

Mental Health and Drug & Alcohol Issues in the Older Adult

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Module Overview

In this module, we will discuss the mental health issues which affect older people. We will examine depression, dementia, and delirium as well as the most common psychiatric disorders and substance abuse.

Learning Objectives

By the end of this module, you will be able to:

- Identify the major mental illnesses that affect older adults
- Describe the causes and symptoms of depression
- Describe the causes and symptoms of dementia
- Describe the components of a dementia assessment
- Discuss communication techniques that can be used to interview and assess demented individuals
- Define delirium and describe the causes, symptoms, and appropriate intervention
- Discuss the barriers to identifying substance abuse issues in older people
- Identify signs that a client may have a substance abuse problem
- List appropriate questions that can be directed to an older person which can be used to identify a substance abuse problem

Study Steps

1. Review the content of this section.
2. Review recommended Acts, Laws and Regulations regarding mental health and involuntary commitment
3. Complete the self-evaluation quiz and use the answer key to review your answers.
4. Review the content of any of the questions you answered incorrectly.
5. Plan with your supervisor to complete transfer of learning activities.

Content

Read the module Mental Health and Drug & Alcohol Issues in Older Adults.

Mental Health and Drug & Alcohol Issues in the Older Adult

Overview

Mental illness is a red flag for elder mistreatment both in the victim and in the abuser. An elder who suffers from some form of mental illness may be more likely to self-isolate or self-neglect. Due to the mental illness, the elder is also more vulnerable to mistreatment by others. In this module we will examine the most common types of mental/cognitive manifestations seen in older adults: these include depression, dementia, delirium, specific psychiatric disorders, and substance/medication abuse.

General Observations

- Mental disorders among the elderly go unrecognized or are often masked by somatic complaints
- Clinical presentation of mental disorders in the elderly may be different, making diagnosis of treatable illnesses more difficult
- Detection may also be complicated by co-existing medical disorders. These disorders may include:
 - Circulatory problems due to strokes, high blood pressure, or heart failure
 - Infections, especially urinary tract infections, kidney infections, or high fever
 - Metabolic imbalance related to diabetes and heart medication (water pills)
 - Nutrition: poor eating habits due to diet, physical illness or financial problems, especially in diabetics
 - Breathing problems causing lack of oxygen, especially emphysema
 - Sensory loss: decreased vision, hearing taste, smell, and touch, and reduced sensitivity to pain

Part 1: Depression

Depression is the most common and most underdiagnosed mental condition in the older adults. It isolates the individual, fills him/her with hopelessness, and, if not recognized or treated, may lead to physical illness, institutionalization or suicide. Depression is likely to lead to self-neglect and may make the older adult vulnerable to neglect and exploitation by others. Depression takes different forms and we will discuss them.

General Observations about Depression

- The incidence of depression in the general population is 10%, in individuals 65 and older it increases to 20%
- 16 to 25% of all reported suicides in the United States are in the 65 plus population
- Individuals with dementia have a 25 - 30% risk of getting depressed
- Community surveys have found that depressive disorders and symptoms account for more disability than medical illness
- Untreated depression can lead to physical illness, institutionalization, psychosocial deterioration and suicide
- Minor Depressive Episode affects more older adults – 8 – 20% community residing elders, up to 37% older patients in primary care settings
- 25%-30% of people with dementia also suffer from depression
- Depression is treatable and treatment can lead to a better quality of life

Types of Depression

- Major Depression
 - Not triggered by a life event
 - Characterized by:
 - General sadness
 - Feelings of hopelessness,
 - Depressed mood
 - Loss of interest or pleasure
 - Appetite disturbance
 - Insomnia or hypersomnia
 - Psychomotor agitation or retardation
 - Fatigue or loss of energy
 - Feelings of worthlessness or guilt
 - Decreased concentration indecisiveness
 - Thoughts of death or suicide
 - Impaired level of functioning
 - Usually requires hospitalization and medications
- Reactive Depression
 - Triggered by life losses, increased disabilities, and grief reactions
 - Related to physical conditions such as stroke, cancer, chronic pain, and heart disease
 - More common in those with low self esteem
- Late Onset Depression
 - Subset of patients with major or minor depression
 - Onset later than age 60
 - Greater apathy
 - Less lifetime personality dysfunction
 - Cognitive deficits more pronounced

- Greater medial temporal lobe abnormalities on MRI
- Risk of reoccurrence higher
- Masked Depression or Pseudo-Dementia
 - Complaints of physical discomfort, problems with memory and difficulty problem solving
 - Medical workup suggested

Symptoms of Depression in the Older Adult

- Changes in:
 - Sleep patterns
 - Appetite
 - Energy level
 - Mood
 - Anxiety
- Increased confusion
- Lack of awareness of being depressed
- Loss of motivation, withdrawal and irritability
- Changes in brain chemistry
- Suicidal ideation

Indications and Interventions

- Changes must last consistently for minimum of 2 weeks
- Physicians do not always identify it and elders do not always reports it
- Document what you see; gather data to relate to primary care physician and/or evaluator
- Refer the elder for an evaluation
- Follow your agency's protocol for referrals for the appropriate evaluation

Depression and Suicide

- Older adults have the highest rate of suicide – 21 per 100,000 individuals twice the overall national average
- Highest rate is in white men over age 85 and is about 65 per 100,000
- Out of 97 older adults who committed suicide age 50 and older, 51 had seen their physician within 1 month of the suicide

Depression and the Nursing Home

- Occurrence 10 times higher than those elderly residing in the community
- Associated with distress, disability and poor adjustment to the facility
- Most common cause of weight loss in long term care
- Can lead to lack of energy, withdrawal, refusal of care, screaming

Antidepressant Medications

- Can be used for a variety of disorders

- Categories of antidepressants
 - Tricyclic (Elavil, Tofranil, Norpramin, Sinaquan, etc)
 - SSRI – Selective Serotonin Uptake Inhibitors (Prozac, Zoloft, Paxil, etc)
 - Dual Action Anti-Depressants (Effexor, Remoran, etc)
 - Other anti-depressants
- Side effects and interactions
 - Each category of medication has possible side effects
 - Multiple medications can cause severe reactions and interactions
- Worker and client should understand
 - The reason for prescribing the medications
 - The desired effect
 - Any side effects
- Consult with the prescribing physician if there are any questions
- Be certain all physicians, including specialists, are aware of OTC meds

Assessing Depression

- Gather the following information
 - Previous treatment history for depression
 - Family History of depression
 - History of response to interventions
 - Current and past Alcohol/Substance use/abuse
 - Any changes in the following that have lasted longer than 2 weeks
 - Sleep disturbance
 - Interest
 - Guilt
 - Energy
 - Concentration
 - Appetite
 - Psychomotor change
 - Suicidal thoughts
- Assessment Tools: Geriatric Depression Scale – A brief questionnaire developed by Yesavage *et al.*, used to measure depression in older adults. Participants respond to questions by answering “yes” or “no” based upon how they feel on the day of the examination. The original version contains 30 questions, while a newer more user-friendly version contains just fifteen. See Appendix A of this module for copies of the long and short forms of the questionnaire. The short form may also be completed on-line at www.stanford.edu/~yesavage/Testing.htm.

IMPORTANT: If an elder is expressing suicidal ideation consult immediately with a supervisor. If they state they have a plan, consult a supervisor and mental health crisis hotline as an “emergency” precaution.

Part 2: Dementia

Dementia (from Latin de- "apart, away," + mens (genitive mentis) "mind") is progressive decline in cognitive function due to damage or disease in the brain beyond what might be expected from normal aging. Particularly affected areas may be memory, attention, language and problem solving, although particularly in the later stages of the condition, affected persons may be disoriented in time (not knowing what day, week, month or year it is), place (not knowing where they are) and person (not knowing who they are). Dementia is a non-specific term that encompasses many disease processes, just as fever. Dementia is most often manifested by the victim being unable to recall or repeat what has occurred.

Types of Dementia

- Reversible Dementias: what causes them
 - Drugs
 - Dehydration
 - Electrolyte imbalances
 - Emotional disorders
 - Metabolic disorders
 - Endocrine disorders
 - Ear/ear dysfunction
 - Nutritional deficiencies
 - Trauma
 - Tumor
 - Infections
 - Acute illness
 - Seizures
 - Strokes
 - Sensory deprivation
- Irreversible Dementias
 - Alzheimer's Disease
 - 50% of all Dementias
 - Diagnosis of inclusion
 - Age related, though not consequential to the aging process
 - Heredity issues
 - Behavioral manifestations
 - Multi-Infarct or Vascular Dementia - strokes, mini-strokes, TIA's
 - 20% of all Dementias
 - Abrupt onset, step-wise decline, focal deficits
 - Vascular history
 - More susceptible to depression
 - Treatment options differ
 - Alcohol-induced Dementia

- Subcortical Dementias
 - result from dysfunction in the parts of the brain that are beneath the cortex. Usually, the forgetfulness and language difficulties that are characteristic of cortical dementias are not present. Rather, people with subcortical dementias, such as Parkinson's disease, Huntington's disease and AIDS dementia complex, tend to show changes in their speed of thinking and ability to initiate activities. *From www.webmd.com*
- Pick's Disease
 - A type of dementia in which damage to nerve cells causes dramatic alterations in personality and social behavior but typically does not affect memory until later in the disease. *From www.webmd.com.*
- Huntington's Disease
 - An inherited brain disease affecting the body that is characterized by mood changes, intellectual decline, and involuntary movement of limbs. *From www.webmd.com.*
- Parkinson's Disease
 - A progressive, nervous system disease with an unknown cause in which nerve cells in a specific area of the brain begin to die off. People with Parkinson's disease lack the neurotransmitter dopamine and have symptoms such as tremors, speech impairments, movement difficulties, and often dementia later in the course of the disease. *From www.webmd.com*
- Lewy Body Disease
 - A dementing illness associated with protein deposits called Lewy bodies, found in the cortex of the brain. *From www.webmd.com.*
- Creutzfeldt-Jakob Disease
 - A rare disorder of infectious and genetic origin that typically causes memory failure and behavioral changes. A recently identified form is thought to be due to eating meat from cattle affected by "mad cow disease." *From webmd.com.*

Stages of Dementia

Dementia is a progressive disease that proceeds through stages.

- Early stage, Mild dementia: usually lasts 2-4 years
 - Recent memory loss
 - Appears absent minded
 - Poor concentration
 - Moody and withdrawn
 - Denies forgetting
 - Still emotionally tuned to the environment
 - Vocabulary reduced
 - Writing difficulties
 - ADLs and motor control remain OK
- Middle stage, Moderate dementia: may last 2-12 years
 - Distant memory loss
 - Social behaviors forgotten
 - Decisions difficult
 - Cannot do complex tasks
 - Disoriented
 - Irritable, pacing

- Night wandering
- Hiding and accusing others of stealing
- Can understand when cued
- Poor attention span
- Slow or hesitant when expressing thoughts
- Difficulty with complex ADL tasks
- Poor coordination or balance
- Late stage, Severe dementia: last from 1 year to death
 - No apparent memory
 - Little or no thought observable
 - Very irritable
 - Language and communication limited: words have no meaning
 - Unable to do ADLs
 - Incontinent
 - Lack of independent motor control

Behavioral and Psychological Symptoms of Dementia

All individuals with dementia have deficits, but how they are experienced depends on their personality, style of coping and their reaction to the environment. The level of impairment and behavior manifestation varies from person to person. Behavioral and psychological symptoms of dementia are treatable with the appropriate level of care, medication and support. The level of care, medication and support may increase with time. Any change in functioning and behavior puts increased stressors on the elder and their caregiver increasing the potential risk of abuse.

General Symptoms of Dementia

- Symptoms of disturbed perception, thought content, mood or behavior that frequently occur in persons with dementia:
- Impairment of the short and long-term memory, including one of the following:
 - Impaired abstract reasoning
 - Impaired judgment
 - Aphasia (language disturbance)
 - Apraxia (action disturbance)
 - Agnosia (recognition disturbance)
 - Personality change
 - Disturbance of work and /or social functioning
- Behavioral changes
 - Hallucinations (Usually Visual)
 - Delusions
 - People are stealing things
 - Abandonment
 - This is not my house
 - You are not my spouse
 - Infidelity
 - Misidentifications

- People are in the house
- Talk to self in the mirror as if another person
- People are not who they are
- Events on television
- Depressed Mood
- Anxiety
- Apathy
 - Decreased social interaction
 - Decreased facial expression
 - Decreased initiative
 - Decreased emotional responsiveness
- Wandering
 - Checking
 - Attempts to leave
 - Aimless walking
 - Night-time walking
- Verbal Agitation
 - Constant requests for attention
 - Verbal bossiness
 - Complaining
 - Relevant interruptions
 - Irrelevant interruptions
 - Repetitive sentences
 - Verbal aggression
 - Screaming
 - Cursing
 - Temper outbursts
- Physical Agitation
 - General restlessness
 - Repetitive mannerisms
 - Pacing
 - Trying to get to a different place
- Handling Things Inappropriately
- Hiding Things
- Inappropriate Dressing or Undressing
- Physical Aggression
 - Hitting
 - Pushing
 - Scratching
 - Grabbing things
 - Grabbing people
 - Kicking and biting
 - Pinching
 - Pulling hair
- Disinhibition

- Poor insight and judgment
- Emotionally labile
- Euphoria
- Impulsive
- Intrusiveness
- Sexual Disinhibition

Case Scenario

Mr. J. and his wife have been married for 50 years. They have always enjoyed good health, had a good income, and looked forward to playing golf in their retirement. Mrs. J. started experiencing confusion and would ask the same question over and over. Although she was diagnosed with Alzheimer's disease, Mr. J never believed that she was sick. She looked fine to him. He became increasingly impatient with her questions, began verbally abusing her, and, when he felt at his wits end from her behavior, he would shake her "out of it" and cause severe bruising on her arms.

Special Considerations in Communicating with People with Dementia

- Use simple words
- Use gestures to help communicate
- Ask one question at a time: repeat or rephrase if necessary
- Take your time; allow client time to respond
- Break down tasks into simple steps, given one step at a time
- Be calm and reassuring
- Speak slowly and distinctly
- Address person by name
- Identify yourself frequently
- Maintain eye contact
- Position yourself in front of person so you can be seen
- Don't disagree with made-up stories: redirect
- Have realistic expectations

Assessment of Dementia

A comprehensive cognitive assessment includes in-depth questioning and mental status testing. In order to do this, you must have already engaged the elder and established rapport and a level of trust. Let us examine which components of intellectual functioning require review, the types of questions you will ask, and the methods available to access this information.

- Components
 - Orientation: Is elder in tune with what is happening? Does elder know where he/she is? Does elder know the season, current events, people in the room?
 - Attention: Is elder easily distracted? Can elder follow the conversation?

- Recall: Does elder remember things from the remote past? Can elder remember what happened yesterday? Today?
- Language: Can elder comprehend what you are asking? Does elder repeat him/herself? Does language make sense?
- Interpretation: Can elder explain abstract concepts?
- Writing, Drawing, and Calculating: Can elder write name, draw a simple picture, do simple addition?
- What to ask, How to listen
 - Ask about family, previous occupation, hobbies
 - Ask about a typical day: what time elder arises, how needs are met, who comes around to help
 - Ask a variety of questions about the weather, current events, people in the news.
 - Ask about any concern in elder's life: recent crisis, medical treatment, problem with son or daughter
 - Intersperse questions with varying degrees of difficulty to relieve stress
 - Know elder's educational level and first language
 - Observe for attention and distractibility
 - Be alert for one word or "I don't know" responses: they may signal depression
 - Determine if highly developed social skills are hiding a cognitive impairment
- Engagement and trust building techniques
- Observations of environment, personal hygiene, ability to do ADLs
- Assessment tools: used as a supplement to worker's assessment
 - Folstein Mini Mental Status Exam – Mini Mental State Examination (MMSE) is used to test for impairment of cognitive functions such as memory, thinking, attention, reasoning, decision making and dealing with concepts. Individuals receive points when they respond correctly to the question or successfully complete the task.
 - See <http://alzheimers.about.com/od/diagnosisissues/a/MMSE.htm> for additional general information.
 - See <http://www.fhma.com/mmse.htm> for the questions and point scoring.
 - See <http://www.minimental.com> for purchasing information.
 - Clock Test – A simple neurological test used as a screening tool for Alzheimer's and other types of dementia. The individual is asked to draw a clock, put in all the numbers, and set the hands at ten past eleven.
 - See http://alzheimers.about.com/od/diagnosisissues/a/clock_test.htm for more information and the scoring system.
- Refer for comprehensive geriatric assessment
- As needed consult with your supervisor regarding a complete evaluation.
- Note that local AAA may not have resources and a referral may need to be made – consult with your supervisor.

- As an individual's level of dementia increases, caregivers will need specialized training and support. It is critical that a caregiver knows how to use non-abusive methods to the above-mentioned behaviors.

Medication Interventions for Dementia

A PS worker does not need to memorize all the medications and their side effects. The most commonly prescribed medication for dementia is Aricept. It is important to be familiar with the various names and then conduct further research as needed.

- Cognitive Dysfunction Interventions
 - Cholinesterase Inhibitors
 - Estrogen
 - Vitamin E
 - Selegiline
 - Ginkgo Biloba
- Antianxiety Medication
- Antipsychotic Medication
- Mood Stabilizers
- Cholinesterase Inhibitors
 - Aricept
 - Exelon
 - Razadyne (formerly Reminyl)
 - Cognex

Know your local resources that can provide information and support groups for caregivers.

Part 3: Delirium

Delirium is a temporary, reversible condition often confused with dementia because of its symptoms. Delirium is a medical emergency. Accurate assessment and diagnosis is necessary so that individuals can be given the appropriate treatment.

Causes

- Malnutrition
- Dehydration
- Systemic diseases
- Blood clots
- Small strokes
- Medications
- Metabolic/endocrine
- Infections

Symptoms

- Rapid onset of confusion
- Fluctuating level of consciousness
- Hallucinations
- Disorientation
- Confusion
- Memory problems

Part 4: Psychiatric Disorders

There are a variety of psychiatric disorders that can impact on an older person's vulnerability and risk of abuse, neglect, or exploitation. We will present the most common disorders, their symptoms, and treatment/intervention possibilities.

Anxiety

In the aged, anxiety rarely occurs in the absence of depression. Anxiety is a universal human experience that may be a catastrophic reaction to a recent event or a series of events over time. Anxiety manifests itself as emotionally- based physical symptoms.

- Causes
 - Environmental issues – an existing or new stressor in the home
 - Developmental / Psychosocial issues – recent changes in health
 - Anxiety Disorders – an existing problem
 - Organic Anxiety Disorders due to:
 - Respiratory
 - Endocrine
 - Neurologic
 - Neurological
 - Nutritional
 - Cardiovascular
 - Medication
- Antianxiety Medications address:
 - Situational Anxiety
 - Panic Disorder
 - Insomnia
 - BPSD
 - Anxiety
 - Acute Agitation
 - Sleep Disturbance
- Types of Antianxiety Medications
 - Benzodiazepines (ex. Ativan, Xanax, Librium, Valium)

Paranoia

In the elderly, paranoia may be the result of social isolation, a sense of powerlessness, and a progressive sensory decline. In early dementia, memory problems may cause paranoia as well. It is important to determine what are actual threats and separate them from unfounded suspicions. An elder's children may actually be planning to put her in a nursing home, or they may have forced her to change her will, or there really may be a gas leak in the home. Paranoia is a source of frustration for local law enforcement, rescue squads, etc.

Case Scenario:

Mrs. K. lives alone, far from family and friends, and has begun to lose her hearing. She believes there are people in the attic who are conspiring to take her home away from her. She calls the police 4 times a day to report strange noises and insists that an officer come and arrest the perpetrators.

Personality Disorders: Obsessive-Compulsive

Obsessive-compulsive disorder is usually exhibited through the need for repetitive, ritualistic behaviors. Sometimes hoarding behavior is a result of obsessive-compulsive disorder. Hoarding can also be a result of a recent loss, dementia, or life-style.

- Hoarding as a psychiatric condition
 - Excessive collection and retention impeding day to day functioning
 - Hazard or potential hazard for the individual
 - Items include animals, paper, food items, and piles of things
 - Isolated and live alone
 - Distress to neighbors and service providers
 - Hoarder is attached to her/his "things" and animals
 - Difficult to treat, as the hoarder does not see a problem and is very defensive

Case Scenario:

Mr. W is a 68 year old male living in a single family home in a nice neighborhood. He dresses appropriately and looks clean. He leaves his house daily at 8:00 am and returns each day at 5:00 pm as if on a work schedule. He has few friends in the neighborhood. Suddenly one day, he was observed eating food from a nearby eatery dumpster. After a few days of this continued behavior, the local police were called to help. Mr. W was brought to the AAA office for intervention. Believing him homeless or crazy, they did not want to send him to lock-up. Within a few hours, desiring to be freed from "this jail," Mr. W. agreed to take the care manager to his home. Once at the house, Mr. W went to a rear area where a ladder reached to the second floor. He went up the ladder, opened the window and crawled inside. Once inside, the worker was asked to come in too. To her surprise, all three floors of the house were piled, floor to ceiling, with neatly stacked, folded newspapers from 20 years to present. What should happen now?

Personality Disorder: Narcissistic

An individual with a narcissistic personality disorder is basically concerned with his/her own needs and uses others. This type of personality wears out service providers. This type of individual is not nurturing or supportive, and probably is not appropriate in a caregiver role.

Other Psychiatric Disorders

- Mood Disorders with Psychosis
- Bipolar disorder
- Schizophrenia / Late-Onset Schizophrenia
- Other Personality Disorders
- Adjustment Disorders

Antipsychotic Medications

- Used to control
 - Schizophrenia
 - Delusional Disorders
 - Mood Disorders with Psychotic Features
 - Severe Personality Disorders
 - Behavior, Psychological Symptoms of Dementia
 - Delusions, Hallucinations, Paranoia
 - Aggression and Violent Behavior

- Types of Medications
 - Low potency (Thorazine, Mellaril)
 - Intermediate potency (Trilafon, Loxitane, Moban)
 - High potency (Haldol, Navane, Prolixin)
 - Atypical medications (Risperdol, Zyprexa, Closaril)

<h2>Part 5: Alcohol and Substance Use/Abuse in Older Adults</h2>

The physiological and cognitive effects of substances on the elderly, if undetected by the worker, may lead to misdiagnosis of the situation. Some of the effects of alcohol in the elderly include confusion, disorientation, irritability, heart palpitations, weight loss, depression, and sleep disorders. Medication mismanagement can also cause severe medical reactions including liver and renal failure.

Prevalence of the Problem

- 10-12% individuals over 65 have a drinking problem
- Alcoholism is four times more common among men 65 and older
- Up to 17% of older adults 60 years and older may be abusing prescriptive drugs

- Greatest risk factor for abuse of prescription medication was being female
- 6-11 % elderly patients admitted to hospitals abuse alcohol
- 20% of elderly patients in psychiatric wards abuse alcohol
- 14% of older individuals seen in emergency rooms abuse alcohol

Types of Substance Abuse

- Early Onset
 - Usually begins in early adulthood
 - Lifelong addiction
 - Exacerbated by age, medical conditions, other medications
 - Has a poor prognosis
- Late Onset
 - Begins at later age
 - Result of losses (physical, personal) and grief
 - Better prognosis for treatment

Barriers to Identification and Treatment

- Ageism
 - Negative stereotyping
 - Problems explained as a function of age
- Lack of Awareness/denial by older adult, family, community
- Protective Service and other professionals do not recognize problem
 - Lack of a complete and adequate history
 - Alcohol related problems may be mistaken for medical or psychiatric problems
 - Older individuals live alone, often isolated
 - No job related difficulties
 - Usually no legal problems
- Comorbidity
 - Medical complications
 - Cognitive impairment
 - Depression
 - Sensory deficits
 - Lack of mobility
- Special populations
 - Women
 - Less insurance and income
 - Prescribed and consume more psychoactive medications
 - Racial and ethnic minorities
 - Language barriers
 - Lack of knowledge/understanding of cultural belief systems by professionals
 - Homebound adults
 - Isolation
 - Lack of transportation

- Shrinking social network
- Likely to self-neglect

Symptoms of Substance Abuse

- Sleep complaints
- Cognitive impairment, memory, or concentration disturbances
- Seizures, malnutrition, muscle wasting
- Liver function abnormalities
- Persistent irritability (without obvious cause) and altered mood
- Unexplained complaints
- Incontinence, urinary retention, difficulty urinating
- Poor hygiene and self-neglect
- Unusual restlessness and agitation
- Complaints of blurred vision or dry mouth
- Unexplained nausea or vomiting
- Changes in eating habits
- Slurred speech
- Tremor, loss of motor coordination, shuffling gait
- Frequent falls and unexplained bruising
- Public urination or exposure
- Weight loss
- Rapid depletion of assets (this may also be a sign of financial exploitation)

Warning Signs

- Worrying about effectiveness and dosage of prescription medication
- Overmedicating; renewing prescriptions for past conditions
- Complaining about physicians who refuse to write prescriptions
- Self medicating
- Withdrawing from family, friends and neighbors
- Involvement in minor traffic accidents
- Bruises, burns, fractures, especially if elder does not remember how or when they were acquired
- Changing in personal grooming or hygiene
- Empty alcohol containers hidden in garbage, closet, under bed

Assessment

- Interview in a nonthreatening, nonjudgmental way
 - Direct questions: examples
 - “Do you ever drink alcohol?”
 - “How much do you drink when you do drink?”
 - “Do you drink when you are lonely or upset?”
 - “Does drinking help you sleep better?”
 - “How do you feel when you have stopped drinking?”
 - “Have you ever felt you should cut down on your drinking?”

- “Have people annoyed you by criticizing your drinking?”
- “Have you ever felt bad or guilty about your drinking?”
- “Do you think drinking is interfering with your health other aspect of your life, safety?”
- “Does anyone else’s alcohol abuse impact on your safety?”
- Indirect questions; general topics
 - Medical or health problems
 - Regular visits to a doctor, switching doctors, multiple doctors
 - Recent negative or unwanted event that altered the way elder has lived
 - Feelings and management of change
 - Problem/use of prescription /over-the counter drugs
- Screening tools
 - Michigan Alcoholism Screening Test- Geriatric Version (Mast-G) – A “yes/no” questionnaire used to screen older adults for alcoholism. The original version contains 24 questions while a shorter version (S-MAST-G) contains 10 questions.
 - For an example of the long form, see <http://www.naatp.org/pdf/secad/05speakers/13MAST-G.pdf>
 - For an example of the short form, see <http://www.naatp.org/pdf/secad/05speakers/41AnewS HORTMAST-GOct%207-1.pdf>
 - CAGE Questionnaire – A four-question assessment instrument used to identify potential alcoholics. For more information including the specific questions and the scoring system, see https://www.premiera.com/stellent/groups/public/documents/pdfs/dynwat%3B4545_34101756_1688.pdf
- Know local substance abuse resources
- Refer for evaluation

Case Scenario

Mr. and Mrs. Q have been married for 50 years. Mr. Q had always been a heavy drinker, but his drinking increased when his wife became ill and more dependent on him. Mrs. Q. used to be able to deal with her husband’s drinking, but now she is in a wheelchair and can no longer drive to the store. She is a severe diabetic and must take insulin and use a special diet. Her husband spends his nights at the bar and his days sleeping off a hangover. When he is awake and at home, he is angry and verbally abusive. Mrs. Q. fears asking him to buy her medication and food.

Treatment

- Cognitive-behavioral approaches
- Group-based approaches
- Individual counseling
- Medical/psychiatric approaches

- Marital and family involvement/family therapy
- Case management/community based services and outreach

Conclusion

When dealing with older people with mental health issues, it is recommended to use a multidisciplinary approach. Interventions should be culturally sensitive and client-focused. Interagency collaboration and promoting understanding/ cooperation among agencies are of utmost importance. A complete workup should take into account the following:

Protective Services workers need to be familiar with the following agencies and their responsibilities/limitations. Establish a contact and develop a common referral form/process with:

- Community Mental Health Centers
- Crisis Intervention/Emergency Services
- Inpatient Psychiatric Services
- Area Agency on Aging
- Private consultants
- County Mental Health Programs (partial)
- Local Crime Watch Groups/Local Police
- Drug Task Force Members

To effectively address mental health issues in the older adult, a comprehensive assessment needs to be made. The following are components:

- Medical History and Physical Exam
- Laboratory tests
- Psychiatric Assessment
- Psychological testing
- Evaluation of functional abilities
- Social support evaluation: family, friends, available services

Self-Evaluation Quiz

Answer the following questions:

1. Infection, dehydration, and metabolic disorders can all be causes of reversible dementia.

T F

2. In early stage dementia, the individual has no apparent memory and little communication ability.

T F

3. The Folstein Mini Mental Test is used to assess reactive depression.

T F

4. Multiple medications can cause severe reactions and interactions in older adults.

T F

5. Delusions are not associated with dementia.

T F

6. When working with demented individuals, it is important to break down tasks into simple, one-step commands.

T F

7. When the onset of confusion is rapid, the client should be assessed for delirium.

T F

8. Hoarding behavior can be the result of a narcissistic personality.

T F

9. Substance abuse in older adults is often not recognized because the problem may be attributed to medical conditions.

T F

10. Direct confrontation is the best way to assess an older adult who is suspected of substance abuse.

T F

Review your answers with the answer key at the end of this section.

Transfer of Learning Activities

When you get to the office shadow a worker as he/she interviews a client with known and/or suspected MH issues.

- What signs did you observe: in client's behavior, in client's appearance, in the environment?
- What interview techniques were used to engage and/or assess the client's mental illness?
- Were any assessment tools used (Folstein Mini Mental, Geriatric Depression Scale, etc.)? If so, how were they administered? How did the client respond to being "tested?"
- What interventions did the worker try?
- What resources do you have in your county to address the mentally ill client? What type of substance abuse treatment for older adults exists in your county?

References

- Bender Dreher, B. (2001). *Communication skills for working with elders*. New York: Springer Publishing.
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- Smyer, M. & Bartels, S. (Eds). (2002, Spring). Mental health and mental illness in later life [Special Issue]. *Generations* 26.
- Substance Abuse & Mental Health Services Administration. (2000). *Substance abuse among older adults: A guide for treatment providers desk reference*.
- Thomas, N. D. (1997). Hoarding: eccentricity or pathology: When to intervene. *Journal of Gerontological Social Work*, 29, 45 –55.

Resources

Alzheimer's Association – www.alz.org
1- (800) 652-3370 Greater PA Chapter
1- (800) 272-3900 National

ADEAR – adear@alzheimers.org

Temple University
Institute on Protective Services

Basic Protective Services
Mental Health & Drug & Alcohol Issues

1-(800) 438-4380

Alcoholic Anonymous - <http://www.alcoholics-anonymous.org/>
Specific Area Contact Information: http://www.aa.org/en_find_meeting.cfm

County Drug & Alcohol Agencies
1-877-PA-HEALTH (1-877-724-3258)
Specific Area Contact Information for PA:
<http://www.dsf.health.state.pa.us/health/cwp/view.asp?a=173&q=199790>

<p style="text-align: center;">ANSWER KEY Mental Health and Drug & Alcohol Issues and the Older Adult</p>

1. Infection, dehydration, and metabolic disorders can all be causes of reversible dementia. **True**
2. In early stage dementia, the individual has no apparent memory and little communication ability. **False** (*This happens in late stage dementia*)
3. The Folstein Mini Mental Test is used to assess reactive depression. **False** (*The Folstein Mini Mental is used to assess dementia*)
4. Multiple medications can cause severe reactions and interactions in older adults. **True**
5. Delusions are not associated with dementia. **False** (*Delusions are a symptom of dementia*)
6. When working with demented individuals, it is important to break down tasks into simple, one-step commands. **True**
7. When the onset of confusion is rapid, the client should be assessed for delirium. **True**
8. Hoarding behavior can be the result of a narcissistic personality. **False** (*Hoarding behavior may be the result of obsessive-compulsive disorder*)
9. Substance abuse in older adults is often not recognized because the problem may be attributed to medical conditions. **True**
10. Direct confrontation is the best way to assess an older adult who is suspected of substance abuse. **False** (*Interviews with older suspected substance abusers should be non-judgmental and non-threatening.*)