremanagement.*The Gerontologist,55*(3),448-61.

8.IOM (Institute of Medicine).(2008).*Retooling for an aging America: Building the health care workforce.*Washington, DC: TheNational Academies Press.

9.The 21st Century Cures Act.(2015)H.R. 34, 114th Congress.

10.Vespa, J. (2018).*The graying of America: More older adults thankids by 2035*.U.S.Census Bureau. www.census.gov/library/stories/2018/03/graying-america.html March 2018
11. U.S.Census Bureau.(2018).*Older people projected to outnumber children for first time in U.S. history*.Release Number:CB18-41.

12. U.S. Census Bureau.(2017). *The 2017 national populations projections* from https://www.census.gov/programs-surveys/popproj.html

13. Center for Behavioral Health Statistics and Quality (CBHSQ).(2017a). *2016 national survey on drug use and health: Detailedtables*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

14. As defined in the U.S. Federal Register, Vol. 58, No. 96; May 20, 1993.16.SAMHSA and AOA.(2013).*Issue brief 8: Integration of behavioral health and physical health care*. RetrievedonMay 1, 2018from https://www.ncoa.org/wp-content/uploads/Issue-Brief-8-Integration.pdf

15. American Association of Suicidology.(2017).*Suicide data 2015*.Retrieved onMay 1, 2018 fromhttp://www.suicidology.org/Portals/14/docs/Resources/FactSheets/2015/2015datapgsv1.pdf?ver=2017-01-02-220151-870.

About the Course Presenter:

Course Presenter Nicole Hiltibran, MA, LMFT, is a graduate from Pepperdine University, where she earned her Masters Degree in Clinical Psychology with an emphasis in Marriage and Family Counseling, and is a Licensed Psychotherapist. Nicole has 25 years of experience serving adults, children, couples and families both in the public sector and private practice. Nicole has written state licensing exams for the California State Board of Behavioral Sciences for 10 years as well as offering continuing education courses to licensed mental health and social work professionals including LMFT's, LCSW's, LPCCs, RN's, and PhD's.