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**Senior Mental Health****NAMI Education Meeting****Elizabeth D. Binckes, Supervisor Adult Services Intake, LCSW-C****Sybil Greenhut, Program Manager, Mental Health Services for Seniors and People with Disabilities****June 14, 2007**

Clinical depression affects 10% of the general population. Almost 20% of persons 55 and older experience specific mental disorders that are not a normal part of aging. Of the 33 million Americans 65 and older, 5 million suffer from serious, persistent symptoms of depression. On the other hand, 60-80% of older adults treated for depression respond to that treatment.

Symptoms of depression: (1) change in appetite, (2) change in sleep patten, (3) motor agitation or retardation, (4) fatigue or loss of energy, (5) feelings of worthlessness, self reproach or excessive guilt, (6), difficulty thinking or concentrating, and (7) recurrent thoughts of death or suicidal ideation.

With major depression, 5 or more symptoms are present; in minor depression, at least 2 are present, but fewer than 5.

Sometimes depression may be caused by understandable trauma, including ●loss of social status or job (or similar problems) ●loss of physical capacities, ●loss of home, ●bereavement, and ●isolation. Cognitive impairment and other physical disorders may also contribute. Less than one third of older adults who need treatment for depression actually receive it.

Older adults are more likely to report physical symptoms than psychological problems; this is due at least in part to stigma, fear, and shame. But few physicians screen for mental health disorders in older people because visits are often too short. Furthermore, diagnosis may be confused with co-occurring dementia and interactions with the many medications that older adults may take.

Some medicines contribute to depression, including ●anti-anxiety agents such as valium, Librium, Ativan, and Serax ●●analgesics, ●all narcotics, ●Naprosyn, and ●Motrin, ●anti-psychotics Thorazine, Haldol, Navane, Mellaril, and Prolixin, ●Sedatives and hypnotics, including Dalmane, Halcyon, Restoril, phenobarbital, and Seconal, ●antihypertensives like Aldomet, Inderal, Cataapres, Sinemet, and ●antiparkinsonian agents such as sinemet. Hormones also may change mood and behavior; these include ●estrogen, ●progesterone, and ●steroids like Prednisone, Medrol, and ACTH.

Alcohol and street drugs like marijuana, and cocaine also contribute to depression.

There are also serious risks for depressed people: the incidence of heart disease doubles.

Medical disorders can cause depression; these include ●neurological disorders, such as Parkinson's disease, and Multiple Sclerosis (about 10-27% of stoke survivors are clinically depressed), ●metabolic disorders such as electrolyte imbalance caused by kidney failure, ●COPD, ●malignancy (25% of persons with cancer have clinical depression), and ●endocrine disorders such as thyroid disease, adrenal or pituitary imbalance.

Suicide among seniors. White males have the highest suicide rate. According to the website "National Strategy for Suicide Prevention" the highest suicide rate of any age group is 65 and older. Risk Older adults have a higher prevalence of depression and are likely to be more socially isolated.

Medical professionals need to find out if an older patient has a history of suicide attempts. Have they made plans to kill themselves? Is the patient depressed and withdrawn? Does the person's cognitive ability vary? Is he or she taking medicines? Is someone available to stay with the person until their mood improves? Are there people the older adult can share emotional thoughts with? Is there evidence that the patient is not taking his/her prescribed medications? Is drinking a problem? (50% of suicides are alcohol-related.)

Sybil pointed out that in addition to depression, the most frequent issues for older adults are anxiety, cognitive loss, and substance use.

If an older adult drinks, there is a risk of their prescription medication interacting with alcohol. Due to slowed metabolism in seniors interactions have more time to occur and will resolve more slowly.

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Suggested drinking for older is as follows: (1) no more than one drink a day (5 ounces of wine, or 12 oz of beer, or 1.5 oz of liquor such as whiskey, gin, vodka, or 4 oz of liqueur) (2) maximum 2 drinks on any given occasion, (3) lower limits for women (one drink.)

The current statistic is that 14% of adults over the age of 65 meet the criteria for alcohol abuse/dependency. It is four times more common in men than women. Four in five admissions for substance abuse treatment among retired persons in a 2003 study reported alcohol as the primary substance of abuse.

Sybil Greenhut noted that alcoholism in seniors is underdiagnosed by Doctors. A study at Johns Hopkins Hospital reported that doctors accurately diagnosed alcohol abuse in only 37% of the elderly compared with 60% of the non elderly with alcoholism.

Other reasons for underdiagnosis of alcoholism in older adults is that the social isolation of many seniors reduces the likelihood that the older person will come into contact with those who might detect and refer them for treatment.

Older adults do not usually self identify or seek services for substance abuse. There is a stigma issue for the client and their family. Seniors can get intoxicated on much less alcohol than a younger person. Attitudes of family members can contribute also. An example of that would be saying that drinking is one of the few remaining pleasures of this aunt or uncle.

It is important to be able to recognize a drinking problem. Some of the symptoms of alcoholism are: drinking to calm nerves, loss of interest in food, gulping a drink fast, lying to try to hid the drinking habits, drinking alone, hurting oneself or someone else, while drinking, needing more and more alcohol to get high, feeling irritable when not drinking, having medical, social, or financial problems caused by drinking, and being drunk more than three or four times in a year.

Alcoholism in older adults can lead to the following conditions: hypertension, cardiac arrhythmia, and myocardial infraction, an increased risk of hemorrhagic stroke, cirrhosis of the liver, decreased bone density, gastrointestinal bleeding, depression, malnutrition, and sleep disturbances.

Over 75% of people over the age of 65 take a prescription medication. More than half of commonly prescribed medications have some sedating side effects. According to the handbook entitled "Mental Health in Later Life," age related changes in the body make seniors more vulnerable to the effects of alcohol, drugs, and medications. As people age, the body experiences changes that impact the absorption, processing and excretion of drugs and alcohol.

With the baby boomers approaching older age, there is a predicted increase in substance abuse. That is because of the willingness of baby boomers to take a wide range of drugs to deal with physical and mental health problems than previous generations. For example, in 2006, the typical age of a drug addict was in their mid-30's to mid'50's. In 1985 the age of the typical drug addict was 32. In 1970 it was 22!

Sybil Greenhut also spoke about the warning signs of Alzheimer's disease, the causes of delirium, and the differences between dementia and delirium.

The ten warning signs of Alzheimer's are (1) recent memory loss, (2) difficulty performing familiar tasks, (3) problems with language, (4) disorientation of time and place, (5) poor or weaker judgment, (6) misplacing things, (7) cages in mood or behavior, (8) personality changes, (9) problems with abstract thinking, and (10) loss in initiative.

The causes of delirium are physiological. They are due to infection, fever, dehydration, or medications.

There are differences between dementia and delirium. Dementia can last for months or years. It is stable over the course of the day. In contrast to that, delirium has an acute onset, often at night. It can last hours, days or weeks. Delirium fluctuates with periods of clarity.

Elizabeth spoke about aging and disability services in Montgomery County, Maryland. An invaluable number to remember is 240-777-3000. That is the office of Aging and Disability Services. The office hours are 8:30 a.m. until 5:00 p.m. After those hours, the phone line automatically goes over to the crisis center. This is therefore is a 24 hour phone line.

The goal of the Aging and Disability Services is to assist individual to live safely in the community in the least restrictive setting. There are four different agencies with Aging and Disability Services. They are information and assistance unit, case management, adult protective services and public guardianship.

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The information and assistance unit provides disability outreach, Hispanic senior outreach, and assists family caregivers.

Case management is involved with adult foster care, senior care needs such as assistive devices, home care services, adult public guardianship, and a medical assistance waiver program. There is currently a waiting list of 280 older adults for those services in Montgomery County.

Adult protective services is the only program at Health and Human services that is state mandated. This agency deals with senior abuse, neglect, and financial exploitation of a vulnerable. Elizabeth Binckes stressed that a vulnerable adult is someone who is not able to participate in a plan of care or remove themselves from a dangerous situation. It is important to remember that someone is not vulnerable just because they are a senior citizen or have a mental illness. For example, Ted Turner, who is a senior citizen, would Not be considered vulnerable. One would also not consider Mike Wallace who has depression as vulnerable.

If a claim of abuse is filed with adult protective services, an investigator must come out within 5 days. The investigation of abuse will be completed in 30 days.

Elizabeth Binckes also spoke about guardianship and guardianship alternatives.

Guardianship is the legal authority to act as a substitute decision maker for another person and manage his/her affairs. The adult “lacks the capacity” to communicate and make informed decisions. The terms “lacks capacity” means that the individual does not understand a proposed procedure, is unable to understand the risks and benefits of that procedure or unable to understand the risks and benefits of an available alternative.

To obtain guardianship one must have 2 certificates that state the individual lacks capacity. The person must be adjudicated to be incompetent by a judge. Guardianship is enforceable.

Elizabeth Binckes pointed out that with guardianship you are not responsible for the “behavior” of the individual. For example, if that person rings up a big credit card it would be their responsibility to pay it.

Guardianship is a last resort. It results in the removal of legal rights and the individual’s ability to make his/her decisions. Guardianship should be initiated only after other less restrictive alternatives have been evaluated and determined not appropriate to meet the needs of the individual.

The alternatives to guardianship are power of attorney, representative payee, conservatorship, and advance directives.

A senior citizen must have their full mental capacity at the time that Durable power of attorney is executed. A DPA (durable power of attorney) for health care names the attorney and identifies the treatment the person desires. The DPA of finances names the attorney to handle the finances.

A representative payee is a person appointed to manage state benefits, federal benefits, or entitlement program payments on behalf of the person to make sure the individual’s needs are met.

In a conservatorship a person appointed by the court to manage the estate for an individual incapable of taking care of his/her affairs.

With an advance directive the adult gives written instructions which guide care when that individual is terminally ill or incapacitated and unable to communicate his/her wishes.

An alternative to full guardianship is temporary guardianship. That is useful for cases of severe illness or injuries where long term effects are not yet known. Temporary guardianship is limited to 3 months but may be extended for another 3 months. After that time, other guardianship options must be explored.

There are 4 types of guardianship: (1) guardianship of property, (2) guardianship of person, (3) temporary guardianship, and (4) permanent guardianship.

In the Handbook “Mental Health in Later life” there are several resources listed for senior citizens. They are:

1. Health Facilities Association of Maryland (HFAM) This organization offers information on nursing home care and assisted living options as well as information on services, fees, and guidance for finding a facility that best matches a person’s needs. Their number is 410-792-4390 or 310-490-8413. Web site: [www.hfam.org](http://www.hfam.org).

2. Maryland Association of Adult Day Services, Inc. (MAADS). MAADS assists in finding day programs for seniors with functional or cognitive impairments. Their number is 800-725-1300. Web site: [www.maads.org](http://www.maads.org)
3. Maryland National Capital HomeCare Association (MNCHA). This organization provides information on home care options. Website: [www.mncha.org](http://www.mncha.org); phone, 877-316-4157 or 301-473-9802.
4. Office of Health Care Quality (OHCQ). This organization exists to protect the health and safety of Maryland's citizens in health care settings. Phone: 1-877-402-8218 or 410-402-8000; web site: [www.dhmf.state.md.us/ohcq](http://www.dhmf.state.md.us/ohcq)
5. The alcoholism and Addictions Resource Guide. This organization includes directories for treatment centers and alternatives to 12 Step (AA) programs. Web site is [www.soberrecovery.com](http://www.soberrecovery.com)
6. The Geriatric Mental Health Foundation (AAGP). This office provides additional information and resources for patients and caregivers as well as a geriatric psychiatrist locator. Their number is 301-654-7850. Their website is [www.gmhfonline.org](http://www.gmhfonline.org)

Notes taken by Rochelle Banta

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