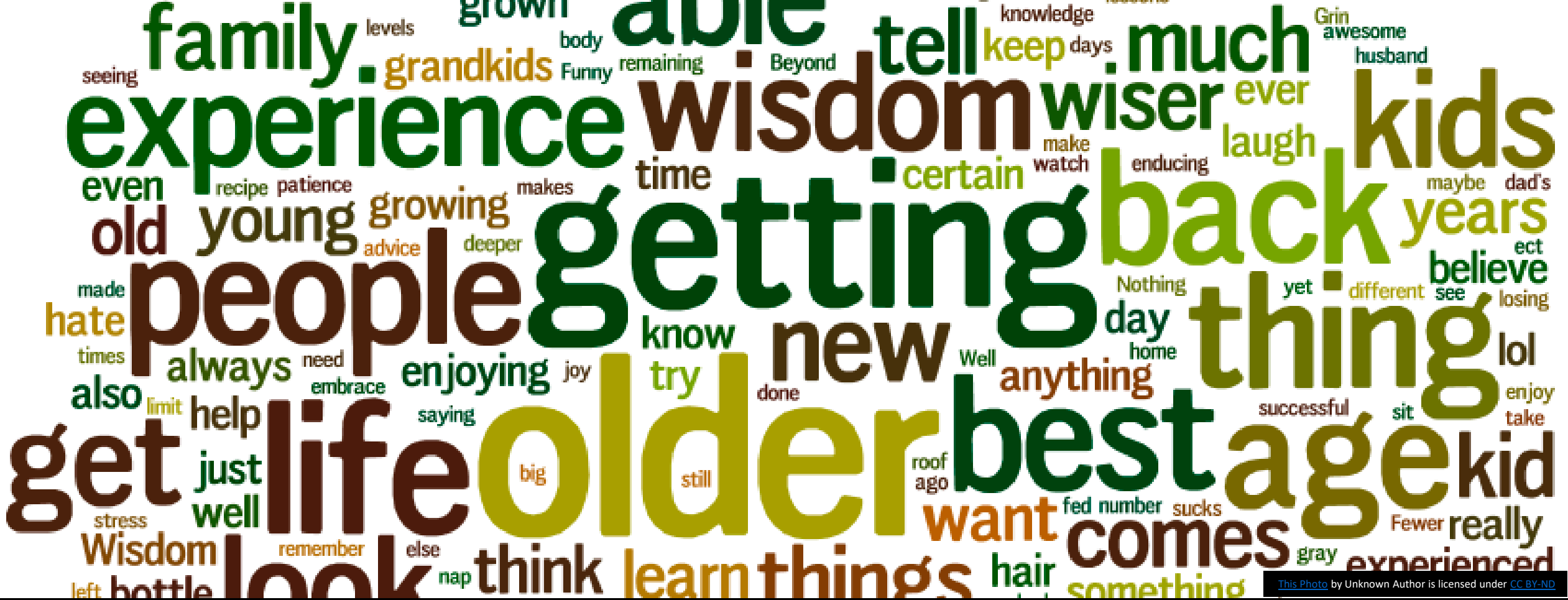


The Elderly and Co-occurring Disorders

Chronic, Medical, Substance Abuse and Brain Disorders

By Evelyn Bowen-Crawford, MSW, CDP, MAC. Evelyn.Bowen-Crawford@Sound.Health

Aging

- 10,000 people turn 65 every day in the US
- By 2060 The number of Americans ages 65 and older is projected to nearly double from **52 million in 2018 to 95 million.**
- The 65-and-older age group’s share of the total population will rise from 16 percent to 23 percent.
- will more than double to nearly 93,000 in 2050.

WASHINGTON STATE	2017
Total Resident Population	7,425,432
Persons 60+	1,581,318
Persons 60+ As a % of All Ages	21.3%
Persons 60-64	464,115
Persons 65-74	682,495
Persons 75-84	302,757
Persons 85+	131,951
# Women/100 Men Age 60+	115.4

2011

Minority Persons 60+	246,826
Minority Persons 60+ as a % of All Persons 60+	**15.6%**
Persons 60+ Below Poverty Level	127,708
As a % of All Persons 60+ for Whom Poverty is Determined	**8.17%**
Minority Persons 60+ Below Poverty Level	28,697
As a % of Minority Persons 60+ for Whom Poverty is Determined	**11.63%**
Persons 60+ Living in Nursing Homes and Other Institutions	21,794
Persons 60+ Living in Nursing Homes and Other Institutions as a % of All Persons 60+	**1.4%**
Persons 60+ in 2010	1,209,764
Persons 60+ Living in Rural Areas in 2010	249,056

Co-Morbidity

When we think about getting older we are usually concerned with:
medical issues and limited abilities/mobility.
Common illnesses are arthritis, diabetes, glaucoma, etc.
After retirement or when family roles change it can affect mood and behavior.
An older adult is at risk for
depression, increased use of substances, ie. alcohol, and more rec
ently marijuana.

Differences between younger and older clients and their treatment.

Complicated/co-morbid health issues
Risk of sensitivity/interactions
to medications
Risk of falling
Increased isolation
Difficulty accessing care/treatment

Prevalence of Disorders Among Older Americans

14-20% Brain Disorders/Mental health conditions

6-21% Prescription drug complications

13-17% Alcohol/substance problems

20-30% Adjustment disorders due to life changes

* US Census Bureau “Older Americans Month” Facts for Features, March 27, 2017

Aging adults experience higher risk of chronic disease. Common chronic conditions include:

- Heart Disease
- Cancer
- Chronic bronchitis or emphysema
- Stroke
- Diabetes mellitus
- Alzheimer's disease

Approximately 80% of older adults have at least one chronic disease, and 77% have at least two. Many conditions that affect the elderly will occur in combination, complicating care for any specific condition https://www.healthypeople.gov/2020/topics-objectives/ topic/older-adults

- 90% of Americans aged 55+ are at risk for hypertension/high blood pressure.
- Diabetes affects 12.2 million Americans aged 60+, or 23% of the older population.
- Advancing age is a high risk factor for cancer, with
- persons over 65 accounting for 60% of newly diagnosed malignancies and 70% of all cancer deaths
- The incidence of **stroke** disease increases with age, in both men and women with approximately 50% of all **strokes** occurring in people over age 75
- (. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1500929)

“In the elderly, research shows the body’s regulation system may no longer function correctly on its own, making dehydration more common—and making adequate hydration even more important.” (https://www.livestrong.com/article/497013-proper-hydration-in-the-elderly/)

Why Water Matters

“In addition to helping the body build new cells, eliminate waste, keep joints lubricated and much more, water is an important part of a system that keeps fluids and electrolytes—chemicals that help regulate body functions—balanced. In the elderly, research shows this regulation system may no longer function correctly on its own, making dehydration more common—and making adequate hydration even more important. What's more, as you age, the amount of total water in your body decreases as well as your ability to sense thirst, which means dehydration can come on quickly. Symptoms of dehydration in the elderly include dry mouth, no urine or very concentrated urine, sunken eyes, lethargy, low blood pressure, rapid heart rate and dry skin. Severe dehydration can lead to seizure, kidney failure, coma and even death.” (https://www.livestrong.com/article/497013-proper-hydration-in-the-elderly/)

Diet Matters

It’s often difficult to understand why some people pass away at age a young age and others live well into their nineties. The body works in mysterious ways but being proactive at *any* age is key.

“Medicine is sick care.
Nutrition is health care.”

People of all ages should consider this quote while striving to increase their own health and quality of life and that of their loved ones.

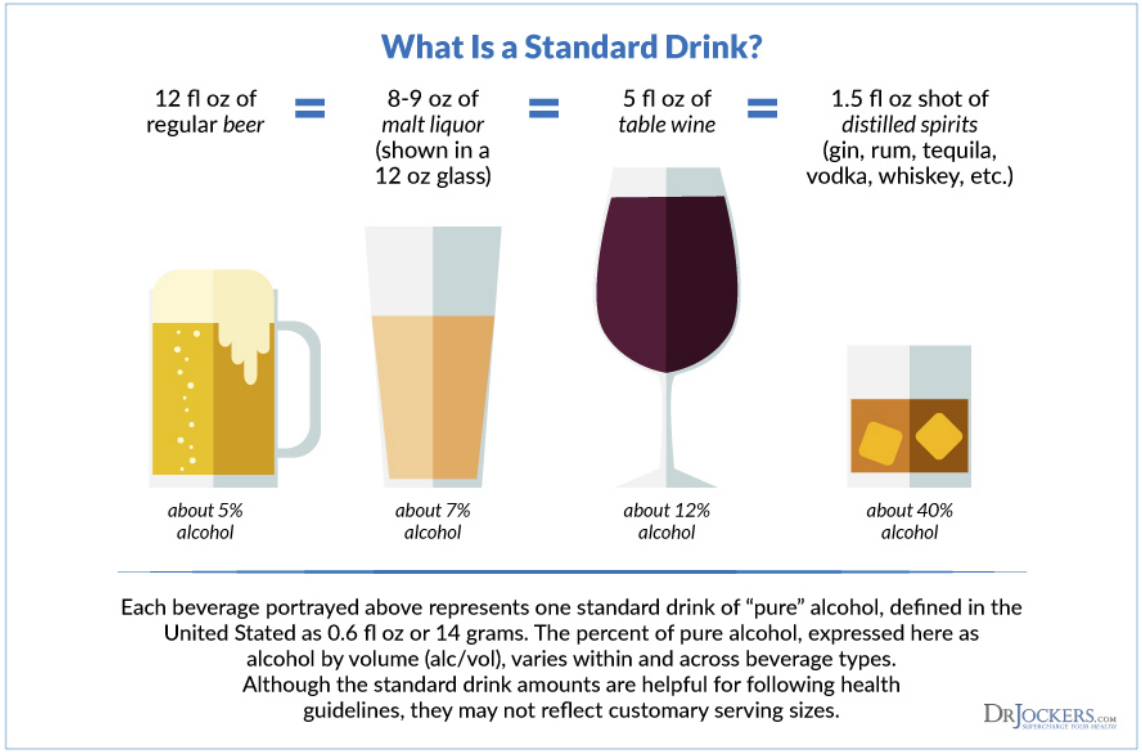
Rates of Substance Abuse in Older Adults

The New York Times reports Illicit drug use in older adults rose from 2.7 percent to 6.3 percent from 2002 to 2011

Around 40 percent of the American population aged 65 and older drink alcohol.

17 percent of American adults over the age 65 have an alcohol use problem.

National Institute on Alcohol Abuse and Alcoholism (NIAAA). Additionally, the New York State Office of Alcoholism and Substance Abuse Services (OASIS).



Drinking Guidelines for Older Adults

Adults over age 65 who are healthy and do not take medications should not have more than:

- 3 drinks on a given day
- 7 drinks in a week

Drinking more than these amounts puts people at risk of serious alcohol problems.

If you have a health problem or take certain medications, you may need to drink less or not at all. (

Dual Diagnosis

- People with co-occurring disorders are a heterogeneous group with multiple medical and social problems.
- Between 14 and 20 percent of the elderly population have suffered from either a mental health disorder, substance abuse disorder or both.

Prevalence

- According to the National Alliance on Mental Illness (NAMI), approximately 50 percent of individuals with severe mental health disorders are affected by substance abuse. NAMI also estimates that 29 percent of all people diagnosed as mentally ill abuse alcohol or other drugs.

Co-occurring Disorders

- The New York Times further publishes that between 14 and 20 percent of the elderly population have suffered from either a mental health disorder, substance abuse disorder, or both, according to a national survey in 2010. Mental illness often co-occurs with substance abuse. Those diagnosed with a mood disorder may be twice as likely to also battle a drug abuse disorder, NIDA reports. In fact, psychiatric disorders and substance abuse may occur as often as between 21 and 66 percent of the time. As we age, physical and mental capacities may deteriorate further blurring the lines between substance dependence and mental illness.

Elderly COD

- Between 12 and 15 percent of elderly patients seeking medical attention abuse prescription drugs, the Community Prevention Initiative (CPI) reports.
- Alcohol is the most commonly abused substance by the elderly population, with prescription medications such as opioid analgesics and benzodiazepine sedatives and tranquilizers coming in second. (ttps://www.dualdiagnosis.org/drug-addiction/elderly-addicts/)
- According to the Office of Applied Sciences at the Substance Abuse and Mental Health Service's Administration (SAMHSA):

Co-occurring Disorders

- “About 7.2 percent of patients with co-occurring disorders are over the age of 50 as compared to 28 percent of patients who are diagnosed with a mental health disorder but no substance abuse issues.
- Men diagnosed with a mental health disorder were more likely to abuse drugs than their female counterparts.”
- https://www.dualdiagnosis.org/mental-health-and-addiction

SYMPTOMS OF CO-OCCURING DISORDERS

“People who suffer from mental illness often experience more serious symptoms when drug or alcohol addiction is involved.

Some of these symptoms include:

- Intrusive thoughts
- Hopelessness
- A lack of motivation or a fear of public situations

The more the individual uses substances to cope with their symptoms, the greater the risk of developing addiction.”
https://www.dualdiagnosis.org/mental-health-and-addiction/]

Difficulties in Treatment Coordination

- Substance abuse and mental health providers, in particular, are not customarily trained in each other's disciplines, nor is the issue of cross-training adequately addressed in medical schools. There is a general lack of knowledge about what the other system does, and often there is a lack of trust born in part of the fear that one system will either subsume the other in any collaborative efforts or fail to fulfill its treatment commitments.

Treatment Barriers

- For a number of reasons treatment for people with co-occurring disorders is problematic, at best. As a result, many of these individuals cycle in and out of costly and often inappropriate treatment settings, such as hospital emergency rooms. Some are being inappropriately treated in other settings, such as jails or prisons. Still others end up homeless and may be receiving no treatment at all.
- In general, outcomes for physical health, substance abuse and mental health disorders are worse for individuals with co-morbid conditions. Meeting participants agreed that this is a population with whom no system is completely successful at this time.

Some of the most common mental health disorders among those with co-occurring disorders include mood disorders, anxiety disorders, personality disorders, and psychotic disorders.

Integrated treatment is more effective because co-occurring disorders often react with or trigger each other. If one condition is left untreated, other conditions may become worse. Often, multiple disorders are woven together through time and experience, and any patient can benefit from the treatment of all disorders simultaneously.

Prescription Drug Use

Between 2013 and 2014, over 40 percent of people 65 years and older used five or more prescription drugs in the past 30 days, according to a report by the National Center for Health Services.

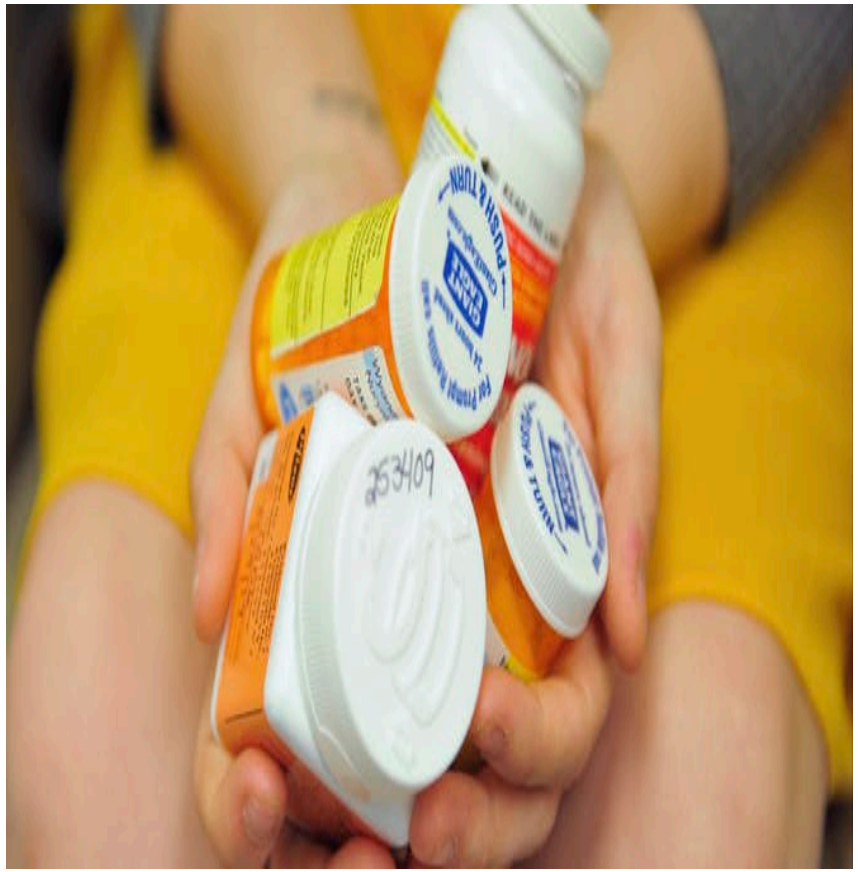
This can result in confusion and misuse when the medication is taken more frequently or consumed in a higher dosage or longer than prescribed.

“The body’s ability to absorb and filter medicines slows with age. Dependence on prescription drugs can result at even lower doses.

Elderly patients with painful chronic conditions such as arthritis and degeneration of the spine started on opiates years ago and continue to have these medications prescribed as they age.

There might not be an acceptable alternative. Non-opioid pain medications like ibuprofen may be risky or even unsafe for people with certain diseases, such as heart failure, high blood pressure or chronic kidney diseas”e. https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

THE OPIOID RISK



Taking opioids by themselves is a great enough risk. **When combined with other sedating drugs, the risk escalates**. For instance, benzodiazepines, familiarly known as benzos, are prescribed for anxiety, panic attacks or insomnia. **Combining opioids with sedatives like benzodiazepines increases the risk of accidental overdose and death**. I

T**he elderly are at increased risk for falls and fractures due to over-sedation** from these drugs. https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

Falls

- “Every 11 seconds, an older adult is treated in the emergency room for a fall; every 19 minutes, an older adult dies from a fall.
- Among older adults, falls are the leading cause of fractures, hospital admissions for trauma, and injury deaths. Falls are also the most common cause of older adult traumatic brain injuries, accounting for over 46% of fatal falls.” https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

“Elderly patients are at risk for injurty or overdose when prescribed benzodiazepines or other sedating medications.

Despite these known risks, prescription use of benzodiazepine increases steadily with age. A 2008 study found that almost nine percent of those aged 65 to 80 were prescribed the drug compared to three percent for those aged 18 to 35.

In addition, long-term use of benzodiazepines, defined as 120 days or more, was higher in the older age group.”

https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

Medication Risks

- **“More than 30 percent of overdoses involving opioids also involve benzodiazepines,** a type of prescription sedative commonly prescribed for anxiety or to help with insomnia. Benzodiazepines (sometimes called "benzos") work to calm or sedate a person, by raising the level of the inhibitory neurotransmitter GABA in the brain. Common benzodiazepines include diazepam (Valium), alprazolam (Xanax), and clonazepam (Klonopin), among others. “(NIDA, March 2018)

Why Benzodiazapines are Prescribed

- Benzodiazepines are prescribed for many medical problems, but there are also lots of psychosocial issues where they may be the go-to agent. Benzodiazepines have been prescribed to help older people cope with losses, including the loss of mobility and the loss of friends or family members.
- Many factors account for the continuing popularity and persistent use of benzodiazepines. There is limited access to alternative evidence-based treatments for insomnia and noted that there's an unwillingness of some older people to consider reducing or discontinuing the drugs.
- Given the pressure to reduce the use of antipsychotics in patients with dementia, it's possible that benzodiazepines are being substituted.
- https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

Abuse in the Elderly Population

- The elderly population is more likely to use drugs as a form of self-medication, as a way to numb physical and emotional pain.
- Much of the elderly population may feel isolated. As a person's social circle diminishes, so does the support network that may be able to recognize problem drinking or an issue with drug abuse.
- Drugs and alcohol make changes to the chemical pathways in the brain, and over time, repeated misuse or abuse may lead to a physical and psychological Many of the symptoms of addiction may be overlooked in elderly population, as they may often also be signs of aging or mental illness.

(https://www.dualdiagnosis.org/drug-addiction/elderly-addicts/)

Identifying the symptoms as from co-occurring disorders of addiction and mental illness can be challenging since many of the symptoms are the same, such as:

- Major depression with cocaine addiction
- Alcohol addiction with panic disorder
- Alcoholism and poly-drug addiction with schizophrenia
- Borderline personality disorder with episodic poly-drug abuse

(https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group)

The Chicken or the Egg?

In some cases, substance abuse appears to cause mental illness, while in others the reverse is true. According to recent research published in the journal *Cerebral Cortex, e*xposure to marijuana in adolescence leads to schizophrenia-like changes in the brain.

Many mental health disorders are exacerbated by the same factors as addictive disorders, such as family history, brain chemistry and personal trauma. Treatment must target both the mental illness and the addictive disorder to produce effective long-term recovery.

Which is it?

Some of the symptoms of brain disorders/mental illnesses such as bipolar disorder, depression and schizophrenia include:

- Depression
- Euphoria
- Social withdrawal
- Moodiness
- Delusions or hallucinations
- Suicidal thoughts
- Anger-related issues
- Fear and anxiety

https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

Symptoms of addiction to heroin, cocaine, prescription pain relievers, marijuana or hallucinogenic drugs:

- Euphoria
- Decreased appetite
- Depression
- Inability to sleep
- Sweaty palms, shaky hands
- Hyperactivity
- Nausea and vomiting
- Irregular heartbeat
- Sudden shifts in personality or attitude
- Poor performance at work or school
- Moodiness
- Paranoia
- Social withdrawal
- Forgetfulness

Along with the symptoms of mental illness and addiction, the consequences of these disorders are similar. Some of these include the following:

- Impaired social functioning
- Unstable relationships
- Financial difficulties
- Unemployment
- Poor physical health
- Increased risk of suicide

Family history and genetic patterns play a significant role in the risk of developing a co-occurring disorder.[3] Psychiatric conditions like depression, bipolar, anxiety disorder and obsessive-compulsive disorder are seen more frequently in first-degree relatives, suggesting that these disorders may be hereditary. Learned responses to fear, stress or loss may also contribute to the link between family relationships and mental illness. https://www.dualdiagnosis.org/mental-health-and-addiction/]

[

The Interactive Nature of Co- occurring Disorders.

“Mental illness and substance abuse can co- occur by chance or by the interactive nature of the conditions”, noted Mark Schuckit, M.D., Professor of Psychiatry at the University of California, San Diego, and Director of the Alcohol and Drug Treatment Program at the San Diego Veterans Affairs Hospital.

“Individuals with psychiatric disorders should be screened for substance abuse disorders, and vice versa,. Treatment will be guided by the specific conditions the individual has; i.e., the clinician may need to treat psychotic symptoms before a substance abuse problem can be addressed.”

Five Most Common Disorders w/Addictions

It’s quite common for certain drugs of abuse to be entangled with specific mental health disorders. These are five of the most common mental health/addiction combinations in play today.

1)Alcoholism and Anti-Social Personality Disorder

2) Marijuana Addiction and Schizophrenia

3) Cocaine Addiction and Anxiety Disorders

4) Opioid Addiction and PTSD

5) Heroin Addiction and Depression

https://www.dualdiagnosis.org/mental-health-and-addiction/]

Alcoholism and Anti-Social Personality Disorder

Alcohol abuse is associated with a number of mental health concerns, including:

- Mania
- Dementia
- Schizophrenia
- Drug addiction

But according to the National Institute on Alcohol Abuse and Alcoholism (NIAAA), antisocial personality disorder (ASPD) has the closest link with alcoholism, as people who drink to excess on a regular basis are 21 times more likely to deal with ASPD when compared to people who don't have alcoholism. Often, the two disorders develop early in life, the NIAAA says, but alcoholism can make the underlying mental illness worse, as people who are intoxicated might have lowered inhibitions, which makes

Marijuana Addiction and Schizophrenia

"It's not unusual for people who have schizophrenia to develop addictions. In fact, a study in the *American Journal of Psychiatry* suggests that about half of all people with schizophrenia also have a substance abuse disorder. However, there's a particularly striking association between marijuana abuse and schizophrenia. It's unclear why people with schizophrenia would abuse this drug, as it seems to produce many of the same symptoms these people experience when in the midst of a schizophrenic episode, but it is clear that marijuana abuse is at least somewhat common in those who have schizophrenia."

Cocaine Addiction and Anxiety Disorders

"People who abuse cocaine often take the drug because it makes them feel euphoric and powerful. However, continued use seems to lead to symptoms that are more indicative of an anxiety disorder, including:

Paranoia
Hallucinations
Suspiciousness
Insomnia
Violence

These symptoms may fade away in people who achieve a long-lasting sobriety, but sometimes the damage lingers and the unusual thoughts and behaviors stick around even when sobriety has taken hold."
https://www.dualdiagnosis.org/mental-health-and-addiction/]

Opioid Addiction and PTSD

"Post-traumatic stress disorder (PTSD) is a mental illness that takes hold in the aftermath of a very serious episode in which the person was either facing death or watching someone else die. Often, people who survive these episodes emerge with very serious physical injuries, and often, those injuries are treated with prescription painkillers. These drugs can also boost feelings of pleasure and calm inside the brain, and sometimes people who have PTSD are moved to abuse their drugs in order to experience euphoria. While people in physical pain do need help to overcome that pain, blending PTSD with painkillers can lead to tragic outcomes that no one wants." https://www.dualdiagnosis.org/mental-health-and-

Lasting Effects

“While heroin can make users feel remarkably pleasant in the short term, long-time users can burn out the portions of the brain responsible for producing signals of pleasure. In time, they may have a form of brain damage that leads to depression. They’re physically incapable of feeling happiness unless the drug is present. This drug/mental illness partnership is remarkably common, but it can be amended with treatment and sobriety.”

https://www.dualdiagnosis.org/mental-health-and-

“Individuals seeking substance use treatment who have one or more co-occurring mental health problems tend to have lower treatment engagement, higher rates of attrition, and poorer treatment outcomes. **Readiness to change** (RTC) is an integral construct in the recovery process, with higher RTC associated with improved treatment outcomes.”

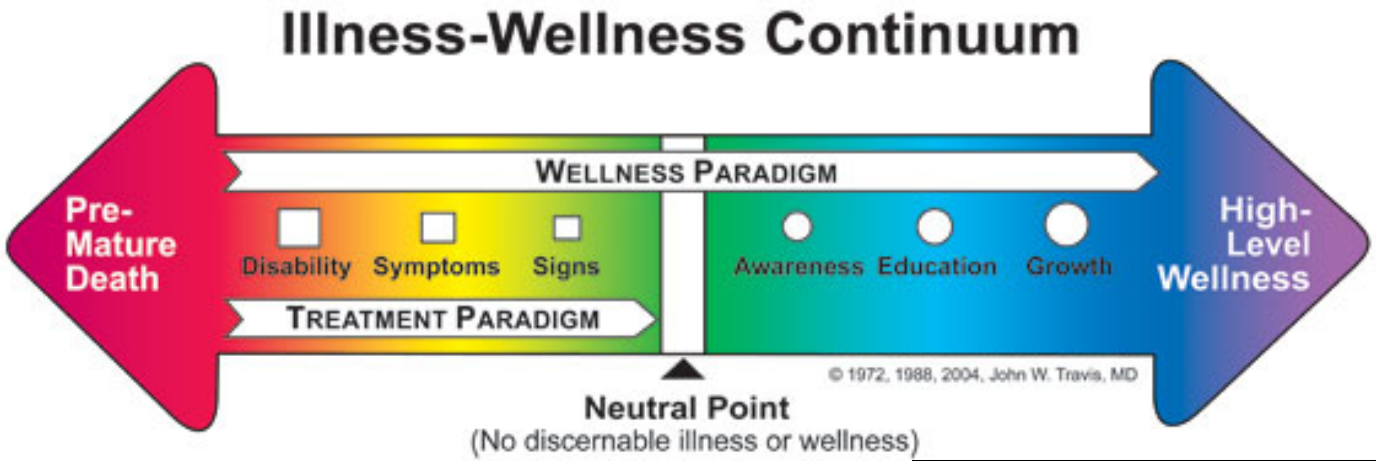
Substance use consequences, mental health problems, and readiness to change among Veterans seeking substance use treatment.

Morris DH[1], Davis AK[2], Lauritsen KJ[3], Rieth CM[3], Silvestri MM[4], Winters JJ[5], Chermack ST[5].

Treatment Approach: People with serious mental illnesses have high rates of co-occurring substance use disorder. Strategies for assessing substance use problems and then to address the treatment of these co-occurring disorders will use principles of treatment of co-occurring disorders, including:

1) Integration of mental health and substance abuse services,
2)Adopting a low-stress and harm-reduction approach,
3) Enhancing motivation,
4) Using cognitive-behavioral therapy strategies to teach more effective interpersonal and coping skills,
5) Supporting functional recovery, and
6) Engaging the social network,
7) Referral for co-occurring disorders treatment in a variety of settings. Treatment of Co-Occurring Psychotic and Substance Use Disorders by Kim T. Mueser & Susan Gingerich

ASSESSMENET



12 steps of assessment

1. Engage client
2. Identify and contact collaterals
3. Screen for COD
    a. Brain Disorder/MH
    b. Family History and Tx History
    c. Dementia
    d. Alcoholism/Substance Abuse

(12 steps of assessment)

4. Determine Quadrant and Locus of Care- Severity (MH/SUD)
5. Determine Level of Care
6. Determine Diagnosis
7. Determine Disability and Functional Impairment
8. Identify Strengths and Supports
    a.Family
    b.Community Support
    c.Personal Attributes

9. Identify linguistic/communication needs and supports
10. Identify problem areas
11. Assess for Stage of Change
12. Plan Treatment

CAGE: The CAGE questionnaire is often used by general practitioners and family doctors as a screening tool for signs of alcoholism. https://www.the-alcoholism-guide.org/cage-questionnaire.html

DAST: The Drug Abuse Screening Test (DAST) was developed in 1982 and is a 28-item self-report scale .

AUDIT -The Alcohol Use Disorders Identification Test is a 10-item screening tool developed by the World Health Organization (WHO)

FOR OLDER ADULTS:

GMAST: Description: The MAST-G (Michigan Alcoholism Screening Test-Geriatric Version) the questions highlight the special employment and social situations of someone who is retired and how that can relate to alcohol abuse.

AUDIT-C: The **Audit**-C is a screening questionnaire developed by the World Health Organization. This test is unique in that it has been validated in six countries and has been used internationally

Assessments for a brain disorder/mental health problem:

Modified MINI: The Modified Mini Screen (MMS) is a 22-item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders.

Mental Health Screening Form-III (MHSF-III) was designed as a rough screening device for clients seeking admission to substance abuse treatment programs. https://www.myaccucare.com/support/guides/pdf/mental_health_screening_form_iii.pdf

K-6 Screening Tool: A screener for mental health problems and as a measure of severity of impact of mental health problems.

https://www.hcp.med.harvard.edu/ncs/**k6**_scales.php

ASAM CRITERIA

6 Dimensions

Dim 1-Withdrawal

- Substance Abuse/need for emergency or acute care
- Withdrawal Scale
- Vital signs
- Assistance/support

Dim 2-Biomedical Conditions

- Physical /Medical Emergency
- Chronic conditions
- Medical History (Dx, labs, medication list)
- Communicable disease
- (Pregnancy)

Dim 3-Emotional, Behavioral, Brain Disorders, Cognitive Conditions and Complications

Acute concerns-danger to self or others (statistics)

Affect ability to participate in treatment modality

Symptoms of addictive disorder that require mental health treatment

(Dim 3)

Is the client able to manage tasks of everyday living (with/without support)

- Social Functioning
- Ability for Self-Care
- Course of Illness/stabilityD

Dim 4-Readiness to Change

- Awareness of severity of Illness-Substance Abuse & Consequences
- Awareness of illness-Brain Disorder (Anosognosia)
- Acceptance of need to change
- Motivation/relationships

Dim 5-Relapse, Continued Use or re-occurrence of behavior/consequences i.e.hospitalization

- Coping Skills
- Hx of success/progress
- Managing symptoms of withdrawal/PAWS or emotional/behavioral symptoms
- Challenges and barriers to recovery

(Dim 5)

Ability to recover without continued treatment

- Awareness of triggers/coping skills to prevent relapse or reccurrance of behavioral symptoms

Interaction symptoms of Brain Disorders and Substance Abuse (MJ and psychosis)

Dim 6-Recovery Living Environment

- Support System (Family and Friends)
- Resources (Financial, Community)
- Legal Status

Common Mental Health Disorders of the Elderly Population:

Depression
Anxiety
Bipolar
Adjustment Disorder
Schizophrenia

Mental Health Assessment

Current symptoms/issues

History of Psychiatric or substance abuse treatment

Medical and functional history,

Social history/Family History

Natural and Community supports

Relationships/Culture

Safety issues

(Safety, rapport, communication, collateral info)

Brain Disorders/ Mental Illness and Older Adults

- One in four older adults experiences some mental disorder including :
- Depression, anxiety disorders, and dementia. This number is expected to double to 15 million by 2030.
- Depression affects seven million older Americans
- People aged 85+ have the highest suicide rate of any age group. Older white men have a suicide rate almost six times that of the general population.

In older adults, symptoms of loss of energy, interest and pleasure together with somatic complaints, especially concerning memory, are the most common complaints
Among elderly individuals who live in the community, 4 to 14% suffer from depression. For older people who live in residential programs or nursing homes, between 35 and 50 % have depression.
Depression is more likely if a person has also serious medical problems, memory and thinking problems or is a family caregivers of dementia patients.

Depression *(leading to functional impairment) DSMV Criteria*

2 weeks or more of low mood

More than five of :

Sleep: too much or too little

Appetite: too high or too low

Problems with concentration

Little interest in ususal activities

Low energy/fatigue

Less activity

Feeling guilty/negative self-talk

Suicidal thoughts

Psychosis(voices/visions/paranoia)

Among older adults, depressive symptoms are far more common than full-fledged major depression. Treatment in the elderly generally takes longer than for other adults. Unfortunately, a substantial proportion of older patients receive no treatment or inadequate treatment for their depression in primary care.

DEPRESSION SCALE

http://geropsychiatriceducation.vch.ca/docs/edudownloads/depression/cornell_scale_depression.pdf

Rule Out:

Bipolar disorder (mania or hypomania is present)

Cognitive impairment (includes apathy, functional problems)

Grief (not suicidal)

Adjustment disorder (stressor related to onset)

Dysthymia (More than two years of being depressed, more days than not/does not meet MDD criteria)

ANXIETY DISORDERS

Mental Health America estimates that up to 14 percent of older adults meet the criteria for an anxiety disorder. In addition, up to 40 percent of those 65 and older suffer from insomnia.

Anxiety disorders are the most common of psychiatric disorders . Symptoms may include nervousness, tension, apprehension and fear related to the anticipation of danger, internal or external.

Panic disorders which involve a period of intense fear that develops suddenly, reaches a peak in a few minutes, causing numbness,tingling, or nausea,a fear of fainting, dying , losing control of body or mind.

Phobias are different clusters of signs and symptoms of anxiety, panic, and phobias. And is experienced when a particular situation, [person or activity is avoided with some of the same symptoms.

Generalized anxiety disorder symptoms are experienced most of time during many circumstances, regardless of the situation or environment.

ANXIETY SCALE

https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=10&cad=rja&uact=8&ved=0ahUKEwjL9LzvmL3aAhWkqVQKHbr2CBgQFghGMAk&url=https%3A%2F%2Fwww.pdffiller.com%2F119117719-fillable-geriatric-anxiety-inventory-form-utmb&usg=AOvVaw1FQsxdVgj25Ic1OFgBvlMU

SYMPTOMS OF BIPOLAR DISORDER

1.Having sad, empty, or hopeless feelings most of the time
2.A depressed mood most of the day, nearly every day, is a sign of bipolar depression.
3.Trouble sleeping at night and staying awake during the day
4.Insomnia (difficulty falling and/or staying asleep) and hypersomnia (sleepiness during the day) are signs of bipolar depression.
5.Often feeling worthless or very guilty
6.Nearly every day, having an excessive or inappropriate level of these feelings is a sign of bipolar depression.
7.Work, family, and/or social life are suffering
8.Symptoms causing a significant effect on these important areas of life are a sign of bipolar depression.
9.At times feeling very euphoric, revved up, and/or irritable
10.These feelings are ways to describe mania. Bipolar disorder includes manic episodes.

SYMPTOMS OF SCHIZO-PHRENIA

Positive symptoms: *Feelings/behaviors that are usually not present*

Believing that what other people are saying isn't true (delusions)

Hearing, seeing, tasting, feeling, or smelling things that others do not experience (hallucinations)

Disorganized speech and behavior

Negative symptoms: *A lack of feelings or behaviors that are usually present,* such as: Losing interest in everyday activities, like bathing, grooming, or getting dressed

Feeling out of touch with other people, family, or friends

Lack of feeling or emotion (apathy)

Having little emotion or inappropriate feelings in certain situations

Having less ability to experience pleasure

Elderly people with dementia-related psychosis are at increased risk of death when treated with antipsychotic medicines

Anosognosia

A physical symptom which prevents understanding of one's illness/disability.

40-60% of those diagnosed with bipolar disorder, schizophrenia

claim that they are not sick and they don't need medication

deny history of problematic behaviors, confabulation

blaming others

defensive, agitated

withdraws from services.

only 50% of those diagnosed with serious mental illness are receiving treatment.

The care providers and family members become frustrated and the clients become alienated..

Those with SMI are frequently discounted or marginalized. Individuals with schizophrenia and other psychotic disorders may be under-counted in prevalence estimation studies. These individuals may be under-represented in household surveys because they may reside in prisons, other institutions, or may lack a permanent address.

Similarly, some people with schizophrenia and other psychotic disorders may not be fully reflected in medical records data because they may not have a documented diagnosis, and/or may receive little or no health care. (NIM) https://www.nimh.nih.gov/health/statistics/schizophrenia.shtml)

Barriers to Treatment

- When untreated, people with severe mental illness are at high risk for a number of negative outcomes that profoundly impact them. These include, homelessness, suicide and victimization, among others.
- Historically, there have been a number of barriers to providing effective treatment for people with co-occurring substance abuse and mental health disorders. To begin with, there is no single locus of responsibility for people with co-occurring disorders. The mental health and substance abuse systems operate independently from one another and from the primary health care system.
- The separation between the substance abuse and mental health systems is driven in large part by the fact that each system has its own treatment philosophies, administrative structures, and funding mechanisms. For example, substance abuse providers may treat mental health symptoms as part of addictive disease, rather than as an independent disorder. In addition, licensure and certification mechanisms reflect different training and experience requirements. Goldman, M. et al. (2018, June).

The case for severe mental illness as a disparities category. *Psychiatric Services*." TAC; https://www.treatmentadvocacycenter.org/

“There is no question that individuals with serious mental illness have poorer access to health care and significantly worse health outcomes compared to the general population. Although some of this difference can be attributed to the symptoms and functional limitations of the mental illness disease itself, Goldman and authors point out that much of these worse health outcomes are due to the discrimination, exclusion and criminalization of individuals with serious mental illness.”

Elizabeth Sinclair
Director of Research

Treatment Advocacy Center

"We believe that the population with severe mental illness represents one of society's most vulnerable and marginalized groups with disproportionately high needs and poor outcomes," the authors conclude. "Ethical priorities compel policy makers, payers, providers, and health services researchers to maintain special focus on populations most at risk. Officially designating severe mental illness as a disparities category is a key step to enhance advocacy to influence policy solutions, practice innovations, and political will.“

References:

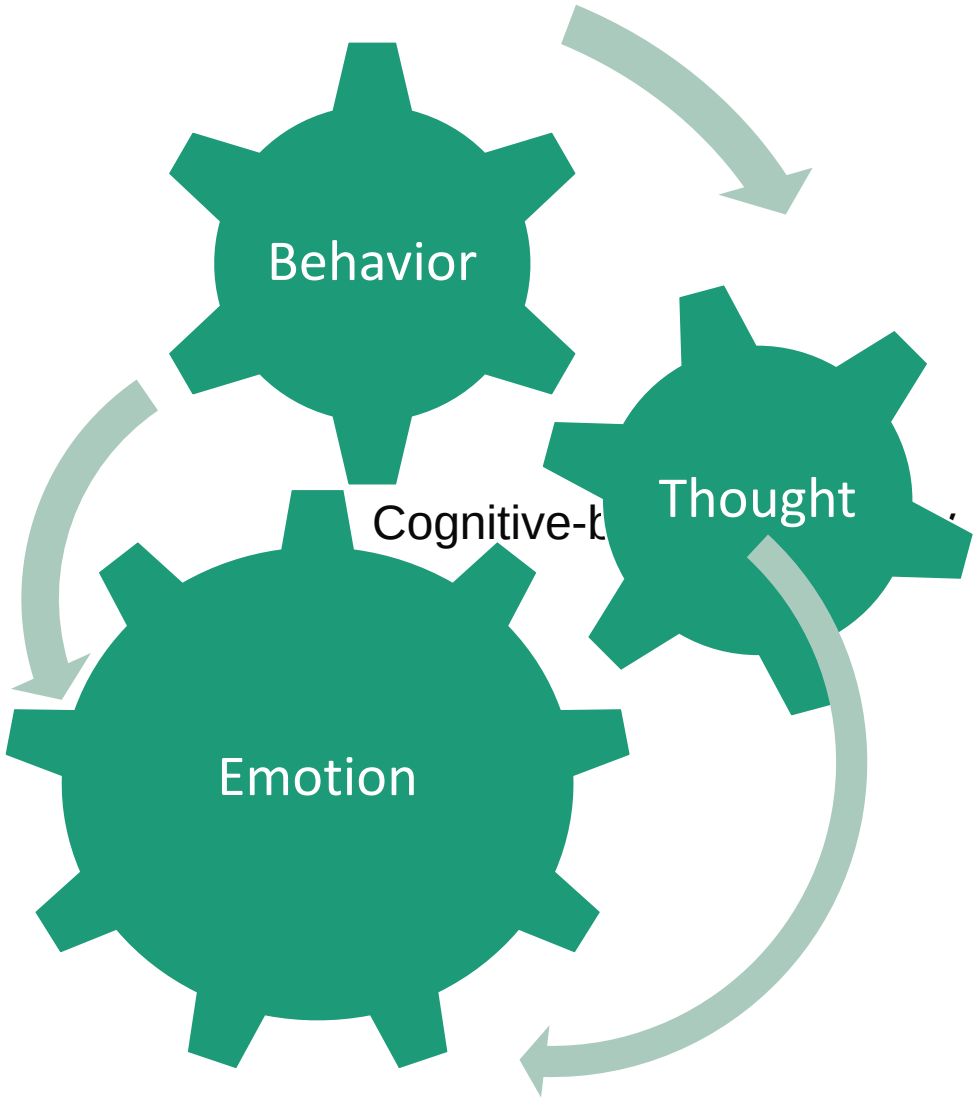
Goldman, M. et al. (2018, June). The case for severe mental illness as a disparities category. *Psychiatric Services*.” TAC https://www.treatmentadvocacycenter.org/

Severe Mental Illness and Life Expectancy

- Without treatment, those with severe mental illness/brain disorder experience a host of negative consequences. Many take their own lives. Others face a shortened life span due to a much-increased risk for other chronic health conditions. Ultimately, those with severe mental illness die, on average, 25 years earlier than their peers.

  Others are lost to the streets. Conservative estimates suggest that one quarter of the homeless population suffers from a severe mental illness. In 2017, that amounted to 138,435 individuals on any single night. Also common are arrests for so-called “quality of life” crimes like loitering and public urination—behaviors that are triggered by illness, not criminal intent.
- Goldman, M. et al. (2018, June). The case for severe mental illness as a disparities category. *Psychiatric Services*.” TAC; https://www.treatmentadvocacycenter.org/

Evidence Based Treatments



Cognitive Behavioral Therapy (CBT) is a type of psychotherapeutic treatment that helps patients understand the thoughts and feelings that influence behaviors. CBT is commonly used to treat a wide range of disorders, including **phobias, addictions, depression, and anxiety.**

Dialectical Behavior Therapy (DBT)

Mindfulness

Interpersonal Communication

Emotion Regulation

A

C

T

Therapy (ACT)

Accept your reactions and
be present
Choose a valued direction
Take action.

Listen

Empathize

Agree

Partner

LEAP Therapy
(Dr. Xavier Amador)

LISTEN: Reflective Listening
EMPATHIZE: Convey Under-standing/Validate Emotions without Judgment
AGREE: Find Common Ground
PARTNER: Make a Plan that both can agree to.

O

A

R

S

- **Motivational Interviewing**

- Open ended questions
- Affirmations
- Reflections
- Summaries


LOST
CONFUSED
UNSURE
UNCLEAR
PERPLEXED

The normal aging process

No major behavior/personality changes

Learning/Intelligence

- Ability to learn stays the same
- **Processing of information slows down**
- **Longer recovery time for stress, injury, medical illness**

Memory changes

- Slower recall/changes can be compensated for

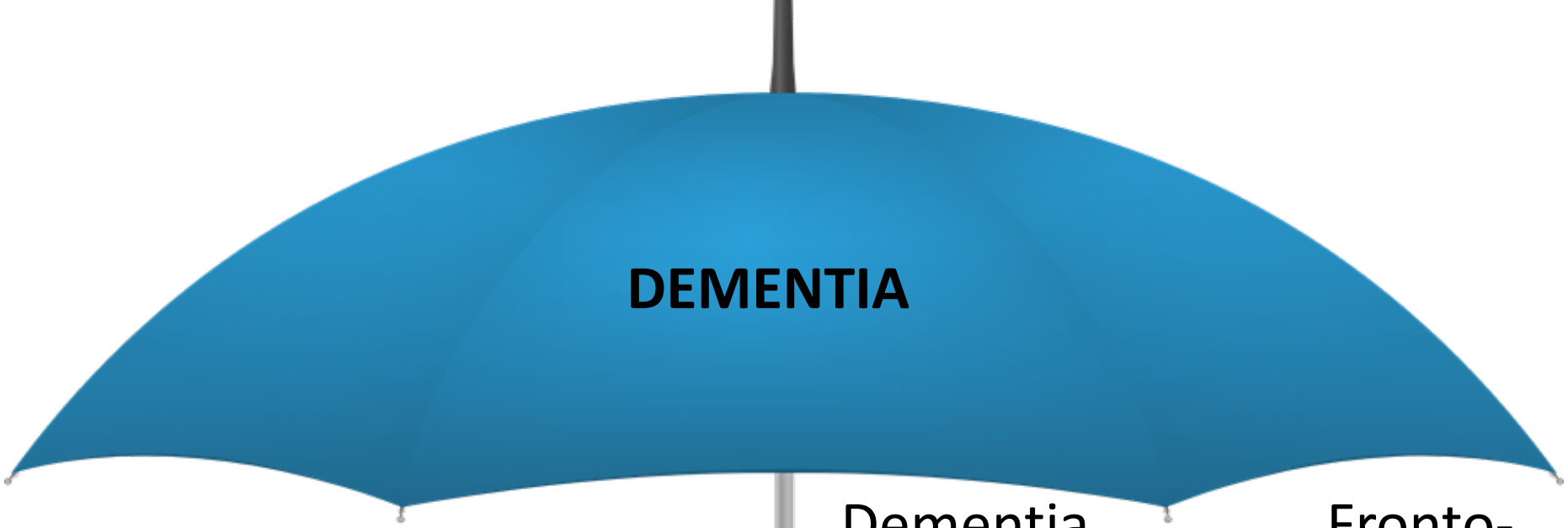
Senses

- **Slow gradual changes – hearing loss, vision, touch – less sensitive, smell – cannot smell smoke as quickly, taste – really drawn to sweets**

Delirium vs. Dementia vs. Depression

Features	Delirium	Dementia	Depression
Onset	Acute (hours to days)	Insidious (months to years)	Acute or Insidious (wks to months)
Course	Fluctuating	Progressive	May be chronic
Duration	Hours to weeks	Months to years	Months to years
Consciousness	Altered	Usually clear	Clear
Attention	Impaired	Normal except in severe dementia	May be decreased
Psychomotor changes	Increased or decreased	Often normal	May be slowed in severe cases
Reversibility	Usually	Irreversible	Usually

https://emergencymedicinecases.com/wp-content/uploads/2016/08/delirium-in-palliative-care-and-hospice-10-638.jpg



Alzheimer's Disease

60-80%

Memory loss, aphasia, apraxia, apathy/depression , poor insight

Vascular Dementia

15-20 % slow processing speed, poor attention, less memory impairment
Progressive, gradual

Dementia w/Lewy Bodies

8-12%

V.Hallucinations, muscle rigidity, Parkinsonism, Tremors, Memory loss
Progressive, gradual/stepwise

Fronto-temporal Dementia

5%

behavior issues, personality changes,, Executive Functioning impairment.
Progressive, rapid.

Tests to Rule Out Treatable Medical Problems:

Mimic Symptoms of Dementia:
Hypothyroidism
Hypercalcemia
Hypoglycemia
Nutritional deficiencies (B-12/folic acid)
Kidney and liver disorders
Infections
Brain tumors
Hearing or vision issues”

A complete blood count (CBC)/rule out anemia
A blood glucose test/rule out diabetes
Blood tests to check kidney function liver function and to measure vitamin B-12 levels
A blood/urine screen for drugs/alcohol or UTI
Cerebrospinal fluid analysis for brain infections
Analysis of thyroid/thyroid-stimulating hormone levels to rule out hypothyroidism
Electroencephalogram (EEG)

- RISK FACTORS FOR DEMENTIA

Smoking

- Alcohol
- Sitting/Sedentary life style
- Depression
- Sleep apnea
- Delirium
- Hospitalization/Sepsis

Head Injury

- Low level of education
- Type 2 Diabetes
- Obesity
- High blood pressure
- Hyperlipidemia
- Cerebrovascular risk

RUDAS Rowland Universal Dementia Assessment Scale

http://www.multiculturalmentalhealth.ca/wp-content/uploads/2014/04/20110311_2011NSWRUDASscoring_sheet.pdf

Frontal Assessment Battery

https://www.meded.help/wp-content/uploads/2017/04/Frontal_FAB_Scale.pdf?x30812

MOCA Montreal Cognitive Assessment

http://baynav.bopdhb.govt.nz/media/1127/moca.pdf

SLUMS vs.MMSE

http://medschool.slu.edu/agingsuccessfully/pdfsurveys/slumsexam_05.pdf

MiniCog https://mini-cog.com

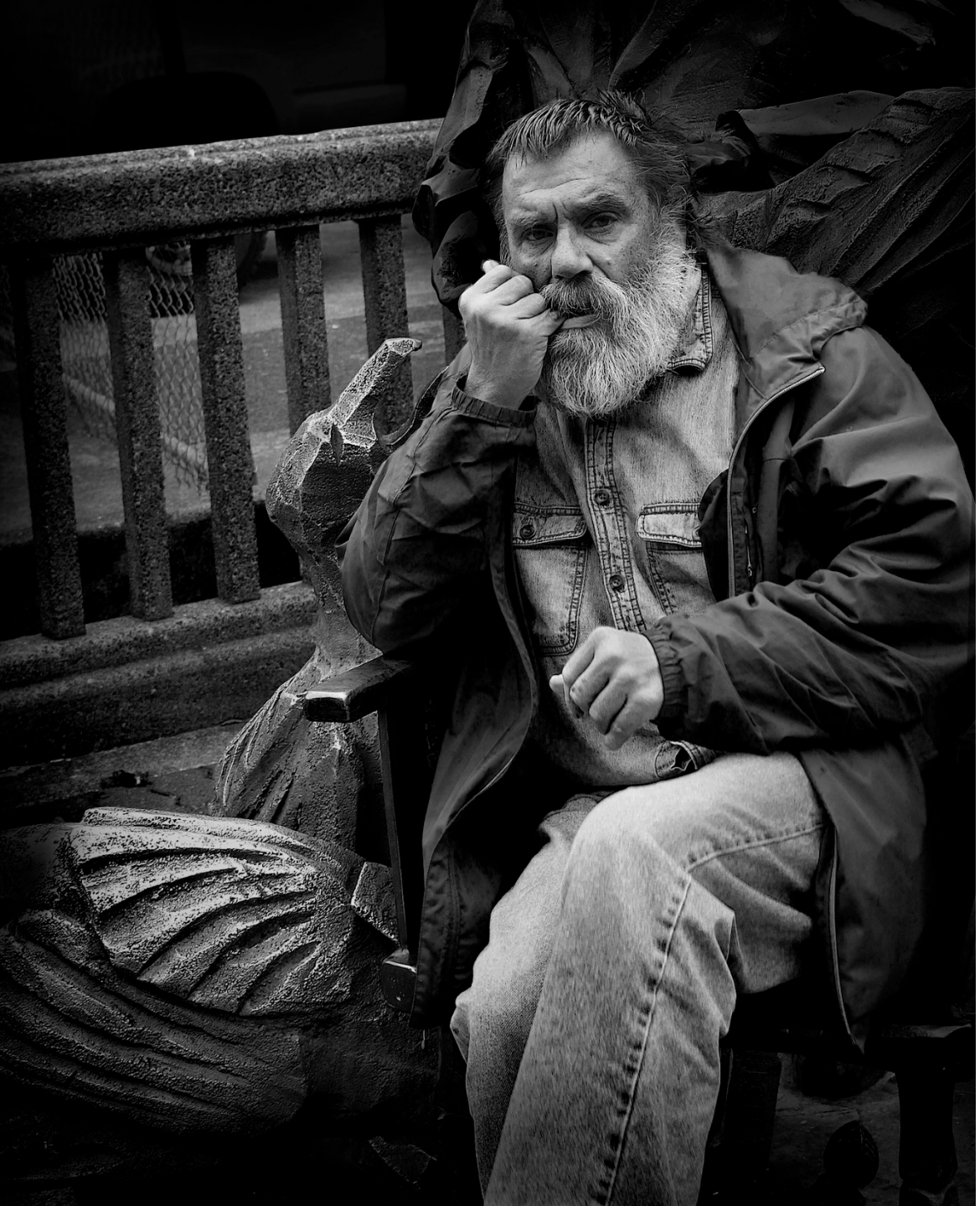
St Louis University Mental Status Examination

Montreal Cognitive Assessment

THE ELDERLY AND HOMELESSNESS

Studies across the U.S. have shown a clear upward trend in the proportion of ‘older’ persons’ (aged 50-64) among the homeless population.

- This is a group which frequently falls between the cracks of governmental safety nets. They are not old enough to qualify for Medicare, however, when their physical health is assaulted by poor nutrition and severe living conditions they may eventually resemble someone much older.
- 44,000 homelessness among people age 65 and older in 2010
  https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group



2015 analysis found that 45% of adults age 65 and older were “economically vulnerable” with incomes below 200% of the poverty threshold in 2013. (Supplemental Poverty Measure (SPM), William Sermons and Meghan Henry, Homelessness Research Institute, The Demographics of Homelessness Series: The Rising Elderly Population, (April 2010) https://www.bmc.org › addiction › grayken-news › elderly-an-overlooked-group

Fact Sheet: Aging in the United States – Population ...
www.prb.org/aging-unitedstates-fact-sheet/

In 2010, the monthly SSI payment for an individual was $703 – well below the poverty line

112% of that income to rent a one-bedroom apartment, or 99% for a studio/efficiency apartment.

If SSI represented an individual's entire income and other essentials were subtracted, then $181 would be an affordable rental price for housing.

There are at least nine seniors waiting for every one occupied unit of affordable elderly housing nation-wide.

Furthermore, the waiting list for affordable senior housing is often three to five years.

- http://nationalhomeless.org/issues/elderly

Older homeless people are more likely to suffer from cognitive impairments compared to younger homeless adults .

Older homeless are likely to suffer from impairments resulting from depression or dementia, which can contribute to the worsening of their physical health.

Isolation also contributes to homelessness among older persons. In 2004 half of the recipients of (SSI) that were 50 years and older had been living alone before losing their homes.

http://nationalhomeless.org/issues/elderly

Studies show that older homeless adults have higher rates of geriatric syndromes, including problems performing daily activities, walking, vision and hearing, as well as falls and frailty when compared to the general population.

Homeless persons between ages 50 and 62 often have similar healthcare needs to housed persons 10-20 years older.

http://nationalhomeless.org/issues/elderly

Criminalization of Brain Disorders

- “An estimated 8.3 million adults in the United States have a severe mental illness. At any given time, 3.9 million go untreated.
  Our health care system actively denies them care, and we criminalize the symptoms of their diseases.
  When someone has a heart attack, an ambulance takes them to an emergency room. When someone is in the depths of psychosis, however, police are called and frequently cart that person off to jail.
- Troubled by alarming symptoms, parents reach out to doctors or crisis services seeking help on behalf of their loved one. However, if their child is too ill to understand the need for treatment, they are told that unless that child himself or herself seeks care, treatment is only available once the child becomes dangerous. And so begins a cataclysmic cycle.”

America's Crime Problems Being Fed by a Broken Mental Health System By John Snook

Incarceration has become the norm.

Forty percent of those with severe mental illness are incarcerated at some point in their lives. Two million are booked into jails each year.

The Treatment Advocacy Center estimates that 383,000 individuals with severe mental illnesses were incarcerated in 2016. But jails are the worst place to provide mental health treatment. Would-be patients are isolated. They deteriorate, are victimized and receive inadequate care.

A 2018 national investigation revealed that since 2010, more than four hundred people with mental illness have died in our nation's jails. Others die before ever reaching a cell. According to our report, "Overlooked in the Undercounted," at least one in four fatal law enforcement encounters involve an individual with severe mental illness. They are 16 times more likely to be killed in such an encounter than other civilians.

America's Crime Problems Being Fed by a Broken Mental Health System By John Snook

Prisoners with Brain Disorders Victimized

- They deteriorate, are victimized and receive inadequate care. Their symptoms result in additional offenses and time behind bars. A 2018 national investigation revealed that since 2010, more than four hundred people with mental illness have died in our nation's jails.

  Others die before ever reaching a cell. According to our report, "Overlooked in the Undercounted," at least one in four fatal law enforcement encounters involve an individual with severe mental illness. They are 16 times more likely to be killed in such an encounter than other civilians.] https://www.treatmentadvocacycenter.org/fixing-the-system/features-and-news/4112-americas-criminal

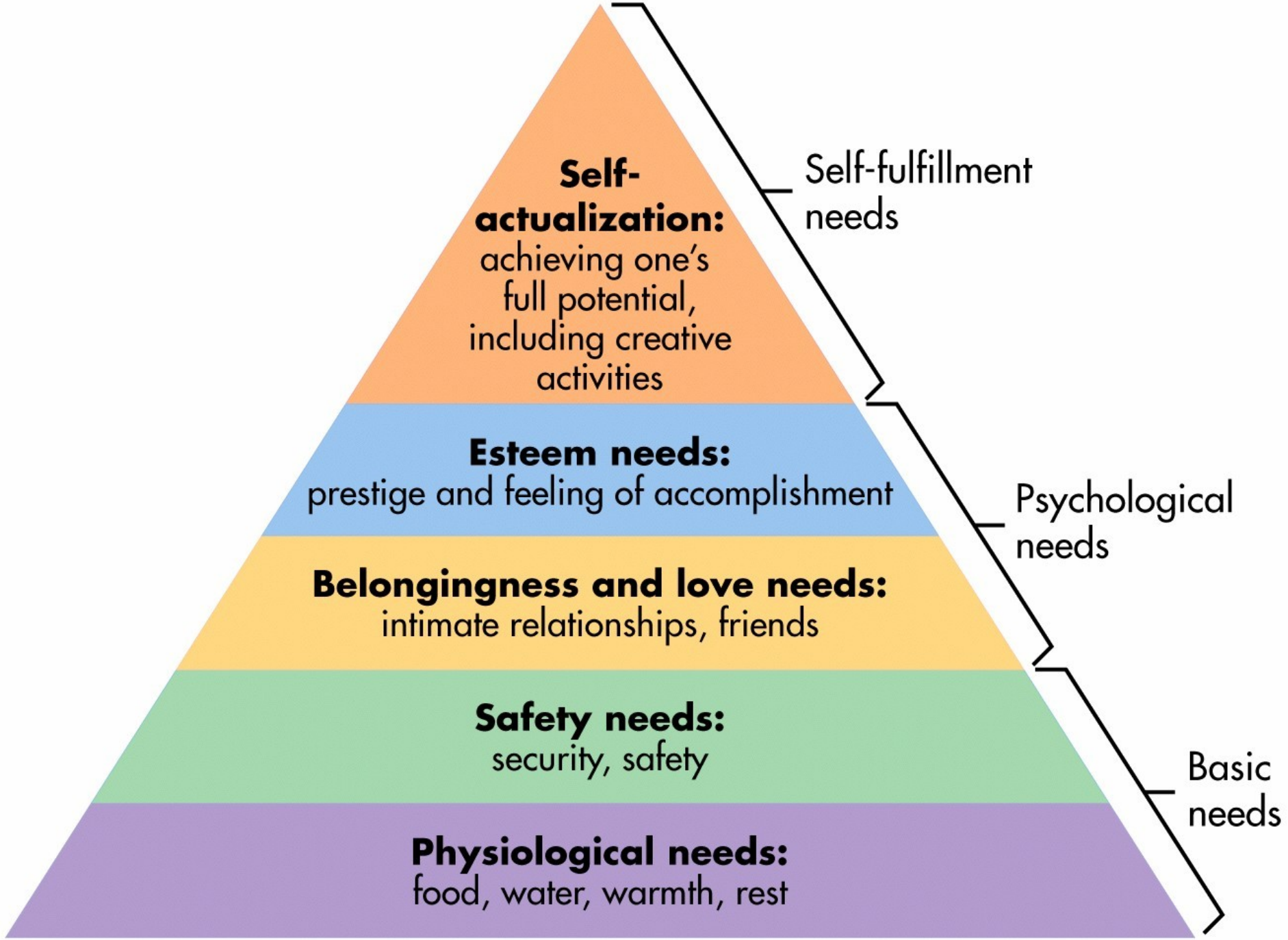
- **

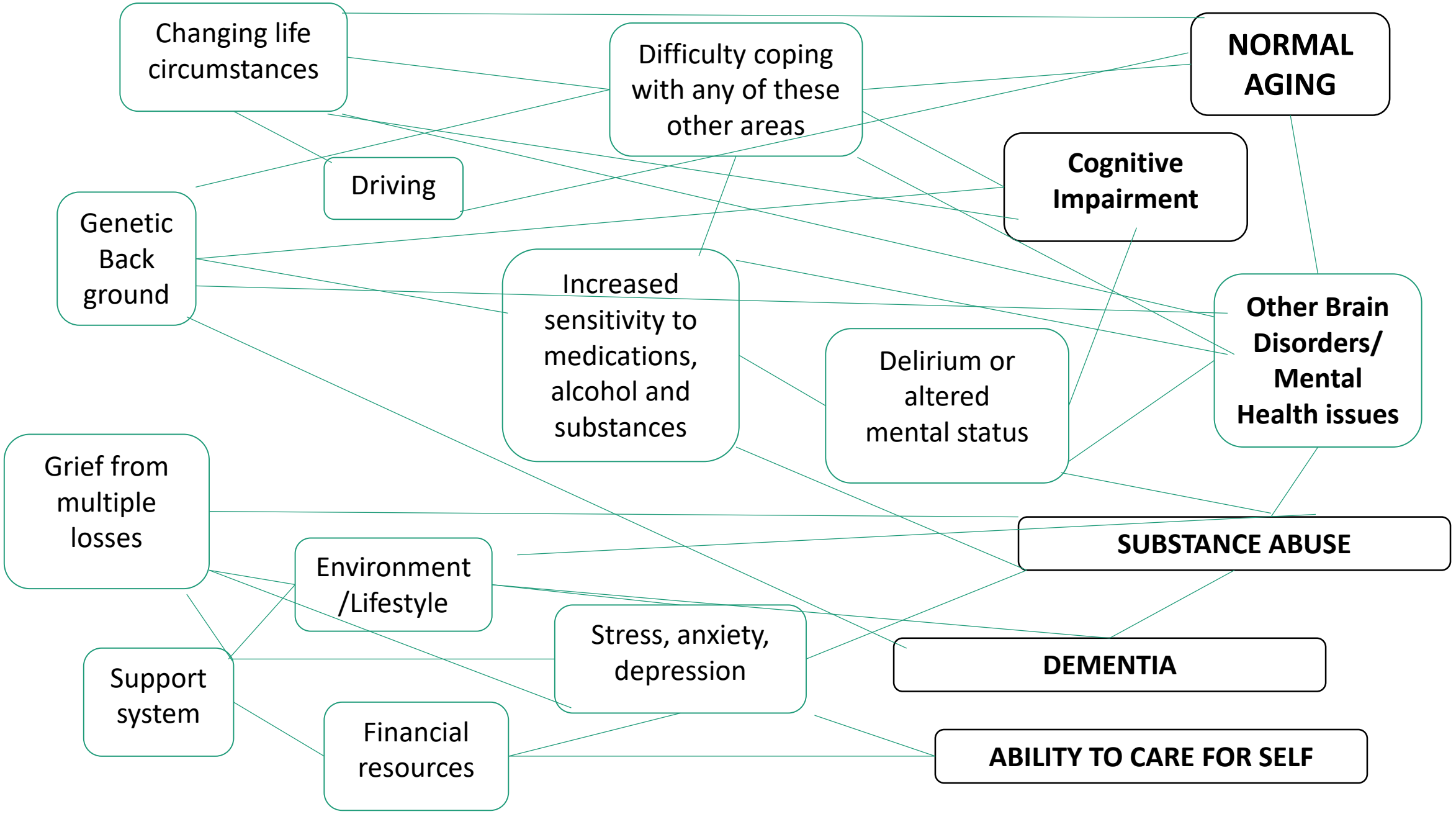
Older Prisoners

- The number of men and women in prison age 55 and older has grown dramatically from 32, 6000 in 1995 to 124,ppp in 210. Now they account for approximately 16 percent of the total prison population
- One study suggest that the driving force behind it is the growth in re-arrests of those who use drugs and have aready been behind bars
- Across the states, the proportion of prisoners 55 years and older range from 4.2 percent to 9.9 percent. The highest rate is found in Oregon, and the lowest in Connecticut. In southern states, the elderly prisoner population increased by 145 percent just during the ten-year period from 1997 to 2007.

SOURCES

- **Primary**
- *State of California Legislative Analyst's Office*: Three Strikes – The Impact After More Than a Decade
- *North Carolina Department of Correction Division of Prisons*: Aging Inmate Population Study
- **Additional**
- *Nation Inside*: RAPP (Release Aging People in Prison)
- https://lawstreetmedia.com/issues/law-and-politics/aging-inmates-prison-crisis/]


Self-actualization: achieving one's full potential, including creative activities
Esteem needs: prestige and feeling of accomplishment
Belongingness and love needs: intimate relationships, friends
Safety needs: security, safety
Physiological needs: food, water, warmth, rest
Self-fulfillment needs
Psychological needs
Basic needs


Changing life circumstances
Difficulty coping with any of these other areas
NORMAL AGING
Driving
Cognitive Impairment
Genetic Back ground
Increased sensitivity to medications, alcohol and substances
Other Brain Disorders/ Mental Health issues
Delirium or altered mental status
Grief from multiple losses
SUBSTANCE ABUSE
Environment /Lifestyle
Stress, anxiety, depression
DEMENTIA
Support system
Financial resources
ABILITY TO CARE FOR SELF

Measurable Goals

- Symptom Improvement and Management
- Functioning Level
- Employment
- Relationships
- Health
- Stability in Housing
- Treatment Plan
- Recommendations of Medical Provider
- Abstinence